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Navtej K. Sandhu
Georgia State University, nsandhu84@yahoo.com

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EXPLORING THE INFLUENCE OF FUNCTIONAL STATUS ON OLDER ADULTS' SOCIAL RELATIONSHIPS IN ASSISTED LIVING COMMUNITIES

by

NAVTEJ SANDHU

Under the Direction of Candace Kemp

ABSTRACT

Social relationships can have considerable influence on physical and mental well-being. AL research suggests that other residents are among the most available social contacts and that co-resident relationships can affect life satisfaction, quality of life, and well-being. Although functional status influences social relationships, research has yet to provide an in-depth understanding of how cognitive and physical function affects co-resident relationships in AL. In this thesis, I present an analysis of qualitative data collected over a one-year period in two diverse settings. The thesis addressed: 1) How does functional status influence co-resident relationships? ; and 2) What factors shape its influence? Analysis was guided by principles of Grounded Theory Method. Coming together and pulling apart signifies the key finding that functional status is multi-directional, fluid, and operates in different ways in various situations and across time. Facility and resident –level factors further affect the influence of functional status on co-resident relationships.

INDEX WORDS: Functional status, Social relationships, Assisted living

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NAVTEJ SANDHU

A Thesis Submitted in Partial Fulfillment of the Requirements for the Degree of

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in the College of Arts and Sciences

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NAVTEJ SANDHU

Committee Chair: Candace Kemp

Committee: Mary Ball

Elisabeth Burgess

Electronic Version Approved:

Office of Graduate Studies

College of Arts and Sciences

Georgia State University

August 2012

DEDICATION

This Thesis is dedicated to my brother, my parents, my husband, and my in- laws who supported me in each and every possible way throughout my Masters' degree.

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CHAPTER ONE

INTRODUCTION

Statement of the problem

The population of older adults in United States is aging very rapidly, and it is expected that by 2030 the population of people above the age of 65 will rise to 70 million from the total of 40,267, 984 as measured in 2010 (Hooyman & Kiyak, 2002; U.S. Census, 2010). With the changing aging trends, the health of aging people is also changing in comparison to previous cohorts. The present cohorts are said to be healthier than the previous ones (Crimmins et al., 2009; Hooyman & Kiyak, 2002). As life expectancy is increasing, the chances of becoming disabled are decreasing and also are being delayed, but not eliminated.

The aging of the population and increasing life expectancy means increasing numbers of individuals with functional limitations. People aged 65 years and above are more inclined to develop functional disability (Lewis & Bottomley, 2008). According to the Profile of Older Americans (2010), in the year 2009, 37% of those 65 and over reported having some type of disability. There are various age related disorders that influences the life of older adults by making them functionally impaired. Hypertension, arthritic symptoms, coronary heart disease, diabetes, cancer, and stroke are highly prevalent in the population of older adults (Lewis & Bottomley, 2008). Apart from these conditions, there are other age-related conditions seen in older adults that make them functionally impaired, including hearing and visual impairments, Parkinson's disease, pulmonary disorders like Pneumonia and Chronic obstructive lung disease, osteoporosis and hip fractures, Alzheimer's disease, dementias, swallowing disorders, renal failure, and incontinence (Lewis & Bottomley, 2008). Assistive devices like canes, wheelchairs, higher commodes, indwelling catheters, and bath chairs can be used to compensate for impairments in terms of performing activities of daily living (ADLs) (e.g., bathing, toileting, transfers, and indoor mobility). For cer-

tain ADLs, like eating and dressing, assistive devices are not yet well developed or highly accepted (Albert, 2004).

When people with disabilities reach the point when they are unable to carry out ADLs and/or live independently, they sometimes require and draw on formal long term care (LTC) services, including residential care. Assisted living (AL) is a LTC setting that caters mainly to older adults who can no longer live independently in their own home; it provides watchful oversight, assistance with ADLs, and certain instrumental activities of daily living (IADLs) (e.g., medication management, meal preparation, and household cleaning) (Ball et al., 2000; Burdick et al., 2005). In the United States, nearly one million individuals reside in AL settings and the number is expected to grow in the coming years (Golant, 2008). The typical AL resident is a woman, 86 years old, who requires assistance in approximately two ADLs (National Center on AL, 2011), and very few have a partner or spouse (Kemp, 2008). Estimates of the prevalence of Alzheimer's disease and other types of dementia among AL residents range from 50% (Ball et al., 2010) to nearly 68% (Leroi et al., 2006). According to Roadman (2001), the prevalence of medical conditions found in AL residents in descending order is: bladder incontinence, heart disease, bowel incontinence, osteoporosis, diabetes, stroke, Parkinson's disease, cancer, multiple sclerosis, and pressure ulcers.

Many elders relocate to AL because they are functionally impaired, but some relocate to reduce social isolation (Ball, Perkins, Whittington, Hollingsworth, King, & Combs, 2005). When older adults move to AL, many maintain pre-existing social relationships with family, friends, and neighbors (Yamaski & Sharf, 2011), and some form new, sometimes meaningful, relationships with others (Ball et al., 2005). Generally, residents have three main types of social relationships, including those with: (a) friends and family outside AL; (b) co-residents; and (c) paid caregivers (Ball et al., 2000; Burge & Street, 2010). Family connections are very important for residents but, for the majority, family members are not available daily (Ball et al., 2000; 2005). Relationships with staff also carry importance (Ball et al., 2005; 2009), but quite often staff members do not have adequate time to socialize with residents beyond their care-related interactions (Ball et al., 2009; Kemp, Ball, Hollingsworth, & Lepore, 2010). Residents' rela-

tionships with other residents in AL can be of considerable importance in their lives and are predictors of life satisfaction (Park, 2009) and quality of life (Ball et al., 2000; 2005).

Research on co-resident relationships in AL is limited somewhat, but recent qualitative research by Kemp, Ball, Perkins, & Hollingsworth (2012) indicates that co-resident relationships in AL can range from strangers to friends and include enemies and romantic type relationships with each resident experiencing unique social careers (i.e. their combined set of co-resident relationships and social trajectory in AL). Kemp and colleagues (2012) identified a number of multi-level factors influencing co-resident relationships, including facility location and community connections, staff training and knowledge of residents, and resident tenure, gender, marital status and family involvement. Cognitive and physical function is also known to significantly affect social relationships (Iechovich & Ran, 2006). Kemp et al.'s (2012) analysis confirmed that residents' functional status is one of the major individual-level factors influencing social relationships in AL. Functional impairment acted as a double-edged sword. It created interactions by means of help given to those with greater impairment from comparatively less impaired residents, but it also hindered interactions and therefore relationships because of frequent medical appointments, pain, incontinence, decreased mobility, speech and hearing impairments, depression, dementia, and other communication barriers. Other researchers note that stigma often is attached to physical and cognitive impairments in AL, which further impedes relationships among residents of varying functional abilities (Dobbs et al., 2008; Perkins, Ball, Whittington, & Hollingsworth, 2012).

Existing findings highlight the importance of co-resident relationships in AL and hint at the complex influence of cognitive and functional status on social relationships. To date, however, research has not provided an in-depth understanding of how functional status affects co-resident social connections or the factors that shape the ways functional ability influences co-resident social relationships and interactions in AL. This research builds upon and expands existing work during a time when AL is growing in popularity and as residents increasingly are older, frailer, and closer resemble nursing home residents of

the past (Polivka, 2008). These patterns are expected to continue and heighten the importance of understanding how cognitive and physical function affects social relationships in this frail population of elders.

Research aims

The purpose of the proposed research is to explore the influence of physical and mental function on residents' social experiences in AL with a focus on co-resident relationships. More specifically, my aims are as follows:

Aim 1: To understand how functional status influences co-resident interactions and relationships; and

Aim 2: To identify the factors that shape how functional status affects social interactions and relationships.

CHAPTER TWO

LITERATURE REVIEW

In this chapter, I review existing literature and establish the research context. This chapter is divided into several subparts. I begin by reviewing literature related to functional status, disability and aging, formal LTC settings among disabled people, social relationships in later life and the interaction of social relationship with health. Then, I discuss, social relationships in AL, factors influencing social relationships in AL, and functional status and its impact on social relationships in AL. I conclude by articulating my research aims and questions.

Functional status, disability, and aging

In Chapter 1, I noted that the population is rapidly aging and that the life expectancy is also increasing. Given the connection between likelihood of disability and age, this situation means increasing number of people with functional limitations. Statistics shows that 65% of the elderly above the age of 65 have difficulty in performing at least one of the ADLs (Vierck & Hodges, 2003, p. 50). This type of impairment rises with age, with 59 % of people aged 65 to75 years and 74% of those aged 75 and over reporting difficulties, respectively (Vierck & Hodges, 2003, p. 50). An individual's "functional status" (George, 1996) is a key factor influencing how people live their lives and interact with others. This term relates to the ability to perform ADLs, which are necessary for self-care and living independently (George, 1996). According to the World Health Organization (2011), "disability" is a general term which further includes three things: impairments, activity limitations, and participation restrictions. Impairment could be further defined as a problem in function and structure of the body; an activity limitation is a difficulty encountered by an individual in doing activities; while a participation restriction is a problem experienced by an individual in involvement in life situations. Verbrugge & Jette (1994, p. 1) define disability as "difficulty doing activities in any domain of life (from hygiene to hobbies, errands to sleep) due to a health or physical problem." Disability in older adults is usually determined by their ability to perform

ADLs and IADLs (Christensen, Doblhammer, Rau, & Vaupel, 2009; Crimmins et al., 2009). However, it is still ambiguous and subjective when trying to quantify disability according to difficulty experienced by individual in performing ADLs and IADLs (Berlau, Corrada, & Kawas, 2009).

Disability type

Cognitive disability is defined as, "significant limitation in thought processing, like conceptualizing, planning, and sequencing thoughts and actions, remembering, interpreting subtle social cues, and understanding numbers and symbols", and can result from all types of dementias, brain injury, stroke and some mental illnesses (Braddock, Rizzolo, Thompson, & Bell, 2004, p.49). Physical disability is defined as "a condition where a person experiences significant deviation or loss in their body function or structure that results in physical limitations in their physical activity that may affect their participation in life, depending on the context within which they live" (Taleporos & McCabe, 2005, p.638).

Both cognitive and physical disabilities can lead to functional disability, which occurs when there are problems performing ADLs and IADLs and is associated with changes related to aging (Dunne, Wrosch, & Miller, 2011). Chronic illness of any type, like hypertension, heart diseases, diabetes, cancer, stroke, arthritis, lung diseases and neurological problems, leads to impairment, which further causes disability (Hung, Ross, Boockvar, & Siu, 2011). Women have higher life expectancy than men, which in part increases their chances of being susceptible to a variety of chronic illnesses (Moody, 2010). Suffering from chronic illness in old age contributes to functional disability (Robb, Small & Haley, 2008) and likely is one reason why older women experience more disabilities and have a greater chance of suffering from functional limitations than men (Freedman, Grafova, Schoeni, & Rogowski, 2008). The recent trend in the United States shows that the prevalence of chronic diseases has increased over time but the prevalence of impairments, except urinary incontinence, and disabilities have been stable over time. So despite the increase in the prevalence of chronic illnesses, the prevalence rate of impairments and disabilities has remained stable over time (Hung, Ross, Boockvar, & Siu, 2011). According to report, the State of Aging and Health in America (SAHA) (2007), among the chronic illnesses in older adults of the age 65 and

above, the order of prevalence from highest to lowest is hypertension, arthritic symptoms, coronary heart disease, cancer of any type, diabetes and stroke. Disease rates vary by gender, race and ethnicity.

Hypertension. Hypertension affects 46 % of older adults (Vierck & Hodges, 2003, 129). It is also a risk factor of heart disease and cerebrovascular disease among older people. The prevalence of hypertension varies among older people on the basis of age, race and gender (Vierck & Hodges, 2003, 129). It occurs most commonly among older adults above the age of 65, blacks, and women. In the year 2000-2001, 65% of Black elders had hypertension in comparison to 49% Hispanics and 47% Whites (SAHA, 2007). Medication and lifestyle changes constitute common treatments for hypertension (Lewis & Bottomley, 2008).

Arthritic symptoms. Arthritic symptoms (i.e. pain and stiffness) are seen among 46 % of the elderly population (Vierck & Hodges, 2003, p. 134). They are more prevalent among older adults, compared to younger adults, women, and non-Hispanics (Vierck & Hodges, 2003, p. 134.) Pain medication and use of assistive devices can enhance the quality of life among arthritis sufferers (Lewis & Bottomley, 2008).

Coronary heart disease. Coronary heart disease, including angina and heart attack, is seen in 21% of older adults (Vierck & Hodges, 2003, p. 134). It is most prevalent among older adults in comparison to younger people, men compared to women, and non-Hispanic whites compared to Hispanics (Vierck & Hodges, 2003, p. 134).

Cancer. Cancer of any type, including breast, prostrate, lung, and colorectal is common among older adults, and every year 59% of the reported cases of cancer are seen in older adults (Vierck & Hodges, 2003, p. 140). Men are 1.7 times more prone to develop cancer than women (Vierck & Hodges, 2003, p. 140). On the basis of race, white women are more prone to develop cancer than black women and men (Vierck & Hodges, 2003, p. 140). After the age of 85, white women are more prone to develop cancer than the white men (Vierck & Hodges, 2003, p. 140). Statistics shows that 22% of Whites had some form of cancer in comparison to 10% Hispanics and Blacks (SAHA, 2007).

Diabetes. Diabetes is seen in 1 out of 10 older adults and is also more common among elders than the younger counterparts (Vierck & Hodges, 2003, p. 138). On the basis of race, it is more prevalent among non-Hispanic blacks. Hispanics have two times more chances of developing diabetes than the non-Hispanic whites (Vierck & Hodges, 2003, p. 138). Statistics shows Diabetes affects 25% of Hispanic elders followed by 23% of Black and 14% of White elders (SAHA, 2007).

Stroke. There are 250,000 to 300, 000 reported cases of stroke annually. Stroke mostly occurs in later life, and 43% of the reported cases are in individuals age 74 and above (Lewis & Bottomley, 2008, p. 292) and more common among men (Lewis & Bottomley, 2008, p. 292). Race-wise, stroke is more prevalent in Blacks and Japanese Americans and geographically it is more prevalent in the southern United States (Lewis & Bottomley, 2008, p. 292). Stroke causes significant impairments and 40 % of stroke patients report limitations in activities (Lewis & Bottomley, 2008, p. 292).

Apart from the above mentioned chronic conditions, hearing and vision impairments, Parkinson's disease, pulmonary disorders like pneumonia and chronic obstructive lung disease, osteoporosis, Alzheimer's disease, dementias, swallowing disorders like dysphagia, renal failure, and incontinence also are common among older adults (Vierck & Hodges, 2003). According to the Alzheimer's Association (2011), Alzheimer's disease is highly prevalent among those 65 and over. In the United States alone, 5.2 million people have the disease. Meanwhile, according to the American-Speech Language Association (2006), there are over 31.5 million Americans suffering from some type of hearing loss and it is more prevalent in men than women.

According to the Profile of Older Americans (AoA, 2010), 37% of older people reported having some type of disability in 2009. There are 18.1 million people aged 65 or over who are disabled in the United States (Brault, 2008). However, Berlau and colleagues (2009) report that the 90 and over age group is one of the most rapidly increasing sections of the population in United States; occurrences of disability are very high among this age group and are projected to increase.

In sum, the prevalence of disability increases with age. Disability in later life is common and can cause problems for individuals and those who support them. Having a disability can compromise older adults' independence, lead to relocation to formal LTC settings, and ultimately can affect their social relationships.

Older adults' experiences with disability

The ways older adults perceive and hence experience their disability varies. According to a study conducted by Moore, Schumacher, Kahana and Kahana (2006), older adults often perceive their disabilities even with the same health status. The results from this study show that some older adults consider themselves disabled and some do not. The way participants perceived their disability depends on many factors, including social, physical, and personal influences. Visiting health care professionals, cessation of driving, suffering from poor health because of chronic illnesses, functional and cognitive impairments, significant decline in functional status over time, and anxiety about health are factors that define the older adult's perceptions of his or her own disability. Some older adults in Moore et al's study perceived themselves as disabled even if they were not functionally impaired. Their experience of suffering from multiple illnesses led to frequent doctors' visits, greater numbers of medications, and somatic complaints, which contributed to self-perceived disability. However, other older adults were less inclined to perceive themselves as disabled even if they had functional limitations because they had greater social support. The idea of perceiving oneself as disabled has further implications in one's proclivity towards using assistive devices, seeking health care, and engaging in safe practices. Presumably, such self-perceptions also influence attitudes towards receiving assistance from others, including relocation to LTC settings, as well as attitudes towards others in the setting.

Formal residential care settings for disabled older adults

Formal LTC is one option for people with disabilities when they reach to the point when they are unable to carry out ADLs/ IADLs and/or live independently. Formal LTC can be provided at age congregated settings and at home also. Most older adults prefer to live in their own homes, but some lack other

options such as family care or move because in-home services are either too expensive or unavailable (Doherty & Kevin, 2002). Keysor, Desai and Mutran (1999) found that people with long-term disabilities chose LTC settings as opposed to staying home because they did not want to ask for help repeatedly from their social network.

Nursing homes and AL residences are two common residential LTC settings in the United States. Nursing homes have existed since the 19th century (Brandy, Gillespie, Liese, & Farley, 2004). In recent decades, AL has emerged as an alternative and is growing in popularity. Although there are new movements afoot, nursing homes are based generally on a medical model, provide skilled care, and usually bear some resemblance to hospitals (Brandy, Gillespie, Liese, & Farley, 2004). Individuals often are shifted to nursing homes after hospitalization as they still require 24-hour watchful oversight and skilled care.

Ideally, and in contrast, AL is based on a social model of care with home-like environments (Brandy et al., 2004). While there is 24-hour oversight, the assistance given is non-medical and help is provided with performing ADLs and certain IADLs (Ball et al., 2000). Typically, AL includes various types of congregate settings that differ from each other in terms of size, service provision, regulation standards, funding, and characteristics of residents (Polivka, 2008). Most states have different names and regulations, but AL typically refers to congregate settings that provide 24-hour watchful oversight, meals, and social activities, some kind of health care and housing (Polivka, 2008). According to AL regulations and licensing (2012), in the state of Georgia, the number of residents per bedroom is limited to 4, and individuals requiring 24-hour nursing care typically are not admitted as residents. In most of the AL settings in the United States, there are apartments or private rooms offered to residents, common dining areas and places for social activities (Polivka, 2008). Polivka (2008, p. 29) summed up AL patterns nationwide noting:

> Although AL settings range considerably in size, presently two-thirds of AL residents live in settings with more than 50 beds, 55% of AL settings are free- standing and re-

maining are attached with other types of settings like nursing homes, rehabilitation centers, board and care homes, independent living apartments and continuing care retirement communities. About half of the AL settings are non- profit, and about half are for-profit; very few are government run.

The cost of AL means that it is not accessible to many older adults. Base monthly fees in AL settings can range from $ 1, 980- $4,700, with fees varying according to the geographic location, type of accommodation, (i.e., private or shared), and number and type of services provided (Polivka, 2008).

As AL is based on a social model of care, according to Brandy and colleagues (2004), residents tend to perceive their quality of life in these settings more positively than in nursing homes in terms of their satisfaction with the environment and care staff, and they tend to have less depression and more control over their decisions related to their daily activities, care, and assistance. AL regulations regarding the provision of autonomy, privacy, dignity and freedom of making choices can increase the quality of life of the residents (Polivka, 2008). Generally, how residents perceive their quality of life in AL appears to depend on various factors. For instance, the acceptance of state payments for low income residents by AL, strong social relationships within the facility and more privacy tends to promote positive perception of life (Street, Burge, Quadagno, & Barrett, 2007). In sum, AL is a LTC option that provides care, and, in theory, helps residents maintain independence and autonomy and also provides a home-like environment (Street et al., 2007), as well as opportunities for social relationships (Ball et al., 2005).

Social relationships

Social relationships can be defined as the recurrent patterns of interactions with others which are dynamic in nature and can change over the life course (Antonucci, 1990). Social relation is an umbrella term which further includes the terms social support, social networks, and social integration (Antonucci, 1990). Social support refers to, “the provision or receipt of something perceived to be needed by the provider, the recipient or both” (Antonucci, Birditt, & Akiyama, 2009, p. 248). Social networks are “the vehicles through which social support is distributed or exchanged” (Antonucci, 1985, p. 96). Social integra-

tion is defined as “the degree to which individuals have formal attachments to social structure” (George, 1996, p. 231). The social make-up of one’s network typically is dependent on personal factors, including for example, gender, race, socioeconomic status, and age (Antonucci, 1985).

Research suggests that women have generally larger network than men and they receive more social support from others (Antonucci & Akiyama, 1987). Gender interacts with marital status as married men mostly receive support from their wives (Antonucci & Akiyama, 1987). Research on racial differences suggests that no racial differences exist in network proximity (i.e., the geographic proximity of members), but African Americans tend to have smaller networks formed of their families with more contact frequency (Ajrouch, Blandon, & Antonucci, 2005). If we take socioeconomic status into account, people of lower socioeconomic status have smaller networks compared to people of higher socioeconomic status (Antonucci, 1985).

In terms of age, it is generally said that social network size decreases with advancing age (Aldwin & Gilmer, 2004). Taking age into account, compared to younger adults, the networks of older people typically are smaller and made up mostly of family members (Ajrouch, Antonucci, & Janevic, 2001) and, to a lesser extent, peer group members (Antonucci, Birditt, & Akiyama, 2009). Relationships with family and peer group members carry different meanings in the lives of older people (Antonucci, 1990). Generally, family members often are more dominant in elders’ social networks but older adults usually prefer friends for support (Antonucci, 1990). Older adults prefer to take support from their friends rather than their family members because they feel less self-competent when they rely for support on their family members (Siebert & Mutran, 1999). Friends tend to have a more positive effect on well-being than the family (Antonucci, 1990), which makes understanding peer relationships, particularly in later life, important.

Social relationships, health, and aging

Social relationships are considered very important in late life because of their impact on the health and well-being of older adults (Park, 2008; Luger et al., 2008). Social engagement (i.e. interacting

and making emotional connections with people) tends to have many positive effects on health, including decreased rates of mortality, higher levels of happiness and quality of life, reduction in the rate of functional decline, reduced depression, and lower chances of suffering from cognitive impairment (Park, 2008; Luger et al., 2008). The association between social relationships and health has been theorized using the "convoy model of social relations" (Kahn 1979; Antonucci, 1985; Antonucci, Birditt, & Akiyama, 2009). According to the convoy model, social relationships involve three major components: (1) social networks; (2) social support; and (3) satisfaction with support. The social network is the backbone of social relationships which further provides the basis for assessing these relationships subjectively in terms of perceptions and interpretations of support. Social support and satisfaction with support are the subjective aspects of social relationships.

Social relationships promote health by buffering stress and by promoting self-efficacy (Antonucci, Birditt, & Akiyama, 2009). Social network composition and social support influence individual health and well-being (Antonucci, Fuhrer, & Dartigues, 1997). A person's network type[i], which is determined by the configuration of network members and the distribution of family and friends, has an influence on their health, with those having restricted non-friends network types being associated with high depressive symptomatology, while diverse network types are associated with low depressive symptomatology (Fiori, Antonucci, & Cortina, 2006; Fiori, Antonucci, & Akiyama, 2008). Social support[ii] has such a remarkable influence that even anticipated social support can reduce the risk of functional disabilities (Shaw & Janevic, 2004). This connection might be related to decreased depression in the presence of anticipated social support or the sense of self efficacy in performing activities that further enhances functioning (Shaw & Janevic, 2004).

Social relationships can further influence the chances of developing or recovering from a disability (Leon, Glass, Beckett, Seeman, Evans, & Berkman, 1999). Leon and colleagues (1999) investigated the influence of social ties on individual capability of developing disability and recovering from disability.[iii]The outcome of this study suggests that having widespread social ties can have useful effects on de-

veloping and recovering from disability. They also found that while social support in terms of emotional and instrumental support may help out in the recovery from disability, it has less effect on developing disability.

If different relationships in older adults' social networks are considered, networks with friends tend to have more protective effects on disability than family relationships (Leon et al., 2001). The relationship between social ties and prevalence of disease or disability can be influenced by physiological mechanisms like immunological responses showing decrease in cellular immunity and higher neuroendocrine and cardiac activities (Seeman, 1996). Similar results were found in terms extensive social relationships and their effect on disability development in the study of Avlund, Lund, Holstein and Due (2004), who further studied the effect of gender and age on developing disability. It was found that men aged 80 years were more likely to show functional decline in the presence of social support, but this finding was not applicable to women. The authors explained the gender differences in this aspect by assuming that those receiving social support in case of men were not as functionally able as those who were not receiving social support. It was also found that social participation has an inverse relationship with functional decline. So overall there is a lower probability of developing disability and more probability of recovery from disability if older adults are embedded in social networks.

The contribution of social relationships in developing a disability is also influenced by the valence of social exchanges (Mavandadi, Rook, & Newsom, 2007). Positive social exchanges are associated with a lower chance of developing disability and vice versa (Mavandadi et al., 2007). On the other hand, negative exchanges between individuals are associated with a greater chance of developing disability (Mavandadi et al., 2007). Further research suggests that a negative element in relationships is seen in majority of the relationships, particularly in close relationships (Antonucci et al., 2009). This is referred to as, "ambivalence in close relationships", where people have both positive and negative aspects attached to their close relationships (Antonucci et al., 2009).

Social isolation or loneliness represents the opposite form of social engagement, where a person is emotionally and physically disconnected from others, their surrounding community, and society, more generally (Park, 2008). Loneliness can exist in integrated and non-integrated social networks. Loneliness further leads to depression and poor wellbeing, which can further affect the health of an individual (Golden, Conroy, Bruce, Denihan, Greene, Kirby, & Lawlor, 2009).[iv] Loneliness can be influenced by social opportunities, which in turn are influenced in part by one's living arrangements.

Social Relationships in AL

AL research finds that the need for assistance is the most common reason elders relocate to these residential care settings; some move to overcome isolation and to be around other people. Ball and colleagues' (2000) qualitative study of 17 AL settings involved three counties of suburban-Atlanta. The AL settings ranged in size from small with the capacity of two residents to large with the capacity of 75 residents. Data were collected using structured face-to-face interviews and observations of 55 randomly selected residents from the 17 AL with the ability to participate as directed by providers. Reflecting the general AL population, the sample composition mainly women aged 65 and above, white and college-educated. Participants had a mean facility tenure length of slightly more than a year. The authors described three types of relationships in these settings: (a) Relationships with friends and family outside the AL; (b) with co-residents; and (c) with the caregiving staff. For many of the interviewees, when they felt they were not getting proper attention from friends and family outside the facility then they would compensate by making friendships with co- residents and staff. Some participants even reported forming family-like relationships with the AL staff, particularly caregivers. According to this study, some true friendships developed among AL residents.

Given the relative availability of other residents, co-resident relationships represent important opportunities for social connections in AL. More recent research in AL finds that co-resident relationships can vary from strangers to friends and also involve enemy and romantic type of relationships (Kemp et al., 2012). Kemp and colleagues (2012) analyzed data collected in three AL sites, which differ from each

other in terms of size, location, ownership, and residents' profiles and identified neighboring and anti-neighboring as two primary ways of interacting between AL residents. They found that in neighboring type of interactions, residents greet and discuss various topics with each other. Many engaged in sharing behaviors (e.g. food, books, etc.) and displayed concern for especially frail residents. Many also engaged in helping behaviors, including assisting with eating, reminding about activities and meals, pushing wheelchairs, giving directions, and also supporting dietary preferences and needs. Residents with friendly, romantic or family connections also sometimes visited each other in their rooms. Overall, neighboring interactions can vary from joking, gossiping and teasing to flirting. Alternatively, anti-neighboring interactions were not friendly. Residents engaged in anti-neighboring by, "bullying, name calling, intolerance, gossiping, shunning, harassing, disagreements, and physical confrontations" (Kemp et al., 2012, p.13) during meals, informal gatherings and while involved in activities.

Co-resident social relationships can influence residents' health, well-being, and life satisfaction (Park, 2008). Park (2008), for example, studied 82 residents across eight AL communities in Alabama. Through surveys conducted face-to-face interviews, Park found that having meaningful and friendly relationships with one's co-residents and the AL staff promoted feelings of life satisfaction and also reduced depressive symptoms. In this study, mealtimes were identified as important in helping to reduce residents' depressive symptoms. Meanwhile, Street and colleagues (2007) examined the importance of social relationships to residents' well-being in AL. The data for this study were taken from the Florida Study of Assisted Living and includes a sample of 384 cognitively-intact residents aged 65 years and over. In this study, relationships formed within AL were the main predictors of resident well-being. External friendships with families and friends outside the facility did not have significant effect on the measures of well-being. Good relationships with the staff and co-residents showed more positive effects on person's well-being. One possible reason for the absence of effect of external friendships on residents' well-being was related to the life situation of the residents prior to moving to AL. Many participants had been living alone and had no significant contact with their families. Moreover the sample for this study is from Flori-

da, which is a hub for retirees. It was, therefore, suggested as a possibility that the participants were already living away from their families after migrating to this state.

A similar study investigating the predictors of psychological well-being of AL residents was conducted by Cummings (2002) in a single AL and included 57 residents. Questionnaires were administered to participants using face-to-face interviews. Depression was common and highly related to participants' degree of functional impairment and difficulty performing ADLs. Social support of any kind appeared to be a powerful predictor of enhanced psychological well-being. Participating in social activities arranged by the AL also has been shown to decrease depression in residents (Mitchell & Kemp, 2000). However, residents' psychological well-being is not solely dependent on the number of social activities, but also on the quality of relationships they have with other residents and staff (Cummings, 2002; Cummings & Cockerham, 2004). Overall, it is clear that quality social relationships can develop within AL and can play a great role in influencing residents' psychological well-being. Moreover, there are a number of factors that influence residents' relationships, their functional status, and the relationship between the two.

Factors influencing social relationships in AL

There are various factors that can influence the social interactions of AL residents. These factors operate at different levels, including societal, facility, and individual levels (Kemp et al., 2012). At the societal or community level, factors can include, for example, federal and state regulations. Kemp and colleagues (2012) found for example, that the Health Insurance Portability and Accountability Act (HIPAA) influenced social relationships of the residents. According to HIPAA, the privacy of the residents living in the communal settings has to be protected. So, as a means of protecting privacy, residents often are unable to learn about the health and well-being of co-residents who are sick or have relocated. Location of the facility also was influential as the involvement of community members, particularly religious institutions, enhanced co-resident interactions and relationships.

There are various facility-level factors that can influence the social relationships of the residents. These include the size of the facility, physical and social environment, policies and practices, staff educa-

tion, and knowledge and activity programming (Kemp et al., 2012). Ball et al's (2005) AL research suggests that facility size influences social relationships as smaller homes typically promote greater interaction among residents than larger homes. Even in the smaller homes, heterogeneity in terms of different race and class of the residents disappears and they develop family like relationships with each other. This is evident in the following passage:

> Blue Skies has the most heterogeneous resident population, with variations in race, class, age, gender, and disability; when the Jamaican culture of the owner and primary staff person is added, the home's diversity increases. Yet small size may temper the discordant effect of heterogeneity (Ball et al., 2005, p. 198).

However, the smaller size of the AL also negatively influenced co-resident relationships because the smaller population limited relationship partners and options. These limited options in small homes primarily influence the romantic type of relationships because sometimes residents do not have any prospects among them (Ball et al., 2005, p. 199). As a female resident in a small home noted, "It would be nice to find a nice man in my life, somebody to go out with and talk to. There's not one in it now" (Ball et al., 2005, p. 199).

The physical environment in terms of the lay-out of a setting also can affect or promote social relationships whereas comfortable spacing in the common areas can promote interactions and social relationships between the residents (Kemp et al., 2012). In the study conducted by Kemp and colleagues (2012), one AL in the sample had high levels of resident frailty and relationships were hindered somewhat by the physical layout. Residents using assistive devices such as walkers and wheelchairs faced difficulty in moving around or gathering because of limited usable common spaces. The dining room was the only area large enough to fit all residents at one time remained closed outside of mealtimes - a practice that further limited resident from congregating. Lu, Rodiek, Shepley and Duffy's (2011) research on corridor walking in AL determined that walking is very important for residents and an important context for co-resident interaction. They concluded that having a corridor with hand rails, flooring safe for walk-

ing, areas for resting, and corridors wide enough for two walkers, promotes social relationships among residents.

Formal activity programming also influences social relationships in AL, and participation in activities enables residents' interactions. Some AL communities craft policies to, "foster togetherness" and consequently do not allow residents to have televisions in their rooms instead encouraging them to watch T.V. in the common room by showing programs of their interest (Ball et al., 2005, p. 196). Active staff involvement also helps in promoting relationships among the residents as evident in the study conducted by Kemp and colleagues (2012). They found that although, participation in activities is sometimes open to all residents, staff play a key role in encouraging the residents to participate in the activities. Staff knowledge and experience therefore are crucial in encouraging relationships among the residents. Facilities can promote interactions by crafting policies encouraging staff to introduce new residents to the co-residents and with resident interest, encouraging them to talk about their personal lives including past experiences and families. Sometimes the rapid changes of the staff members and their limited numbers lead to residents asking for help from the co-residents and make them closer because of their reciprocity (Ball et al., 2005).

Mealtimes and the seating arrangements in the dining room are influential in forming co-residents relationships (Kemp et al., 2012). Various types of interactions are noticed among the residents during mealtime like, "greeting, conversations, tiffs, showing concern, helping and sharing" (Kemp et al., 2012, p. 13-14). Sometimes facilities assign dining room seating, but sometimes, "rigidity in seating is generated more by residents claiming ownership of a particular seat, and conflicts arise when other resident attempts to usurp this right" (Ball et al., 2005, p. 192). Sometimes facilities divide floor occupancy according to the gender, for instance women are given one floor and men are given the other floor of the AL, which can inhibit interactions among them (Ball et al., 2005). Strict facility rules can impede relationships by stigmatizing the cognitively and physically impaired residents by transferring them to one level of care to another on the basis of their decline (Dobbs et al., 2008). This mostly happens in AL settings with sep-

arate dementia care units (DCUs) when AL residents who decline are shifted to locked care units (Dobbs et al., 2008). Facility factors can also interact with the individual factors like functional status in influencing the social relationships among the AL residents.

Research in a variety of AL settings has identified a number of resident factors, including their personal characteristics, family involvement, attitudes, preferences, and strategies, and functional status that influenced social interactions in AL. Kemp et al (2012) found residents' personal characteristics, including age, gender, race, marital status, and culture played a large role in influencing the relationships among residents. On the basis of age, younger residents sometimes avoid older residents and do not consider themselves to fit in the majority of the older residents in AL. Yet sometimes helping relationships developed between young and old. On the basis of race, other work suggests that sometimes residents choose the AL facility on the basis of their race and class (Ball et al., 2005). Residents sometimes seek out co-residents on the basis of their common race and geographic location and identify themselves with the similarities in these characteristics while also separate themselves from others (Kemp et al., 2012). Gender also plays a role because of which mostly men are more prone to develop relationships with the opposite sex in comparison to the women (Kemp et al., 2012). Marital status influences relationships wherein couples have built-in companionship, but often one spouse adopts the role of informal caregiver, which limits opportunities for interacting with others (Kemp, 2008; Kemp et al., 2012). Kemp's (2008) qualitative study involving 20 married couples living together in 11 AL settings identified three types of couples: (a) independent; (b) inter-reliant; and (c) restricted- independent. These couples were named according to the type of interaction they were involved in and the degree of social integration they showed in the AL setting. On the basis of these characteristics, "independent couples were those who although help each other in meeting their physical needs but they were not fully dependent on one another for emotional support or for social activity" (Kemp, 2008, p. 243). Inter-reliant couples were "virtually inseparable and rarely left one another's side" (Kemp, 2008, p.243). Restricted-independent couples were those who "engage in time-restricted activities without the other and wanted to be active and independent, as

they had in the past, but, in many cases, perceived that caregiving responsibilities prevented this outcome" (Kemp, 2008, p. 245). It was further found that married couples who were independent because of having the same functional status and fewer physical limitations socialize with the other residents and also develop friendships with them. Meanwhile, the inter-reliant couples have moderate to high levels of disability and they engage in social distancing and spend most of the time together and do not socialize with others. They show social distancing to maintain their previous identity of constant togetherness (Kemp, 2008).

Residents' prior personal and professional experiences can help them to relate to co-residents and promote interactions between them (Kemp et al., 2012; Ball et al., 2005; Yamasaki & Sharf, 2010). Commonality in terms of same interests and hobbies also promotes relationships among them (Kemp et al., 2012). Having an active outside social circle can act as a signal of persons' willingness to form new social relationships with co-residents (Burge & Street, 2010). Kemp et al (2012) conclude that family participation is also influential in promoting co-resident relationships. Sometimes active family involvement in residents' lives inhibited socialization with other residents. But, sometimes families encourage residents to socialize with others and even participate in organized activities or promote relationships by taking residents on outings for dinner, church or other events. Lack of family involvement in their lives can prompt the development of family-like relationships with the co-residents.

Residents' attitudes and preferences in term of interacting with others also play a role in determining social relationships with the co- residents. Some residents consider themselves as private and do not like interacting with others and feel happier by sitting alone in their rooms (Kemp et al., 2012). Some residents preserve privacy as the aspect of autonomy so prefers it by regulating contact with the other residents (Ball et al., 2005). There are also residents who are "proactive" and promote socializing in AL by "welcoming new residents, keeping apartment doors open, attending activities, and sitting in public places" (Kemp et al., 2012, p. 21). Attitudes and preferences pertaining to social interaction and relationships often are influenced by an individual's functional status.

Functional status and its impact on social relationships in AL

Functional status is one of the major individual-level factors influencing social relationships in AL. Suffering from any kind of disability affects social relationships. To examine the inclination of healthy older adults to form relationships with older adults suffering from disability, a study was conducted by Iecovich and Ran (2006). The data for this study were collected by interviewing 70 residents in two different residential settings (Old age homes in Israel). Participants in this study were functionally independent and aged 65 and above. In one setting, both functionally independent residents and residents with disability were living in the same building on different floors. There was a common cafeteria, lobby, garden and elevators for both type of residents and hence they had more chances to meet each other. The other setting had different buildings for functionally independent and residents with disability, which meant there were fewer chances for the two groups to interact. It was found that the reactions of functionally-abled older adults towards older adults with disability depended on the physical layout of the facility. Healthy older adults in the integrated facility had more tendencies to develop negative attitudes toward their disabled peers than those who lived in the separate facilities. One interpretation of this finding is that functionally-able older adults relate themselves to the disability as possible outcomes of their own future and could ultimately lead to death. Being fearful from this perspective would mean they would tend therefore to avoid the older adults with disability.

Stigma is "the assignment of negative worth on the basis of devalued group or individual characteristics" and can be associated with physical and cognitive impairments, consequently impeding relationships among residents in AL (Dobbs et al., 2008, p. 517). Dobbs and colleagues (2008) examined stigma and ageism in six residential care AL communities. Data collected from staff, families, and residents demonstrated that both physical and cognitive impairments are stigmatized in these settings. People avoided those who were suffering from dementia. Some residents and families believed it to be contagious and avoided going near cognitively impaired residents. Similarly, physical impairments and using

wheelchairs were stigmatized and those without physical impairments did not like to go on outings with other residents who used wheelchairs. On the other hand, stigma attached to impairments can act in a positive way too for residents who felt good when they assisted residents with dementia.

According to the study conducted by De Medeiros and colleagues (2011) at three AL housed in the same building, friendships exist among residents with dementia in AL. The characteristics of these friendships follow the cultural and stereotypical stereotypes which are; common interests, reciprocity, reliability, and intimacy. “How friendship is conceptualized does not always coincide with how it is observed and possibly experienced in this population” (De Medeiros et al., 2011, p. 15). This is because staff perceived the existence of friendships among the men who were made to sit at the same table by the staff. But, on observation and interviewing the residents, it was found that there hardly exist any friendships among them. Nested social groups are also seen among residents having dementia (Doyle et al., 2011). The interaction which takes place in each group is distinct from other groups. There exist environmental and organizational barriers to the intergroup interactions. The environmental barriers are because of demarcation of three AL by means of locking the doors connecting these three facilities. The organizational factors are related to the staff preferences in completing their tasks like taking residents to their room after meals rather than providing them an opportunity to interact with each other (Doyle et al., 2011).

Sometimes residents attach meanings to their relationships with other residents who are functionally similar to them (Ball et al., 2005; Perkins et al., 2012). This happens in the case of residents suffering from dementia as they repetitively talk to each other about the same things and but forget that they had talked about them earlier (Ball et al., 2005). However, difference in functional status inhibits relationships among the residents (Ball et al., 2005). Generally, residents with comparatively good functional status distance themselves from the residents with poor functional status (Ball et al., 2005). Residents with comparatively good functional status act like this to construct positive image in comparison to that of functionally poor residents (Ball et al., 2005). Also, inter-reliant couples in AL settings engage in “social

distancing for maintaining their identities and viewing themselves as separate from others" (Kemp, 2008, p. 244). Sometimes residents because of their poor functional status prefer privacy and do not want to be bothered by others and prefer to spend most of the time in their rooms, which further constricts their social relationships (Ball et al., 2005, p. 200). Similarly residents with a good functional status prefer privacy to avoid interactions with cognitively impaired residents as they get tired listening to their repetitive talks (Ball et al., 2005, p. 200). Occasionally, the facility also decreases functionally good residents' opportunities to interact with functionally poor residents by planning activities that are not meant for them (Ball et al., 2005).

The notion of self-care, "ADLs, IADLs, and health care and promotion activities" also influences residents' social relationships based on their functional status (Ball et al., 2005, p. 135). Self- care can promote relationships among residents by creating emotional ties when they support each other's self-care activities; it also can foster a sense of community (Ball et al., 2005). Yet, functional impairment can be a double-edge sword, simultaneously promoting interactions and relationships because of helping between residents of varying physical and cognitive abilities and creating barriers to interaction and relationships because of frequent medical appointments, pain, incontinence, decreased mobility, speech and hearing impairments, depression and dementia (Kemp et al, 2012).

Summary

Older adults are more prone to disability than any other age group. Disability can increase dependence on others, including family members, and can lead to the need for formal care. Due to the high expenses of in-home care services, as well as the scarcity of in home service providers, some older adults opt for residential care settings. AL is one of the rising residential preferences for frail older adults who need assistance in performing ADLs and IADLs. Ideally, this type of setting provides a more of home-like environment and encourages aging in place. When they come in contact with other AL residents, new social relationships can develop and sometimes friendships can develop. Relationships formed between

residents in AL may hold considerable meaning and effect on well-being. These relationships also may be both positively and negative affected by residents' physical and cognitive functional status.

Purpose of the Research

The studies conducted thus far on the association of functional status with social relationships have examined the effect of social relationships on disability and effect of disability on social relationships. Studies also have shown the inclination of functionally-abled people to form friendships with adults suffering from disabilities living in same and different buildings (Iecovich & Ran, 2006). Kemp and colleagues (2012) identified functional status as one of the factors influencing social relationships in AL and it is apparent that stigma is an important concept in understanding its effect on co-resident interactions (Dobbs et al., 2008). Ball and colleagues (2005) identified the notion of self-care and finding meanings from interactions that influences the relationships of residents based on their functional status. To date, however, few, if any studies have attempted to provide an in-depth understanding of how functional status, cognitive and physical, operates as a factor in creating or hampering co-resident relationships in AL. Research aimed at understanding the connection between functional status and the formation of relationships can contribute to the development of strategies aimed at promoting positive social experiences in AL. I will be addressing the existing research gap by examining the connection between functional status and co-resident relationships in AL, a setting with increasing levels of resident frailty.

Research aims and questions

The overall goal of this thesis is to examine the social experiences of residents in AL with a focus on understanding the role of functional status on co-resident interactions and relationships. Specifically, my thesis will address the following research aims and questions:

Aim 1: To understand how functional status influences co-resident interactions and relationships

a) How does mental status influence co-resident interactions and relationships?

b) How does physical status influence co-resident interactions and relationships?

Aim 2: To identify the factors that shape how functional status affects social interactions and relationships.

a) What resident factors (e.g., behaviors, personal and situational characteristics, and social involvement) influence how functional status affects co-resident relationships?

b) What facility factors (e.g., physical layout, size, staff involvement) influence how functional status affects co-resident relationships?

CHAPTER THREE

METHODS

In this chapter I describe the methods used for conducting my research. As secondary data analyses is conducted, I will describe the primary study and its methods in detail and methods for conducting secondary data analysis and the characteristics of the subsample used in the thesis.

Primary Study

The primary study, "Negotiating Residents' Relationships in AL: The experiences of Residents" (R01 AG030486-01A1, Mary M. Ball, PI) had the following three aims:

1. To learn how residents experience relationships with other residents in the AL setting.
2. To understand how individual, sociocultural, and environmental factors shape how residents experience relationships with other residents in the AL.
3. To identify successful strategies of AL residents and staff that help residents negotiate and manage social interactions and relationships with other residents.

Methods and Procedure

The data for the larger study were collected over a two-year period in eight AL settings located in and around the metro-Atlanta area. The homes differed from each other in terms of their location, size, ownership, and resident profiles. Data collection included: participant observation, informal interviews, and formal in-depth interviews with staff, residents, administrators and visitors, as well as surveys with residents. A ninth home was used to collect additional survey data with residents.

The observation guide appears in Appendix A and provided structure for the observations researchers made of activities and the physical and social environments. Informal interviews were part of natural interaction with those in the setting. Questions were generated spontaneously according to the situation and ongoing data analysis. Observations and informal interviews were recorded in detailed field notes.

Formal in-depth interviews with administrators (n=9), activity staff members (n=9), care staff members (n=14) and residents (n=49) were conducted, recorded, and transcribed. Interview guides for administrators, activity staff members, care staff members and residents, relevant to my study appear in Appendices B, C, D, and E, respectively. The formal in-depth interview of the administrator was conducted during the first month of study and lasted for about one and half hours on average. Information about policies and procedures related to residents' relationships, their knowledge about residents' relationships, their idea about the factors influencing the resident's relationships, and their attitude about importance of residents relationships were asked from the administrators during the interview. Similarly in-depth interviews with activity staff asked about their knowledge, attitudes, and the influence of the activity programs on residents' relationships. In-depth interviews with care staff members were conducted after developing rapport, generally after three months in the setting. Staff was asked to reflect on the importance of residents' relationships, their knowledge of residents' relationships, and their thoughts about the factors influencing co-resident relationships. Informal interviews were conducted with all residents who were willing to speak with researchers. Cognitively-intact residents who had resided in the home for at least three months were invited to participate in a survey (see Appendix F) collecting information about residents' personal characteristics, health status, support needs, and social support networks. The survey also asked an open-ended question about co-resident relationships. These responses are included in the study's qualitative database.

Purposive stratified sampling among cognitively intact residents was used to select participants for formal in-depth interviews. Participants were selected to allow variability in terms of gender, race, disability, socioeconomic status, marital and parental status, tenure in AL, and health status. These in-depth interviews were conducted after sufficient rapport was created and generally were preceded by survey participation. On average, interviews lasted between 1 to 1 ½ hours. The interview collected information about daily routines, social relationships with co-residents and with persons outside AL settings, and the meanings they attach to the relationships.

Field notes, in-depth interviews, and open-ended survey questions are included in the qualitative data base for this study. Overall, there were a total of 3660 hours of observation and 1166 visits. All visits were recorded in field notes and became part of the qualitative database along with 49 interviews and 178 responses to the open-ended survey questions.

Subsample and Present Analysis

Participants and settings

For the present analysis, I examined data collected from two AL settings: Oakridge Manor and Garden House. Each are described separately below. Select characteristics for each home appear in Table 1.

Table 1. Select characteristics by home

Characteristic	Oakridge Manor	Garden House
Average Census	45	16
Capacity	55	18
For Profit	Yes	Yes
Ownership	Corporate	Private
Monthly fee range	$ 2,700-$ 5,295	$ 2,550-$ 2,900
Race or culture	African American	Mostly white, African American (2)
%Men	40%	18%
% in wheelchairs	22%	0%
% with Dementia (AL)	34%	24%
Dementia Care Unit (DCU)	yes	yes
Age Range	54-102	65-96
Number of Deaths	5	1

Oakridge Manor is for-profit, corporately-owned and houses middle-class and wealthier African American older adults. It has the capacity for 55 AL residents (does not include DCU residents), but an average of 42 residents lived at Oakridge when the study was conducted. There were 22 residents with dementia and 14 wheelchair-bound residents when the study was conducted. Ten residents used walker and 9 residents used cane. The age of the residents ranged from 54 to102 years. The physical environment of Oakridge Manor is explained in the following lines quoted from the work of Ball and colleagues (2005), p. 133

> Oakridge Manor is built by keeping the residents independence in mind. It has wide halls with handrails, an elevator, good lighting, shower chairs in all bathrooms, and washers and dryers for resident use. Residents have private bedrooms, and most have private baths, which provides more space for supports such as microwave ovens, ironing boards, hospital beds, rolling desk chairs, computers, and hanging valets. The paved path encircling the building makes a pleasant and safe walk place to walk. Apart from it, only a few baths have roll-in-showers; closet rods are out of reach for residents in wheelchairs; the chairs in the lobby area are low and soft; the upstairs halls are long; the door to laundry room is heavy; and the nearby shopping center is up a hill on a busy street with no sidewalks.

Field note data further describe the home:

> Oakridge Manor has separate DCU on the first floor. The DCU has its own dining room. The activities program also runs separately in the DCU. The reception area is also on the first floor, just opposite to the front doors. It has a lounge area which included 3-4 tables with chairs and couple comfortable chairs. The lounge area also has a large entertainment console that spanned one entire wall which included a large flat screen television and various books. French doors in the room led to an outside patio/porch that serves as a smoking area. The facility has a sunroom where all the resident council meetings and activity programs takes place. The sunroom

> is nicely decorated and includes a desk for the activities director, a small kitchen area, a large flat screen television, and books; an "ice cream parlor" and piano. A soda vending machine is in the far back left corner. Overall, the Oakridge Manor is very stylishly decorated, almost like a fashionable hotel <OR080605AMG >.

Garden House is privately owned, for profit, and caters mainly to middle class white residents. It has a capacity of 18 residents, and 16 resided at the home during the data collection period. This facility has a separate DCU. There were 5 residents with dementia in the home when the study was conducted. Nine residents used a walker and 3 used cane. Residents ranged in age from 64-94 years, with the mean age of 86.2 years. All residents had private rooms and private baths. Each room had two large windows with outdoor views. One resident who lived in the "extra care unit" (not really DCU) spent most of his time in AL, ate his meals there, and participated in AL activities.

Field note data describe the home:

> The Garden House is a yellow-colored building and its main entrance faces the street. Around the side of the building, there is a very large porch with French doors and a number of large rocking chairs. As you enter through the side of the building, there is a reception desk straight ahead. Beyond the reception desk is the dining room. Straight ahead is the activity room. Between the reception area and activity room, there is a living room. There is a piano in the living area. To one's left is a hallway that leads to the administrative office and the original front door. To one's right, there is another hallway with residents' rooms on both sides. The hallway ends in a little sitting area with a couch, skylight overhead and book cases on the end wall. The couch faces a door, which leads into the DCU. Just opposite to entrance of DCU is the TV room. The beauty shop is located at the left corner of the TV room <YW090908CLK>.

Available Data

Information about the data collection from each home is given in Table 2. Data were collected during the first year of study (2008-2009) from the Oakridge Manor. There were 578 hours of observation in and 178 visits to Oakridge. Observations and informal interviews conducted during this time form part of the field notes. Formal in-depth interviews included 1 administrator, 2 activity staff members, 3 care staff members and 9 residents. Nineteen residents were surveyed, including the 9 in-depth interview participants. Data were collected in the Garden House during second year of the study (2009-2010). There were 154 hours of observation and 47 visits in this setting. Formal in-depth interviews were conducted with 1 administrator, 1 activity staff, and 3 residents. Eight residents completed surveys including three who participated in an in-depth interview. The qualitative data are stored in Nvivo 9.0 - a qualitative analytic program that will be used to manage the data and assist with organizing analysis.

Table 2. Data collection by type and location

Data Type	Oakridge Manor	Garden House	Totals
Participant observation (hours/visits)	578/178	154/47	732/225
In-depth interviews (n=)			
Administrator	1	1	2
Activity Staff	2	1	3
Care Staff	3	0	3
Resident	9	3	12
Resident Surveys (n=)	19	8	27

Design and Data

Qualitative methods involve the in-depth study of participants where detailed knowledge is collected by means of observations, informal and formal in-depth interviews (Ragin, Nagel, & White, 2003). Qualitative research gives voice to its participants (Hendricks, 1995). By means of qualitative research,

the possible relationship can be explained by understanding the mechanism which makes up the relationship. In other words, the hypothesis developed in quantitative study can be explained by the qualitative study by means of understanding social processes. Evidence from participants' social worlds can be used to define meanings and mechanisms. Furthermore, social worlds constantly changes so the existing theories can be refined and even extended by means of qualitative study. Even new theories can be generated (Ragin, Nagel, & White, 2003).

My approach is qualitative and I focused my analysis exclusively on interview and field note data. My approach is qualitative because this approach addresses participants' insights about the research questions. Using this approach, one can judge what factors affect co-resident relationships on the basis of their functional status. By using this approach, the why and how questions related to the association between functional status and co-resident relationships are answered.

Secondary Data Analysis

Grounded theory approach (Strauss & Corbin, 1998) was utilized to analyze the data. This approach means that theory was developed from all the themes, concepts, and categories that emerge from the data. The data was analyzed by means of coding. In the initial or open coding, key concepts were identified by going through line by line of the data as guided by my research questions. The indicators related to the key concepts were found out. "The data are broken down into discrete parts, closely examined, compared for similarities and differences, and questions are asked about the phenomena reflected in the data" (Strauss & Corbin, 1998, p.102). In sum, concept- indicator model was utilized to conduct an open coding. For example, the coding of the following list of information was done in this way:

> As she sat down, she greeted everyone and Mrs. F asked her, "Did you have a good nap?" Ms. H said that unfortunately, she did not because her arthritis was very painful in her knees. Both Ms. G and Ms. F expressed their sympathy and they both recommended taking some pain medication.

From this piece of data, the concept, “arthritis” emerged and the indicator, “she did not because her arthritis was very painful” was attached to the above mentioned concept. The other concept, asking about well -being and health was identified and “Did you have a good nap?” was attached to the above mentioned related concept. In this way, open coding was done. Dimensionalizing or variable formation was done by means of constant comparison of the key concepts, where the various related concepts were placed under one category. For instance, various concepts such as stroke, amputations, arthritis, vascular problems, and other conditions and associated surgeries were placed under the variable, “mobility related problems.”

The next step was to conduct an axial coding (Strauss & Corbin, 1998), where various categories were interrelated to each other or in other words it is, “ a process of relating categories to subcategories” (Strauss & Corbin, 1998, p. 847). “Subcategories also are categories that answers the questions of when, where, why, how, and with what consequences” around a focal category (Strauss & Corbin, 1998, p.125). For instance, in the axial coding we related various subcategories of resident level factors with each other. The conceptual model explains the axial coding further. As evident in the conceptual model, residents’ attitudes, behaviors, perceptions, and strategies were further dependent on personal and situational characteristics and functional status and hence were related to each other. Similarly, social involvement was further dependent on residents’ functional status and hence related with each other. Also, various facility level factors were interrelated with each other. The physical environment determined facility rules and admission/ retention criteria, activity programming, and staff practices, interventions, levels, and organization and thus was related to each other. Then certain facility level factors such as activity programming, and staff practices, interventions, level and organization determined social involvement of residents and hence related to this resident level factor. In the next step, selective coding (Strauss & Corbin, 1998) was done to generate a core category, where other categories were related to the core category. The conceptual model further explains the selective coding. As explained in the conceptual model, all the facility level factors such as physical environment, facility regulations and admission/ retention criteria, activity pro-

gramming, and staff practices, intervention, level and organization were related to the core category, "coming together and pulling apart". Similarly various resident level factors such as individual characteristics, residents' perception, attitudes, behaviors, perceptions, and strategies, functional status, and social involvement were also related to the core category, "coming together and pulling apart". "Coming together and pulling apart" signifies the key finding that functional status is multi-directional, fluid, and operates in different ways in various situations and across time. In certain circumstances, functional status can bring residents together physically, socially, and emotionally in positive ways, helping them to form helpful and friendly relationships. In other situations, functional status can "pull" residents apart physically, socially, and emotionally, creating barriers to the development of positive or meaningful co-resident relationships. This core category is further defined in chapter 4 and chapter 5. Also through the process of selective coding, a main story was told about the relations between different categories and this is explained further in chapter 5 through conceptual model of coming together and pulling apart.

CHAPTER FOUR

FINDINGS

COMING TOGETHER AND PULLING APART:

THE INFLUENCE OF FUNCTIONAL STATUS ON CO-RESIDENT RELATIONSHIPS IN AL

In this chapter, I examine my first research question regarding the influence of functional status on co-resident interactions and relationships in AL. I begin by introducing and elucidating the core category, "Coming Together and Pulling Apart", which emerged from the Grounded Theory analysis described in the previous chapter. I then examine the specific influences of residents' physical and cognitive status, including how the presence or absence of different types of impairments operate and relate to the core category.

Coming Together and Pulling Apart

"Coming together and pulling apart" signifies the key finding that functional status is multi-directional, fluid, and operates in different ways in various situations and across time. As will be seen, in certain circumstances, functional impairments can bring residents together physically, socially, and emotionally in positive ways, helping them to form helpful and friendly relationships. The residents will be seen coming physically together by means of helping each other and by engaging in different health-related conversations. Meeting, greeting, and asking about each other's health and well-being can make residents "come together" socially. Sympathizing, showing concern, and sharing problems related to health also can bring them together emotionally. In other situations, functional status can "pull" residents apart physically, socially, and emotionally, creating barriers to the development of positive or meaningful co-resident relationships. Maintaining social distance, complaining, othering, showing frustration or intolerance for, and avoiding contact with each other are examples of how residents can be physically, so-

cially, and emotionally "pulled apart" from one another as a result of variations in functional status. Thus, the presence or absence of certain physical conditions including, vision impairments, mobility-related problems, painful conditions, speech impairments, hearing impairments, and other medical conditions, as well as mental conditions such as dementia-related cognitive impairments and mental illnesses can both unite and divide residents. Moreover, as will be detailed in Chapter 5, the influence of functional status on co-resident relationships is further dependent on individual involvement and a number of other factors.

Coming Together and Pulling Apart: The influence of Physical Status

There are various conditions that influence the physical status and functioning of an individual. Among those living in Oakridge Manor and Garden House, these conditions included: vision, hearing and speech impairments; painful conditions (e.g., arthritis); mobility related problems; and medical conditions that affect quality of life (e.g., allergies, and gastro-intestinal and respiratory problems). The presence or absence of these conditions affected physical functioning and in turn exerted influence on co-resident relationships and interactions in AL and were catalytic to residents coming together and/or pulling apart socially, emotionally, and even physically. Each condition is examined in turn below.

Vision impairments. Residents' vision abilities ranged widely in both AL settings and were related to a variety of conditions, including macular degeneration, glaucoma, bulbous eye and cataracts. A small minority had no vision problems. Many, however, required glasses to navigate their daily lives or to engage in certain tasks such as reading or playing games. Some required a certain type of lighting to function. Still others were, "totally blind."

Processes of coming together and pulling apart were seen among residents with variable visual abilities. In a number of situations, having vision impairment influenced co-resident interactions and relationships in ways that brought residents together. Mostly, residents with vision impairments tended to get help from their co-residents. For example, in the following passage from Oakridge Manor field notes, a blind resident, Mr. C, received help by means of verbal directions from his fellow residents while trying to navigate his surroundings on two separate instances:

> Mr. C was the first to head out of the sunroom. He did so with the guidance of those around him including Mr. S and Ms. G. They instructed him by saying, "Go left" or "A little to the right." He made it about five feet with their direction and me moving objects out of the way. . . Mr. C asked Mr. S to tell him how to get back to his room. Mr. S hollered, "Go straight back" and tried to give him instructions verbally.

Notably, a helping relationship developed between Mr. C and Mr. S who was younger, more physically fit, and had good vision relative to many of his fellow residents. Being neighbors further enhanced this helping relationship. Neighboring is an important activity in AL that often is expressed through helping between residents (Kemp et al., 2012). As the following field note passage indicates, the process of coming together occurred between the two residents in part because of Mr. C's blindness:

> Mr. S and I talked about Mr. C. He explained that he liked him a lot and that they had gotten to know one another because their rooms were side-by-side. Mr. S says he helps Mr. C out, often coming and going to the dining room, and said they get along . . .

Researchers observed helping amongst those with variable visual abilities during a variety of other scenarios including resident activities such as bible study and Bingo. Residents without vision impairments often offered help to those with such impairments. Mrs. F, for example, offered assistance to Mr. B, another legally blind resident from Oakridge Manor. Field note data elaborate:

> Mr. B. explained that Mrs. F gives him prayers [during bible study] even though she knew he couldn't see to read them. According to Mr. B, Mrs. F says she'll come to his room and read them if he wanted her to.

Researchers also witnessed sharing between residents with similar visual limitations. For example, in a friendly gesture, Oakridge Manor resident, Mr. B, shared his spectacles with Mrs. S, "Mrs. S complained that she couldn't see, so Mr. B offered her his glasses. She took them and this remedied the situation. However, Mr. B could not see and could no longer participate in the activity."

Helping or coming together as a result of vision impairment was also seen during meals where

tablemates helped in various ways from orienting to getting the lighting just right. Mr. T, of Oakridge Manor for example, was the tablemate of Mr. B, whose vision was affected by lighting. For Mr. T, getting the lights just right for Mr. B was a daily ritual, as he reported during an interview:

> Now the only thing about it I feel like I overdo, when I get around now to eat—that lamp up above the table. . . I got to keep pressing on the button to get it to stay on . . . and I have to deal with that every day because Mr. B, he can't see. No, he got to have that light from the lamp and from the window. The shade's got to be open. . . So every day before I eat I'm down there with this switch.

Consequently, Mr. B and Mr. S shared a friendly relationship. Data excerpts from the Oakridge Manor suggests, "Mr. B really likes Mr. S" and "it is apparent that Mr. B enjoys Mr. S's company in the dining room."

Sometimes residents joked around about their vision impairment. Ms. T and Mr. C, for example, developed a friendly relationship as tablemates. She often helped Mr. C "get acquainted" with the food and items at his place setting. Along with their other tablemates, considerably joking and teasing transpired, some of it surrounding Mr. C's blindness. For example, on the occasion of Ms. T's 91st birthday, Mr. C joked, "Wow. You sound so much younger." Additional field note data elaborate on their relationship:

> Ms. T said that Mr. C probably wouldn't be down for dinner – he typically only comes to breakfast and lunch. Mrs. S began to giggle and said that Mr. C seems to have a crush on Ms.T. Ms.T laughed and said it was because he couldn't see her! She then said that she's glad that he appreciates her "voice and brain."

Vision impairments did not always contribute to residents coming together socially or to the generation of positive encounters. Rather, vision impairments also could represent barriers to positive resident relationships. Sometimes, residents got frustrated from their condition of vision loss, so this could hamper their relationship with others, limiting co-resident interaction. This process can be seen in case of

Mr. B of Oakridge Manor who got frustrated from his ongoing vision decline from macular degeneration and was not socializing with others. Instead, some days he would sit alone on the patio. His friend Ms. T said, “There are times when Mr. B gets very sad, like a little boy about his ever decreasing eyesight.” Field note data support this observation, “Mr. B seemed to be a little bit down in the dumps today – he wasn’t as chipper as usual. He said that he was frustrated because his eyesight was failing and he couldn’t see very well today.”

Sometimes, other residents gossiped about the visual impairments of other residents, sometimes expressing the view that such residents should not participate in activities, which in a way could be a means of connecting socially with others. Mrs. F and Ms. G of Oakridge Manor, for example, gossiped about Ms. H’s visual impairment and made it known that they felt Ms. H should not participate in choir rehearsal. This scenario brought Mrs. F and Ms. G together by providing them the topic for gossip and pulled Ms. H apart from the other residents, as illustrated in the following passage:

> Mrs. F stated that Ms. H was blind and was on a walker because she had other health problems. She said that the Deacon takes Ms. H to choir rehearsal, but that she shouldn’t be going since she was blind and couldn’t see the sheet music anyway, Ms. G chimed in saying it didn’t make any sense for her to go to choir rehearsal since she was blind and couldn’t read the sheet music.

Having vision impairment is not always about coming together. Pulling apart is also observed, as illustrated in a field note passage describing an encounter in which Mrs. A of Oakridge Manor vented her frustration with Mr. C:

> Mrs. A passed by on her walker. She was visibly upset. She said, “You see what happened to me?” I looked and saw that her pants were wet. I asked what happened. She said, “That blind man spilled his water all over me.”

As a consequence of this event and Mrs. A’s lack of tolerance for Mr. C, no future interactions were seen between these two residents.

Mobility-related problems. Many, but not all, residents in both AL settings experienced limited mobility as a result of stroke, amputation, vascular problems, arthritis, and other conditions and associated surgeries. To counteract mobility- related disabilities, residents used a range of assistive devices, including canes, walkers, and wheelchairs. Coming together and pulling apart can be seen in a variety of mobility-related situations. Coming together around this dimension of functional status took the form of helping, inquiring, joking around, sharing compliments, and reminding. Helping was seen in various scenarios and ways. For example, residents sometimes helped others using assistive devices during group activities, including exercise sessions, as the following field notes from Garden House indicates:

> When exercises were over, the group (Mr. W, Ms. B, Ms. S and Mr. P) thanked one another and the men folded up the chairs…After putting the chairs back, Mr. P grabbed Ms. S's walker and delivered it to her and left the room. She was grateful.

Residents also offered help to those using walkers when they return to their AL home after shopping, especially when they had shopping bags. The following Garden House field note excerpt illustrates this type of assistance:

> Ms. M told me that she wasn't doing that well and was having so much pain in her legs and feet. She also said she'd had some trouble walking. I asked where her walker was; she told me it was inside. I immediately fetched it. I offered help with her bags, but she indicated that her neighbor, Ms. W had carried her purchases in.

The coming together process surrounding mobility-related function also was seen through the exchange of information among residents, often among those of similar functional status. For instance, field note data illustrate such information sharing between Mr. B and Mr. M of Oakridge Manor, both wheelchair users:

> Mr. B told me that his regular electric wheelchair was being repaired and he had a loaner that wasn't as good. He also explained that most people don't know they can get an elec-

> tric wheelchair. Mr. M asked him about the procedure, and Mr. B said he needed his doctor to prescribe one for him.

Mobility-related issues often brought residents together even further through joking, especially around shared experiences. At the Garden House, for example, residents joked around with one another, referring to their walkers by the names of luxury cars as is evident in the following passage: "Mrs. D and Ms. P got up with the help of their respective walkers, which Mrs. D had informed me were their "Cadillacs" - hers metallic red, Ms. P's metallic green."

Coming together also takes place when residents observed the mobility of the other residents. In the Oakridge Manor, for instance, Ms. T and Mrs. S discussed the improved mobility of Mr. R., who usually had used a wheelchair most of the time. A field note passage explains:

> Mr. R walked by behind a caregiver. He was pushing his wheelchair. Ms. T nudged Mrs. S and said, "Look he's walking." The two women observed his journey to the table and remarked on how wonderful they thought it was.

Coming together is seen among residents who notice and look out for one another. At the Oakridge Manor, for instance, Mr. B noticed that Mr. K had left his cane and told him about it, as illustrated in the following passage:

> Mr. M made some effort to incorporate Mr. B in the conversation, but it seemed to be a bit beyond him, either that or he was just focused elsewhere. At one point he yelled very, very loudly, "Mr. K!!" to Mr. K who was in the hallway "YOUR CANE." Mr. K left his cane in the dining room.

Mobility-related issues also created barriers to interaction and the development of positive relationships among co-residents. For example, in a number of instances residents' limited mobility impeded social relationships or positive encounters with others. Sometimes residents with mobility problems, particularly those who used assistive devices, chose to opt out of outings and activities which otherwise would be opportunities for social connections with co-residents. For instance, Mrs. A of the Garden

House, who experienced pain and stiffness related to arthritis and arterial disease of her legs and had to use walker to get around, no longer participated in activities or outing as she once did when she was more mobile. The following passage illustrates this transition:

> Mrs. A does not go on the bus outings anymore. She used to go when they went shopping, but now her grandson comes to have lunch with her and take her shopping. She said she could go on the bus, but her legs don't work as well as well as they used to. It's hard for her to get on and off the bus.

She also did not participate in activities within the AL, including singing—one of her favorite pastimes—because of her limited mobility, as substantiated by the following data excerpt from the Garden House:

> I asked Mrs. A why she didn't want to sing with the volunteer pianist. She told me she tried to go a few times, but that she can't sit in any old chair and the fact that her walker is too bulky. She said it's just not convenient and her legs hurt so much by the time she gets to the end of the hall.

Co-residents sometimes lacked patience with less mobile residents when these residents blocked their way with their wheelchairs and walkers. This scenario had an overall negative impact on relationships. In Oakridge Manor, for instance, when Mr. R's wheelchair blocked Mrs. S's path she complained: Meanwhile, I walked over to Mrs. S and she was waiting to get to her seat. Mr. R sits directly behind her. He was wheeling himself in place and she complained that he was taking too long.

Consequently, Mr. R was moved to a different seat in the dining room which restricted their future interactions and relationship prospects. Also, Mrs. S often complained generally about the residents in wheelchairs blocking her path from the dining room to the elevator. She said:

> They're pulling their wheelchair and pull right up in the, like in the exit where you go out, like on the elevators and stop right there. So if you going to get on the elevator, you got to go around them and the same thing in the dining room when you're getting ready

> to eat, they bring the wheelchairs in and they walk them, put them in the aisles, and you got to maneuver around them things. It's like, you got your eyes, you can see. You're sitting in the wheelchair. You can see that blocking. There's somebody behind you that want to get by and you're blocking. You've got everybody behind you jammed up waiting for you to move this wheelchair out the way.

Residents using assistive devices sometimes unintentionally harmed other. For instance, Mr. B of Oakridge Manor, who himself was a wheelchair user, complained about residents using walkers, running over his foot. The following data excerpt illustrates:

> Mr. B's foot is cut and he can't wear a shoe. He told me that he wears two socks on the un-shoed foot because, "The old people run into it." He told me that they don't watch where they are going, especially when they are in the elevators and those with walkers.

Data also indicated that residents sometimes used devices as weapons, which could upset other residents, as the following passage from Oakridge Manor illustrates:

> Ms. J dislikes the behavior of a resident who . . . uses a stick, and wears a cap. She said he lifts his cane off the floor and pokes people with it. Ms. J thinks this is dangerous because this resident, could lose his balance because he could fall, or he could accidentally poke someone eyes out. She said this resident does not know when to stop playing and she does not find his actions funny.

Other residents agreed and some avoided or tried to minimize contact with him.

Painful conditions. Certain conditions, including arthritis, injuries from falls, fractures, cancer, migraines, and osteoporosis, caused pain among residents in both Oakridge Manor and Garden House. Pain affected a variety of body parts (knees, back, elbows, stomach, toes, shoulders, neck and also have headaches) and influenced their co-resident interactions in ways that both united residents and prevented social engagement. In some cases co-residents showed concern, sympathized, gave advice, joked around, and even helped those residents suffering from painful conditions. These behaviors occurred in a variety

of situations, including encounters during mealtimes, in common areas, and even in resident rooms/apartments. The following encounter between Mrs. F and Ms. G illustrates such behaviors:

> Ms. H joined the table…Mrs. F asked her, "Did you have a good nap?" Ms. H said that unfortunately, she did not because her arthritis was very painful in her knees. Both Ms. G and Mrs. F expressed their sympathy and they both recommended taking some pain medication.

Conversations often transpired among resident surrounding the treatment of painful conditions. Generally, residents shared their pain-related worries. Consequently, whether solicited or unsolicited, co-residents often offered solutions or strategies for dealing with painful conditions, as evident in the following data excerpt from Oakridge Manor:

> Ms. C entered the room. She was wearing her wig and pushing her walker. As she sat down, she complained to Mr. D, Ms. J and me that her back was bothering her and she was out of sorts. Mr. D advised her to make a doctor's appointment soon and get it looked at. Ms. J agreed and repeated Mr. D's advice.

This is similarly evident in the Garden House, where Ms. M and Mrs. A conversed about their similar treatment experiences:

> Ms. M told Mrs. A about her hip and the fact that she wanted me to know how good it was to be healthy and to enjoy youth. Mrs. A told Ms. M about her experience trying to get a cortisone shot and wondered whether Ms. M's insurance would cover it. Mrs. A didn't get a shot and told Ms. M, "I find if I wait long enough, some things just correct themselves." I nodded, but also suggested that it wasn't always necessary to live with pain. Both women agreed.

In this way, Mrs. A and Ms. M come together as they shared talks on their common painful condition.

In an another instance, Mrs. F of Oakridge Manor showed concern for Ms. P's painful arm condi-

tion and even went to her room every day to learn about her well-being, which promoted interactions and closeness between them. The following data excerpt illustrates:

> Mrs. F then leaned over and expressed her concern over Ms. P's health condition (for some reason she had her arm in a sling). Mrs. F told Ms. G she was very worried because she knows that Ms. P is in pain, but saw her respond to the nurse's question, "Does it hurt?" by saying, "No." Ms. G said, "Well, maybe it doesn't hurt her or it didn't at that moment." Mrs. F seemed unconvinced by this hypothesis and said, "I know it hurts her. I go in to see her every night before bed and lately she has been wincing and making faces when she moves her arm. I know it hurts her.

Residents also joked around their painful conditions and shared laughs, which promoted interaction and camaraderie and sometimes diffused tension. For instance, the following field note passage from Oakridge Manor notes one such exchange during dinner among a table of women:

> Ms. J arrived and shortly thereafter, Ms. T joined the table. Ms. J said she'd had a terrible headache and it wasn't better. Ms. T said she was sleepy. Ms. J offered that they were quite a table. One of them was a "sleepy head" and the other was a "swimming head." The ladies laughed.

Helping also transpired when co-residents asked staff to give analgesics to residents in pain. For, instance, Mrs. J of Oakridge Manor had severe pain because of cancer and she came to Mrs. F in her room for help. Mrs. F sympathizes with her and immediately called the staff for help. Mrs. F helped her in each and every possible way when even staff denied help. Thus, she developed a supportive relationship with Mrs. J and once said she gave Mrs. J "emotional support." The following passage illustrates further this coming together through:

> Mrs. F called for help and a male caregiver told her that there was nothing that could be done. He said that a hospice nurse was on call (and Mrs. F asked where they were?). He said that the hospice nurse would be there at seven a.m. to give Mrs. J medicine to stop

> her pain. Mrs. F was horrified because Mrs. J was horribly sick and kept begging for something to stop the pain. She said she kept after caregivers after the male left and told them to call 911. They resisted for the longest stating that they were not supposed to call 911, but after Mrs. Foster persisted, they finally did.

Although pain can cause residents to reach out to one another in supportive ways, it also could act as a barrier to relationships. Those who experienced pain sometimes resisted participating in group activities and going for meals, preferring to spend time alone in their rooms. This situation is evident in the following field note passage, describing the researcher's encounter with Ms. M of the Garden House:

> On my way out, Ms. M was coming up the hall. I stopped to talk with her. She told me her hip was hurting. She was going to go to the movie with her table mates, but thought it best to go to her room, sit in her recliner and relax.

Hearing impairments. Hearing impairments among residents in both AL settings ranged from mild hearing loss caused by ear infection due to allergies to significant age-related hearing loss. Hearing impairments were significant communication barriers among residents in both homes and contributed almost exclusively to "pulling apart" among residents. Often when residents tried to have conversations with those who had considerable hearing loss, they ended up being frustrated from repeating themselves again and again. They also had to yell, which often resulted in abandoning the conversation in mid-discussion or avoiding them altogether. Co-residents also complained about others' hearing impairments and often engaged in social exclusion by avoiding them in any group conversations.

Co- residents typically showed frustration with residents with hearing impairments when they tried to converse during mealtimes or activities, as illustrated in the following passage describing a Garden House mealtime conversation:

> I asked Ms. M what she would have been up to in the afternoon. She told me she was in her room reading. Ms. B asked what she was reading. Ms. M repeated "A Nicholas Sparks book" several times – the final time she was frustrated and practically yelled it as

> Ms. B couldn't hear. When Ms. B asked how it was, Ms. M rolled her eyes and said, "I don't know, I just started reading it. I got it for my birthday."

Similarly, a description of watching a movie at the Garden House shows similar frustration:

> Then, Ms. B surveyed everyone asking if they could hear. Ms. M, Ms. M .E and Mr. P all said they could hear, but could not make out what was being said. When she asked Mr. P, the two had difficulty understanding one another. Mr. P kept repeating himself and appeared to be mildly frustrated with her. For her part, Ms. B looked at me and said, "He can't hear."

Mr. P and Ms. B's relationship was somewhat limited. During an interview Ms. B, who wore a hearing aid, *said*, "I could be more friendly with Mr. P, but he won't get a hearing aid and I get tired of yelling at him."

The significant hearing impairment of some residents required that they be yelled at in order to hear. As with Ms. B, some co-residents complained that doing so was unpleasant. Many residents with hearing impairments also did not enjoyed being yelled at, which further prevented communication and opportunities for social connections and contacts among residents. Mr. L and Ms. W of Oakridge Manor did not talk to each other at meals. Ms. W said, "Mr. L is sort of hard of hearing. And he doesn't want you yelling at him. So I don't talk to him." Similarly, Mr. M of Oakridge Manor did not like yelling and says of Mr. H, "I talk to him whenever I feel like yelling and whenever he wants to hear." Consequently, this acted as a barrier for their regular interactions and resulted in only occasional exchanges.

Co- residents sometimes also ignored conversations altogether when their efforts to talk to those with hearing impairments seemed to go nowhere. This scenario often was seen during encounters in common areas and during mealtimes. A field note excerpt from Oakridge Manor illustrates:

> When we got in the hall, Mr. C (who is blind and hard of hearing) was sitting in his wheelchair facing the sunroom entrance. Ahead of me, Mr. S leaned to the side and addressed him. Mr. C, told Mr.S he could not understand what he was saying. Mr. S said

> something again. I too was unable to make out his message. Again, Mr. C could not understand the soft-spoken message and asked him to repeat it. Mr. S turned to me, shrugged his shoulders and kept going.

Social exclusion was also seen surrounding hearing issues. On occasion residents simply excluded others from conversations, as can be seen in the following instance:

> Mr. W, Mr. P and I talked about movies. Mr. W told me about the "old days" when there were only silent pictures. Mr. P seemed to be excluded from Mr. W's discussions, partly because he can't hear him, but partly because Mr. W has a way of dominating the conversation.

Sometimes residents with hearing impairments asked those without such impairment for help. This situation was seen in the case of activities, such as watching movies where residents have varying levels of hearing impairment and required help from a third party with good hearing. Field note data explain:

> I walked up the hall and saw Ms. B standing in front of the couch. She was consulting with Mrs. D and Ms. P. The two were in their usual spot at the end of the hall. Ms. B was asking Mrs. D to come into the TV room to see if she could hear the sound from the video (It's a Wonderful Life) she and Mr. P were attempting to watch.

Sometimes hearing impairments also were a source of joking and humor, particularly when hearing impaired residents misinterpreted entire conversations. The following passage from the Garden House illustrates:

> After Mr. P stopped talking about Ms. B, Ms. W commented that if you have to go, it's better to go fast. Her thinking was that you don't have people waiting on you to die. Mr. P was having a difficult time hearing Ms. W and me. We both have soft voices. In this instance, he didn't hear her and said, "Nobody waits on me. I have to make my own bed." Ms. W laughed at the miscommunication and said, "It doesn't get made until I make."

Speech impairments. Speech impairments among residents at the Garden House and Oakridge Manor were the result of missing teeth, aphasia among persons with dementia (when residents have difficulty finding words), and stroke. Speech impairments functioned mostly as communication barriers and consequently resulted almost exclusively in "pulling apart" among residents. Sometimes when residents were unable to understand what their fellow resident was saying, they ended the conversation altogether. This is evident in the following passage from the Garden House, where Ms. R's aphasia acted:

> I asked Ms. R where she was from. She answered something that sounded like Florence. Ms. M. L and Ms. M.E did not know where that was. Ms. M. E asked her if it was in another state. Ms. R nodded. Ms. M. E asked which state. Ms. R answered but no one understood. Ms. M. E asked her to repeat it and she did. Again, no one understood and felt it rude to make her repeat it again.

Sometimes, residents stopped contributing to conversation due to the frustration of having to repeat themselves. The following passage from Oakridge Manor illustrates this situation:

> Mr. K stood up and said something to his table mates. He is very difficult to understand as he speaks softly and is missing teeth. Mrs. S said to me, "What'd he say?" I did not know. She then said loudly to Mr. K, "Can't hear you." He repeated his statement and she replied, "Still can't hear you." He then said, "Can't hear", shrugged his shoulders, laughed and disappeared, presumably to find Ms. M.

Similarly, Ms. R of the Garden House did not complete the conversation with Mrs. D due to her aphasia in the following passage:

> Ms. R complained about being cold. Mrs. D told her she had a sweater on and shouldn't be cold. She then drew her attention to what she was wearing, a t-shirt, and said she wasn't cold. Ms. R nodded. Several times Ms. R started to say something, mostly low-

> volume mumbling that sounded as if she was unsure about what she was saying. Mrs. D asked her to repeat and she didn't.

Coming together and pulling apart can also be seen in combination. In the following instance, Mrs. F of Oakridge Manor tried to help Mrs. D on account of her speech impairments (coming together) during bible study while Mrs. D was trying to read. Some members of the audience were tolerant while others, like Ms. W, demonstrated frustration (pulling apart) at the same time and was making facial expressions of intolerance:

> Every once in a while Mrs. D offered her opinion, sometimes interrupting. She was struggling to participate because she's wasn't able to find the words. She was also confused about what was taking place in the meeting. Mrs. F was very patient with her and tried to help her get on point and explained several times what they were doing (regarding the readings). Everyone was a little frustrated, but show tolerance and patience. At one point, Ms. W closed her eyes as if waiting it out.

The above passages also illustrate the intersection of cognitive impairment and speech issues and their influence on co-resident interactions.

Other Medical conditions. Residents of Garden House and Oakridge Manor also had other medical conditions, including allergies and respiratory and gastrointestinal problems. These conditions influenced their overall physical functioning, which in turn influenced whether or not residents came together or were socially divided. For instance, a few residents experienced regular coughing fits, which most frequently occurred during mealtime while eating or drinking, and they tended to be avoided and somewhat ostracized. Co- residents sometimes looked at them with disgust. As the following field note passage attests, at Oakridge Manor this scenario led to a seating arrangement change in dining room:

> Mr. R said Mr. S developed a bad cough and was sitting at a '45-degree angle and very close to him.' He said that he would cough incessantly and that it was greatly disturbing

> him. Mr. R spoke with someone, complaining that the cough was bothering him. He told me that he was moved and was now eating at the front of the room.
>
> As a result, Mr. R developed a strained relationship with Mr. S.

In very rare cases, coming together is also seen when the co-residents showed concern and attempted help, as the following passage from Oakridge Manor illustrates:

> Meanwhile, Ms. J was sitting in the far back corner near the "ice cream parlor." She began coughing violently and Mrs. A, who was sitting next to her, leaned over and began rubbing her shoulder. She asked Mrs. J, "You okay?" Ms. A then handed Mrs. J a tissue for her nose and said, "There you are." It was very motherly.

In some situations, reactions to such situations varied, with coming together and pulling apart operating simultaneously, as shown in the following passage, where Mr. R's wife and Ms. H ignored his habitual coughing while other residents expressed concern:

> Mr. R continued to cough. Ms. M instructed him to spit it [gum] out but Mr. R did not. Mrs. F turned around (again) with the scowl still on her face letting everyone know that she was concerned (I suspect that she was fearful that he was going to choke.). I mentioned to Ms. H that I was afraid he was going to choke. She is as cool as a tall drink of water. She said as calmly as she could (she is always so laid back), "He does that all the time." . . . Mrs. R, his wife, sat there as if nothing was going on.

Pulling apart is almost exclusively seen among residents with allergies. In the following instance, Ms. P of Oakridge Manor refused to participate in activities on account of her allergies, even with encouragement from co- residents: "I asked Ms. P if she would like to play Bingo. Ms. M encouraged her to do so, but Ms. P declined citing her allergies." However, Ms. P also conversed with other residents about her condition in a way that connected her to others.

Coming together was seen in case of the resident Ms. M of Garden House who suffered from chronic stomach problems. In the following instance, residents showed concern and tolerance when she used the toilet frequently during an outing:

> As we pulled out of the driveway, Ms. M asked how far it would be. I asked her if she wanted to stop. She did. The activity director pulled into the Quick Trip, but said, "Now we'll have to wait in line for sure at Longhorn's." She let Ms. M out. While she was inside, everyone spoke about her with concern. Ms. J said, "I hope she makes it." Activity director agreed and said if she had an accident, we'd have to take her back to Garden House. Ms. A suggested she do it." Everyone seemed relieved. Ms. S said, "Have you ever? Poor thing. I didn't realize it was that bad. Wouldn't it be terrible?"

Most, if not all of the residents at Garden House knew of Ms. M's condition and were sympathetic and supportive. Ms. M shared a good relationship with the residents, Ms. S, and Ms. M. H in particular, and considered them nice. Ms. S talked about her relationship with Ms. M saying she "didn't know what she would do without Ms. M."

Coming Together and Pulling Apart: The influence of Mental Status

Residents' mental status also had a considerable influence on co- resident interactions and relationships. More specifically, cognitive impairment and mental illness often acted as social barriers. Cognitive impairment in the residents of Garden House and Oakridge Manor is caused primarily by dementia and can be depicted in various ways, such as violation of social norms, memory loss, repetitious conversations, difficulty comprehending, inappropriate eating, and improper sexual behaviors. Mental illnesses like schizophrenia and depression were also seen in some Oakridge Manor residents. Conversely, being mentally alert promoted relationships among the residents. Hence, mental status as a whole also influenced the process of coming together and pulling apart.

Cognitive impairments. As mentioned above cognitive impairments can be manifested in various forms. When residents cognitively impaired as a consequence of dementia violate social norms, many

co-residents grow intolerant and frustrated. Pulling apart is primary as it significantly influences present and future interactions and, consequently, relationships. For example, over the course of a year Mrs. D from Oakridge Manor increasingly violated social norms during interactions with her fellow residents. In the following passage, her progressive dementia resulted in interruptive behaviors during a book club meeting:

> Mrs. D repeatedly interrupted the group with off topic comments. Mrs. F seemed somewhat exasperated as she told Mrs. D very politely that they would talk after Ms. G was done speaking. Mrs. D then proceeded to laugh absolutely hysterically as she walked back to her seat. I overheard Mrs. H lean over to Mrs. S and say, "What in the world is she talking about?

Similarly, another Oakridge Manor resident, Mrs. S, violated social norms due to her dementia during an activity, which led to a rebuke:

> During the next round, Mrs. S entered the room and scouted for a vacant bingo chair. The only one was beside Mrs. F. She walked directly over to the table and said to Mrs. F, "Move your pocket book." Mrs. F scowled openly scrunching her face up indicating her displeasure… Ms. S sat down and reached for Mrs. F's bingo cards. Mrs. F was quick to put her in her place by saying, "If you are going to sit there, just sit there and don't touch or say anything."

Memory loss adds to the dimension of pulling apart among the residents when they argue with each other and maintain social distance. Sometimes residents with memory problems could not identify faces or remember names, which created confusion and hindered interactions. Memory problems also led to completely forgetting conversations. An Oakridge Manor resident without cognitive impairment explained the challenges of interacting with certain residents with dementia: "So a lot of time they get confused where—their faces, their names, or different conversations they may have with another person. So it's kind of confusing. Sometimes they're happy together sometimes they don't." In this way, having

memory issues creates barriers in residents' interactions and relationships. The following interview data from one Oakridge Manor residents suggests memory loss as the reason behind many co-resident arguments:

> Interviewer: So you think that's why people get in arguments sometimes? Yeah.
>
> Resident: Yeah and they don't remember—a lot of them don't remember the room.
>
> Interviewer: They don't know where to sit, maybe?
>
> Resident: Hmm?
>
> Interviewer: They don't remember where to sit maybe—like which spot is theirs, do you think?
>
> Resident: Yeah.

The impact of such memory problems is further illustrated in the following passage from Oakridge Manor:

> Mrs. S entered the sunroom and made a bee-line for Mr. S's recently vacated seat. I overheard the ladies at the table try to explain to Mrs. S that the seat was taken. Mrs. S didn't seem to understand and she got very frustrated and was asking all sorts of question. Within minutes, Mrs. S and Mrs. J were in a heated screaming match at one another. Mrs. J yelled at Mrs. S for "trying to spoil everyone's fun time."

Many, though not all, cognitively intact residents maintain a social distance from residents with memory loss. The administrator of Garden House explained, "I will tell you that the ones that are alert don't have a lot of patience for the ones that have some memory loss."

Memory loss also results in interrupting or ending conversations in midstream, as elaborated in the following passage:

> Ms. R tried to participate in the conversation. Ms. M told me she can't understand her because she talks to low. So, Ms. M said, "Wait a minute until I come to you." She walked over to Ms. R and sat right beside her on the couch and leaned in. Ms. R started to speak,

> but nothing came out. Ms. M said, "You forgot what you were going to say, didn't you?"
>
> Ms. R nodded. Ms. M looked at me and said, "She forgets."

Sometimes, having a memory loss also promotes residents' interactions and relationships, such as when co- residents offer reminders or give directions. The Garden House administrator said, "You know some of the ones that are a little bit confused, you know, they're always losing things and helping each other find things. So yeah, they help each other a lot." Coming together also was seen in residents joking around about their memory losses. Sometimes residents forget the location of bathrooms and their seats in the dining room, which co- residents helped them find. Mrs. R, for instance, of Oakridge Manor usually forgot the location of the restroom, which Mrs. P helped her find, as evident in the following passage:

> Mrs. P walked by with Mrs. R in tow. She was trying to get her to the bathroom. Mrs. R looked sad and tired. Soon, they came back up the hall toward the sunroom. Mrs. P was holding Mrs. R's hand.

Similarly, her co-resident, Mr. B helped remind her to use the restroom. He once said, "Sometimes I have to remind Mrs. R to go to the bathroom. "I say, Mrs. R, it's time to go to the bathroom."

In some cases, having memory issues of a similar nature tended to promote friendships between residents. In Garden House, for instance, three residents of varying cognitive status forms a clique shared a very friendly relationship and spent most of their time together while working on puzzles. The data excerpt from the Garden House illustrates their relationship further:

> Mrs. D and her two little partners . . . they all three have different versions of dementia. . . Mrs. D is a real caregiver. If it hadn't been for her, I guarantee you Mrs. F's kids would have gone crazy by now. Mrs. D has taken up a lot of that time just sitting with her or working crosswords . . .

As suggested in the above passage, the process of coming together is seen among the residents with similar cognitive status. Friendly relationships also developed among cognitively intact residents. Mrs. F, Ms. G, and Mr. M, for instance, of Oakridge Manor forms a clique, had a friendly relationship

and they often engaged in conversations that included joking, teasing, sharing laughs, discussing politics and games, and gossiping about functionally impaired residents. They also talked about going to the senior center to participate in activities such as aerobics as they did not find the activities being offered in Oakridge Manor meaningful.

In certain scenarios, cognitive impairment served a protective function. Field note data explain:

> Throughout dinner, Mrs. D was struggling socially. In addition to finding it difficult to think of specific words she wanted to use in the course of conversation, she had difficulty following any conversation that she'd not initiated. In many cases, this meant interrupting or blurting out whatever came to her mind. At one point Mrs. D interrupted Mrs. F (while she was telling a joke), with her own line of thought. Mrs. F was not about to tolerate being interrupted (it likely happens a lot). She held her hand up with her palm outwards (in a "stop" gesture) in the direction of Mrs. D's face and backed up by a very serious facial expression, said, "No. Not now. I'm talking"…Mrs. D turned to her head to her left and under her breath and over her shoulder I heard her say, "Well. Excuse me." A few minutes later she returned to normal and had likely forgotten about the incident.

Mrs. D's failing short-term memory thus protected her from having hurt feelings following being put in her place by her tablemate, Mrs. F.

Residents with cognitive impairment also often engaged in repetitive conversation, which many co-residents did not tolerate. The following passage from Oakridge Manor illustrates the effect of such behaviors:

> Mrs. F said that Mrs. B has asked her where her room was "about a million times." Mrs. F said that Mrs. B approached her today and asked her the same question once again. Mrs. F said she told Mrs. B to never ask her that question again because it was really starting to bother her.

Thereafter, Mrs. F actively avoided Mrs. B. Similarly, Mrs. A of Garden House who was cognitively intact said she was not close to any of her fellow residents and that she merely tolerated, "People that talk about the same thing over and over and over again and can't remember what they talked about with you before."

Residents also had difficulty comprehending or following directions because of their cognitive impairments. Sometimes co-residents were intolerant of situations such as these. In Oakridge Manor, for example, cognitively impaired Mrs. S often interrupted activities to ask for direction as the following field note captures:

> Mrs. S had difficulty understanding the numbers I was calling throughout the game. This seemed to greatly bother Mr. B, who was sitting near her. He would occasionally turn around and yell the correct number to her, or he would shake his head. I noticed Mrs. F getting exasperated with Mrs. S as well.

Mrs. S often was avoided by her fellow residents. Cognitively intact residents were especially likely to engage in social and physical distancing from her and others with similar behaviors.

Very rarely, coming together was observed when residents joked around and shared a laugh about a resident's misunderstanding —sometimes at their expense. The following field note provides an example from a group activity:

> The activity staff member read a story about younger people choosing not to legally marry and then solicited opinions from her audience. Mr. T feels marriage is very important. Mr. K thinks people should do what they want. When Daisy asked Mrs. S her opinion, she replied, "Yes. I'm here." Everyone shared a laugh at that.

Residents having cognitive impairment sometimes had difficulties eating, which could make dining room experiences unpleasant for those around them. A few residents refused to eat; others ate without

conventional table manners. In response to the researcher's question about residents' preferences not to sit with other residents, the administrator of Oakridge Manor talked about two groups that residents avoid:

> One group is an individual that may not be able to chew their food so well so they may take it out of their mouths, which is not comfortable. Another, it may have to do with grooming, well; he blows his nose or coughs at the table, which is, they don't want to be with. But the other is contributed to the dementia where, 'What am I going to do?' She's asked for oatmeal and then she says she doesn't want it once they get back, so they feel that the person is annoying.

Appetite levels can change with dementia, as was the case with Mrs. D of Oakridge Manor. Her lack of appetite and food consumption was a major source of concern for her friend and tablemate, Mrs. F, who routinely showed concern about her weight loss noting, "She looked like broomstick" and tried to make her eat. At the same time pulling apart was seen among them, when Mrs. D repeatedly went to Mrs. F's room asking for food. The passage below illustrates Mrs. F's changing attitudes toward these requests:

> Mrs. F told me that Mrs. D says she is not hungry, but then comes to her asking for food. Mrs. F seemed very worried about Mrs. D and said she would end up in the dementia care unit before long because she was wasting away... Mrs. F said Mrs. D came into her room Monday night and was hungry. The next night, Mrs. D knocked on her door and was hungry. She fed her again. She said she told her son about this and he told her that he did not want Mrs. D to eat up all of her food.

On account of inappropriate sexual behaviors observed in Oakridge Manor, residents with dementia, particularly women, sometimes required some special oversight given their vulnerability. Speaking of intimate relationships, Oakridge Manor's administrator explained:

> The men, if they could find a mate, they would and the interesting thing is some of the more independent men, they're more likely to be attracted to residents with dementia.

> It's almost like there's that vulnerability there, where you're not going to go to Mrs. F or not going to go to certain residents. So instinctively, they know the residents that would be more vulnerable.

In these instances, staff intervention often was warranted.

Inappropriate sexual behavior sometimes occurred between cognitively impaired residents. In one instance this situation led to infidelity and a falling out behind husband, wife, and co-residents - all cognitively impaired. The activity director explained:

> Mrs. S went out of town to Vegas with her daughter and left Mr. S and she comes back and she finds Mr. S and Ms. M in the bed together…And with her Alzheimer's, dementia, I think she remembers, but she…she was just upset, she was upset with both, so from that stemmed a whole bunch of stuff where she didn't forget, she honestly didn't… And the example, there were sitting in the activity room, they were sitting side by side and he said something, something was said and she said, you said what?! You did what?! And she punched him right in the face. She was mad, she was angry and she was like, "Don't say any shit like that to me."

Despite all three having cognitive impairment, the infidelity had lingering effects on the relationships among and between them and often required staff oversight and redirection.

Mental illness. Some residents in Oakridge Manor experiencing mental illnesses, like schizophrenia and depression, showed exclusively the process of "pulling apart." These mental illnesses acted as barriers in developing residents' connections and relationships.

Mrs. I had schizophrenia and showed extreme emotional outbursts and instability and frightened her neighbor Mrs. F. Whenever Mrs. F's family came to visit, she complained that Ms. I would speak in voices, rant, swear, and embarrass her. Mr. M, who lives on the same floor, explained of Ms. I, "When she goes off, she turns everybody off." According to him, she talked crazy and engaged in verbal and physical attacks. As a consequence, she was moved to the dementia care unit. A staff member noted, "We

had to move Ms. I because Mrs. F did not want her up here. She couldn't tolerate her behavior" and also said, "Mrs. F thinks that the Oakridge Manor is no place for Ms. I. She feels that she is a threat to the residents in the DCU and in the home."

A few residents in Oakridge Manor also had depression, which acted as a relationship barrier. Depression meant residents were sad and often socially withdrawn. Depressed residents were less involved in activities and talked less to others. Mrs. A, for example, had depression. She was sad all the time and found little happiness in anything. She also did not participate in activities and rarely talked to others. Field note data capture a typical exchange with a researcher:

> Before I entered the sunroom, I knelt down beside Mrs. A, who was now sitting in the wingback chair in the hallway. She looked very forlorn and sensing she needed a bit of attention, asked her how she was doing. She responded with her usual statement, "I'm surviving". . . I asked Mrs. A what would make her feel better and she said "nothing."

Summary

Overall, this chapter explained how the presence and absence of certain physical and mental conditions influence the coming together and pulling apart of co-resident relationships in AL. It also is evident how coming together and pulling apart occur in different situations, i.e., in certain situations coming together is seen among the residents despite of functional impairments and in other situations, pulling apart is seen. It is also realized that sometimes both the components acts together in the same situations and is further dependent on the factors such as individuals' perceptions of themselves and others and their tolerance for situations and behaviors.

CHAPTER FIVE

FINDINGS

FACTORS SHAPING THE INFLUENCE OF FUNCTIONAL STATUS ON CO- RESIDENT INTERACTIONS AND RELATIONSHIPS

This chapter answers the second research question about factors shaping the influence of functional status on co-resident relationships. Analysis identified multiple factors operating at the facility and resident levels. Figure 1 illustrates these factors and their role in shaping the influence of functional status on the process of coming together and pulling apart. As shown, facility-level factors such as admission/ retention criteria have an influence on the resident profile and therefore on functional status of the residents. The activity programming is further dependent on this profile and influences residents' relationships and levels of integration of those with variable functional states. As well, the availability of spaces for running activities is important and, hence, the physical environment also is important. Staff practices and intervention take place in the physical environment and can moderate the effect of physical and mental status on co-resident relationships. Hence, facility level factors are interrelated and also are connected to resident-level factors such as individual characteristics, residents' attitudes, behaviors, perception, and strategies and social involvement. The explanatory model shown in Figure 1 depicts the interrelationship between these factors and their further influence on the core category, "coming and pulling apart". The key factors are further elucidated below.

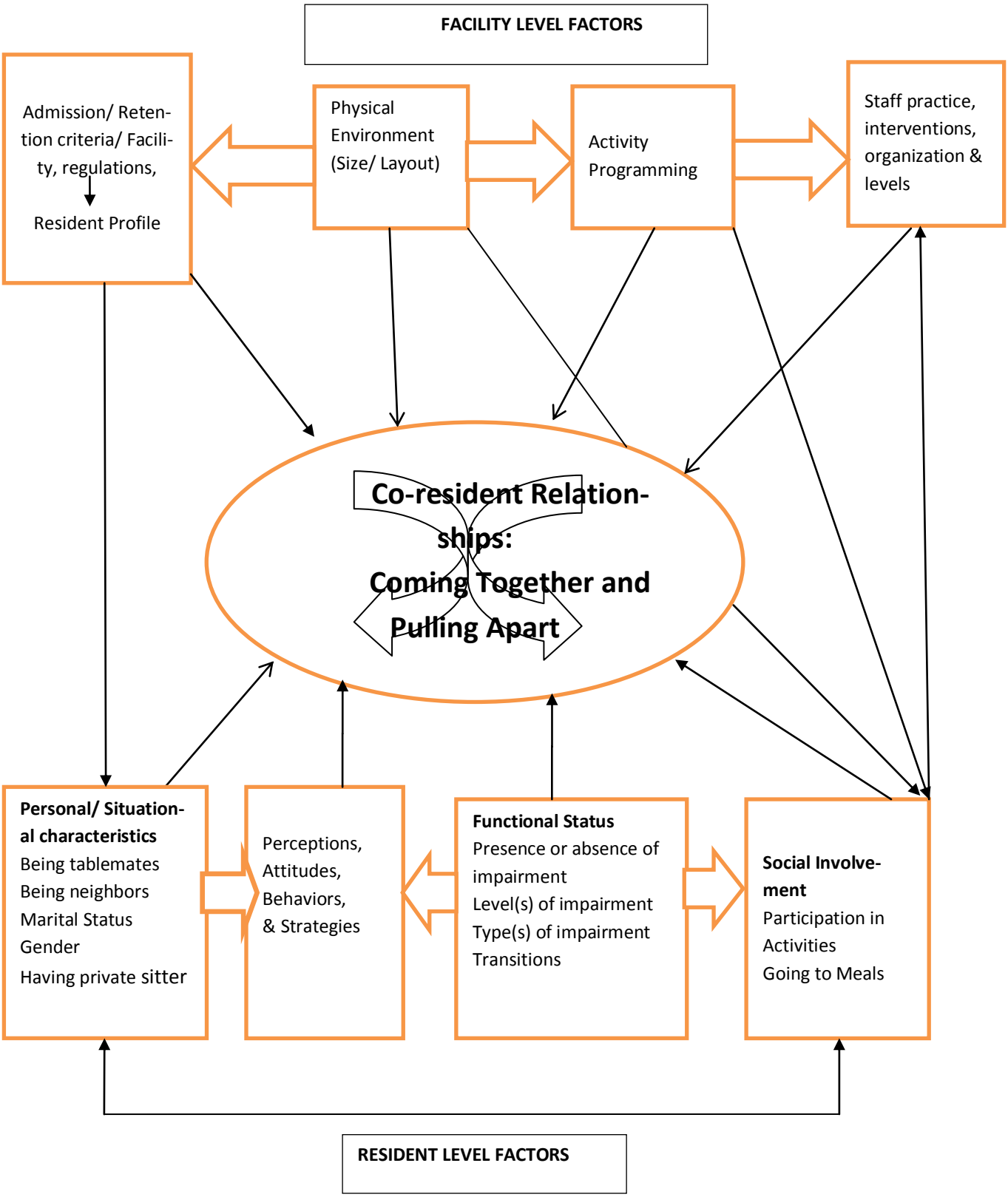

Figure 1. Conceptual model of Coming Together and Pulling Apart

Facility-level factors

There are various facility-level factors that shape the influence of functional status on co- residents' interactions and social relationships. These factors include: physical environment, admission/ retention criteria, activity programming, and staff practices, behaviors, and interventions. These factors act differently in each of these facilities.

Physical environment. The physical environment of the facility in terms of size and lay out is also an important aspect that shapes the influence of functional status on core category, "coming together and pulling apart." Garden House is smaller and has a much lower resident capacity than Oakridge Manor. With fewer co-residents to get to know, residents were more familiar with each other and there existed a strong sense of community. Consequently, all residents interacted frequently and made relatively strong social connections despite some functional impairment. Moreover, Garden House is single story building with most residents sharing a hallway. Its wide hallways are spacious enough to allow residents with walkers to walk together. The presence of a dining room, activity room, and TV room allowed residents to socially engage in common areas regularly and without having to travel too far from their apartments. It is also easy to get to front porch, which was popular among residents, accessible, had comfortable furniture and also provided protection from sun and rain.

Relative to Oakridge Manor, Garden House residents had more patience for those with poor functional status. Because of closer relationships, the administrator described the setting as a "big family clarifying that people get along with some family members better than others. You don't choose your family members. She feels that people generally get along with one another and look out for each other."

Oakridge Manor is physically larger and has a resident capacity of 55. As Oakridge Manor caters to the African American population, overall there exists a sense of community because of commonality of race, religion and cultural values. Yet, this commonality is not sufficient to maintain a sense of community in all circumstances. When functional status intervenes, residents with good functional status were less familiar and less tolerant towards the residents with poor functional status. Moreover, Oakridge Manor is

a multistory building with elevators. The dining hall is located on the 1st floor and the majority of resident rooms are on the 2nd. Because almost a fourth (22%) of residents used wheelchairs, congestion was common surrounding elevator access, which led to social conflict and pulling apart. But, there are spacious areas like the sunroom, Patio and activities room which are more accessible for walkers and wheelchairs, and residents gather and interact in these areas and interact with one another, which promotes coming together.

The physical environment of the facility further influences staff practices, behavior and interventions because staff engages with residents at the common spaces, like dining halls, hallways, activity rooms etc. The physical environment also exerts an influence on activity programming because availability and accessibility of common spaces affects the design and implementation of activities. Hence, the physical environment of the facility is interrelated with the other facility level factors such as staff practices and interventions, activity programming, and admission/ retention criteria.

Admission/ retention criteria/ facility regulations. The admission and retention criteria further exert an influence on the resident profiles of the facility. The Garden House had very strict admission and retention criteria. The administrator explained that they only admit residents who can ambulate 50 feet "on their own steam" whether in a wheelchair or not and transfer from the bed or in the bathroom independently. They discharged residents when their care needs were too great. She explained, "That's I guess the benchmark for me is when my staff's just killing themselves moving the person around or trying to do too much." The admission/ retention criteria were also strict because of less number of staff members. Hence, residents often were moved to the DCU when they were still cognitively receptive but showed decline, had incontinence issues, did not take care of their hygiene, behaved in socially inappropriate ways, wander, and who were taking up staff time during meals. Consequently, AL residents at Garden House did not have significant cognitive or physical impairments. None of the residents used a wheelchair, although many used walkers and canes. Relative to Oakridge Manor, Garden House residents were

more tolerant of each other and expressed fewer negative attitudes and behaviors with coming together between residents a more frequent occurrence. In general, higher acuity facilitated social relationships.

Other than observing personal care home regulations and not taking residents they assessed as potential dangers to themselves or others, Oakridge Manor's rules of admission were not as strict as Garden House. They transferred residents to the DCU who required higher level of care and who had extreme behavioral problems, wandered, were anti-social, and whose care needs exceeded the AL staff's ability to meet them. Those who showed aggression and resisted care in AL also were likely to be transferred. The resident profile at Oakridge though included some residents with severe physical and cognitive impairments. Mental illnesses, like schizophrenia and depression, were also seen. Unlike Garden House where there was not a great deal of resident variability in functional status, there existed high variability among the Oakridge Manor residents and considerable variation in coming together and pulling apart. Fellow residents also were less tolerant.

The facility regulations influence the personal and situational characteristics such as allowing residents to have private sitter that can further affect co-resident relationships. Also, the overall facility rules and policies, including the admission and retention criteria, also have an influence on the activity programming, which is designed to accommodate residents' functional status. So, in this way facility regulations, admission/ retention criteria, and activity programming are interrelated.

Activity programming. Each facility has different activity programming. The Garden House offered various activities which varied from individualized to group activities, such as watching movies, exercise sessions, puzzle playing, and regular resident outing. Certain activities (e.g., movies and exercise sessions) were run by residents. Moreover, all the residents in Garden House had similarly low levels of functional impairment and they never complained of the type of activities being offered. One problem surfaced with regard to the resident-run movie activity because the resident in charge was hearing impaired, which led to some social discordance, as evident in the following passage:

> Mr. P and I talked about the movies he'd been watching. I told him his job was important. He admitted it was a hard one. He was never sure what people would like. He then said he finds identifying the correct volume for the movie is a bigger challenge. He then spoke about Ms. S and Ms. B without mentioning them by name saying one can't hear and the other wears a $3,000 hearing aide that makes her too sensitive to volume. He just picks a volume that he thinks is best (which might not be the best strategy given his hear difficulties). In any case, he said he generally pleases one or the other not both and finds that very hard.

At Oakridge Manor, the activities being offered included bingo, Pokeno, bible study, choir practice, exercise sessions, and outings in the community. Staff ran most activities, which were targeted to appeal to the lowest functioning resident. Hence, residents with higher functional status complained about the types of activities being offered, believing that they did not match their functional levels. They blamed the residents with poor functional status for what they perceived as poor activity programming, which led to pulling apart between residents of varying functional status. The following three passages show instances of social distancing and "othering", including "us" and "them" attitudes:

> Mrs. D began to talk about her not being happy with the activities that were offered… She said she wanted to see some things that the 'adults' could do. I asked her what types of activities she would be interested in and she said, "Whatever the other more active people want to do. You see, it is not fair that the adults don't have anything to do." Mrs. D frequently distances herself from the more disabled residents. She continued, "Most of the activities are very childish, like those nursery rhymes, and you see these people sitting around with stains on their clothes or food dribbling from their mouths," she motioned to illustrate that some people had food dribbling from their mouths on the side, some on the front. She turned her nose up in disgust as she made her point.

> Ms. G said that it wasn't 'fair' that they couldn't go and that she wanted to see more activities that she could do. She and Mrs. F feel as if there are more activities that cater to the more impaired residents. They wish that they had more interesting and fun things to do that would appeal to them, who are more active.

> Mrs. F walked to the back of the room and stood next to me chatting. She said, "Look at this," – motioning to the residents who were in the room sitting still. She said, "This is what I am talking about. It is so hard to be here and this is why I need something a little more. I have spoken with Big Bethel and they want me to come over there to live. I play the piano here for a variety of activities and they act like they don't appreciate me at all."

Because of the frequent complaining by residents with good functional status about activity offered, the facility made an effort to design activities to match residents' functional levels. They divided them into different groups on the basis of their cognitive abilities. While perhaps a positive move for those with higher cognitive status, the practice also stigmatized residents with poor cognitive function and segregated residents of differing statuses. Overall, a pulling apart was seen among the residents on basis of the activity programming in Oakridge Manor. The following passage illustrates the way of stigmatizing the residents with poor functional status by starting a new practice of dividing residents into different groups according to their functional levels:

> Activity director said that their facility was starting a new program where the residents are grouped together based on their skill level. There are four levels: Legacy, Reminiscence, Transitions, and Reflections. She said that the women would be getting a name tag that had their name and "Legacy Ambassador" written on it. She said that everyone should wear the name tag to their monthly meetings. She told the ladies that she wanted to get some activity ideas that were appropriate for their skill level and that touched on the topics of physical and mental health, spirituality, and community.

However, this practice was short-lived and the activity calendar continued to reflect a program open to all residents. The problem of integrating residents of variable functional statuses continued.

Staff practices, interventions, organization and levels. Staff plays a key role in shaping the influence of functional status on co- resident relationships. Sometimes, residents with good functional status makes strong connections with staff persons and do not like to interact with the co-residents, a preference that could influence the co- resident relationships in a negative ways. But, staff also plays a key role in encouraging residents to participate in activities and to make connections with the co-residents. Sometimes, they intervene and resolve the conflicts between residents and promote the process of coming together among them.

The staffing organization and levels also vary in the facilities. In the Garden House, the number of staff members was less and was somewhat less involved with the residents because they did not require as much hands on care and are, on balance, able to manage independently. Thus, overall the residents were seen making social connections with each other despite of the presence or absence of functional impairments, because they did not have much opportunity to get close to staff members.

In the Oakridge Manor, residents with poorer functional status needed more staff assistance. Residents with good functional status complained that they did not get the quality of care because staff provided most of the care to residents with poor functional status. This influenced going to meals because higher functioning residents thought that they even got meals past the scheduled timings because staff was busy in taking care of those residents and some became jealous of their fellow residents. As a result, they considered residents with poor functional status, “a problem.” This situation resulted in pulling apart of co-resident relationships as illustrated in the following field note passage, where Ms. G and Mrs. F of comparatively good functional status presented their viewpoint of staff intervention with functionally poor residents:

> Ms. G said to me, “You probably don’t want to hear our complaints.” I told them that, actually, I did want to hear them – it was okay to vent. Mrs. F then leaned over and said in a

> hushed voice while pointing to the man in the wheelchair, "He is the problem." Ms. G and Mrs. F were very upset for a couple of reasons. First, they didn't think "Assisted Living" meant living with people with such significant care needs. Second, they both voiced concerns that the amount of care that "certain residents" require diminishes the quality of care that can be provided to the higher functioning residents. For example, Mrs. F said that meals are never, ever served on time because all the staff is busy taking care of the residents who can't get ready and down to meals alone. Ms. G said that it is pointless to even go to the dining room at the announced meal times because the entrée isn't served for at least another hour…Both seem to think that they deserve much better care than what is currently provided to them at the Orange home, especially considering the hefty monthly fee they pay.

Also, in Oakridge Manor coming together aspect occurred as a result of staff intervention during an activity involving residents with variable functional statuses. Disagreements often took place between residents in these scenarios and required staff intervention to smooth things out. This practice is evident in the following passage involving Mrs. S, a resident with significant cognitive impairment:

> During a lull in the game, Mrs. S noticed that there was a bingo chip under Mr. B's chair. She pointed this out to him many times. Each time Mr. B said that either he or the activity person would get it later when they were finished and cleaning up. Just minutes later, Mrs. S again said, "Do you know there is a chip under your seat? You'd better pick it up." Mr. B clenched his fist and shook it out in front of him – as if he was toying with the idea of punching her. He yelled back "Do you know you come downstairs in your nightgown??" Both activity staff in unison told them to calm down and stop fighting.

Care and activity staff often stepped in to resolve disputes between residents of variable functional statuses. They settled the ongoing conflicts between the residents in various ways such as by changing their seating arrangements in the dining room, by relocating their apartments, by moving some to the

DCU, by redirecting the attention of problem-causing residents through changing topics and settings, by removing the triggers that made residents aggressive and caused further conflicts, and sometimes by involving the family members also.

Hence, various facility level factors influence the co-residents relationships and thus the coming together and pulling apart process. As is clear, these facility-level factors also interact with resident-level factors to shape the influence of functional status on co-resident relationships.

Resident-level factors

There are various resident factors that shape the influence of functional status on the co-resident relationships. These factors either directly influence the coming together and pulling apart of resident relationships or interact with facility-level factors to shape this influence. The resident factors that play a key role in this association are functional status itself, personal and situational characteristics, perceptions, attitudes, behaviors, personality, and strategies, and social involvement in activities and meals.

Functional status. Functional status can directly influence co-resident relationships. Its effect is further dependent on the existence, level, and type of impairment and permanent transitions faced by residents due to ongoing functional decline or acute health events, which may lead to moves to the DCU and temporary transfers to hospitals or nursing homes.

Absence of certain impairments in the residents can make them come together with impaired residents in order to help them, show concern and sympathize with them, and advise, inquire, inform and share their worries. Nevertheless, this aspect also pulls them apart as residents lacking impairments often cannot tolerate impaired residents and display negative attitudes and behaviors towards them.

Residents' relationships with each other are also dependent on the level of functional impairment. Generally, co- residents ignore residents with the highest levels of impairment, which typically include those experiencing both physical and cognitive impairment. For example, Mr. R from Oakridge Manor was wheelchair bound, had significant cognitive issues because of dementia, slept all the time, and had speech impairments. Thus, pulling apart typically was the outcome of Mr. R's functional status on his co-

resident relationships. Other than his wife, who also has dementia and lived with him in AL, he was mostly ignored. Field note data explain:

> Mr. T then told me that he feels sorry for Mr. and Mrs. R. He said they don't seem to know what's going on and no one really pay them, especially Mr. R, much attention. Mrs. R had come into the sunroom and was sleeping in a chair. Mr. R was still alone.

Although his wife often was nearby, she sometimes forgot he was her husband and also ignored him or wandered off leaving him alone.

The types of impairments also influenced the process coming together and pulling apart. Hearing, speech, and cognitive impairment, and mental illnesses almost exclusively produced a barrier in residents' interactions. Pulling apart was mostly seen in residents suffering from these types of impairments. Overall, co- residents tended to be intolerant towards residents with these types of impairment.

As Kemp and colleagues (2012) have noted, residents' have social careers that change over time and are influenced by health. Thus, residents' permanent health conditions also influenced the core category, coming together and pulling apart, among residents over time. When residents face decline, they may isolate themselves from others. Alternatively, other residents sometimes pull away from them socially and change occurs in their friendships. They may distance themselves, stop helping them, and no longer want to associate with them. As Mrs. D of Oakridge Manor's cognitive decline progressed, her former friends no longer bothered with her. When asked about the influence of residents' functional status on relationships, Oakridge Manor's activity director responded from the resident perspective:

> Okay, with my mental health, if I can still do the thing like participate without it being a one on one type environment, then that's pretty much, that's an okay thing. But once you start to slip a little bit, then…let me back up and give you an instance. We're friends, just like Mrs. D, they knew she thought she was a little better than them, Mrs. F and Ms. G and a few of them, but she slipped a little bit now, so they don't bother with her as much. They would save her a seat for exercise and make sure that no one sat there because it

> was Mrs. F, Ms. G, and Mrs. D. But now she has declined so much, they don't care who-ever sits in that seat now, they don't care.

Field note data confirm that Mrs. D of Oakridge Manor was initially close friends with Mrs. F and Ms. G., but her cognitive decline changed their interaction patterns and relationship.

Health decline also can end friendships between residents. Interview data excerpt from cognitively intact Oakridge Manor's resident explains:

> Interviewer: What happens when a friend declines mentally or physically—like when one of your friends has physical problems and maybe gets real sick or can't communicate the same way that you all used to communicate—how does that affect the relationship?
>
> Resident: Well, it's sad—but it's the only thing I can mention.
>
> Interviewer: Does the relationship end or does it continue?
>
> Resident: No. It ends

Similarly, another permanent transition, moving to DCU, also pulled residents apart. When residents moved to the DCU, co-residents became sad, showed concern, and were afraid at the same time yet did not maintain contact with them and often were relieved to be free of the association. There is stigma attached to moving to the DCU and many residents feared they might also have to move. This fear is further explained by an activity director of Oakridge Manor from the residents' perspective:

> But if they go to the DCU, it's kinda sad and scary for them at the same time because they don't want it to happen to them. I had people say, I sure hope that don't happen to me. I say, it doesn't happen to everybody, I say, but when something happens like that, that's what we're here for, to be supportive. I said, they'll be okay and once you bring them back out to visit the area, which is what we've been doing, it helps too, they see they're not debilitated, whatever. Cause that's the scary part for them, what makes them sad, they think it can happen to them.

However, the following excerpt from an interview with a resident from Oakridge Manor shows a

lack of friendship between AL residents and DCU residents:

> Interviewer: Are you friends with residents in the dementia care unit? Or in the nursing home—well, we don't have a nursing home here—but in the dementia care unit, do you have friends that live back there?
>
> Resident: No, I don't know anybody.
>
> Interviewer: Do you have any friends in the dementia care unit on the other side of the building?
>
> Resident: No.

In cases of temporary transitions (i.e. hospitalization), co-residents typically expressed concern and wanted to know about the health and well- being of the missing residents. The co-residents adopted strategies to maintain contact and connection with them by preventing respite residents from taking their dining room seats. When the residents came back from the hospital, they also greeted and welcomed them, an example of coming together. When asked what happens to resident relationships during a resident's temporary hospitalization, the executive director of Oakridge Manor explained

> Ok, in that particular situation, there's always a concern where they want to know: Where did they go? What was going on with them? When are they gonna come back? So you find that there is still that level of anxiety, but they want answers. It always about answers and what I find is that it's a little difficult in this environment because you can only give them so much…So when they go out for a short period of time, there's seems to be this compulsiveness of how are they doing, you know, what's going on, how are they doing. So I think you have more questions, I think they want to know what's going on, they always want to know when they're gonna come back. And one of the things I find is that they're very, let's say we have a respite [resident] coming in and while they're gone they may sit there is that that's not cool with them. They're not open, they're not open in respect of having other people join them at the table or sit at the area where they do certain

things. They always leave the seat open, so they're expecting them to come back.

Similarly, in the following field note passage from Oakridge Manor, Ms. G welcomed and greeted warmly Ms. H who was just returning after being in the hospital for few days:

> Ms. G walked into the reception area and noticed Ms. H. She walked over to her and said, "Welcome home. How are you feeling?" Ms. G hugged Ms. H and explained that they missed her at the book club. We left the ladies to visit. As we did, Ms. H was explaining that she had been in the hospital.

Functional status also indirectly influences coming together and pulling apart by interacting with other categories, such as personal and situational characteristics, social involvement and perceptions, attitudes, personality, and behaviors, including strategies.

Personal and situational characteristics. Personal and situational characteristics, such as being tablemates and neighbors, gender, marital status, and having a private sitter also shape the influence of functional status on the process of coming together and pulling apart. The facility often assigns residents to dining tables and rooms and has policies regarding the use of private sitters. The use of private sitters by residents is also dependent on financial resources of residents to pay for them.

Residents in both Garden House and Oakridge Manor engaged more often with those in closer physical contact, including their neighbors, and this proximity facilitated behaviors related to functional status. As noted earlier, higher functioning residents helped lower functioning ones by pushing their wheelchairs and navigating them to the common areas of the AL and by carrying their shopping bags for those encumbered by a walker, and these helping behaviors tended to happen more regularly between neighbors. Sometimes, proximity related to functional status also led to pulling apart. In the Oakridge Manor, for instance, Mrs. F who was cognitively intact did not tolerate the schizophrenia associated behavior problems of her neighbor, Mrs. I. Following field note data proves this further and show the intersection of factors, including mental illness, being neighbors, intolerance, and facility intervention:

> During the interview, Mrs. F talked about Ms. I and said she used to live next door to

> her…staff member spoke as if she could not understand why Mrs. F was so intolerant of Ms. I. She said it is because of her that Ms. I was moved to the DCU.

Being tablemates also shaped the influence of functional status on coming together and pulling apart. As noted in an earlier section, tablemates helped each other in various ways, including, asking about one another's well-being, improving lighting, finding silverware, and assisting in feeding as well as saving seats , joking about their physical and mental problems, sharing worries related to their conditions, encouraging eating, and offering remedies. They also missed other tablemates who were hospitalized, moved to the DCU or missed meals because of poor health. Similarly, the following data excerpt from Oakridge Manor shows helping among the tablemates because of Mrs. P's painful arm condition and Ms. H's dementia: "During a brief quiet moment, I observed two helping behaviors. I saw Ms. T take Mrs. P's glass of water and help her take a sip. Then, Mrs. D fed a steamed carrot to Ms. H."

Marital status has an influence on the association between functional status and co-resident relationships and interactions. Being married, particularly if one spouse is the primary caregiver for the other, can negatively influence co-resident relationships. It is evident in the following instance from Oakridge Manor, where Mr. M, with very good functional status, is socially constrained because of his caregiving responsibilities for his wife who had severe dementia and incontinence. Field note data elucidate:

> Eventually Mr. M came back to his table and his tablemate Mr. T. He explained that he had to take his wife to the bathroom and she'd decided not to come back. He was gathering up some things from the table to take upstairs to their apartment.

Similarly Mr. M participated in activities, only if his wife's health was good. Thus, in this way he loses the opportunity of making social connections with other residents.

Spousal support further influences relationships with the co-residents because most of the time these residents are unable to develop helping relationships with other residents.

Gender also shaped the influence of functional on co- resident relationships in that residents in general tried harder to accommodate to physical impairments of residents of same gender. This can be

seen in case of Mr. W and Mr. P who were friends and had hearing impairments and used strategies to keep the communication going between them. For a long time, Mr. P and Mr. W had been only men in the Garden House and Mr. W once used a metaphor to describe their male bonding: “There’s not much between a pair of roosters and a bunch of sitting hens.” A data excerpt from the Garden House illuminates their strategy: “Mr. W’s hearing is worse than his and that the two of them don’t get mad at each other because of their hearing but just keep asking the other to repeat themselves when necessary.”

Presence of private sitters also influenced the process of coming together and pulling apart. Oakridge Manor, for instance, allowed a private sitter for Mrs. P, who was confined to a wheelchair, had a sling on her right arm, and slept most of the time. Mrs. P also had enough financial resources to pay for a sitter. The presence of private sitter allowed Mrs. P to remain in her room most of the time, even for meals, which restricted her contact with other residents. Having a private sitter also was a barrier to helping from other residents. Consequently, the closest relationship Mrs. P had was with her private sitter, who seemingly was her life line and made it possible for her to stay at the Oakridge Manor because her care needs were beyond what Oakridge Manor could provide.

These personal and situational factors further influenced residents’ perceptions, attitudes, behaviors, and strategies in shaping the association between functional status and co-resident relationships.

Residents’ perceptions, attitudes, behaviors, and strategies. Based on the presence or absence of functional impairments, residents shape their perceptions, attitudes, strategies and behaviors towards each other. For Instance Mrs. F, an Oakridge Manor resident with good functional status held negative attitudes towards residents with poor function, such as Mr. R. She regularly gave such residents dirty looks and demonstrated little tolerance towards them. She often was frustrated with their behaviors and chose to maintain social and sometimes physical distance from them. The following field note passage demonstrates:

> When Mrs. F came in [to the sunroom], she beckoned for staff member to come there. I heard her say, “Move him,” raising her cane to point to Mr. R. I was slightly taken aback

at this. Mrs. F does not want much to do with some of the really sick, old people.

Unlike Mrs. F, certain residents understand, are compassionate and patient with those who have poor functional status, especially those with cognitive impairments. They were not harsh with them and showed greater tolerance. Field note data from Oakridge Manor elucidate such tolerance of Mrs. H with comparatively good functional status towards the residents with poor functional status during a bible study, when her co-resident Mrs. F made a derogatory remark about Mrs. S on account of her severe cognitive impairment :

> Mrs. H said that we should be sensitive to people who are experiencing dementia and that such behavior is a common occurrence in assisted living facilities. She said that everyone in the room should be thankful that they aren't suffering the same kind of memory problems as Mrs. B.

Along with residents' perceptions, attitudes, and behaviors, strategies also shape the influence of functional status on co-resident interactions and relationships. The underlying strategy of some higher functioning residents is helping other residents, particularly those in wheelchairs. They felt they lacked activities in AL and providing such assistance helped pass the time and was meaningful. The data excerpt from Oakridge Manor further elucidates this strategy of Mr. T, who has good functional status:

> Mr. T told me that there wasn't much to do at the Oakridge Manor. As a result, he spends much of his day 'helping those who can't help themselves." He helps people get around, especially those in wheelchairs. He also helps people get to their rooms and to the bathroom.

This resulted in coming together for Mr. T the formation of helping relationships with co-residents.

Facility level factors like admission/ retention criteria shape residents' perceptions, attitudes, behaviors, and strategies through influence on the overall resident profile. Unlike in Oakridge Manor, the generally higher functioning resident profile in Garden House creates fewer situations for development of

negative perceptions, attitudes and behaviors. The development of residents' perceptions, attitudes, behaviors, and strategies is further influenced by social participation in activities and meals.

Social involvement. Social involvement through participation in activities and meals was influenced by the presence and absence of functional impairments. As noted previously, being tablemates fostered interaction and a variety of helping behaviors, which led to relationships. The executive director of Oakridge Manor explained this interesting dynamic:

> We have, at one of our men's tables, we have a resident who has to have lactose free milk and someone with severe, severe dementia, I was pouring the milk and I was about to pour it in his cereal out of a little container, he says, "No, no, no, no he has to have the special milk". But isn't that something? So that proves the theory of structure, that proves the theory of consistency and looking at this particular resident, because he's had the dementia for so long, but because of that he has been able to maintain so well… And at another table where they're, I find that as the dementia has progressed, at one table there is less verbal communication, but there's still that level of dependency because I see that when they're there, they eat better as a group.

In general, residents with good functional status like Mrs. F were more involved socially exclusively with other higher functioning residents while residents with poor functional status like Mr. R were not. Coming together thus was seen in case of Mrs. F, who had more opportunities for social contact, and pulling apart was seen in case of Mr. R, who had fewer such opportunities.

CHAPTER SIX

DISCUSSION

This qualitative study explored the influence of functional status on older adults' social relationships across two diverse AL settings that varied by size, location, and resident characteristics. By utilizing principles of Grounded Theory Method core category, "coming together and pulling apart" offers an explanatory framework for elucidating variability in types of social relationships experienced by AL residents on the basis of their overall functional status. This key finding further signifies that the influence of functional status is multi-directional, fluid, and operates in different ways in various situations and across time. The conceptual model further explains the direct and indirect association of facility- and resident-level factors with functional status and its influence on co-resident relationships in AL. Study findings advance existing literature on the association between functional status and social relationships in AL by providing an in-depth understanding of how functional status, namely cognitive and physical functioning, operates as a factor in creating or hampering co-resident relationships in AL.

The concept, "coming together and pulling apart" is novel and advances knowledge by describing and explaining the process of variability among co-resident relationships in AL. It highlights the fact that functional status can bring residents together in some circumstances and can also pull them apart in other situations physically, emotionally, and socially—processes that can occur simultaneously or vary over time. As shown, there are various ways residents can come together as a result of their functional statuses. In contrast, pulling apart was evident among certain residents and their social engagement or disengagement with others. The influence of functional status on the process of coming together and pulling apart was dependent in large part on the presence or absence of certain physical and mental impairments, and among those with impairment, levels of impairments, type of impairments, and health-related transitions. As research shows, residents with good functional status (i.e. those with few, if any, impairments who are relatively independent) often have negative attitudes and perceptions of and behave poorly towards those

with poor functional status (Iecovich & Ran, 2006). This analysis also confirms that residents with good functional status often distance themselves from residents with poor functional status and avoid contact (Ball et al., 2005; Perkins et al., 2012). In this study, residents with good functional status engaged in distancing, and hence pulling apart from other residents. They often were intolerant of and frustrated with more functionally impaired co-residents. It also was found that residents without any impairment can come together with residents of poor functional status by showing helping behavior towards them (see also Kemp et al, 2012), by asking about their health and well-being, by showing concern, and by offering advice.

As suggested by existing literature, pulling apart or the barriers in developing relationships related to functional status is almost exclusively seen in residents with certain kind of physical impairments such as hearing impairments, speech impairments, and mobility-related problems and certain mental impairments such as cognitive impairments and mental illness (Dobbs et al., 2008; Kemp, 2012; Park et al., 2012). It was further found in this study that hearing impairments and speech impairments were major communication barriers among residents. Such impairments can make residents end conversations and social interactions altogether. Residents sometimes must yell in order to communicate with hearing impaired or challenged residents. This strategy can lead to frustration or make the person being yelled at uncomfortable. Nevertheless, coming together as a result of hearing loss or impairments was also seen — a new finding that is not evident in existing literature. Helping behaviors in terms of selecting the correct sound volume of TV was observed and involved residents of varying hearing abilities, including those with hearing impairments. Scenarios such as watching movies were venues for these behaviors. Moreover, joking and humor also was seen among residents with and without hearing impairments in ways that illustrate sharing and coming together.

Consistent with existing literature, pulling apart was seen among residents with mobility-related problems. As noted in Chapter 2, stigma (i.e., the assignment of negative worth on the basis of devalued group or individual characteristics) often is attached towards residents using wheelchairs (Dobbs et al.,

2008). In the present study, certain residents complained of those in wheelchairs either by blocking pathways in the dining room or elevator access, and also harming them unintentionally by running over or bumping into them with their wheelchairs. Hence, wheelchair users sometimes were stigmatized in Oakridge Manor where many residents were intolerant towards wheelchair users. The negative self-perception of certain residents with mobility-related problem, including wheelchair users, also restricted them from participating in activities and going on outings, thereby limiting opportunities for social connections with others. Similar to Kemp and colleagues' (2012) and Perkins and colleagues' (2012) findings, helping behavior brings them together through the pushing their wheelchairs and walkers especially to and from mealtimes and activities.

Findings from research conducted in nursing homes (Gubrium, 1975), and AL (Dobbs et al., 2008; Perkins et al., 2012) about social exclusion and stigmatization of mentally impaired residents, which acted as barriers to the development of social relationships among residents (Park et al., 2012), were found in this study. This study confirms these findings and also suggests that in general, residents without cognitive impairments were intolerant towards those with cognitive impairments. These residents typically were intolerant towards these residents who violated social norms, experienced memory loss, and consequently, had repetitious conversations or had difficulty comprehending, or engaged in inappropriate eating practices and improper sexual behaviors. This intolerance further led to conflicts and disagreements among residents and hence restricted both present and future prospects of social relationships. In very rare instances that are not evident in the existing literature, coming together was seen among residents in terms of helping memory-impaired residents locate missing items, reminding them of certain activities, joking around about the memory problems, and encouraging residents with poor appetite to eat. As others have noted, the similarity of functional status in terms of residents having cognitive impairments can lead to friendly relationships with each other (Ball et al., 2005; Doyle et al., 2011) and the formation of cliques (Perkins et al., 2012). It is further found in this study that residents having cognitive impairments were seen spending time with each other, particularly by participating in activities that were

mind stimulating. The pattern of relationships was seen in the group of residents having cognitive impairments where one resident acted as a caregiver for the other residents of the group. As a caregiver of the group, that resident leads the group and reminds other group members of certain activities, helps them when they are sick, and also tries to engage them in conversations. The married couples also acted as caregiver of each other, where one spouse takes care of the other by taking him/her to meals, activities, restrooms, and other common areas. Inter-reliant couples, as described by Kemp (2008), were found in this study, where one spouse acted as a caregiver of the other having cognitive impairments and they also participated in social events together.

Social careers (Kemp et al., 2012) are seen among residents showing permanent transitions, such as decline and moves to the DCU. For residents fortunate enough to forge positive relationships, particularly friendships in AL, decline typically has a negative influence, particularly when it alters living arrangements. It further was found that friendships end altogether when residents are moved to the DCU, resulting in limited or no further interaction. In the case of residents experiencing health declines, friendships also were affected. Residents did not show characteristics of their earlier friendships, such as meeting and greeting almost every day and saving seats for them on an outing.

Others have noted that mental illnesses such as schizophrenia and depression can negatively influence co-resident relationships in AL (Kemp et al., 2012). In this analysis, presence of mental illness exclusively pulled residents apart. Behavioral problems associated with schizophrenic residents scared many of their co-residents and increased their intolerance levels. This condition ultimately hinders relationship development, leading to isolation of mentally ill residents as others distance and avoid them. Meanwhile, residents with depression remain in their rooms most of time and, because of lack of self-esteem and energy avoid activities, distance themselves from co-residents and hence engage in the process of pulling apart. Depression is not a minor issue in AL. A recent national survey found that approximately 28% of AL residents suffer from depression (National Survey of Residential Care Facilities, 2012).

As recognized by Kemp et al (2012), multilevel factors influence co- resident relationships and also are identified in this study in order to understand the factors that directly and indirectly shape their influence on functional status on ties. This study identified and further elaborated the association of these factors with functional status in determining co-resident relationships. It also offers an illustrative conceptual model. As was shown, these multi-level factors shape processes of coming together and pulling apart. The physical environment, facility rules, admission/ retention criteria, activity programming, and staff practices, intervention, levels and organization are various facility-level factors that associate and divide residents on the basis of their functional status. The physical environment explained some of this association further by operating indirectly on functional status's influence on co- resident relationships. As identified by Perkins and colleagues (2012), residents with dementia were socially accepted in small sized facilities and excluded in large size facilities; this is confirmed in the present study where Garden House's smaller size, lower level of cognitive impairments and accompanying, family-- type relationships among residents was seen, and these factors negated the negative effect of poor functional status on residents' relationships. Oakridge Manor's bigger size negatively influenced relationships among residents of varying functional abilities because of comparatively less camaraderie among residents with good functional status compared to the residents with poor functional status, which ultimately pulled them apart. The presence of spaces accommodating residents' wheelchairs and walkers does not give the other residents any opportunity to complain about blocking their ways and hence does not negatively influence their relationships in Garden House. But, narrow aisles in dining halls and limited space for elevator access in Oakridge Manor made the residents intolerant towards residents using wheelchairs because they frequently blocked pathways.

Facility rules and admission/ retention criteria further directly determined residents' profiles in each setting. Overall, Oakridge Manor had residents with poor functional status, as a consequence of lenient admission criteria, involved in the process of pulling apart while coming together was seen in Garden House where residents had comparatively good functional status as a result of stricter admission policies.

Activity programming was another facility-level factor which indirectly defines the association of functional status with co-resident relationships. The type of activities being offered in the facility shapes residents attitudes, behaviors, and perceptions towards residents with poor functional status. Generally, residents with good functional status complained that types of activities being offered in Oakridge Manor were not meant for them and did not match their functional levels. They often blame residents with poor functional status for this practice and engaged in othering and social distancing from them. Unlike in Oakridge Manor, the type of activities being offered in Garden House matched all residents' functional levels as residents do not show much variability in their functional levels. This finding was supported by Ball and colleagues' (2005) study as they found that the facility decreased higher functioning residents' opportunities to interact with others by planning activities that are meant for lower functioning residents.

As illustrated in the Kemp and colleagues' (2012) analysis, staff characteristics also play role in promoting and hindering social relationships in AL. It was further found in this study that staff practices, interventions , level and organization were other facility-level factors that elaborated the relationship between functional status and coming together and pulling apart among residents, exerting an indirect influence on this association. Unlike Garden House, in Oakridge Manor, there were more staff members and also more residents having high level of functional impairments. Hence, staff members were seen most of the time taking care of these residents which invoked the feeling of jealousy among residents with good functional status. As a result, some of the higher functioning residents complained that they did not get the good quality of care. Such a scenario was not evident in Garden House and hence coming together was seen among the residents and confirmed the Ball and colleagues' (2005) study findings that due to fewer staff members in some facilities, residents ask for help from each other and hence become closer.

The various resident factors that influenced the association between functional status and co-resident relationships were resident and situational characteristics, including residents' perceptions, attitudes, behaviors, and strategies, and their social involvement by participating in activities and going for meals. As identified in Kemp and colleagues' (2012) work, situational characteristics or those assigned by

the facility, such as being tablemates or neighbors, and resident characteristics such as gender and marital status (Kemp, 2008), influence resident interactions and relationships in AL. This study further elaborates that the above mentioned situational characteristics and resident characteristics also shaped the influence of functional status on the process of coming together and pulling apart. Being tablemates and being neighbors promoted helping type relationships among residents of variable levels of functional status. Generally, as supported by existing literature, neighboring is an important source of providing support among residents (Kemp et al., 2012), and , as found in this study, neighbors of good functional status helped residents with poor functional status by pushing their wheelchairs and navigating them to the common areas of the AL, and also by carrying shopping bags. As evident in existing literature, being neighbors also made residents "pull apart", where they engage in anti-neighboring interactions by, "bullying, name calling, intolerance, gossiping, shunning, harassing, disagreements, and physical confrontations" (Kemp et al., 2012, p.13) during meals, informal gatherings and while involved in activities. It was further found in this study that this happened sometimes when residents could not tolerate mental illness related extreme behavioral problems of their neighbors and forced staff to relocate those residents and hence engaged in social as well as physical distancing.

Consistent with Kemp and colleagues' (2012, p. 13-14), findings emphasized the importance of mealtimes and the seating arrangements in the dining room in forming co-residents relationships. Meals were sites of various types of co-resident interactions, including "greeting, conversations, tiffs, showing concern, helping and sharing." The present analysis found that, as tablemates, residents come together with others by joking about their physical and mental problems, sharing worries related to their conditions, encouraging each other to eat when one has appetite issues, and also offering remedial advice. They also miss each other when tablemates are absent at meals due to poor health, temporary hospitalization, or more permanent relocations to the DCU.

The present study confirms what existing research suggests about the influence of marital status on relationships. Couples have built-in companionship, but often one spouse adopts the role of informal

caregiver, which limits opportunities for interacting with others (Kemp, 2008; Kemp et al., 2012). The present study adds further knowledge regarding marital status and its influence on the association between functional status and co-resident relationships. Generally among couples, the spouse with good functional status who often engaged in caregiving for the spouse poor functional status was less involved with other residents. Spousal caregiving responsibilities hence pulled them apart from others as most of their time is spent caring for or monitoring their spouse. As suggested by the existing literature, gender also plays a role because men are more prone to develop relationships with the opposite sex in comparison to women (Kemp et al., 2012). The present study further adds to knowledge that being in a minority is an individual characteristic that negates the negative influence of hearing impairment in the small facility, Garden House, where the majority of the residents were females and promoted friendly relationships among the minority of male residents having hearing impairments and also made them use strategies to resolve the communication barrier among them. Being in minority, they were more close to each other as they had less same- sex friendship options.

As evident in existing literature (Ball et al., 2005; Dobbs et al., 2008; Kemp et al., 2012), residents with poor functional status often were avoided and socially excluded as a result of their disability. This direct association is further elaborated in the present study where another grouping of resident-- level factor, i.e., residents' attitudes, behaviors, perceptions, and strategies was guided by the functional status, which further exerted an influence on co-residents' relationships. Generally, residents with good functional status carried negative attitudes, perceptions, and behaviors towards residents with poor functional status and were intolerant toward them. This scenario ultimately involved the process of residents pulling apart from each other. It was further found that in rare cases when residents were tolerant, they very patiently tried to interact with residents having poor functional status and understood and sympathized with their condition and hence engaged in the process of coming together. Residents also adopted strategies to compensate the functional impairments of other residents and hence engaged in the process of coming together.

As supported by existing literature, attending meals and activities were important for promoting residents' interactions and relationships (Ball et al., 2005; Kemp et al., 2012). The present study further elaborates that social involvement also directly affected the relationship between functional status and the process of coming together and pulling apart among residents. In general, residents with good functional status were involved socially by attending meals and participating in activities. Residents with poor functional status were social isolated from others as they were very less involved in activities and also if they go for meals were left isolated by other residents. Hence, in certain instances, even if they tried to socially engage they ended up being isolated from other depending on their types and high level of impairments.

Implications and recommendations

AL communities are gaining popularity. Residents are requiring greater assistance with ADLs are moving to these settings and typically are older and frailer than in past years (Golant, 2008). Current survey data shows that 42% of the AL residents have cognitive impairment and 34% have heart disease, and 38% residents needed assistance with three or more ADL (National Survey of Residential Care Facilities, 2012). Residents' relationships with other residents in AL can be of considerable importance in their lives and are predictors of life satisfaction (Park, 2009) and quality of life (Ball et al., 2000; 2005), but intervening functional status of residents add to the complexity of the relationships that residents experience. The key findings from this study carry importance for the rising numbers of people with variable functional status who inhabit or will inhabit AL in the years to come. As found, mental and physical impairments can act as barriers to social interactions and relationships, but positive aspects of social relationships like helping, inquiring, informing, showing concern, giving advice, sharing problems related to health, sympathizing, and maintaining contact during temporary transitions can also be seen among the residents. Hence, there are various recommendations that can be made on the basis of this study's findings to reduce the negative influence of functional status on the development of social relationships among residents. First residents, staff, and families should be educated about various physical and mental impairments and their related symptomatologies. This education could help residents (who are capable of

learning) understand their co-residents' conditions and perhaps be more sympathetic, which would help promote the positive attitudes, behaviors, and perceptions. Similarly, staff members' knowledge about residents' impairments related symptomatology could make them act in supportive and positive ways during residents' impairment-related scenarios, such as settling conflicts caused by residents' cognitive impairments. Consequently, they could identify ways to promote interactions among residents and could help in reducing the divide between residents of variable functional status. As the existing literature illustrates, families play a key role in the development of co-resident relationships (Kemp et al., 2012) and sometimes families promote stigmatization of cognitively impaired residents (Dobbs et al., 2008). Therefore, educating families also could be useful in encouraging co-resident relationships, including those residents with relatively poor functional status.

Also, residents with certain type of impairments could be encouraged to use adaptive devices. For instance residents with hearing impairments should be encouraged to use hearing aid so that the impairment-related communication barriers can be reduced. Measures should be taken to provide resources or support to residents to buy adaptive devices, which are highly expensive and not affordable.

If possible, residents also should be encouraged to adopt a healthy lifestyle by participating in group exercise sessions. Such participation can promote interactions among residents and also slows or reduces the chances of permanent transitions, such as decline and associated moves to the DCU. Even the existing literature shows that incorporating walking programs in the daily schedule of AL residents can improve their chances of social interactions, physical health, and higher perceptions of life (Lu et al., 2011; Taylor et al., 2003). Even, if residents prefer not to participate in group exercise sessions, measures should be taken to use an individualized approach in prescribing exercises for them, which could later improve their overall physical and subjective health. Any improvement in health also could make the residents involve socially in activities and indirectly help in promoting interactions and relationships with co-residents.

Facilities should also adopt a measure to educate their staff about social relationships and roles

they play in enhancing social relationships and reducing barriers related to residents' functional status. As mealtimes are also important for promoting social interactions, measures should be taken to provide seat assignments not on the basis of availability. Assessing residents so that the residents having commonality in interests and professional backgrounds could be seated together as a potential strategy. This practice could ultimately reduce the negative effects of functional status and promote interactions among residents of differing functional statuses.

In general, activities should also be devised according to residents' needs, preferences, abilities, and interests by adopting an individualized approach. Measures should be taken to reduce conflicts and disagreements among residents with variable functional levels during group activities. For instance residents with dementia-related comprehension problems and hearing impairments could sit close to the activity leader. By sitting close by residents with these types of impairments can listen to the activity leader's instructions, ask questions directly to them, and not interrupt the ongoing activity. The facility should educate staff about measures that need to be taken to abolish functional status related co-resident relationship barriers during activities. Activity-related evaluation should be completed on a frequent basis so that residents can engage in activities that best match their preferences and changing functional levels. AL facilities should also design their common areas spacious enough so that wheelchair bound and walking residents can easily ambulate and should not block the ways. As suggested by Lu and colleagues (2011), there also should be corridors with hand rails, flooring safe for walking, areas for resting, and corridors wide enough for two walkers which could promote social relationships among residents.

Strengths, limitations, and future directions

This study's strength lies in the fact that the primary data is rich, gathered in a variety of ways, from multiple perspectives and collected over a one year period by a trained team of researchers. Findings advance the literature by offering a new explanatory framework for explaining the influence of functional status on relationships in this setting. The framework is more nuanced and shows the complexity of the processes than existed previously in the literature.

Nevertheless, there are certain limitations to my study. The study is limited in terms of data availability. The research questions determining the effect of functional status on social relationships were answered only on the basis of available data. Nothing was modified or added in terms of interviewing and observing residents based on the research questions of my study. Ideally, Grounded Theory Method is conducted where data collection and analysis occur side by side and data can be saturated during the study by modifying interview questions. Moreover, I did not get an opportunity to observe and look at the settings and people through my eyes. Every person's way of looking at and attaching meaning to the things varies according to their background and experience. I depended on data collected by other observers and recorded according to the meanings they attached to the situations. Although, I got an opportunity to visit Garden House once and observed the physical environment, I did not get the chance to observe the day-to-day life and activities of residents. There is another limitation in terms of the type of functional impairments that are hidden like impairments related to arthritis, Guilin Barrie syndrome, multiple sclerosis and some skin disorders like psoriasis that are not always apparent or described, but could impact social relationships. Hence, there are various unanswered questions that can be explored in the future studies by conducting actual qualitative or mixed method studies. There are various conditions that are very common among AL residents such as bladder incontinence, heart disease, bowel incontinence, osteoporosis, diabetes, Parkinson's disease, multiple sclerosis, and pressure ulcers. These conditions and there consequent effect on co-resident relationships should be explored in future studies as these conditions are most prevalent among AL residents. Further analysis should make use of quantitative data where firstly the level of functional impairments of residents should be measured by utilizing ADL and IADL scales and similarly the social characteristics such as social networks and social support should be measured. The statistical association should be identified and explained alongside findings from the qualitative data. There is also a need for future studies to explore the novel concept of, "coming together and pulling apart" by conducting actual studies involving a bigger sample, so that this concept and related recommen-

dations for reducing functional status related barriers can be applied for the benefit of large and growing AL resident population nationwide.

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Appendix A

NEGOTIATING SOCIAL RELATIONSHIPS IN ASSISTED LIVING:
THE RESIDENT EXPERIENCE

OBSERVATION GUIDE

SUMMARY OF TOPICS (A detailed guide for each topic follows the summary)

I. Planned Group Activities:
Bingo, exercise sessions etc.
Parties

II. Informal Group Activities:
Television (e.g., residents assemble to watch sports)
Smoking, talking in groups, playing cards
Residents helping with facility chores

III. Solitary Activities:
Sewing, reading, working crosswords, etc.
Writing letters
TV watching

IV. Mealtimes
Breakfast
Lunch
Dinner
Organized snack time

V. Residents Leaving the Facility
Alone
With other residents, family, friends, provider
Field trips with facility

VI. Visitations
From residents, family members, friends and other from wider community

VII. Unexpected Occurrences
Medical emergencies
Other crises

VIII. Helping Behaviors:

ADL / IADL help
Helping around facility

NEGOTIATING SOCIAL RELATIONSHIPS IN ASSISTED LIVING:
THE RESIDENT EXPERIENCE
OBSERVATION GUIDE

I. Planned Group Activity

Researcher: _____
Date (include day of week): _____
Time: _____
Length of Observation:_____
Descriptive Notes:

Where does the activity occur?

What were the sequences of events? **(Timing of events)**

Who is present at the beginning?
How long do specific events last?
What signals the end of the activity?

Who was involved in the activity?

Who stayed for the entire activity?
Who left? Why?
Who joined late? Why?
Who needed help doing the activity? Who helped?

Describe the social environment:

How do people organize into groups?
How do they address each other?
How do participants arrange themselves in the social space? (diagram if necessary)
Describe the frequency and type of interactions?
Describe body language (gestures, people's expressions, etc.)
What do people say?

Reflective notes:

II. Informal Group Activities

Researcher: _____
Date (include day of week): _____
Time: _____
Length of Observation:_____
Descriptive Notes:

Where does the activity occur?

What are the sequence of events? (timing of events)

Who is present at the beginning?
How long do specific events last (e.g., Wheel of Fortune was on for 1 hour)
What signals the end of the activity?

Who is involved in the activity?

Who stayed for the entire activity?
Who left? Why?
Who joined late? Why?
Who initiated the activity?

How are things done?

Is anyone excluded/not invited?

Describe the social environment:

How do people organize into groups?
How do they address each other?
How do participants arrange themselves in the social space? (diagram if necessary)

Reflective notes:

III. Solitary Activities

Researcher: _____
Date (include day of week): _____
Time: _____
Length of Observation:_____
Descriptive Notes:

Who is involved?

Where did the activity occur?

Is residents' room?
Facility common space?

What were the sequence of events? (timing of events)

What events led up to the activity (e.g., resident's wishes were ignored in TV room)
Did resident take a break from their activity? (How long did the break last?)
What signaled the end of the activity (e.g., resident was tired, meal started, was interrupted)?

How were things done?

Due to disability, did the resident have to use special strategies?

Describe the social environment?

Was the resident alone in their room?
Were others watching?
Describe the environment (room, social climate)
If helpful, diagram the setting
Was anything said?

Reflective notes:

IV. Mealtimes

Researcher: _____
Date (include day of week): _____
Time: _____
Length of Observation:_____
Descriptive Notes:

Describe sequence of events

Who arrives early for meals? Why?
Who arrives late? Why?
Do residents arrive in groups or alone? who accompanies whom?
How long do meals last?
Describe events that occur, e.g., dispensing medications, disruptions

Where do people sit for meals?

Do residents sit in different locations each time?
How do residents find their seats (e.g., are there place cards/do staff direct them?)
How do residents decide where to sit, with whom to sit?
How are tables/seating arrangements arranged (e.g., males with males)
Make diagrams
Note changes in seating patterns
Are any residents absent? Who notices if they are? What is said?

Describe the social environment:

How do the residents relate to each other (e.g., helping each other/ignoring each other)?
Do conflicts occur between residents? If so, what is said?

Reflective notes:

V. Residents Leaving the Facility

Researcher: _____
Date (include day of week): _____
Time: _____
Length of Observation:_____
Descriptive Notes:

How were things done?

Did someone pick the resident(s) up/Did resident walk take a bus?

***If Known* --Where did the resident (s) go?**

Describe the social environment:

How do the residents relate to each other (e.g., helping each other/ignoring each other)?

Do conflicts occur between residents? If so, what is said?

Reflective notes:

VI. Visitations

Researcher: _____
Date (include day of week): _____
Time: _____
Length of Observation:_____
Descriptive Notes:

Who is involved in the visit?
Note participants and relationship to the resident

Where did they visit? (e.g., in resident's room, picnic area outside)

What were the sequence of events?
Was the visit planned/spur of the moment/daily or weekly regular activity?
What happened during the visit? (How long was each activity?)

What was done? (e.g., talking, eating, walking, etc.)

Describe the social environment:
How do the resident and visitor(s) relate to each other
Is there conversation?
Who talks to whom?
How do they address each other?
What do they say?
Do conflicts occur? If so, what is said?
Are visitors attentive to residents' needs? If so, what do they do?
Is resident attentive to visitor(s)' needs? If so, what does he or she do?
Describe body language (gestures, people's expressions, etc.)

Reflective notes:

VII. Unexpected Occurrences

Researcher: _____
Date (include day of week): _____
Time: _____
Length of Observation:_____
Descriptive Notes:

Where did the activity occur?

What were the sequence of events (timing of events)

Who was involved in the activity?

How were things done?

Describe the social environment:
How do participants relate to each other?

Do conflicts occur? If so, what is said?
Are other participants attentive to residents' needs? If so, what do they do?
Describe body language (gestures, people's expressions, etc.)

Reflective notes:

VIII. Helping Behaviors

Researcher: _____
Date (include day of week): _____
Time: _____
Length of Observation:_____
Descriptive Notes:

Where did the activity occur?

What were the sequence of events? (timing of events)
What events led up to the activity (e.g., was it routine or did resident have an urgent need)?
Did the resident ask for help?
Did someone ask the resident for help?
Was the activity interrupted? (for how long?)

Who was present?
Did the resident have the privacy they needed?

How were things done?
How much help did the resident get (give)?
Describe procedure, give details

Describe social environment:
How do the participants relate to each other?

Is there conversation?
Who talks to whom?
How do they address each other?
What do they say?
Do conflicts occur? If so, what is said?
Are participants attentive to each other's needs? If so, how?
Describe body language (gestures, people's expressions, etc.)

Reflective notes:

Appendix B

NEGOTIATING SOCIAL RELATIONSHIPS IN ASSISTED LIVING:
THE RESIDENT EXPERIENCE

IN-DEPTH ADMINISTRATOR INTERVIEW
FACILITY RULES

Now I would like to ask you about some of your policies or house rules. (Get written list if available)

1. Could you describe your policies about: (Probe about whether enforced or not)

   Residents helping other residents

   Seating assignments for meals

   Participation in organized activities

   Residents spending times in their rooms

   Residents eating meals in their rooms

Information about Residents

The next questions are about the kinds of residents you serve.

2. Now, could you describe your current resident who requires the most care. (Probe for needs and care given)

3. What about the resident who is most difficult?

4. Could you tell me about any behavior problems residents have?

Resident-Resident Relationships

Now let's move on to residents' social relationships. Let's start with the focus of this study, residents' relationships with other residents.

5. How would you describe the social relationships between residents?

Probes:

What kinds of relationships would you like to see develop between residents?

Do friendships develop between residents?

Are there disagreements between residents? If so, what are the sources and how are they resolved?

Do cliques develop among the residents? If so, what is the basis for including and excluding certain residents?

To what extent do residents gossip about other residents? Who? Why?

Could you tell me about residents who might be socially isolated?

6. Could you describe any help residents give to one another?

Are there any rules about helping?

6. What happens to residents' relationships when someone leaves the facility?

Probes:

What happens to resident relationships if a resident leaves temporarily (e.g., a hospital stay)?

Are resident relationships maintained when a resident moves to another area of the facility such as the Dementia Care Unit? (If applicable)

What happens to relationships if a resident moves to another location?

Factors Influencing Relationships between Residents
This next set of questions deals with factors that influence residents' relationships with others.

7. What do you think promotes positive relationships between residents?

8. What do you think prevents positive relationships between residents?

9. How does a resident's health status influence their relationships with other residents?

Probes:

Physical health

Mental health

Cognitive functioning

What happens when there is a change in functional or cognitive health status?

Appendix C

ACTIVITY DIRECTOR INTERVIEW

ACTIVITY PROGRAM

Now, let's talk a little about the activity program you have here.

1. Could you tell me about your activity program?

Types of activities
Variation in activities for men and women, different disability levels, cultural differences

2. What are your goals for your activity program?

3. Who participates in activities?

Variation based on activity type
Cognitive and physical status
Type of resident most likely to participate

4. What do you think keeps some residents from participating?

Variation based on activity type

Now let's talk more generally about residents' social relationships with other residents.

5. Could you describe any help residents give to one another?

Type of help
Type of resident
Any facility rules about helping?

6. What do you think prevents positive relationships between residents?

7. What do you think promotes positive relationships between residents?

8. How does a resident's functional status influences their relationships with other residents?

Probes:
Physical health / Mental health
Cognitive functioning

What happens when there is a change in functional or cognitive health status?

9. What happens to residents' relationships when a resident leaves the facility?

When they leave temporarily
Transferred to the DCU or nursing home?

Appendix D

DIRECT CARE STAFF INTERVIEW

1. Could you describe any help residents give to one another?

   Type of help
   Type of resident
   Any facility rules about helping?
   How does helping affect relationships?

2. What do you think promotes positive relationships between residents?

   Why?

3. What do you think prevents positive relationships between residents?

4. How does a resident's health status influence their relationships with other residents?

   Probes:
   Physical health
   Mental health
   Cognitive functioning
   What happens when there is a change in functional or cognitive health status?

5. What happens to residents' relationships when a resident leaves the facility?

   When they leave temporarily
   Transferred to the DCU or nursing home?

Appendix E

NEGOTIATING SOCIAL RELATIONSHIPS IN ASSISTED LIVING:
THE RESIDENT EXPERIENCE

TYPE 2 RESIDENT INTERVIEW GUIDE

What led to your move to the facility?

Probe for:
What were the events precipitating the move (e.g., change in health status, change in support system, etc.)

How long have you lived in this home?

How was this particular home chosen?

Now let's talk about mealtimes.

Which meals do you go to?

Probe for:
Why does or does not go.
Whom do you usually sit with?

Probe for:
Differences in seating patterns
Reasons for seating patterns, any variability, rules, degree of choice
Satisfaction with seating pattern

Have you ever moved from one table to another? Why?

What would make you not want to sit with another resident?

How do you think where you sit affects friendships with other residents?

Are you friends with residents at your table? Why or why not?

SOCIAL SUPPORT NETWORKS

These questions are designed to find out more about residents' ADL and IADL needs and abilities and the function of their social support networks in these activities. This section also will address help residents provide to others. The social network map will be used as a guide in asking these questions.

Help Needed and Received:

For the activities that the resident has indicated in Type 1 interviews they need help with, ask if any changes have occurred in the following and reasons for the change:

Kind of help needed
When, how often needed
Verify who provides (facility caregivers, family, friends, other residents)
How / where provided
What led to change and when change occurred

Is there any help you need now that you are not receiving?

Probe for:

Type of help desired
Reasons for not getting
Who would like to provide

How do you feel about being helped?

Probe for:

Variation in feelings related to who performs and to the type of help

Help Provided:

For the help that the resident has indicated in Type 1 interviews that he or she provides to others, ask if any changes have occurred in the following and reasons for the change:

Kind of help provided
When, how, how often
Why provided
Verify who provided to (family, friends, other residents)

How do you feel about helping?

Probe for:

Variation in feelings related to who helps and type of help given

SOCIAL RELATIONSHIPS/INTERACTIONS

These questions address the resident's social life, with whom contact is maintained, how, when, how often, what these relationships and interactions mean, what barriers interfere with, and how much choice and control resident has over them

RELATIONSHIPS WITH OTHER RESIDENTS

Let's talk about your relationships with other residents.

First, how do you get to know other residents in the home?

Probe for:

During activities
In dining room
Through other residents, staff
Personal strategies

Now, tell me about which resident(s) you are closest to in this home.

Probe for:

When they met
How they met
How often they get together, where, and when
What they do together
Level of satisfaction with type and amount of contact
What about this person they like

Have you made new friends this year?

Probe for:

Who
When they met
How they met
How often they get together, where, and when
What they do together
Level of satisfaction with type and amount of contact
What about this person they like
What led to the friendship

Who is your best friend?

Probe for:

Who, whether resident or not
When they met
How they met
How often they get together, where, and when
What they do together
Level of satisfaction with type and amount of contact
What about this person they like
What led to the friendship

Are there any residents you avoid contact with?

Probe for:

Who
Why
When, how often, where

How much time do you spend alone?

Probe for:

Whether has enough "alone" time
Times of day / daily activities when social contact preferred

Could you describe any help you give to other residents? (unless covered earlier in interview)

Probe for:

Who residents are
Type of help given and frequency
Attitudes/values about helping
Barriers to helping, facility rules

Could you describe any help other residents give to you? (unless covered earlier in interview)

Probe for:

Who residents are
Type of help given
Satisfaction with help
Attitudes/values about being helped
Any differences to being helped by family members or staff

Factors Influencing Relationships with Other Residents

Transitions

Have you lost any friends this year?

Probe for:

Who
When they met
How loss occurred- death, move, transfer
How they met
How long they had known the person
How feel about the loss

How did you deal with this loss?

Probe for:

Personal strategies
Help from others
Who, type of help, outcomes for resident

What happens when a friend declines mentally or physically?

Probe for:

Effect of specific type of decline

Changes in interaction and support patterns

Are you friends with residents in the DCU or in the nursing home (for facilities with more than one care level)?

Probe for:

Who

Type and frequency of interaction

When they met / how they met

Barriers to continuing friendship

Appendix F

Facility Code: _____ **Resident Code#**

If resident did not list any other residents in their network map, ask them the following question:

In talking about people who are most important to you now, you did not name in other residents who live here. Could you talk a little about what kind of relationships you have with other residents? [Record verbatim]

If the resident names quite a few residents in their network map, ask them the following question:

I notice you listed quite a few residents as being important to you in your social network. Could you talk a little bit about how these relationships came about? [Record verbatim]

[1]Generally, there are four types of networks i.e. diverse, family focused, friends focused and restricted. Restricted networks are further divided into two types i.e. restricted non-friends unsatisfied and restricted non-family unsupported. The restricted non- friends unsatisfied type of networks consists of those who are unmarried, have smaller network size, have low frequencies of contact with friends, less involvement in activity and very low emotional support and satisfaction from the relationships. The restricted non- family supported network type consists of those who are unmarried, have small geographically distant networks, have low frequency of contact with families, low involvement in the activity, low emotional support but relatively more satisfied with the relationships. The restricted non-friends unsatisfied network type is associated with high depressive symptomatology and diverse type is associated with low depressive symptomatology (Fiori, Antonucci& Cortina, 2006; Fiori, Antonucci& Akiyama, 2008). The behavioral and physiological mechanisms may also describe the association of social relationships with health although the empirical evidence supporting these pathways is scanty (Berkman, 1995).

[1]The data for this study come from a subsample of the first wave of the survey of Aging, Status, and the Sense of Control (ASOC), completedin 1995. It consists of the sample of 1,103 older adults ranging in ages from 60 to 95 years. Information about the anticipated social support was collected by means of four item scale asking about their agreement regarding any social support in the future. The information about the functional disability was collected by means of their responses on their perceived difficulty in performing 5 instrumental ADLs and tasks from Nagi physical functioning scale.
[1]Data for this study were collected from the sample living at communities in New Haven by means of interviews conducted on yearly basis from 1982-1991. Participants were 65 years and over. Six items index of ADLs (Branch, Katz, Kniepmann, &Papsidero, 1984), like bathing, eating , dressing, using the toilet, walking across a small room, bed to chair transfer and 3 items Rosow- Breslau index (Rosow& Breslau, 1966), like doing heavy household work, walking up and down the stairs and walking half a mile were used to measure their disabilities. Social network ties were measured by using a scale which identifies the number of ties through face to face contacts, non-face to face contacts and geographic proximity with children, friends, relatives and confidant. Social support was measured in two aspects of emotional support like talking about problems and instrumental support like helping in IADLs.

[1]There was a study conducted by Golden and Colleagues (2009), in which data were collected from 1,299 community dwelling older adults above the age of 65 by means of interviews. Information about loneliness, depression, well- being, hopelessness, life satisfaction and happiness was collected by Geriatric Mental State (GMS), social networks were assessed using the Practitioner Assessment of Network Type schedule developed by Wenger. It was found that loneliness and non- integrated social networks both independently affects the mood and well- being of the sample. Hopelessness and depression is also seen in them which might engage those people in the act of self- harming, thus affecting their health.