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Social Support in Elderly Nursing Home Populations: Manifestations and Influences

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Abstract

The purpose of this study was to describe the characteristics of social support and the influencing factors on social support in nursing home environments. Observations and staff questionnaires from two central Florida nursing homes were used in this grounded theory study to answer the following questions: (1) How is social support manifested? and (2) What are influences on social support? Social support manifestations seemed predominantly superficial and did not appear to involve complex reciprocal relationships, however, when reciprocal resident tasks were observed, they appeared to have significant value and were sources of pride for the residents. Facility behaviors and policies required by governmental mandates appeared to result in significant resident dependency, a situation that mitigates against significant social support.

Keywords

Social Support, Nursing Home, and Elderly

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Social Support in Elderly Nursing Home Populations: Manifestations and Influences

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The purpose of this study was to describe the characteristics of social support and the influencing factors on social support in nursing home environments. Observations and staff questionnaires from two central Florida nursing homes were used in this grounded theory study to answer the following questions: (1) How is social support manifested? and (2) What are influences on social support? Social support manifestations seemed predominantly superficial and did not appear to involve complex reciprocal relationships, however, when reciprocal resident tasks were observed, they appeared to have significant value and were sources of pride for the residents. Facility behaviors and policies required by governmental mandates appeared to result in significant resident dependency, a situation that mitigates against significant social support. Key Words: Social Support, Nursing Home, and Elderly

In the year 2040, 77 million Americans will be over the age of 65 (Stone, 1999). Since an estimated 1,465,000 people over the age of 65 occupied nursing homes on any given day in 1997 (Gabrel, 2000), a large number of this aging population will undoubtedly require some type of long-term care.

Recognizing the generalized perception of substandard quality of life in nursing homes, the Institute of Medicine recommended in 1985 that residents should be cared for in such an environment as will promote maintenance or enhancement of their quality of life. (Uman et al., 2000, p. 167)

Repeatedly researchers have reported on the health benefits resulting from social support (Cohen-Mansfield, 2000; Lee, 1985; Siebert & Mutran, 1999). According to Atchley (2000), social support consists of people we can count on to provide ongoing emotional support, affirmation, information, and assistance, especially in times of crisis. Interestingly, nowhere is the enormity of the impact of social support potentially more critical than in the institutionalized elderly.

Purpose

The purpose of this study was to identify the characteristics of social support and the influencing factors on social support in a nursing home environment. Analysis of the social support dynamics within these long-term care or nursing home settings, particularly the relationships between residents, and the meanings and characteristics of

these relationships, as well as the influences on social support, may potentially contribute to increased holistic and resident-centered services and perhaps enhanced resident well-being.

Literature Review

Definition of Social Support

Atchley's (2000) aforementioned definition of social support is a broad definition of social support. Other academic theoretic definitions add that the recipient should have a perception of someone caring for them and a resultant sense of well-being (Hupcey, 1998). Hupcey enumerated the factors required for social support as follows: (a) the act of providing a resource, (b) the recipient having a sense of being cared for or a sense of well-being, (c) the act having an implied positive outcome, (d) the existence of a relationship between the provider and the recipient, (e) support not given from or to an organization, the community, or a professional, and (f) support that does not have a negative intent or is given grudgingly.

Given these constraints, it is unclear as to whether social support is present in cases of critically ill, incoherent recipients, in cases of negative outcomes in which either the recipient or provider perceive the support actions as positive, in support given from or to an organization, the community, or a professional, and in support that has a negative intent or is given grudgingly.

In order for social support to yield maximum life satisfaction benefits, it must include the ingredient of reciprocity (Lee, 1985). Reciprocity involves mutual sharing or giving and helps to sustain self-worth. In fact, Hess and Soldo (1985) reported that impairment actually increases as reciprocity decreases.

Theories of Social Support

Theories related to social support are both divergent and overlapping. The convoy theory of social support describes three layers of support protection: the innermost layer or most intimate and important social support providers, the second layer that includes important, but less intimate, social support providers, and the outer layer that is close only in respect to the function of an individual's role, as in the case of a co-worker (Siebert & Mutran, 1999).

Activity theory proposes that social activity and involvement with others results in an increased ability to cope with aging, improved self-concept, and enhanced emotional adjustment to the aging process (Lee, 1985). Activity theory presumes that changes in social involvement are imposed by society. For example, mandated retirement ages often isolate elders from work related social contacts. Additionally, fixed incomes imposed by retirement often limit the ability to engage in certain social activities.

In contrast, disengagement theory assumes that social involvement decreases with aging, and is a normal part of the aging process that is independent of other aging phenomena (such as debility), and is mutually beneficial for both the individual and society (Lee, 1985). Elders often disengage as a means of cushioning themselves from the inevitable grief due to loss of peers from illness and death (Lee). Additionally, elder

disengagement makes room for younger individuals entering the work force or seeking leadership positions.

Exchange theory postulates that there is a dependence of those with fewer resources upon those with greater resources resulting in a social power disparity (Lee, 1985). This dynamic may offer an explanation as to why elders frequently prefer peer relationships that are more likely to offer equality rather than cross-generational relationships.

For the purposes of this study, Hupcey's (1998) delimited definition of social support was used. Additionally, all of the aforementioned social support theories were considered when observing the phenomenon of social support in a nursing home environment. Due to the limitations of the study, resident perceptions of relationships and of the impact of those relationships on residents' sense of well-being had to be surmised from observations. Therefore, it is difficult to truly know whether observed isolation was a negative attribute as described in the Activity theory or a normal aging process as described by the Disengagement theory. Additionally, the Exchange theory can be used to explain the limited benefits that might be gained through resident-staff interactions.

Research Design

Methods

This research was founded within a grounded theory perspective. Grounded theory involves the inductive construction of categories from the observed data, not from preconceived hypotheses, and then the determination of relationships among these categories via discoveries from continued observations (Charmaz, 2006; Tesch, 1990). The topic of social support was selected based on its reported importance to health and well-being, and the scarcity of social support overtly witnessed during the 10 years the researcher spent as a nurse practitioner, making twice-weekly rounds at nursing homes. Grounded theory, as further defined by LaRossa (2005), includes elements of induction, deduction, and verification and cannot be disengaged from the researcher's experiences. As such, this research attempted to describe social support among elderly nursing home residents and illustrate the influences on social support in this environment.

Observations and staff questionnaires from two central Florida nursing homes were used to conduct this grounded theory study and were used to answer the following purposive questions: (1) How is social support manifested? and (2) What are the influences on social support? The first question was intended to illuminate the researcher's prior impressions of the limited existence of social support in nursing homes. The remaining question was intended to discover factors that may have influenced social support within the nursing home environment.

Setting

The setting for this study included two central Florida nursing homes that represented diverse populations, fee structures, and philosophies of care. They were selected from a listing retrieved from *The Florida Nursing Home Guide* provided by the Agency for Health Care Administration (AHCA, n.d.), based upon their apparent

demographic differences and their convenience to the researcher's location. In order to verify these differences and philosophies of care, inquiries were made to the admissions coordinators at two central Florida nursing homes. The admission coordinators of the selected facilities were asked about their facility's philosophy of care (organization-centered or patient-centered), bed capacity and types (i.e., Medicaid, Medicare, private pay, or mixed), and patient demographics (e.g., average age of residents, length of stay, gender, reason for admission). While it is possible that facility population sizes might have affected outcomes, there was no attempt to match the facilities' total bed capacities.

Once access was granted, a request for a facility liaison to serve as an orientation guide to the facility was assigned by the administrators. The liaison appointed at one facility indicated that she lacked the time to assist with an orientation and the liaison at the other facility resigned prior to the initiation of data collection. The researcher's sense that the task of being a liaison was an unwanted burden being added to the liaisons' busy work schedules induced no further pursuit of liaisons. In hindsight, effective liaisons might have improved staff understanding of the researcher's presence and increased staff participation.

Institutional review board permission was granted to conduct this study by the author's academic institution. While there were no institutional review boards for either of the facilities, the facility administrators were apprised of the study and consented to permit observations in what were deemed public or communal areas. Because elders are regarded as vulnerable populations akin to children or prisoners, and given the many that are diagnosed with dementia and their competence to consent to participation would be questionable, no permission was sought to interview facility residents. Researcher conversations with residents were initiated by the residents and not purposefully pursued.

Nursing home Diamond is a non-profit 60-bed facility. Fifty-eight of these beds are in semi-private rooms and two are in private rooms. This facility accepts both Medicare and private insurance, and maintains a nearly full census. The lowest daily charge at this nursing home is reported in *The Florida Nursing Home Guide* provided by the Agency for Health Care Administration (AHCA, n.d.) to be \$122. In the local community, Diamond is commonly considered to be an affluent nursing home. Adult independent living and congregate living facilities are located on the premises. Although not confirmed, it is possible that residents of Diamond transitioned from these other adjoining facilities, and relocated from the independent living and adult congregate living to the nursing home sections as their debility progressed. This factor could potentially increase their social networks through a familiarity with other translocated residents.

Nursing home Ruby is a for profit 103-bed facility that includes 86 semi-private rooms and 17 private rooms. This facility accepts Medicaid, Medicare, private insurance, HMO insurance, VA, CHAMPUS, and worker's compensation. The average census typically ranges from 85-90 residents, 59% of whom are insured by Medicaid. The lowest daily charge at this facility is reported by *The Florida Nursing Home Guide* provided by the Agency for Health Care Administration (AHCA) to be \$115. In the local community, Ruby is commonly considered to be a middle income nursing home. During the course of this study, Ruby's ownership changed. While local management and staffing remained essentially constant, policies and procedures affecting residents and staff changed. Staff reported reductions in their benefits, and a substantial decline in the resident census.

It should be noted that the nonprofit and for-profit differences between each facility would suggest that any profits earned from resident fees would be reinvested in the facility in the case of nonprofit organizations, and could be issued to shareholders in the case of for profit organizations (Firoz & Wightman, 2002). These differences likely have more impact on tax structures than on the respective facilities' philosophies and implementations of care (Firoz & Wightman).

A third nursing home representing a lower socioeconomic population of predominantly African American residents was invited to participate in this study. However, due to this facility's ongoing construction and renovations, residents were being continually displaced, and it was deemed inappropriate by the administrator to conduct this study within this facility at this time. No other facilities within this general locale met the specific demographics of this nursing home. Thus, no further facilities were sought for this study.

Sample

Since this research was designed to describe features of the life of a particular subculture, the sample population was inclusive of the entire selected nursing homes' public milieus including staff, visitors, and residents of all ages. While observations for this study focused on elderly nursing home residents, no specific age demarcations were prescribed for the residents being observed.

Although resident demographics were not precisely determined, the population residing at Diamond was observed to be more homogenous in respect to age, race, and ethnicity than that of Ruby. Residents at Diamond seemed to be generally older and all appeared to be of Caucasian descent. Residents at Ruby were of varied races, ethnicities, and adult ages.

Staff participants were selected based on purposive sampling. Efforts were made to include staff members from a variety of disciplines (activity coordinators, administrators, therapists, nurses, nursing assistants, and other service staff). Only staff members who were unable to communicate in English, and were unwilling to allow available interpreters to assist them, were excluded from participation in this study. Nursing home staff typically represent a wide variety of races and ethnicities and hence, different spoken languages. It is quite likely that language barriers distanced the researcher from these employees and contributed to their reticence to participate. It is unknown whether the perspectives of these employees might have offered additional or alternative insights.

Although more than 30 staff members were approached at Diamond, only 15 staff members agreed to accept questionnaires, and only one questionnaire was returned by a Licensed Practical Nurse (LPN). Staff members at Diamond who refused participation indicated a lack of time, a lack of knowledge in the subject matter, or simply refused without offering an explanation.

Questionnaires were accepted at Ruby by 50 staff members including nurses, occupational and physical therapists, activity coordinators, social service staff, maintenance personnel, and administrative professions. A total of six questionnaires were returned from Ruby. Three of them were from LPN's, one from a dietician, one from a physical therapist, and one from a social services director. Only one staff member

(housekeeping) approached at Ruby refused to accept a questionnaire, and her refusal was based on language and literacy barriers. This individual persisted in refusing the questionnaire despite an offering of assistance for completion of the questionnaire.

The seven respondents from the two facilities worked at their respective facilities from one to ten years. One respondent from Ruby indicated temporary status through an employment agency. The three LPN's, the dietician, and the physical therapist had worked with elderly clients for more than 11 years. The social services director had worked with the elderly for one to five years. Respondents described their elder care preparation as formal education, continuing education, experiential job training, and as those experiences involved in being a facility instructor.

Data Collection Procedures

Data were compiled from a series of observations and open-ended staff questionnaires. Staff interviews and focus groups were an intended component of this study, but no staff agreed to participate in these activities. Whether their refusal to participate was due to time constraints, social distancing from the researcher, or a general air of suspicion is unknown. Several staff members inquired as to whether the researcher represented a state survey team member auditing the quality of care of the facility. A facility liaison may have offset this impasse. Regrettably, it was this triangulation of qualitative data that was intended to create a richer base of evidence and enhance the accuracy of interpretations (Thomas, 1993).

Approximately 30, one-to-two hour visits were made to each of the nursing homes over a 6-month period of time. Visiting sequences varied and were randomly made. Visits occurred predominantly during the day and evening shift hours. Since little resident activity was observed in public domains during the late-night time period, night shift visits were minimal. Attempts were made to observe a variety of scheduled formal and holiday time activities.

Observations focused on the interactions of residents with other residents, with family members, with facility staff members, with volunteers, and with friends or other visitors. During these observational visits the researcher stood in hallways, beside nurses' stations, or sat in dining rooms, the activity room, or on the patios. Observations were collected in the form of hand-written field notes. During observational visits, open-ended questionnaires were distributed to all nursing home staff willing to participate in this study.

On one occasion, an elderly male resident with a commanding presence inquired as to what the researcher's function was and why she was writing in a notebook. It was explained that I was studying life in nursing homes. This was received with a grimace, seemingly indicating his disdain for either the environment or the researcher's endeavor. On another occasion, the wife of a resident diagnosed with Alzheimer's dementia made a similar inquiry. She apologetically explained that her husband had been the most wonderful man, but that his disease had caused him to become violent and she could no longer handle him at home.

Several of the facility staff members inquired as to whether I was from the state survey team and there to evaluate the facility. The nature of the researcher's task was then revealed, and their assistance in understanding the life of the nursing home through

questionnaires or focus groups was requested. Numerous visits to the staff break areas were also made in order to recruit staff participation.

Observational and questionnaire data collection strategies were employed in each of the selected nursing homes and collected until patterns appeared to be reoccurring, answers to the research questions were reasonably apparent, or staff members' willingness to participate dwindled.

Instruments

The questionnaire for the nursing home staff members was developed specifically for this research. Individual items were based on a review of several of the social support instruments identified in the current literature. Instruments reviewed for this purpose included: Measures of Perceived Social Support (Turner & Marino, 1994), Social Support Questionnaire (Sarason, Levin, Basham, & Sarason, 1983), and Model of Support Provisions (Haines, Hurlbert, & Beggs, 1996). A pilot study that included interviews of a variety of staff members' perceptions of social support in long-term care at a single nursing home (not used in this study) was conducted by this researcher and provided an additional guide for the content of these questionnaires. Content validity was established through expert opinions provided by the dissertation committee of faculty members overseeing this research. (See Appendix A for interview schedule for staff.)

Data Analysis

Field notes were initially transcribed to the interview section of EZ-TEXT, a Center for Disease Control (CDC) sponsored program for the analysis of text-based data (Carey, Wenzel, Reilly, Sheridan, & Steinberg, 1997). Responses to questionnaires were transcribed to the open-ended question section of the CDC EZ-TEXT analytical program. Separate databases were maintained for each of the two nursing homes.

Analysis began with open coding. Field notes were read and reread, and dissected into discrete parts. Through constant comparisons for similarities and differences, categorical properties were identified that exemplified dynamic relationships that might impact social support. For example, interpersonal interactions demonstrated similarities within resident-family member dyads, but were very different from resident-staff member or resident-resident dyads. Each successive category and subcategory or related category represented typical incidents discovered in the observations.

These constant comparisons continued until additional categorical relationships did not produce new relationships and appeared to be saturated. Structure and function surfaced as larger abstract categories that subsumed the more discrete categories. Structure was labeled milieu and encompassed the entire sensory environment of the nursing homes. A focus on how the properties of the environment influenced social support emerged. For example, observations of dining room social interactions were different from observations in other areas of the facility. However, what appeared to be purposeful manipulations of the environment to create a home-like atmosphere did not seem to influence social interactions. Function was subdivided into interactional patterns and activities that were antecedents or consequences of social support were extracted.

Each of these divisions was further categorized into specific relationships representing various social support dynamics. These sub-categories included: interactions between residents, between residents and staff, between residents and families, and formal and informal activities. The transcribed notes were then methodically read and reread to compare emerging patterns and themes. This review allowed the researcher to essentially reenter the field from new perspectives (Van Maanen, 1995). Sections were highlighted and notes were made in the margins of the text. This process resulted in the addition of new categories, reflecting the literature reviewed for this research; social control and medicalization. The result was the following six core variables: homelike milieu, social control and medicalization, dependence, independence, interactions, and nursing home activities.

Continued coding within each theme or category led to additional subcategories derived to aid reflective insights. For example, during observations at each of the facilities, it was noted that tables in the dining room were adorned with small vases of flowers. This observation was initially categorized as a property of the structure and then subsequently the milieu. Additionally, this was subcategorized as a homelike property of the environment. More detailed observation identified that the flowers at Diamond were real and the flowers at Ruby were plastic. This contrast led to memos that questioned the socioeconomic antecedents that might contribute to this difference, and the consequences that this difference might have on the residents. It was further noted that residents at both facilities appeared unaware of these table accessories. They were never observed to touch or attempt to smell the flowers, and hence did not appear to influence social relationships.

The categories of social control and medicalization were subdivided into the predominating functional activities of daily routines, dining experiences, and medical interventions. While dining experiences are certainly a component of daily routines, it encumbered such a substantial portion of the field notes that it was granted a subcategory of its own. The enormity of the notes attributable to dining experiences was likely due to observations for this study being limited to public domains, as well as the vast amount of time allocated to eating and feeding for the nursing home residents and staff. In both facilities, a great deal of time was spent preparing the dining facilities and residents for meals, serving and eating or feeding food, and then briefly relocating residents to other communal areas or the perimeters of the dining rooms, so that the rooms could be readied for the next round of residents or the next meal time. In Diamond, the dining room constituted the main area of congregation and did double duty as the day room. In Ruby, there was a separate small day room, but the dining room was used for activities that required a larger setting or for television viewing. The dual purposes of the dining rooms often blurred the distinction between meal times and other activities.

The original topics identified were relabeled as resident social support, staff social support, and family social support in order to describe social support's existence in one or more of these relationships, to determine if it differed among these relationships, and again, to uncover how policies and organizational structures might impact the presence of social support. Interactions among all relational roles appeared to occur on a continuum. Therefore, the following subcategories were added to the major theme of interactions: isolation, superficiality, interaction seeking, deeper relationships, and reciprocity. This continuum is consistent with the convoy theory of social support discussed by Sauer and Coward (1985).

Nursing home activities were further divided into the subcategories of formal and informal activities. These activities were differentiated from the daily routines that fulfill medical and survival needs. Formal activities are structured, typically by facility staff, and serve the purpose of resident entertainment. Examples of formal activities might include sing-alongs or bingo games. Informal activities included unstructured events that assisted residents in passing time such as television watching or lining residents up in public domains such as the hallways. In contrast, daily routines were defined as those tasks that were deemed by the staff to be either essential to the resident's physical hygiene, medical needs, or nutritional needs. Examples might include bathing, meal times, or nap times.

Since reciprocity, a key factor in social support (Lee, 1985), requires a degree of independence that permits interdependence, the recurrent themes of dependence and independence were interwoven throughout the other major themes. Dependence appeared to prevail over independence, and was subcategorized through open coding into childlike treatments and hierarchies.

An example of the transition from field notes and observations to memos, categorizations, and analysis follows. This is further explicated in the description of findings (see Table 1: Themes and Subthemes). The following is a brief excerpt from field note observations at Ruby.

Resident: "I can't eat it with THAT!" The spoon had other food on it along with the applesauce. The staff member turns to talk with the visitor at the table and continues to feed the reluctant resident. The resident unsuccessfully attempts to regain the staff member's attention, but eventually gives in and eats her meal. (Field notes, October 2, 2002)

The selected categories and subcategories appeared at once somewhat fragmented and considerably overlapping. Attempts to identify relationships among the categories resulted in what appeared to be antecedents, intercedents, and consequences. Antecedents included structure, function, social control, and medicalization, and appeared to determine the types of interactions that were observed. Intercedents were divided into contexts and conditions. Contexts included special locations, dining activities, daily routines such as hygiene, medical interventions, and activities that were either formally arranged by the facility, such as guest entertainers or Bingo games, or more informally determined by the facility such as television viewing. Intercedent conditions included types of relationships (e.g., staff-resident or family member-resident) and their associated power dynamics (e.g., dependent or independent). The intercedents appeared to determine the degree of interaction that was observed. Antecedents predicted intercedents and the intercedents were interdependent. Finally, consequences of the antecedents and intercedents that identified resultant types and degrees of interactions were labeled as isolation, superficial relations, interaction-seeking activities, deeper relations, and reciprocity. Figure 1 depicts the interrelationships among the categories that surfaced.

Table 1

Themes and Subthemes

Major Themes	Sub-themes
Structure	
Homelike Milieu	
	Socioeconomic differences
Function	
Social Control & Medicalization	Daily Routines
	Dining Experiences
	Medical Interventions
Dependence	Childlike Treatment
	Hierarchies
Independence	
Interactions	Superficiality
	Isolation
	Interaction Seeking
	Deeper Relationships
	Resident Social Support
	Reciprocity
	Family Social Support
	Staff Social Support
Nursing Home Activities	Formal Activities
	Informal Activities

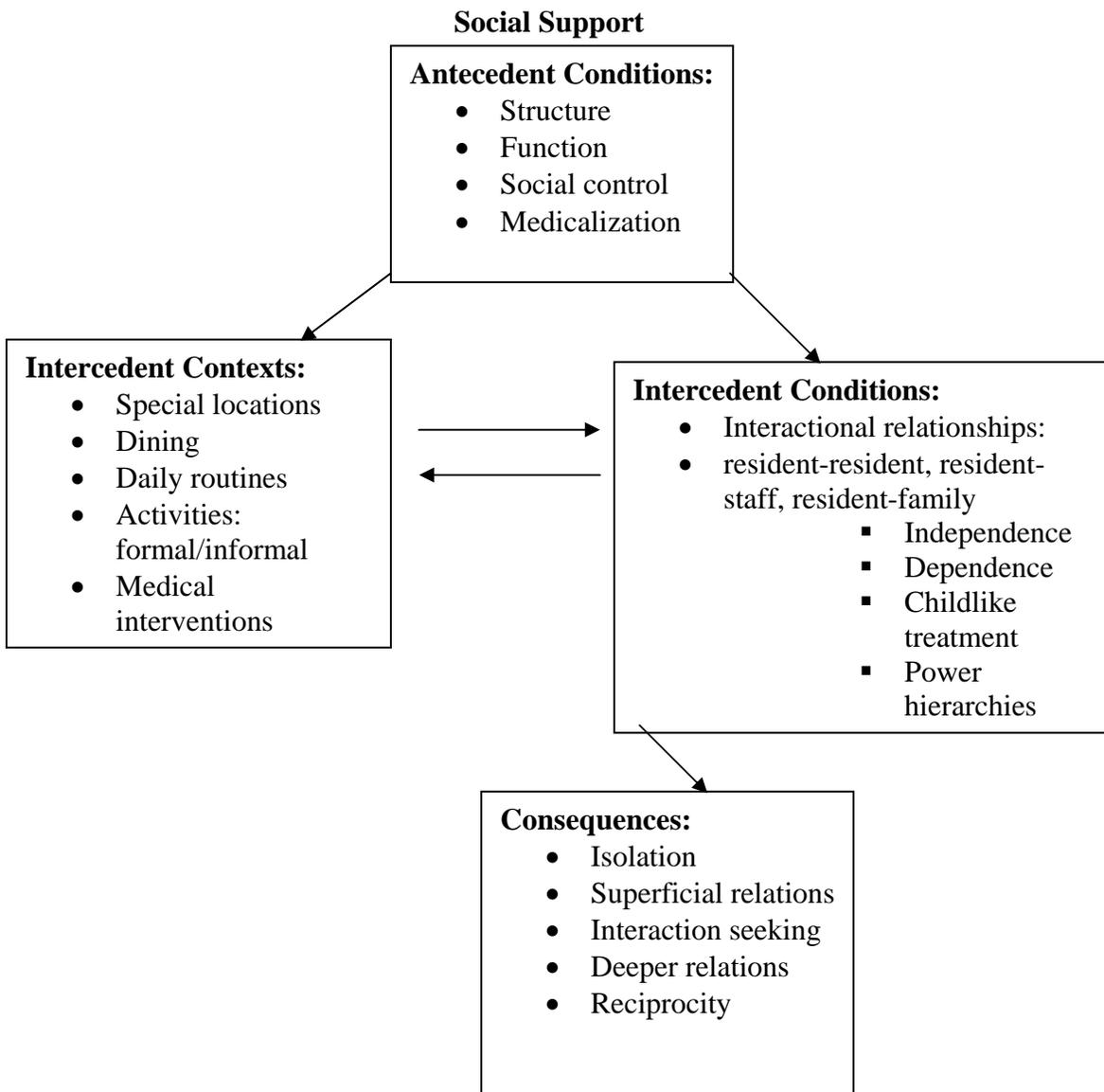
Peer debriefing was conducted informally with expert members of the faculty overseeing this research. Debriefings consisted of monthly electronic and face-to-face discussions of observations and interpretations, and allowed for the validation of common observations and the exploration of alternative interpretations. Several of the faculty members, who had previously been nurse practitioners providing nursing home care, shared similar experiences and interpretations of the isolation and apparent medicalization that permeated the observations. One of the panel members, with a concentration of interest in aging and end of life issues, felt that the interpretation of the events represented a harshness and lack of empathy that she was not ready to accept. She encouraged further observations to determine if alternative interpretations would be revealed. However, continued observations did not add to the impressions, and only served to support the original impressions. Counter exemplars were rare and extraordinary effort was needed to interpret subtle cues as evidence of social support. Perhaps researcher biases overshadowed these observations. Nonetheless, a rival explanation could be that social support has a very different appearance in this context,

one that does not necessitate reciprocity or one that does not necessitate the individual requests support in order for the experience to be defined as social support. Within this context, observations of social support may have been mislabeled or overlooked.

As a means of ascertaining credibility, a doctorally prepared sociologist accompanied the researcher to one of the facilities on three occasions. Field notes and interpretations were compared. Interestingly, the field notes were relatively equivalent, but the differences that emerged were related to the sociologist's non-medical background and unfamiliarity with nursing homes. For example, the sociologist was unable to differentiate some of the family members from staff, while the researcher was able to make this inference based on the family member's attire and possession of a purse that would not typically accompany a nursing assistant during her duties in the dining room. LaRossa (2005) explains this discrepancy as an inevitability of mental lenses that aid researchers in seeing relevant data.

The proposed triangulation of methods via use of staff questionnaires, interviews, and focus groups was intended to develop trustworthiness in the data collected and interpreted from the field notes. Unfortunately, participation in the questionnaires was sparse and no staff agreed to participate in interviews or focus groups.

Figure 1. *Relational model of factors influencing social support.*



Findings

Milieus

Medical equipment, alarms, and interruptions from overhead speakers were overt institutional reminders, more frequently noted at Ruby than at Diamond, but both facilities made valiant attempts to appear homelike through artifices such as bird cages, flower centerpieces, and framed paintings.

During rare informal conversations, residents at Ruby conceded to the researcher that it was their home for “the time being,” but referred to going to their “homes” only when leaving the facility to visit relatives. This is congruent with Kahn’s (1999) determination that most nursing home residents were “making the best of it.” Apparently, the aesthetic efforts to create a homelike environment may have fallen short of the residents’ expectations, were negated by the requirements of the facilities’ dual functions to be both hospital and home, or simply suggest that there was a longing for their previous homes. This longing may not be unique to elders relocated to nursing homes, but it was a frequent refrain among the residents.

Social Control and Medicalization

A nurse’s aide busily flits from resident to resident in the Diamond dining room. She efficiently takes the residents’ blood pressures and appears oblivious to the ongoing entertainment. Focused on her task, she seems to be unconcerned with any interruption she may be causing either for the piano player or for the residents. Her need to adhere to prescribed medical routines appears inconsistent with the efforts to create a socially stimulating environment. (Field notes, August 23, 2002)

Nursing homes serve multiple purposes. Nursing homes must fulfill the medical dictates of governmental accrediting and certifying agencies, and they are the collectives that provide end of life lodging and care for an aging population. Morgan and Stewart (1999) recognized the need for nursing homes to meet each of these objectives as a tenuous balance that necessitates a degree of conformity and routine that is likely to be counterproductive to a homelike atmosphere and the development of internal social support structures.

The tenuous balance was apparent at both Diamond and Ruby nursing homes. At times the balance tipped towards one need over the other, but the two needs were obviously so intertwined and entrenched that only a new resident or visitor might be aware of the possibly dichotomized objectives; creating a home and adhering to institutionalized requirements.

Dependency

Residents’ physical and cognitive debilities at both facilities force patterns of dependency. This can be accomplished simply by virtue of staff providing residents their requested care (Resnick, 2001). However, residents’ dependencies appear to be further

magnified by staff and family behaviors. Staff and family members were frequently heard communicating with residents in high pitched, singsong, monosyllabic patterns, as if interacting with small children. While this behavior may appear endearing, the dependency that it engenders is inconsistent with the definitions of social support (Hupcey, 1998).

Residents were labeled as “feeders” by the Ruby Department of Nursing Chief and assigned to the second dining experience in order to allow for their increased time demands placed on the staff. Bibs are required for all residents during dining sessions at each facility. As if to further humble the residents, servers at Ruby often toss bibs at the seated residents. Some residents then attach their own bibs. Others wait patiently for a staff member to fasten them around their necks. Bibs are obviously a catch all for wayward food, but are also used by staff to roughly wipe the mouths of feeders that painted their faces with colorful pureed mixtures. The apparent abruptness noted by the staff was not necessarily a disregard for the residents as much as it may have been a need to adhere to their tiring schedules and assigned multiple wards. The simple difference between Diamond and Ruby remained aesthetic. Bibs at Diamond, like all else, match, and bibs, at Ruby were an array of different sizes and colors. This homogeneity at Diamond replicated the demographics of the residents and also may have been the result of greater available funds.

A woman resident sits in the dining room at Ruby. She appears dispirited, makes poor eye contact with her tablemates, and ignores the commotion of meal serving surrounding her. Closer observation reveals watery eyes. Upon questioning, the woman quietly shares, “I need to go to the bathroom and they said I have to wait.” (Field notes September 2, 2002)

The freedom to choose when and what to eat, and when to perform personal hygiene activities was lost to the dependence rendered by disability and overshadowed by facility regimentation required to achieve administratively determined responsibilities .

In addition to selecting and preparing residents’ meals, staff cut residents’ food, buttered their bread, told them when to swallow, and even told them in what order to eat the items on their plates. For example, a staff member at Ruby points at a resident’s plate and commands, “Eat that last. Eat that first...now swallow...now drink” (field notes, November 2, 2002). Certainly, there are occasions when people with disability may benefit from explicit instruction in performing activities of daily living. Indeed, a patient with dysphagia, difficulty coordinating swallowing, might require these explicit cues. However, the tone and manner of these deliveries appeared to be hurried. Staff appeared to be preoccupied with the need to expeditiously complete their tasks in order to move on to their next duties, which might include simultaneously assisting one or two other frail residents with their meals.

Perhaps in an effort to please and be compliant, residents actively conformed to staff and families’ expectations and responded in dependent childlike manners to the childlike treatment they received. During a brief conversation, a resident, commenting on her inability to help others, remarked, “No, I don’t help others because of my sickness” (field notes, September 11, 2002). Another resident using similar phraseology, comments that adapting to the nursing home, “Depends on what you’re in here for...what your

sickness is” (field notes, October 2, 2002). An unfortunate and unanswered refrain that captured this theme is heard from a resident sitting in the hall at Ruby. She persists to whimper, “Help me. Help me. Help me...” (Field notes, September 11, 2002). Paterniti (2000) suggests that residents’ acquiescence and identification with *sick roles* legitimize staff perceptions of resident categorization and treatment. A resident remarked, “I can’t participate (referring to a formal, but passive nursing home activity). I am too sick.”

Hierarchical differences between facilities can be speculated to be socioeconomic in origin. Staff at Ruby appeared to act as if they were social equals or superior to Ruby’s residents. Ruby’s residents likely come from similar economic backgrounds as their attending staff. Diamond’s staff appeared to be very aware of a class difference between themselves and the residents of Diamond, and therefore, the staff seemed to respond accordingly in a more subservient manner. A number of the residents at Diamond appeared to have private nurses that were very deferential. The differences noted at Diamond seemed to place the staff at a greater social distance from their residents, which might suggest that any services rendered by the staff would be perceived as professional services and not social support (Hupcey, 1998). While reliance on another person is a component of social support, a unidirectional, nonreciprocal dependency is not likely to promote self worth and generate the benefits of social support (Lee, 1985; Pearson, 1986).

Independence

As one resident summarized, “The nurses tell you when to eat, sleep, take your meds, and dress...but it’s ok if you still have your mind” (field notes, November 13, 2002). Perhaps cognitive freedom is the ultimate form of independence (Kurlansky, 1995). Additionally, residents secured their freedom of choice physically and verbally within the constraints of their deficiencies. Most independent behaviors were witnessed in the dining areas as residents covered their mouths or pushed away a feeding hand. They seemed to take pride when they were victorious, smiling, and stealing knowing glances at their neighboring table mates, and they appeared undaunted and persisted with their refusals when their efforts failed to avert the feeding hand and increased the feeder’s frustrations.

Interactions

Interactions fell on a continuum from isolation to deeper relationships. The predominance of observations included those interactions occurring at the extreme of the continuum that included isolation and superficiality. Perhaps this was due to observations limited to public areas. Most resident interactions at Diamond and Ruby give the appearance of polite superficiality. Upon entering and leaving the dining areas residents might scan the room, avoiding eye contact, and rarely greeting one another with a smile, hello, goodbye, or “See you at supper” (field notes, September 2, 2002).

A curious phenomenon was observed at both facilities. When residents did engage in conversations, they seemed to do so stealthily when staff members were not watching. This was possibly another means of isolation or perhaps demonstrations of deeper connections.

Examples of deeper relationships and socially supportive relationships were less frequently observed, and were often subtle and difficult to differentiate from more superficial interactions. Whether this is a function of an environment that purposefully or inadvertently obstructs social support (Deaton, Johnson, Johnson, & Winn, 1999) or a mirror of the interactions found in society at large (Siebert & Mutran, 1999) is left undetermined. Observations of potentially deeper relationships were expressed with limited physical intimacy or contact and included known spouses sharing a cigarette or cup of coffee, or patting each other's hand. Had the researcher not been aware of a marital relationship, these observations may have been interpreted differently. Of key interest and demonstration of social control's influence on social support, was the additional knowledge gained through a conversation with a nursing assistant that this couple roomed separately due to the husband recently being hospitalized, and now occupying a Medicare funded bed, and the wife remaining in a Medicaid funded bed.

On occasion a resident at Ruby propelled another in a wheelchair. This appeared to be a truly symbiotic relationship, as the pusher often needed the structural support of the wheelchair in front of her to maintain her balance. Some residents at Ruby clung tightly to baby dolls. A resident rocked and cuddled her blanketed clown doll, cooed to it, and made loving eye contact with it. Some residents were given the responsibilities of caring for facility pet birds, passing out bibs in the dining room, or gathering others for church services. These rare observations of reciprocity seemed to imbue a great deal of satisfaction for the involved residents who executed their tasks with intensity.

Nursing Home Activities

Formal and informal nursing home activities seemed uninspiring to most residents and seemed to be poor stimulants for socialization. An argument could be made that resident debility was the contributing factor leading to the observed inertia. Certainly debility results in decreased participatory ability and limits the array of activities that might be employed as entertainment. However, by definition, the word "entertainment" suggests a passive activity, whereby the person, in this case a nursing home resident, receives a diversion (Stein, Hauck, & Su, 1980) and does not necessarily provide for social interaction. While most individuals enjoy some distracting amusements, an activity designed to create greater resident involvement, especially one that allows for resident reciprocity, might be more successful in producing socially supportive interactions. Nursing home activities were dominated by television and movie watching, an occasional guest singer, and Bingo. The latter was reminiscent of toddler parallel play and involved little resident interaction.

The seven staff questionnaire respondents added to these insights. When asked which things discouraged interactions illness, confusion, and dementia are the leading responses. Additionally, grouping dissimilar residents together during activities was perceived as a potential deterrent to interactions. This is substantiated by Pearson (1986), who reports that similar, not dissimilar, ethnic, and social class values contribute to social support accessibility.

In order to encourage interactions, questionnaire respondents suggested exercise classes, staff acknowledgement of residents' individuality, and a friendly and kind staff approach to residents. However, strict schedules maintained in order to accomplish

required tasks appear to prevent these occurrences. During a musical event at Diamond, a nurse's aide approaches a male resident and informs him she was taking him to the bathroom. Interestingly, the resident did not indicate a need to use the bathroom, but it was apparently his designated time and he left the event without contention. Patterns of regimented hygienic interventions are not unique to Diamond. A resident at Ruby is observed attempting to fruitlessly negotiate bath time with a nurse's aide. The resident wants to go back to sleep, but the aide has other plans and is the ultimate victor. The resident is bathed.

Summary of the Findings

This study was initiated in an attempt to describe the characteristics of social support, as well as the factors that influence social support in nursing home environments. Through the use of grounded theory methodologies, field notes, and reflections of characteristics of social support, and factors that facilitated and factors that detracted from social support in an elderly population residing in nursing homes, were organized into categories and subcategories within structural and functional sociologic domains.

Manifestations of social support in this environment were subtle and infrequent. Endorsements of social support included homelike atmospheres, independence, reciprocity or interdependence, and activities that promote interaction. In regard to a homelike atmosphere residents, not patients, "create a notion of home" (Reed-Danahay, 2001, p. 50). Thus, despite the apparent necessity to meet both medical and social needs, they may be mutually exclusive objectives. For example, interrupting a presumably social activity such as a sing along to take blood pressures, an obviously required medical task, appeared to disenfranchise the resident's attention from the group interaction. Their eyes shifted to the staff member and the medical equipment, and they did not necessarily refocus their attentions on the song leader. The aforementioned married couple separated by medically, or economically differentiated room designations, is yet another example of these dichotomized objectives.

Detractors to social support included institutional regimens and routines, dependence, and activities that promote isolation. Paterniti (2000) in her study of identity development in adverse circumstances in a chronic care institution, reported that tight work agendas compel residents to be dependent on staff and, in fact, result in labeling of residents according to the demands placed on staff. For example, the nursing chief identified one set of diners as "feeders." Paterniti's findings were supported in this study. Interestingly, Paterniti also identified acknowledgement of residents' individuality as a mechanism for improving care, but found that hectic facility schedules limited the ability to obtain or to read complete resident histories and to gain a full understanding of residents' situations. Langer and Rodin (1976) submit that admission to a nursing home is an example of the slippery slope that usurps an elder's personal power and results in a sudden mental and physical decline. Even when nursing home staff are genuinely attempting to help residents, they may be inadvertently undermining the residents' sense of control (Langer & Rodin). While the preponderance of findings from this study are derived from observations and field notes, the staff questionnaire responses validated resident positions of dependence.

Limitations of the Study

The potential limitations of this study included the cognitive impairment of observed residents, physical impairment of observed residents, limited data dimensionality due to the selected vulnerable population, and the Hawthorne Effect of a researcher as an observer-participant. Additionally, the generalizability of a qualitative study is limited to the selected settings and samples of that study (Thomas, 1993).

In retrospect, the construct of social support as typically defined, may not be applicable to nursing homes, and the efforts to identify these features within the nursing home may have been futile. Perhaps social support is evidenced in novel ways within nursing homes. Since these ways may not be clearly known to this researcher, they may have been overlooked. According to Hupcey (1998), the factors required for social support include (a) the act of providing a resource, (b) the recipient having a sense of being cared for or a sense of well-being, (c) the act having an implied positive outcome, (d) the existence of a relationship between the provider and the recipient, (e) support not given from or to an organization, the community, or a professional, and (f) support that does not have a negative intent or is given grudgingly. While provision of resources were clearly observed, support was almost exclusively derived from staff within an organization, and appeared to be at times given and received grudgingly. Determination of well-being and positive outcomes could be better ascertained through interviews with the nursing home residents, a component that was not included in this research. Elders are considered vulnerable populations, and elders residing in nursing home may have the added vulnerability of cognitive deficits. These characteristics make obtaining consent and assent from nursing home residents for study participation that would include interviews a challenging endeavor. However, attempting to make assumptions about the value of someone's relationships, solely based on external observations, can lead to misinterpretations. The residents perceptions of their relationships provided through oral or written interviews might have revealed socially supportive benefits not appreciated from the researcher's observations.

The topic of social support was selected based on its reported importance to health and well-being and the scarcity of social support overtly witnessed during the researcher's 10 years of nurse practitioner rounds. The visits to the nursing homes during the study had distinctly different aims than the medically focused and time constrained visits made during nurse practitioner rounds. During the latter, the focus was on charts, diagnoses, lab reports, and responses to treatments. It was only on later reflection that the humanity of the facilities was even considered. The observations were initiated with the excitement that there were no time constraints that are economically necessitated when trying to provide medical consultation as a nurse practitioner, and that observation in a non-medical role would provide the opportunity to view these facilities from a different perspective. However, it is possible that past experiences had already been ingrained in the beliefs of the researcher and that continued observation might not alter these beliefs.

As explained by Lincoln and Guba (1985), it is the researcher's responsibility to determine whether she has risen above her own inevitable biases and preconceptions, but these biases undoubtedly influenced the interpretation of the findings and might have contributed to the inadvertent exclusion of counter exemplars. Efforts were made to

confirm interpretations through the expert panel of faculty overseeing the research as well as the sociologist recruited for several observational sessions. Additionally, despite several decades passing, the participant observational works in nursing homes reported by Gubrium (1975) and Diamond (1992) were read after the initial writing of this study, and were jarringly similar to the findings and interpretations of this study. Despite these apparent confirmations of transferability, this researcher entered the setting with experiential predetermined biases that were the original impetus for this study; social support was not readily apparent if at all existent. For many years prior to this study, the researcher, as a nurse practitioner, observed residents in nursing homes. While these observations were focused on clinical issues such as disease progression and responses to medication regimens or other treatments, the *living* condition of residents in the nursing homes were observed. Impressions of these living conditions seemed to be that of meeting basic physical needs and limited fulfillment of social or spiritual needs. Indeed, these experiences often compelled the researcher to enter and depart the nursing homes quickly, completing necessary tasks and not extensively contributing to residents social needs. When residents were acknowledged by the researcher with a hello and their name they seemed to be delighted by the recognition. This phenomenon provoked a curiosity that was no doubt an underlying reason for pursuing this study.

Validation of the researcher's interpretations of observations are critical to the trustworthiness of a qualitative study. In this study, staff interviews and focus groups were intended to provide this convergent validation. Since staff interviews were sparse, and no staff members agreed to participate in focus groups, trustworthiness is relegated to the few occasions when another researcher entered the setting, and his observations and interpretations were compared with that of the primary researcher. Lack of setting participant perspectives, both staff and residents, limit the trustworthiness of this study's interpretations.

Relevance to Clinical Practice

Since the ability to validate observations through triangulation was limited, the following implications for practice must be viewed as the researcher's suppositions. Reassessing and adapting a number of structural, functional, and philosophic nursing home policies and procedures might advance the possibility for social support to exist in a nursing home environment. Structurally, aesthetics that provide a homelike atmosphere, while possibly overrated, likely have some merit (Kahn, 1999).

From a functional stance, providing residents with choices might ameliorate social control and dependency. Functionally, there is probably little that can be done to reduce inherent medicalization without altering the political and economic mandates that affect nursing home policies.

The multi-functionality of the nursing home as both home and hospital seems to necessitate a degree of medicalization in order to assure resident safety and well-being. Nevertheless, residents can be freed of their dependent *sick role* through staff that are educated to permit resident independence and interdependence, and an environment that promotes self-care (Resnick, 2001).

Perhaps passive activities, such as television viewing, should be limited. This seems to be less of an entertaining diversion for the residents and more of a convenient way for staff to corral residents between meals. Providing greater opportunity for activities that encourage interaction could foster social support.

Activities that involve resident storytelling might be successful. Haight and Olson (1989) recommend educating nurse's aides in the use of life reviews. Storytelling, or narratives that relate aspects of their personal histories, could serve multiple purposes. They allow a resident to reminisce and stimulate personal memory, maintain their identity, and share their identity with both residents and staff. This sharing and contextualizing of identities is apt to improve social support and allow staff members to understand resident's perspectives and desires (Paterniti, 2000).

Additionally, activities might incorporate reciprocity. Many of the observed activities placed residents in a receiving role. Most residents appeared to gain the greatest sense of satisfaction from helping others and being productive (Krause, Ingersoll-Dayton, Liang, & Sugisawa, 1999). Assigning residents to chores and tasks that are within their abilities or that match their interests could certainly fulfill this purpose.

Recommendations for Further Research

Further research that includes more input from staff, family, and most certainly the residents themselves is warranted. Determining means to overcome barriers to accessing information from vulnerable populations, such as institutionalized and cognitively impaired elders, would aid this effort. This would, however, require determination of resident competency to consent to participation and/or assent along with consent from a legal guardian. Exclusion of those not determined to be competent would likely and significantly reduce the sample and further skew the findings and even questions the current definitions of social support.

Continued time in the field, furthering the efforts of the present study, with the additions of a liaison might result in improved staff-researcher rapport, and increased staff participation in the study. Additionally, continued observations might reveal additional findings that either support or confound the original work.

Consideration of a participant observation study might yield additional insights. Several researchers have pursued the meaning of nursing home life through participant observation as nursing assistants (Diamond, 1992; Gubrium, 1975). Interestingly, although their perspectives were different and perhaps add more trustworthiness than that of an observer-participant, their observations and interpretations did not differ significantly from those of this study. They did, however, place the observations within the context of the challenges faced by the staff, and thus softened the appearance of staff indifference recorded here. For example, Diamond in his participant role as a nursing assistant, explained that the need to establish power and control to accomplish his duties "...brought out behavior that came across as cruelty" (p. 155).

Customarily it is difficult to make generalizations from qualitative studies. To better determine the impact of sociopolitical and economic forces on social support observations from a greater number of facilities in a wider range of geographic areas, or with more distinctly different philosophies of care might be useful. A replication of McAllister and Silverman's (1999) study that compared two Alzheimer's care units, one

that followed a medical model of care, and one that followed a social model of care, might help to guide administrative decisions that impact resident life. In accord with this study, they concluded that the medical model discouraged social bonding and resident interaction (McAllister & Silverman).

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Appendix A

Interview Schedule for Staff

1. Briefly describe your job/duties at this facility.
2. How long have you worked for this facility?
3. How long have you worked with elderly clients?
4. How do residents in this facility interact with other residents? Staff? Family?
5. Are these interactions helping relationships?
6. How do these relationships develop?
7. What things do you believe increase these relationships?
8. What things do you believe limit these relationships?
9. Why do you think that these relationships are important?
10. Do you think there is anything that you could do that would increase these relationships? Please describe them.
11. Do you think that there is anything that the facility could do to increase these relationships? Please describe them.
12. During your training/education for your current job, was social networking or social support discussed? Please elaborate.

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