The meaning of nursing home friendships

This research report on the social networks of institutionalized elderly people describes four types of networks and focuses on resident–resident interaction. Friendship themes of intimacy, social support, reciprocity, and companionship provide a basis for examining similarities in and differences between the network types. Discussion draws on the study results through examination of the meaning of friendship and interpretation of life-span themes.

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SOME ACCOUNTS OF nursing home life suggest that little fraternization can occur in such depersonalized and regimented environments.[1–3] Others call attention to factors deemed central to friendship formation, such as spatial proximity, in which location influences friendship patterns, because people tend to be friends with those they see on a regular basis near their rooms, in dining areas, or in hallways;[4–10] age, in which people seek out their contemporaries for socialization;[10,11] and social or communication skills, in which a willingness and an ability to speak lucidly are key determinants of sociability.[10] However, a focus on the environmental features and personal characteristics of residents alone

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does not provide an adequate understanding of the dynamics of friendship ties in institutional settings. Social network analysis permits a contextualized interpretation of possible interactional patterns.

The purpose of this article is to examine the meaning of friendships between nursing home residents. The data on which discussion is based were drawn from a 3-year field study of the social networks of institutionalized elderly persons. Institutionalization as a major life change may require individuals to restructure and redefine themselves in relation to their personal networks. The meaning of nursing home friendships is associated with the ways in which residents' networks provided recognition and support for social identities.

This article has three related parts. The section on methods describes sample, setting, and research procedures; the section on results describes four types of networks derived from data analysis, with particular reference to the nature of friendship ties between residents; and the final section draws on the results through an examination of the meaning of friendship and an interpretation of life-span themes.

METHODS

Sample and setting

Study participants were residents of a 212-bed health-related facility housed within a county-operated long-term care institution that also is licensed to provide acute and skilled levels of care. In the focused phase of the research, 238 residents (76% of the available health-related facility population) were assessed for participation in the study. Inclusion criteria required residents to be at least 55 years old, to be able to give reasonable and consistent responses to interview questions (orientation to person and place, and enough intact memory to describe socialization patterns as structured by the interview), and to have adequate concentration and attention span. There were 21 refusals, 27 were less than 55 years old, 121 others did not meet inclusion criteria, and 69 signed a human subjects form consenting to participate.

The participants comprised 37 women and 32 men with an age range from 55 to 95 years (mean, 73). There was a wide range in terms of length of time people had lived in the health-related facility: 30% of the sample had been there more than 5 years, 30% had been residents for 1 to 4 years, and 40% had been residents in the institution for 1 month to 1 year. Most participants were white (n=60; 87%). Two had received no formal education, but most had some grade school (n=24; 35%) or high school (n=27; 39%) experience. A smaller number had graduated from high school (n=9; 13%) or had attended college (n=7; 10%). The majority were widowed or divorced (n=38; 55%) or had never married (n=25; 36%). Six participants (9%) had spouses who were still living. Participants were ambulatory and were able to perform most of their self-care.

Research procedures

Fieldwork techniques and a social network profile approach developed by Sokolovsky[12] were used to gather data. Prior to in-depth interviews and network mapping, there was a period, extending over a year, of unstructured observation of participants in the study setting. Information from field notes of con-

versations, activities, observations, and analytic notations was helpful in structuring questions used later to focus on the usual and likely types of interactions in which elderly residents might be involved.

Data were gathered on all direct contacts that participants had with people in and outside of the institution. Semi-structured interviews involved two or more tape-recorded sessions of about 2 hours each. An interview guide was used, and field notes of additional conversations and observations were kept. Information covered characteristics of participants and of network members; when, where, how, and how often contact took place; the sorts of things people talked about and did for one another; and which network members knew and interacted with other network members. Only after the extent and behavioral aspects of the network were obtained were questions asked about the subjective importance of network ties. Consequently, the networks were not limited to subjectively important people or friends.

While elicitation of network data was the primary focus, a conversational interviewing style facilitated the collection of other kinds of information about participants' lives before institutionalization, recent changes in networks, current routines and reactions to institutional life, and residents' perceptions of how they were doing in general and with regard to their health status.

The doctoral student employed to assist the principal investigator in conducting interviews was trained in the techniques used, and interobserver reliability was monitored with transcripts of interviews and audiotapes used as substantive checks on interpretation. Sokolovsky, the developer of the network profile approach, served as a consultant, listening and commenting on some of the taped interviews and accompanying documentation.

Analysis of network data involved description of 1) the structural characteristics of networks (size, clustering, and interconnectedness of network members) and 2) the interactional characteristics of networks: that is, content (specifically defined resources such as conversation, advice, food or money, shopping, errands and physical assistance), frequency of contact, intensity (measures of importance of ties, friendship and intimacy), multiplexity (whether a tie provides one or more types of resource), and directionality (whether resource exchange tends to be reciprocal or whether resources flow only in one direction). Egocentric network diagrams were drawn for each participant. The number of ties and measures of the above variables were recorded in table form for relationships in four interactional spheres (kin, outside non-kin, institution staff, and residents).

Four types of networks were identified that differed in terms of size, clustering of ties in particular spheres, interconnectedness, and interactional characteristics. These types are called institution-centered, kin-centered, small cluster, and balanced. They are discussed in connection with four friendship themes that provide one basis for examining similarities and differences between the network types. These themes are intimacy, social support, reciprocity, and companionship.

Intimacy

Intimacy is a characteristic of close friendships that involve trust, emotional attachment, sharing of personal thoughts, and exchange of confidences. Elderly persons who

have lost confidantes through retirement, relocation, or death may find it difficult to regain similar levels of intimacy in newer friendships. Success depends on finding individuals who share needs, interests, and experiences.

Social support

In terms of network theory, social support is defined as a set of contingent resources that flow through ties and networks. Common types of resources exchanged among institutionalized elderly include food; cigarettes; reading material; small loans; errands; personal assistance with, for example, feeding or dressing; and visiting. However, the supportive potential of available resources rests in their interpretation. It is residents' perceptions of the nature and quality of social network interactions that determine the extent of support realized in terms of esteem enhancement and coping assistance.[13]

Reciprocity

The ability to give and receive enables individuals to have some control of social situations in which they engage. Ideally, friendship mutualities are based on reciprocity. Friends rely on one another out of a shared sense of responsibility and a confidence in the willingness and ability to return favors. Researchers have commented on the limitations that institutionalization can place on reciprocal exchange. Kayser-Jones[14] and Shield,[15] in their anthropological studies of nursing home life, have described two settings in which residents' lack of exchange commodities deemed valuable to others lessened their claims on the good will of staff and peers, increasing their dependency and social isolation. Contrasting examples also were given of other nursing home settings in which residents' ability to reciprocate enabled them to assert control and maintain acceptable adult-level relationships.

When individuals' major needs for food, shelter, and services are met by the institution, the basis for reciprocal relationships shifts to companionship, exchange of advice and information, and occasional small material transactions (eg, money loans and other favors). If these are valued by residents, there likely will be some negotiable means for them to establish friendship mutualities.

Companionship

Researchers have noted that social support and companionship have different effects on health and psychological well-being.[16,17] While support is more often viewed in the context of esteem enhancement and coping assistance,[18,19] "companionship protects people from the emptiness and despair associated with loneliness."[16(p1134)] Companionship has been more consistently related to friendship satisfaction than has social support. Unlike support relationships that involve helper and helpee, companionship is nonhierarchical. Self-disclosure occurs out of a natural yearning for empathic or playful understanding. The goal of this kind of social connectedness is more likely that of pure enjoyment and relaxation. Friendships that

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embody this quality are important for preventing loneliness and depression.

The typology that follows shares some features with those in Bott's classic study of family networks[20] and more recent network analyses.[21,22] Its function in relation to these empirical findings is heuristic; that is, it facilitates a discussion of the different response patterns observed in the data. Research projects involving the construction of typologies share an underlying concern about demonstrating that differences exist. Such classifications are tentative and ideal in the sense that they are invented for the purpose of categorizing the patterns of relationships that are "teased" from the data. This means that there is an accounting for how individual cases fit into typologies, but there may be ways in which certain ones do not completely conform. Network types are not useful as fixed categories. Their usefulness lies in their capacity to guide attention to alternative kinds of behavioral organization.

RESULTS

Table 1 displays the typology along with the means and ranges for the following network features: age, total network size, ties outside of the institution, institutional ties, ties with other residents, residents identified as friends, and unwanted network ties with other residents. Examples of resident–resident interaction associated with each network type are given in the text, including quotes from transcripts of taped interviews. Quotes are coded by case number (#), gender (M/F), and age. All names are fictitious.

Institution-centered networks

Institution-centered networks were among the smaller networks, with proportionally fewer outside contacts as opposed to intra-institutional contacts. Ties were more often simple and of low intensity. Of the 27 people (39% of total sample) with this type of network, 20 (74%) were men who initially claimed to have no friends. However, for most, there existed a hierarchy of relationships that distinguished between

- Acquaintances: people you recognize and greet on occasion, but who are known casually and not seen every day;
- "Buddies": more than casual acquaintances, they are people you "chum around with," with whom you may exchange favors and be more revealing of yourself; and
- Friends: people upon whom one can rely for help and in whom one can confide.

Some examples of these distinctions follow:

#7/M68: I'd call him an acquaintance . . . [He's] not as close as a friend . . . see . . . I don't know how far he'd go if I was gonna be shot . . . gee, I wouldn't know . . . no . . . I have no friends.

#30/M60: Mike is my best buddy. We go everywhere together, and we talk stuff over . . . give each other advice. ("Could he be a friend?" I [interviewer] asked) Well, I don't know. I haven't dipped down into his personality . . . [for example] I don't know if I could tell a big secret to him or not . . . and if he'd keep it confidential.

Using these distinctions, 22 (80%) of the 27 admitted to having a few other residents as "buddies" or "friends." However, 12 of the 27 were unable to identify friends among the other residents.

For residents in institution-centered networks, a strong value was placed on independence and being able to look out for oneself. They attached importance to devel-

Table 1. Network typology, mean (range)

Network type	Age	Network size	Outside ties	Institutional ties	Residential ties	Resident friendships*	Unwanted residential ties
Institution-centered (n = 27) 7 female 20 male	71 (57–88)	14 (4–25)	5 (1–15)	9 (1–16)	6 (1–23)	1 (0–5)	2 (0–9)
Kin-centered (n = 18) 13 female 5 male	77 (55–95)	17 (7–33)	10 (2–19)	7 (1–16)	5 (1–9)	0.7 (0–6)	3 (0–7)
Small cluster (n = 5) 2 female 3 male	81 (67–94)	13 (7–18)	6 (4–10)	7 (3–13)	4 (1–7)	3 (1–5)	0.6 (0–1)
Balanced (n = 19) 15 female 4 male	71 (58–83)	35 (17–71)	17 (7–36)	18 (8–35)	10 (5–23)	3 (0–9)	5 (0–20)

*The number claiming zero friendships (vs. buddies or acquaintances) were as follows: institution-centered = 12; kin-centered = 12; small cluster = 0; and balanced = 5.

oping their own routines that brought them into contact with individuals with whom they could pass the time or from whom they could obtain material goods and services with a minimal amount of emotional involvement. For example:

#41/M60: I don't make myself known to too many people. [My roommate], he's pretty good company. He tells me about his life and being in the army. Pretty interesting! . . . At least it's someone to talk to once in a while . . . [if] your family never comes in.

#50/M86: [My roommate] don't bother me any. I don't hang out with him, . . . [but] he'd get anything I wanted for me. He goes all over . . . [In the dining room, people] talk some. Jane don't say much, but she's pleasant. Bert and I talk. Between meals, I go down to the porch . . . There are other people down there, but we don't go down to talk. We go down to . . . have a smoke . . . and watch television.

Staff sometimes characterized these residents as "users" because of the superficial, exploitative appearance of their relationships. Residents themselves emphasized the utility of network ties. Generally, though, they believed that friends and buddies could empathize about their common lot.

Most informants denied close ties with other residents and characterized themselves as loners, but they were not socially isolated. They talked with satisfaction about companionship with "buddies" that settled into casual, familiar routines of small talk, sharing meals, meeting at appointed times to pursue an activity, or sitting quietly together. "It helps to pass the time," they said. And many maintained at least one confidant.

Intimacy was neither overtly expressed nor as intensely experienced by these persons as by those in other types of networks. This observation is consistent with a number of community-based studies of the elderly in inner cities and on skid row, which report intermediate levels of intimacy in friendships.[23-28] Sokolovsky and Cohen[29] explained that the highly selective intimacy in the networks of many inner-city elders focuses on the safest contacts they can find in a world viewed with fear and suspicion. Resistance to forming intimate relationships and reluctance to admit to close friendships are mechanisms of adaptation to difficult urban environments. Such networks serve to limit and check controlling influences of external social agencies.

Ties sometimes developed between the frail elderly and the more able-bodied, who offered aid. For the one helping, the behavior seemed to generate a positive feeling of self-worth, and for some, it seemed to be a way of saying, "these others are in bad shape, but I don't really need to be here." Some people who denied having any important ties with fellow residents often were observed spending a good deal of time consoling, being protective of, or running errands for others. These were nonreciprocal relationships, in which there was opportunity for enhancement of self-esteem through downward comparison (claiming to be better off than others).[30] Again, the emphasis was on self-sufficiency and functionality within and in spite of attendant groupings of other residents. For instance:

#29/M58: I feel out of place here . . . I don't deserve to be here. [Pushing peoples' wheelchairs back from activities] makes me very sensitive. I feel as though they're jealous of me that I can walk . . . I've got to [be helpful because] I feel so guilty being here.

Residents in institution-centered networks expressed a number of attitudes and behaviors of avoidance and antagonism. Most (22) of these residents identified members of their personal networks toward whom they were indifferent. Some were intensely disliked (See Table 1, "Unwanted Residential Ties" column). Examples follow.

#30/M60: [My roommate] . . . all he does is lay on his bed and moans and groans and sleeps in his clothes. I don't like pigs that sleep in their clothes.

#29/M58: He's very quiet . . . too quiet. I never talk a lot, but I like to say "Hello" . . . and a few of the social amenities, but he doesn't respond.

#46/M77: Everyone I ever liked here died on me . . . How am I gonna get along with these guys? I come in here first . . . I hit a guy in the elevator [knocked some teeth out] . . . The guy punched me first. Then I let him have it . . . The good ones [the good residents] die like flies . . . The bad ones, like me, don't. You gotta be angry to live . . . What do you suppose would happen if I wasn't mad at anybody anymore? . . . Well, I'd start loving 'em . . . No! I learned survival techniques in the service.

Some expressed satisfaction at the thought that they controlled aspects of their personal routines by avoiding or ignoring less desirable folks to whom they felt superior. One resident commented:

#5/M73: I sit around with them and listen to their barking, and when I get tired, I go to bed . . . Bob is the only one I talk to . . . and he's a little wacky too . . . [Of] course, it took me a while to figure him out, but I made it.

Thus, in various ways, through selective use of a hierarchy of relationships, preoccupation with helping other residents deemed less fortunate, avoidance, and antagonism, residents expressed the value of self-sufficiency. They created limited opportunities for support and reciprocal exchange of resources. However, the intermediate levels of intimacy and companionship experienced with other residents often were insufficient to overcome loneliness.

Kin-centered networks

Kin-centered networks varied in total size. Most were composed of between 10 to 30 members (range, 7–33). In many cases, kin ties equalled or exceeded institutional contacts, and residents had an average of four relatives who visited and communicated with them on a weekly or monthly basis. Of the 18 people (26% of total sample) with this type of network, 11 were very "engaged" in emotional ties to families, which made it difficult for them to accept new relationships and activities. One complained:

#70/M77: Quiet is the way I like it . . . guys walking back and forth and yelling and screaming at each other . . . I call my kids and friends so I have someone to talk to.

When naming other residents who were part of their networks, people identified them as unwanted ties, definitely not friends. Some were so preoccupied with kin ties that they became antagonistic if pressed to socialize.

What was interesting about residents who did claim to have a few "friends" was the tendency to apply this label to residents who were "friendly" or helpful, even in cases of very minimal interaction. For example:

#4/F72: I see her every day, but she doesn't eat at the table with me every day. ("Is she a friend?") So far [she is]. . . . I don't talk to her. ("Does she

talk to you?") Yes . . . she opens my cereal for me.

Friends were often people whom residents in kin-centered networks liked to be near. They made few demands and at times fulfilled some dependency needs. For one resident who expressed a fear of other residents, being near her "friend" was a source of comfort. Many of these friendships were difficult to detect on the basis of observation alone. Residents acquired knowledge of one another from living in close contact, and they may have imagined that they played a more active role in a relationship than was apparent. The relationships were real to them, but they were not necessarily seen that way by others. When I mentioned a resident's longing for her friends after she had been moved to another unit, the response from a staff member was, "Yes, but she never had anything to do with them. She probably perceives that there was something going on there, but she would never have anything to do with anybody." Those residents identified as friends, also did not validate this claim, though the resident in question was sometimes identified as a member of others' networks.

Seven residents in kin-centered networks were becoming "disengaged" or distanced from ties with family members. Outside ties were diminishing with less frequent contacts. Tentative contacts with other residents often were strained, however, as residents found it difficult to form new relationships that approached those that they had formerly enjoyed. Some residents experienced fear of others around them. Said one:

#55/F55: I'm scared of 'em . . . You got so much . . . ya gotta *deal* with so much. And it's disturbing to your rest. Now I didn't feel good this morning, but this lady [another resident] came to talk to me . . . She's been checking on me and talking like I been her sister.

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Residents in kin-centered networks were vulnerable to the tedium and minor upsets of daily institutional life. They complained about their helplessness and loneliness despite efforts at support from family and staff.

Small cluster networks

Small cluster networks involved established cliques operating within larger networks that, otherwise, were most like institution-centered networks. One resident remarked about another member of his cluster:

#9/M94: Frank and I kinda chum together . . . We visit in each other's rooms and eat together . . . He pushes my chair and we go off . . . have a beer . . . [visit] with the guys.

Five residents (7% of total sample) were involved in small cluster networks. The focus on good friend clusters appeared to serve as a buffer, insulating people from some of the movement and change in the larger institutional world of which they were a part. There was less attention placed on avoidance of other residents, with more time spent on nurturing and enjoying the exclusiveness of these close ties. The focusing of energy within smaller friendship circles enhanced opportunities for reciprocity and support. The intimacy of residents' relationships did

not prevent loneliness for family and old friends, but the loneliness was shared. And some of the best examples of companionship were in small cluster networks in which group identity was reinforced through established daily routines and small acts of kindness.

Balanced networks

Balanced networks were the largest networks, most containing 20 to 45 members (range, 17–71) distributed across resident, staff, kin, and outside friend sectors. There were multiple types of resource exchange, and greater interconnectedness of a wide range of contacts facilitated the flow of communication and support. Of the 19 people (28% of total sample) with this type of network, 15 (79%) were women. Some claimed to be naturally gregarious, but, for others, friendship circles at previous life stages had been limited to such an extent that institutionalization created an opportunity to make friends. For many, having close friends in whom they could confide was important, but few (5) claimed to have such intimate ties with other residents. Most confidantes were institution staff or people outside of the institution. "Close" ties with other residents revolved less around personal issues and more around daily shared experiences. Claiming a close friendship with another resident enabled them to establish that they were not alone. Close involvement with peers invited comparisons and tensions that at times resulted in hurt feelings, quarrels, and misunderstandings. But that same close involvement provided support for solving problems and resolving differences. Additionally, the friendships described carried with them some delight in laughter, shared secrets, gossip, and emotional release. Trustworthiness was a quality often mentioned in connection with these resident friendships. Typical comments were:

#20/F58: I'm very careful about everything because I don't want any more conflict . . . Everything is *so* tight [here] it *squeaks*, and you say something, and someone misinterprets or misunderstands what you said. Then it comes back said the wrong way . . . I say very little [but] I can tell May most anything. We hang out together. She helps me out, and I help her out.

#42/F67: Carol would make anybody a good friend, and Fran too . . . They can keep their mouths shut, which is quite important around here. I found that out.

All but one resident in this network type spontaneously discussed unwanted ties with other residents. Indeed, there was sometimes so much gossiping, tattling, and bickering among "friends" that staff would threaten to separate them, to place them on different units "for the good of all" if they would not "settle down."

The flow of resources among residents in balanced networks included distinct services such as physical assistance with activities of daily living (which was discouraged by staff, who stressed the need for individual independence), shopping, laundry, sewing, and mending in exchange for money, services in kind, or small gifts. One explained:

#22/F72: I don't pick up or deliver. They have to bring [clothes] to me and come and get them . . . I [do] sleeves . . . false hems . . . sew up seams and cut things off . . . whatever they want . . . [And] I make bags for the backs of wheelchairs when patients want 'em.

A few residents in this type of network seemed to have a need to be needed and expressed values related to caring for others.

For example, they described some of their friendships as relationships that they maintained for the sake of other "poor old people" who required time and attention:

#69/M73: I *devote* my time to Ken because he needs a roommate who'll give him some attention . . . I don't want to make him feel as though he's left out because he can't speak.

#59/F65: I want [my roommate] to wake me up at night when she's in pain. She says, "I hate to disturb you." I says, "Look, God put me here in this room to take care of you . . . and if you pull this off once more [sleeping in the chair all night], I'm not going to talk to you for the day. I'm a God-fearing woman, and I want to help the old."

One of these residents, who regularly ministered to others by welcoming and orienting new residents, visiting the ill and sending them cards, greeting and asking about the health of her neighbors, offering prayers for those who asked, and participating with others in Bible classes and religious services, told of a friend whom she had been visiting in her room on another unit for 7 years:

#1/F78: When I first knew her . . . she'd lost one leg and she declared she'd never let them amputate the other one, but she had to, and then two years or so ago she had a stroke and can't talk. So, when I visit her, I have to do all the talking. And she understands quite well. I gave her a book a friend gave to me. It has beautiful pictures . . . Usually when I go there, I pray with her . . . I would like to visit more people than I do . . . I'm sure I don't do as much as I should.

Thus, residents in balanced networks became involved in close friendships with other residents that satisfied needs to identify with, share experiences with, and confide in another; that reinforced feelings of self-worth through being a person on whom others could rely; and that were consistent with personal values related to caring for others as an ideal and as a moral responsibility.

In summary, residents actively shaped friendship circles that both included and excluded their peers. In cases of institution-centered and small cluster networks, this was evidenced most by controlling personal routines and limiting intimacy through avoidance, antagonism, selective use of acquaintance and friendship relationships, and exclusiveness (formation of cliques). In the case of kin-centered networks, the preoccupation of residents engaged with or becoming disengaged from close kin associations made friendship formation with other residents difficult. Identified friendship ties tended to be superficial and largely unexplored. Residents who evidenced fear and suspicion when interacting with other residents were most apt to equate "friendship" with "friendliness." Balanced networks were most inclusive, with residents fostering and maintaining some intimate and other types of close ties among themselves.

Some resident friendships engendered trust or intimacy. Residents in kin-centered and balanced networks used other network ties (kin, staff, outside friend) as confidantes. But, unlike those in kin-centered networks, members of balanced networks could identify some residents whom they thought were trustworthy. In contrast to those in kin-centered networks, those in balanced networks might still feel lonely, but not alone. Members of institution-centered networks maintained a more discreet and intermediate level of intimacy, which was compatible with values of independence and self-sufficiency, but could not always overcome loneliness. And while the comfortable intimacy of small cluster networks also did

not prevent loneliness, the difference was that the sharing of loneliness fell on empathetic ears.

Support, in terms of coping assistance through exchange of material goods and services, was available with greatest diversity in balanced and institution-centered networks and with most reciprocity in small cluster types. Support, in terms of esteem enhancement, was derived from valued relationships (described as "most" or "very important") that were most often found in small cluster and balanced networks. Esteem enhancement also was obtained by some members of institution-centered and balanced networks through downward comparison, where they saw themselves as better off than other residents, for whom they performed various services. For members of institution-centered networks, this seemed to fit with the need to express independence and the idea that "I don't really need to be here." Members of balanced networks tended to express communal ideals of friendliness and helpfulness.

Companionship was best exhibited by those in small cluster networks. Members of institution-centered networks had limited opportunities for understanding relationships with buddies and friends, while those in balanced networks had some close companions among the residents, with other residents fitting into different relational spheres. Residents in kin-centered networks were least trusting of the good intentions of fellow residents, though some were more willing than others to accept offers extended by their peers.

Overall, the meaning of friendship among nursing home residents is not a unitary concept. There were differences and similarities in the way residents with various network experiences related to particular friendship themes. In this research, members of institution and kin-centered networks seemed most distracted by personal needs and other allegiances that made adjustment to institutional living difficult, whereas residents in balanced and small cluster networks appeared to be better adapted and more fully able to have relationships with other residents. However, across networks, there was a transient element to friendships with other residents that left individuals vulnerable. Residents tended to accept departures of their peers in an "out of sight, out of mind" fashion. Many found excuses for not visiting the ill and dying who had been removed from their midst to the skilled nursing and acute hospital units. Therefore, there were few personal reserves to fall back upon in a crisis or at such a time when personal ability to activate friendships was depleted.

FRIENDSHIP AND LIFE-SPAN THEMES

In modern American society, friendship tends to be viewed as a voluntary and privately negotiated personal relationship. It has been argued that informal friendship ties have achieved greater importance as a result of a perceived general weakening of kinship bonds.[31] Kinship and friendship relationships can function similarly to meet tangible and emotional needs. But the nature and

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availability of kinship as opposed to friendship ties may be expected to change across a life span. The transition to institutional living in later life is an extreme change marked by separation from the community, deprivation of freedom of access to family and other community-based ties, and immersion in a new environment that requires one's sustained presence within a mass of people whom one cannot dismiss and from whom physical distancing is impossible. It is a unique experience in which, whatever benefits may accrue from friendly relations or friendship with other residents, there are risks. In most cases, one is dealing with strangers. The expenditure of energy to pursue and maintain close friendships may be costly and the payoff uncertain. The chance of sustaining yet another loss through illness or death is great. That some residents are cautious about such ties is understandable. However, evidence from this study suggests that the concept of friendship is as complex in the nursing home environment as anywhere else.

On the one hand, nursing home friendships can be viewed as a microcosm of those in the larger society. It is good to affirm the diversity and self-determining potential of nursing home residents as a counterbalance to common views of institutionalized elderly as all the same and as being less capable of expressing themselves than their contemporaries in the community. On the other hand, nursing home friendships are not the same as preinstitutional friendships. They arise out of the immediacy of a regimented and restricted environment that is more intense than life outside nursing homes. How various perspectives on friendship enter into the individual's view of this different world is as much a feature of personality as it is an outcome of experience in social networks. But what residents can do about wanted versus unwanted relationships is another matter. Choices of whom to befriend and whom to avoid are limited to the confines of arbitrarily assembled, constantly available groups of residents, who remain actively engaged with very little time out. There are few opportunities to walk away or make a change. One either deals constantly with network relationships or withdraws.

The meanings of nursing home friendships vary according to network experience, but all are closely associated with needs to maintain one's own integrity and to decide about one's acceptance of and determination to survive in an institutional environment. Some residents resist integration into that world because they are afraid or they believe that they do not belong there. Those who engage other residents at some level have at least partially decided, as a number of residents said, "to make the best of it."

Nursing assessment and intervention

Nurses who practice in nursing home settings can play an active role in maintaining the viability of elders' social identities through regular assessment of individuals' responses to the environment, intervention based on an understanding of the various ways in which people experience the ongoing adjustment to nursing home life, and consultation to families and other staff members through individual counseling and team conferences. A life-span developmental perspective can serve as a useful conceptual base.

Aging and health involve progressive growth and development across the life span. This perspective contradicts theories

that associate the aging process with decline. A life-span developmental view is consistent with Rogers's description of the life process as goal-directed, increasing in complexity of pattern and organization, continuously innovative, rhythmical, and always evolving.[32] Using Rogers's perspective on unitary man, Parse described health as an open process of becoming, a rhythmic process of changing as people interact with their environment, a style of living that reflects their values, transcending with the possibles, and an emergent process unfolding toward greater complexity,[33] and Newman has provided a conceptualization of health as the totality of life process—life, and henceforth health, being all about the expansion of consciousness.[34]

Reed[35] synthesized the views of the above nurse theorists and life-span developmentalists[36] in addressing issues associated with aging and health in adulthood. The following themes from her discussion summarize what nurses need to know if they use an understanding of possible network experiences that were discussed here to guide their assessment of the growth potential and progress of institutionalized elderly people and to inform needed interventions on their behalf.

Theme 1

Ways in which individuals need to conserve and focus their energy.

Ordinarily, energy for development is generated through struggling and moving beyond the experiences that life presents toward the desired and the possible. An absence of interaction with one's environment limits the energy needed for growth. But interaction is impossible to avoid in the close living environments of institutions. Unwanted members of residents' networks in this study represent what to them is a surfeit of relationships that exist but are not of their choosing. "Making the best of it" necessitates conserving energy by focusing interaction in ways that reflect what one sees as desirable and/or possible in one's situation. Patient consideration of energy needs and expenditures in this regard may reveal important information about residents' views of the environment's potential to satisfy some needs.

Theme 2

What individuals construe as context so their *awareness drives the determination of their most meaningful experiences.*

An awareness of the context of experiences develops as people age. The ability of adults to interpret their situation from a broad perspective that takes into account immediate concerns and future consequences is a function of a continuously evolving and increasingly complex life process. There are observable differences across the network types described here. Common to all networks is some interpretation by individuals of the kinds of problems that may be addressed by the formation of friendships with other residents. Thus, whatever risks are involved in these relationships will be balanced against needs for intimacy, companionship, exchange of resources, and support that could be partially satisfied. The nurses' assessments of what network experiences mean to residents will provide a context within which to better understand and evaluate their behavior.

In studies involving network typologies, there is evidence to suggest that some net-

work types may develop out of other types in response to changes across individuals' life spans, such as geographic relocation or the death of important network members.[22] In this research, the kin-centered network may be a transitional type out of which institution-centered or balanced networks evolve if residents become increasingly disengaged from kin ties as a result of diminished contact over time. Similarly, there could be shifts in either direction for individuals in institution-centered or balanced networks in response to the effects of time passage, new opportunities for relationship formation, and loss of network members. It is reasonable, then, to leave open the possibility that individual networks may develop from one type to another in response to a variety of factors. These would need to be explored by means of a longitudinally designed study. However, it is important that such possibilities for change *not* be viewed as inevitable and foreordained.

Theme 3

How particular trade-offs seem to facilitate or hinder productive repatterning, according to an understanding of the individual's point of view.

Trade-offs in development involve the replacement of perspectives and behavior patterns as they cease to be useful. Individuals do not regress to previous ways of perceiving and dealing with life; rather, they repattern in whatever direction seems to be most suited to their understanding of new or changing personal circumstances. The meaning of nursing home friendships lies in a conception of "limited opportunities" for intimacy, support, companionship, and reciprocal aid. Resident friendships can supplement relationships with kin and community-based friends. They cannot substitute for or replace valued preinstitutional ties or life styles, nor do they necessarily relieve loneliness. Productive repatterning involves residents' discoveries of ways in which nursing home friendships can complement other network ties, and willingness to engage with other residents will, for some, be a change in perspective regarding the possibilities in their lives. This repatterning may involve a gradual awakening. Exploration of residents' readiness to learn or change is a type of intervention that should build upon the continuous assessment of how they direct their energies and mobilize network resources.

What old people can tell us about the institutionalization of aging populations—"Making the best of it"

It is expected that older people may find friends, form friendship groups, and discover a sense of community when they have access to others of their age, share the same spatial contexts, and participate together in activities. Willingness to become involved in the social life of the institution is considered to be a sign of adjustment to the environment.

The empirical evidence suggests that friendships and communal feelings can develop, to some extent, among institutionalized elderly people. But, friendship is not extended to or welcomed by everyone. For those who decide to risk involvement, "making the best of it" implies a degree of resignation combined with selectivity in distinguishing between "friend" and "nonfriend" relationships with other residents. Those

who claim no friends may engage in discreet forms of mutual assistance that avoid intimacy, or they may ignore fellow residents and favor other network ties, particularly kin ties.

Assisting residents' adjustments to nursing home life requires respect for their position that institutionalization is not a desirable condition. They have a right to be unhappy about it. But most old people have survived other unhappinesses and disappointments. Remembering past difficulties may be central to finding ways to cope with present obstacles, and seeing oneself as a survivor can bolster self-esteem. Nurses can elicit past experiences, listen, and remind individuals of their strengths.

There is no single correct way for the elderly to pace themselves. It is important for nurses to reserve judgment on how well people are adjusting, because, in most instances, it will be a delayed-action phenomenon. Anticipatory guidance, help with the trivia of daily life (recognizing that small matters in close, intense environments pose serious obstructions to progress), and personal availability that is obvious and perceived are all-important nursing interventions. Developmental gains and repatterning of relationships that emerge must be tailored to the individual who is confronted with "making the best of it" in a setting that should be seen as having both challenges and possibilities.

REFERENCES

1. Bennett RG. The meaning of institutional life. *Gerontologist*. 1963;3:117–125.
2. Fontana A. *The Last Frontier: The Social Meaning of Growing Old*. Beverly Hills, Calif: Sage, 1977.
3. Lieberman MA. Institutionalization of the aged: Effects on behavior. *J Gerontol*. 1969;24:330–340.
4. Firestone IJ, Lichtman CM, Evans JR. Privacy and solidarity: Effects of nursing home accommodation on environmental perception and sociability preferences. *Int J Aging Hum Dev*. 1980;11:229–241.
5. Friedman EP. Spatial proximity and social interaction in a home for the aged. *J Gerontol*. 1966;21:566–570.
6. Jones DC. Spatial proximity, interpersonal conflict, and friendship formation in the intermediate care facility. *Gerontologist*. 1975;15:150–154.
7. Lawton MP, Simon B. The ecology of social relationships in housing for the elderly. *Gerontologist*. 1968;8:108–115.
8. McClannahan L. Therapeutic and prosthetic living environments for nursing home residents. *Gerontologist*. 1973;13:424–429.
9. Retsinas J, Garrity P. Nursing home friendships. *Gerontologist*. 1985;25:376–381.
10. Rytina S, Morgan DL. The arithmetic of social relations: The interplay of category and network. *Am J Sociol*. 1982;88:88–113.
11. Rosow I. *Social Integration of the Aged*. New York, NY: Free Press, 1967.
12. Sokolovsky J. Interactional dimensions of the aged: Social network mapping. In: Fry C, Keith J, eds. *New Methods for Old Age Research*. Chicago, Ill: Center for Urban Policy, 1980.
13. Powers BA. Social networks, social support, and elderly institutionalized people. *ANS*. 1988;10(2):40–58.
14. Kayser-Jones JS. *Old, Alone, and Neglected: Care of the Aged in the United States and Scotland*. Berkeley, Calif: University of California Press, 1981.
15. Shield RR. *Uneasy Endings: Daily Life in an American Nursing Home*. Ithaca, NY: Cornell University Press, 1988.
16. Rook KS. Social support versus companionship: Effects on life stress, loneliness, and evaluations by others. *J Pers Soc Psychol*. 1987;52:1132–1147.
17. Wills TA. Supportive functions of interpersonal relationships. In: Cohen S, Syme SL, eds. *Social Support and Health*. Orlando, Fla: Academic Press, 1985.
18. Heller K, Swindle RW, Dusenbury L. Component social support processes: Comments and integration. *J Consult Clin Psychol*. 1986;54:466–470.
19. Thoits PA. Conceptual, methodological, and theoretical problems in studying social support as a buffer against life stress. *J Health Soc Behav*. 1982;23:145–159.

20. Bott E. *Family and Social Network.* London, England: Tavistock Institute of Human Relations, 1957.
21. Brannen J. Suitable cases for treatment? Couples seeking help for marital difficulties. In: Yoder J, et al, eds. *Support Networks in a Caring Community.* Norwell, Mass: Kluwer Academic Publishers, 1985.
22. Wenger GC. Support networks in old age: Constructing a typology. In: Jefferys M, ed. *Growing Old in the Twentieth Century.* London, England: Routledge, 1989.
23. Bild BR, Havighurst RJ. Senior citizens in great cities: The case of Chicago. *Gerontologist.* 1976;16:63–69.
24. Cohen C, Sokolovsky J. Social engagement versus isolation: The case of the aged in SRO hotels. *Gerontologist.* 1980;20:36–44.
25. Eckert K. *The Unseen Elderly: A Study of Marginally Subsistent Hotel Dwellers.* San Diego, Calif: Campanile Press, 1980.
26. Siegal H. *Outposts of the Forgotten, Socially Terminal People in Slum Hotels and Single Room Occupancy Tenements.* New Brunswick, NJ: Transaction Books, 1977.
27. Sokolovsky J, Cohen C. Being old in the inner city: Support systems of the SRO aged. In: Fry C, ed. *Dimensions: Aging, Culture and Health.* Brooklyn, NY: J.F. Bergin, 1981.
28. Cohen CI, Sokolowsky J. *Old Men of the Bowery: Strategies for Survival among the Homeless.* New York, NY: The Guilford Press, 1989.
29. Sokolosky J, Cohen C. Networks as adaptation: The cultural meaning of being a "loner" among the inner-city elderly. In: Sokolovsky J, ed. *Growing Old in Different Societies: Cross-Cultural Perspectives.* Belmont, Calif: Wadsworth, 1983.
30. Powers BA. Self-perceived health of elderly institutionalized people. *J Cross-Cultural Gerontol.* 1988;3:299–321.
31. Bell RR. *Worlds of Friendship.* Beverly Hills, Calif: Sage, 1981.
32. Rogers ME. *An Introduction to the Theoretical Basis of Nursing.* Philadelphia: FA Davis, 1970.
33. Parse RR. *Man-Living-Health: A Theory of Nursing.* New York, NY: Wiley, 1981.
34. Newman M. *Health as Expanding Consciousness.* St. Louis, MO: Mosby, 1986.
35. Reed PG. Implications of the life-span developmental framework for well-being in adulthood and aging. *ANS.* 1983;6(1):18–25.
36. Lerner RM, Busch-Rossnagel NA, eds. *Individuals as Producers of Their Development: A Life-span Perspective.* New York, NY: Academic Press, 1981.