

ORIGINAL ARTICLE

Activity, friendships and wellbeing in residential settings for older people

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Abstract

Friendships have been demonstrated to influence an individual's psychological wellbeing. This paper reports an investigation into whether friendships influence the psychological wellbeing of residents in long-stay care settings for older people. The study consisted of the observational assessment of activity in 64 residents drawn from three care settings, together with brief structured interviews assessing self-reports of friendships and psychological wellbeing. Results indicated that non-intimate friendships were more common than close friendships. Activity levels were higher in residents with good friends compared to residents without good friends, but the degree of difference was dependent on the home in which the resident lived. Neither activity levels nor friendships were associated with residents' wellbeing. Qualitative analysis of fieldnotes indicated that the pattern of friendships found in the residential settings was influenced by resident choice, the prevailing care regime and aspects of the physical environment. Results are discussed in relation to disengagement theory, the importance of reminiscence in later life, and methodological issues in the measurement of wellbeing in older people.

Introduction

Social interaction, and specifically friendship, is an important influence on the wellbeing of people of all ages (Hartup & Stevens, 1997; Phillipson, 1997). In the UK, approximately 5% of people over the age of 65 live in residential settings (Victor, 1994), an environment not noted for high levels of social interaction (e.g. Clark & Bowling, 1990; Nolan *et al.*, 1995). While much research on activity in residential settings has examined staff–patient interaction (McKee, 1999), recently there has been increasing interest in the interaction and friendships among the residents themselves (Reed & MacMillan, 1995; Reed & Payton, 1996).

The number of residents found to have friends within residential settings ranges widely across studies, as would be expected due to differences in setting, methodology and the operational definition of friendship. Reed and Payton (1996) found that new residents put much time and effort into 'constructing familiarity' with the home and its residents, as having friends within the home allowed residents to discuss everyday life in the home. Kovach and Robinson (1996) found higher levels of life satisfaction in residents who had good rapport with the person with

whom they shared their room. However, a number of studies have found resident friendships to be lacking in intimacy (e.g. Gutheil, 1991; Harel & Noelker, 1982; Noelker & Poulshock, 1984).

The factors that influence friendship formation and maintenance in later life in the wider social world, for example disability (Johnson & Troll, 1994) and cognitive impairment (Chown, 1981), could be anticipated to have similar influence in residential settings, and indeed aspects of physical and mental health have been found to be associated with friendships among residents (Bitzan & Kruzich, 1990; Retsinas & Garrity, 1985). While the attributes of the residents themselves may influence friendships, structural aspects of the social and physical environment—such as the residential setting's philosophy of care, staffing level, care regime and the physical environment itself—will also be influential (Timko & Moos, 1990).

Measuring friendship is a challenging task, as is the measurement of wellbeing in later life. In a structured interview, there is an opportunity for interviewer and respondent to reach agreement over the meaning of key terms (Robson, 1993). However, older people are a special population, from whom the extraction of information might be hindered by memory and failures of communication (Brooker, 1995). Some

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studies use staff as proxies to find out about residents' friendships (Retsinas & Garrity, 1985) and carers to find out about older people's wellbeing (Albert *et al.*, 1996), although such an approach can itself introduce bias.

Observational methods provide a way of assessing behaviour without relying on self-report data or staff or carer ratings (Clark & Bowling, 1990). Most researchers employing observational methods to infer wellbeing and friendships in later life draw explicitly or implicitly on activity theory to guide their selection of behaviours. Activity theory, which emerged in the late 1950s and early 1960s, and remains extremely influential within social gerontology, argues that social interaction is the essence of life for all age groups and that 'those who are able to remain socially active will be more likely to achieve a positive self image, social integration and satisfaction with life' (Barrow, 1992, p. 70). Thus, high levels of activity, communication and patterns of reciprocity will be seen as markers of wellbeing and friendships.

The work here reported was designed to answer three questions. First, to what extent are residential settings for older people characterized by the existence of casual and/or good friendships? Second, is the presence of friendships associated with wellbeing in residents, and do resident characteristics and aspects of the environment influence this relationship? Third, to what extent do self-reports of friendship and wellbeing relate to observed activity levels among residents? To answer these questions, data were collected via an observational study of activity in three residential settings. To complement the observational data, information on friendships and wellbeing were also collected via structured and semi-structured interviews.

Methodology

Site selection

The sampling frame for the fieldwork sites included all nursing and residential homes for older people within the postal district of the research establishment. Nineteen homes were identified and contacted by letter. Follow-up telephone calls established 11 homes willing to participate in the study. From these 11 homes, three were selected by the research team for use as fieldwork sites after consideration of literature produced by the homes, and visits to them. The criteria for selection was that the homes should vary on a number of characteristics: size, in terms of number of residents; the proportion of residents with cognitive impairment and physical disability; physical structure, in terms of the number of floors and communal day areas, and the size and shape of those day areas; and the home care regime, as detailed in publicity literature and policy documents.

Participants

The three selected homes had the following resident composition at the start of the study: home A, 29 residents; home B, 20 residents; home C, 19 residents. Due to mortality, three residents were lost from home B, and one resident from home C. The sample at the end of the observational component of the study, and available for interview, was therefore as follows: home A, 29 residents (24 female, 5 male); home B, 17 residents (14 female, 3 male); home C, 18 residents (15 female, 3 male).

Materials

Observational instrument. The first author had previously been involved in the development of an observational instrument to evaluate the quality of care in long-stay psychiatry wards for older people (Gilloran *et al.*, 1993). Other observational methodologies have been developed to assess quality of care of people with cognitive impairment, including Dementia Care Mapping (DCM; Kitwood & Bredin, 1992; 1993), which has been found to be an appropriate tool for use in care settings for older people (e.g. Brooker *et al.*, 1998). Since the purpose of the present study was to evaluate activity and friendships in older people, the first author's own instrument and DCM were both used as foundations for the development of a new observational framework that would focus on these domains. First, the behaviour category (BC) codes used in DCM were reviewed, and a list of 21 BC codes derived for the present study (see Appendix). Second, in addition to behaviour, the presence or absence of conversation (CV) by a resident was recorded (engaged in conversation included listening attentively). Third, adapting the coding frame of Gilloran *et al.* (1993), the location of each participant at the time of observation was also noted. Finally, significant events and opportunistic conversations with residents were recorded via fieldnotes, written directly onto the observation coding sheet, for subsequent qualitative analysis.

Resident questionnaire. A questionnaire was developed, assessing the following domains: psychological wellbeing (a single question from the Psychological General Well-Being Index (Dupuy, 1984): 'How happy, satisfied or pleased have you been with your personal life during the past month?'—the question has six possible response categories, ranging from 'extremely happy' to 'very dissatisfied'); cognitive status (UK version of the Cognitive Impairment Test; Katzman *et al.*, 1983); number of friends in the home and number of good friends in the home (both measured by scales offering four response categories: none; a few; quite a lot; and many) and who these good friends were.

Staff questionnaire. This questionnaire assessed the ability of all residents on the following variables: mobility; hearing; eyesight (CAPE items; Pattie & Gilleard, 1979); and speech (a question adapted from the three-level classification provided by Booth, 1985).

Procedure

A period of piloting of the observational framework in home A lead to the final instrument described above. With the final instrument, two of the authors (KJM and GH) carried out a period of observation to determine inter-rater reliability for the BC and CV codes. Satisfactory inter-rater reliability was achieved for both variables (BC codes: $\kappa=0.89$; CV codes, $\kappa=0.85$). Time sampling of the residents' behaviour was then initiated, with an observational sweep of the residential setting occurring every ten minutes. First observation of each resident within each ten-minute period prompted a coding of the behaviour in which the resident was engaged at the moment of observation, together with the assignment of a CV code, and the recording of the resident's location. Alongside this procedure fieldnotes were taken recording details of significant events. Activity in each home was observed from 8am to 8pm, with observation carried out in two-hour sessions. Only one session of observation occurred in any given day, so as to prevent an atypical day distorting the data. A total of 72 observation periods therefore occurred in each home, over a period of six weeks.

During the observational study, participants were given structured, questionnaire-based interviews, which took place in the privacy of the residents' own rooms or in quiet areas of the conservatory or dining room. Interviews lasted on average 20 minutes. Where communication difficulties or severe cognitive impairment prevented interviews with the participants themselves, staff provided proxy ratings on each assessment (cf. Albert *et al.*, 1996). Staff were provided with their questionnaire to self-complete and return to the researcher.

Preliminary data analysis

Due to low frequencies of observed behaviour within some BC codes the following categories were combined for analytical purposes: codes N, V and O were combined with code C, which was renamed 'Socially Inactive'; codes G, H, I, J, L and M were combined with code E, which was renamed 'Engaged in Recreational Activity'. No observations were recorded for codes R, S, U or Z, which were deleted from further analysis, and too few observations were recorded in code D to enable further analysis. Of the other variables measured in the resident interview, eyesight was excluded from further analysis due to most residents (85%) falling in one category.

Fieldnotes for each observation session were, at the end of each session, transcribed fully, with the researcher adding detail to the brief notes made while data was being collected. In this way, a journal of significant events, conversations, and the way of life within each home was slowly compiled. This journal was then treated as a text and subjected to thematic analysis (see Smith, 1995; 1996) by the second author. The entire journal was read several times. Then each journal entry (i.e. the summary of each observation session) was examined, and key words or phrases assigned to components of the entry that most adequately captured their content. These represented emergent themes. Comparing and contrasting across entries, emergent themes that were found to be repeated were upgraded in status to recurrent themes, that is, themes that expressed some common and important element of life in the residential settings. Recurrent themes were then retraced to the original entries or place within a given transcript. Examples of events described within the entries or quotations within the transcript that were felt to be exemplars of the recurrent theme were extracted and placed in a file, to be ordered and combined for presentation.

Results

Scores were obtained for each individual resident for each BC code by establishing the proportion of the residents' total observed time that was spent within each BC. This data is presented in Table 1 totalled across all three homes and by each home individually. In addition, the table contains data on the proportion of time residents were observed in conversation, and in three locations: their own room, the sitting room and the dining room. Finally, the table presents the characteristics of the residents obtained through resident interview and staff questionnaire. Residents spent 45.1% of their time being socially inactive, with only 16.8% of time in active social interaction (ASI). There was considerable variation across homes, however, with residents in home B being the least likely to be involved in either passive social interaction (PSI; $F(2,61) = 8.58$, $p = 0.001$) or socially inactive ($F(2,61) = 4.95$, $p = 0.01$), and the most likely to be engaged in recreation ($F(2,61) = 8.44$, $p = 0.001$). Residents spent a fifth of their time in conversation, with nearly half of their time spent in their own rooms. Again, there was considerable variation across homes, with residents in home B being most likely to spend time in their own room ($F(2,61) = 13.16$, $p < 0.001$) and least likely to be in the sitting room ($F(2,61) = 32.14$, $p < 0.001$).

There was also variation across homes with regard to the characteristics of their residents. Over two-thirds of the residents in home C had impaired cognition, compared with less than a third in home B. Across homes, 27.8% of residents reported having no friends, while 58.3% of residents indicated that

TABLE 1. Proportion of resident time spent in different behaviours and locations, and resident characteristics, by home

	All homes	Home A	Home B	Home C
Behaviour category (m, SD)				
Active social interaction	16.8 (15.0)	15.0 (14.9)	18.7 (13.2)	18.0 (17.2)
Passive social interaction	11.3 (10.5)	13.8 (11.4)	3.3 (3.5)	14.9 (9.5)
Socially inactive	45.1 (20.7)	50.6 (19.7)	32.5 (13.0)	48.3 (23.9)
Recreation	15.8 (14.7)	13.1 (14.5)	26.9 (13.5)	9.9 (10.6)
Eating/drinking	18.5 (5.3)	18.2 (6.7)	21.1 (1.8)	16.4 (3.7)
Walking/wandering	5.0 (3.8)	3.4 (2.9)	5.2 (2.4)	7.3 (5.1)
Receiving physical care	2.7 (2.7)	3.6 (2.8)	2.9 (2.8)	1.2 (1.6)
In conversation	20.1 (20.7)	15.4 (17.6)	24.9 (21.8)	23.2 (23.8)
In own room	49.3 (31.3)	52.6 (28.6)	69.8 (18.5)	24.4 (29.5)
In sitting room	23.4 (28.7)	14.5 (19.5)	4.8 (7.0)	55.3 (28.4)
In dining room	17.0 (10.3)	22.2 (12.8)	11.8 (5.5)	13.5 (2.9)
Age: (m, SD)	87.4 (7.42)	87.4 (7.48)	86.8 (7.51)	88.0 (7.63)
Proportion female (%)	82.8	82.8	82.4	83.3
Cognitive status (n, %);				
Not impaired	28 (45.2)	10 (37.0)	13 (76.5)	5 (27.8)
Hearing (n, %);				
No difficulties	38 (60.3)	16 (57.1)	12 (70.6)	10 (55.6)
Mobility (n, %)				
Fully mobile	13 (20.6)	2 (7.1)	5 (29.4)	6 (33.3)
Speech (n, %);				
Normal	51 (81.0)	18 (64.3)	17 (100.0)	16 (88.9)
Friends (n, %):				
None	20 (32.8)	8 (30.8)	6 (35.3)	6 (33.3)
A few	28 (45.9)	16 (61.5)	5 (29.4)	7 (38.9)
Quite a lot	8 (13.1)	0 (0)	4 (23.5)	4 (22.2)
Many	5 (8.2)	2 (7.7)	2 (11.8)	1 (5.6)
Good friends (n, %):				
None	38 (62.3)	21 (80.8)	9 (52.9)	8 (44.4)
A few	18 (29.5)	4 (15.4)	5 (29.4)	9 (50.0)
Quite a lot	2 (3.3)	0 (0)	1 (5.9)	1 (5.6)
Many	3 (4.9)	1 (3.8)	2 (11.8)	0 (0)
Positive wellbeing (%) ¹	46.7	56.0	35.3	44.4

Notes:
¹Positive wellbeing: the proportion of residents recording a response of ‘extremely happy’, ‘very happy’ or ‘generally satisfied’ on the PGWI item.

they had no good friends. Number of good friends was recoded into a dichotomous variable (no good friends/having good friends) due to small numbers within cells, prior to a χ^2 analysis which indicated an association between number of good friends and residential setting ($\chi^2(2) = 6.85, p < 0.05$). There was no significant association between place of residence and wellbeing, with nearly half of the residents reporting positive wellbeing.

Table 2 presents the correlation coefficients for association among resident behaviour, location, and characteristics, including reported friends and wellbeing. There were notably few correlations of any magnitude (due to multiple testing, conventional levels of significance should be applied with caution). Those correlations of some substance (e.g. greater than 0.40) tended to demonstrate anticipated relationships (e.g. $r = 0.51$ for time spent in dining room and time spent eating/drinking). PSI was positively correlated with spending time in the sitting room ($r = 0.41, p = 0.001$) and negatively correlated with spending time in one’s own room ($r = -0.40, p = 0.001$), as was walking/wandering ($r = 0.40, p = 0.001$; $r = -0.42, p = 0.001$) with sitting room and own

room, respectively. Impaired cognitive status was correlated with spending time in the sitting room ($r = 0.47, p < 0.001$), and negatively correlated with spending time in one’s own room ($r = -0.41, p = 0.001$).

There were no substantial associations between having friends and any other variable. Having good friends was, however, associated with ASI ($r = 0.41, p = 0.001$) and conversation level ($r = 0.42, p = 0.001$), and negatively associated with being socially inactive ($r = -0.39, p = 0.002$). Wellbeing had no substantial correlation with any variable. Due to the significant association between good friends and ASI, a series of partial correlational analyses were run to see if functional and/or demographic variables might influence this association. The first order partial correlations between good friends and ASI were as follows: controlling for age, $r = 0.39, p = 0.002$; controlling for cognitive impairment, $r = 0.36, p = 0.004$; controlling for mobility, $r = 0.36, p = 0.005$; controlling for speech impairment, $r = 0.34, p = 0.008$. The fourth order partial correlation between good friends and ASI, with age, cognitive impairment, mobility and speech controlled for simultaneously, was $r = 0.32, p$

TABLE 2. Correlation coefficients for associations among resident behaviour, location, characteristics, reported friends and wellbeing

	Sit. Rm.	Din. rm.	Own rm.	Age	Cog.st.	Hear.	Mob.	Speech	Friends	Good fr.	W-B
Active social interaction	0.09	-0.01	-0.24	-0.15	-0.22	-0.14	-0.23	-0.32 ^a	-0.20	-0.41 ^b	-0.17
Passive social interaction	0.41 ^b	0.14	-0.40 ^b	-0.00	0.31 ^a	0.15	0.06	0.19	0.02	0.04	0.05
Socially inactive	-0.01	0.14	0.06	0.13	0.27 ^a	0.12	0.20	0.37 ^b	-0.28 ^a	-0.39 ^b	0.06
Recreation	-0.25 ^a	-0.28 ^a	0.33 ^b	0.05	-0.24	-0.17	-0.05	-0.37 ^b	0.16	0.18	-0.1
Eating/drinking	-0.02	0.51 ^c	-0.25 ^a	-0.12	-0.11	0.03	0.04	0.13	0.08	0.03	0.04
Walking/wandering	0.40 ^b	0.11	-0.42 ^b	0.10	0.06	0.03	-0.33 ^b	-0.05	-0.13	0.15	-0.12
Receiving physical care	-0.23	-0.13	0.12	0.00	-0.12	-0.12	0.19	0.02	-0.16	-0.08	-0.05
In conversation	0.12	0.01	-0.18	-0.21	-0.24	-0.14	-0.21	-0.32 ^a	0.19	0.42 ^b	-0.17
		In sitting room		-0.01	0.47 ^c	0.18	-0.11	0.09	-0.06	0.10	-0.06
		In dining room		-0.19	0.07	0.16	0.39 ^b	0.40 ^b	0.04	-0.15	0.05
		In own room		0.11	-0.41 ^b	-0.13	0.04	-0.17	0.02	-0.07	0.03
			Age	0.05	0.33 ^b	0.15	0.15	-0.10	-0.04	-0.03	0.20
			Cognitive status		0.06	0.08	0.08	0.21	-0.09	-0.14	0.01
			Hearing		0.28 ^a			0.16	-0.11	-0.02	0.07
			Mobility					0.33 ^b	-0.13	-0.21	0.21
			Speech					-0.20	-0.26 ^a		0.10
			Friends						0.70 ^c		0.09
			Good friends								0.01

key: a = $p < 0.05$; b = $p < 0.01$; c = $p < 0.001$.

= 0.014. Thus, although the absolute size of the correlation between good friends and ASI was reduced to some extent in these analyses, the association remained significant.

Due to the associations between having good friends and both residential setting and ASI, a 2 × 3 ANOVA was carried out with ASI as the dependent variable and good friends (no good friends/having good friends) and home (home A/B/C) as the independent variables. One case was deleted from analysis as a univariate outlier (greater than three SDs from the mean), three deleted due to missing data, *n* = 60. Subsequent evaluation of the assumptions of multi-variate analysis were satisfactory.

There was a significant main effect of good friends on ASI (*F*(1,54) = 19.96, *p* < 0.001, η^2 = 0.27), while home had no effect on ASI (*F*(2,54) = 0.41, *p* = 0.665). However, there was a significant effect for the interaction term (*F*(2,54) = 5.80, *p* = 0.005, η^2 = 0.18). Table 3 displays the cell means, which indicate that for all homes the level of ASI was higher for those residents having good friends. However, home B had the lowest level of ASI among residents with no good friends, while the same home had the highest level of ASI among residents having good friends.

Results of fieldnote analysis

Theme 1: Home ethos, atmosphere and interaction. As expected due to the use of this characteristic in home selection, differences were apparent between the homes with regard to their care ethos. In home B, residents were given considerable autonomy in the course of their lives. Senior staff described a policy of referring to residents as ‘guests’ and considering the home as being ‘like a hotel’. Staff were available to assist with problems any residents might have through the use of a buzzer system, with a buzzer located in each resident’s room. Breakfast was taken in the residents’ own rooms, and it was not until mid morning that there was any communal activity. There were few attempts to organize activities for the residents.

In homes A and C, the residents’ lives were more highly structured by staff. Residents commented upon the friendliness of staff, and how this had helped them settle into the home. As resident RP said: ‘. . . the staff are ever so friendly and down to earth, real

humorous, I like the humour and that sort of thing, from the first day I could see the difference.’ In home A there was a high presence of staff throughout the home and residents could buzz for help if they needed it. Most residents sat in their rooms with their doors wide open so that they could catch staff’s attention if desired or call out to passers-by. One resident explained that, despite the fact that life was heavily structured in the home, the buzzer system allowed him to exert some control over proceedings, by calling staff in when he wanted company or assistance. Residents were not required to sit in the communal areas if it was not necessary for staff to supervise them. In home C most residents were aided by staff in bathing and dressing and were then brought down to breakfast, after which they would sit in one of the communal sitting areas. In this home, it was a policy to encourage residents to sit together, regardless of the level of staff supervision required. Both homes organized activities for the residents once or more each week.

Theme 2: The physical environment and relationships. The physical structure of each home, and the way this structure was incorporated into daily life, played an important role in how relationships between residents were facilitated or limited. In home A most residents stayed in their own rooms. Those who were observed in the sitting room areas were less able and dependent on staff to move around the home. Residents were seated by staff, usually in the same seats each day, with male residents placed in a smaller lounge and female residents placed in a larger TV lounge. In this home, the smallest sitting room had been converted into a dining area, in which seven of the more alert and independent residents took their meals. The residents who ate in the small dining room always sat at the same tables, and described the residents who also sat in this room as friends. Three of these seven residents described all other people who sat in the small dining room as good friends, while none of the seven described anyone outside this group as a good friend.

The larger dining room provided seating for up to 20 residents and again had a regular seating pattern. Most residents were wheeled to this dining room by staff and it was the staff who determined where the residents sat. In this dining room it was usual for conversation to be initiated by staff who were present throughout each meal, with less conversation observed between residents.

In home B for most of the day residents chose to sit in their own rooms with their doors closed. This was not out of necessity, but because in many cases residents preferred to be by themselves. One resident described how she was quite happy because she had ‘the television and I’ve got books and magazines that I can read, I’m quite happy, you know, with what I’ve got.’ Although some residents required physical help from staff, none needed continual supervision. Thus,

TABLE 3. Cell means¹ for 2×3 ANOVA of good friends and home on Active Social Interaction (ASI)

	No good friends	Having good friends
Home A	8.26	19.21
Home B	6.34	32.82
Home C	18.14	27.36

¹ Means represent the mean amount of time residents spent in Active Social Interaction (ASI) expressed as a proportion of total time observed.

residents were not placed in the communal sitting areas for this purpose. When people did use these areas through their own choice they tended to sit in the same seat each time. A group of women who saw themselves as good friends sat together in the lounge most afternoons. Most residents walked to the dining room unaided and chose where they would sit; those that were wheeled by staff were asked their preferences. In between courses there was a large amount of social interaction between residents. Mealtimes provided a focus in this home, people congregated before and after mealtimes around the seats at the end of the ground floor corridor, close to the lift. Two of the residents who sat by each other at each meal named each other as good friends.

In home C virtually all residents spent the day in the lounge or conservatory. Those residents who were mobile often moved between rooms, while most residents sat in chairs around the edge of the room for the whole day. As a result, conversation was often directed at the room in general, rather than to specific individuals. One resident indicated that he was happier being in an area where people passed by, rather than 'being in your own room on your own and nobody going, only your own family, and that's it . . . Here, it's a much better place.' The one resident who named good friends, sat with these people in the conservatory. During mealtimes, people had a particular table to sit at and they kept to this pattern. The one resident who named good friends, sat with these people at mealtimes. In contrast to the other homes there was virtually no social interaction observed in this location.

Theme 3: Caring resident friendships. Most commonly in home C, it was observed how several more able residents took an active caring role towards residents who were more dependent and less able. For example, one female resident, EF, took a caring role toward AB, who spent all day in the communal sitting room. EF, together with female residents LAB and DW, provided a voice for AB who seldom would even speak a word. They voiced their opinions to the staff when AB was sitting uncomfortably, and they ensured that she did not get treated roughly by other residents. EF also cared for IB, who was very ill and weak and spent most of her time in bed. EF took an active role by questioning staff when IB was not brought to sit in the lounge. When describing the kind of relationships that existed between residents, EF said: 'We help each other out as we can, help the nurses out as best we can. We're all friends, we all muck in together.' Another resident, EK, who was fully mobile, would often help other less mobile residents by informing staff of problems and requests, and carrying things for others.

There was some evidence of caring resident friendships in home B, also. Resident MM spoke of how she was keeping busy cheering up DO, a lady who had a broken leg. She was observed visiting DO, and

she spoke of how walking downstairs to DO's room tired her out, but that she was proud of the work she was doing. However, most residents were described by MM as 'keeping themselves to themselves'. In home A, there was little evidence of these caring relationships. Friendships were established on different grounds. Two residents were life-long members of the Salvation Army, and spent much time together talking about their experiences.

Discussion

Approximately two-thirds of residents reported having friends in the home, while just over a third reported having good friends. This finding is in line with previous literature which suggests that non-intimate friendships are the norm for most residents (e.g. Gutheil, 1991). There was little difference between homes with regard to the reported level of friendships, but there was a significant association between home of residence and number of good friends reported. This suggests that the level of non-intimate friendships may not vary substantially across residential settings, but that the level of close friendships does. This is supported by the qualitative analysis of fieldnotes, which indicated that the opportunities for intimacy between residents varied from home to home due to the homes' physical environment and care regime.

Very few of the variables measured showed any substantial association with number of friends or number of good friends. The characteristics of residents that have been shown in previous research to influence friendships in residential settings, for example speech and cognition (Retsinas & Garrity, 1985); hearing and mobility (Bitzan & Kruzich, 1990), were found to be largely unrelated to friendship levels. Unlike the present study, most research has excluded cognitively impaired residents, and this difference in exclusion criteria, together with other methodological differences, might account to some degree for the conflicting findings. However, the qualitative data in the present study emphasizes how physical and cognitive deficits in residents can be both facilitative and limiting of friendships. Thus, heavily dependent residents may actually benefit from caring relationships with other residents. However, if the home ethos is to segregate dependent and non-dependent residents, such relationships may not emerge. Clearly, it is not dependency *per se* that restricts friendship formation, but the way in which dependency is dealt with within the home environment.

The highest proportion of resident time was spent being socially inactive, and residents were most often located in their own room. The figures obtained are similar to those obtained in previous research, suggesting that people living in these environments spend a large proportion of their time in social and emotional isolation (Bowie & Mountain, 1993). The

interpretation of such findings in the past has been that this is due to the nature of the home environment and care regime. However, the fact that some cognitively able residents in the present study chose to stay in their own rooms suggests that residents may exercise volition in disengaging from interaction.

Active social interaction (ASI) was related to number of good friends as reported by residents. This suggests that, in cases where it is impossible to interview residents, observation of ASI might be a proxy measure of the level of friendship quality, but not necessarily of the quantity of friendships. However, with a correlation of only 0.41 between ASI and good friends, there is still a need to develop a more sophisticated proxy measure. ASI was higher in residents with good friends compared to residents without good friends, but the degree of difference was dependent on the home in which the resident lived: residents with good friends in home B had the highest level of ASI of all observed residents, while their fellow home B residents without good friends showed the lowest level of ASI. Qualitative analysis of fieldnotes indicated that the home made no special attempt to bring residents together, and that residents would normally only congregate during mealtimes. Thus, residents without good friends would only have the brief opportunity offered by mealtimes in which to interact with their fellow residents, and their recorded level of ASI is low. ASI for residents with good friends, on the other hand, consisted for the most part of extended one-to-one interactions in private rooms. Thus, the pattern of close friendships found is clearly related to both resident choice and the prevailing care regime.

No measured variable was significantly associated with wellbeing. No association was obtained between wellbeing and place of residence despite observed differences across the homes in care ethos and regime. Of particular importance is the failure to demonstrate the anticipated relationship between reported friendships and residents' wellbeing. This failure runs counter to the majority of research in this area, which indicates significant associations between number and quality of friendships and residents' quality of life (e.g. Blau, 1973; Gupta & Korte, 1994), between high levels of social interaction and residents' wellbeing (Mor *et al.*, 1995), and that friendships are a core component of life quality across the lifespan (Prager, 1998).

There are theoretical and empirical reasons why a low association between friendships and wellbeing might be obtained in older people in residential settings. Research suggests that, in later life, established close friends are retained in preference to making new friends (Lang & Carstensen, 1994), and therefore contacts with relatives and friends from outside the home may have more impact on one's wellbeing than relationships with other residents. In

addition, it is possible that staff-resident interactions might substitute for resident-resident interactions and, for some people, obviate the need for casual friendships with other residents.

Disengagement theory (Cumming & Henry, 1961) suggests that friendships become less important to one's identity and life quality in later life. Erikson (1982) argues that the primary activity in later adulthood is reflection, which is focused on the developmental task of integrity versus despair. It might be reflection on one's past relationships, rather than active participation in present relationships, that is central to some older people's quality of life (Slater, 1995). The finding that many residents chose to keep themselves to themselves, as described by one of the residents in home B, and remain for long periods in their own rooms substantiates this argument. However, personal reflection might also be facilitated through close friendship with an individual with whom one shares a common history, such as the two good friends in home A who were both in the Salvation Army. The failure to find an association between friendships and wellbeing at the group level of analysis might reflect the existence of sub-groups of residents. Certain residents might seek out relationships and hold them dear; other residents might choose a more solitary, reflective existence.

Strengths and limitations of the present study

The main strength of the present study is its multi-method approach. Thus, structured interview assessment found no relationship between friendship and wellbeing. Qualitative fieldnote analysis suggested that, for the most part, resident accounts of friendship were borne out by the amount of time such residents spent in each other's presence, providing concurrent validity to the instrument assessments; and that many residents chose to spend time by themselves. Finally, observation of ASI also provided concurrent validity to the measure of good friendships, and was also found to have a very low association with wellbeing. Thus, the study's findings attain robustness through the multi-method approach.

However, the measurement of wellbeing by a single item was unsatisfactory. This highlights the problem, reflected in other research (e.g. Murray *et al.*, 1998), of the need for a satisfactory measure of wellbeing or more broadly of quality of life, that can be used across age groups, at all levels of cognitive impairment. The present work also needs replication with a larger, more representative sample of the residential population. It was unfortunate that poor distribution of key variables, such as sex and different forms of disability, prevented a satisfactory exploration of their influence on friendships and wellbeing. It would also be valuable, given the finding that the physical environment is an important factor in residents' friendships, to utilize an established measure of

environmental influence (Timko & Moos, 1990). A longitudinal design would also help to unravel the causal links, if any exist, between activity, friendships and wellbeing.

Conclusions

Establishing the role of friendships in the wellbeing of older people in residential settings is important, since the outcome should inform social policy regarding the provision and nature of supportive environments for older people. The bulk of previous research would suggest that friendships among residents are central to their wellbeing. The present study failed to find a link between friendships and wellbeing. Rather, a complex picture emerges, where resident choice might lead some residents to attain close friendships, while other residents seek solitude; and where the physical environment and the care regime of the home can both limit or facilitate friendships among residents. Further research is required into this important area, although work will continue to be hampered if measurement of wellbeing remains unsatisfactory for this age group.

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Appendix: Behaviour Category (BC) codes

- A Interacting with others verbally or otherwise
- B Being socially involved but passively
- C Being socially uninvolved, withdrawn
- D Expressing distress
- E Engaging in expressive/creative activity
- F Eating, drinking
- G Participating in a game
- H Craft activity
- I Using intellectual abilities
- J Exercise, physical sport
- K Walking, standing, moving in wheelchair
- L Performing work or pseudowork
- M Engaging with media
- N Sleeping, dozing
- O Independently engaging in self care
- P Receiving practical, physical or personal care
- R Participating in a religious activity
- S Activities related to sexual expression
- U Communicating without receiving a response
- V Vacate area/unavailable/ in own room
- Z No existing category