Quality of Life in Long-Term Care Facilities

5

5.1 Long-Term Care Facilities

For a variety of reasons older persons give up their old home and move into a long-term care facility. Ill-health, loss of self-care abilities, loss of a spouse or lack of support by the family, or a combination of these events are the main reasons for such a decision. Long-term care facility is a generic term that encompasses different kinds of institutions. Probably most familiar are nursing homes, but there are also assisted living facilities and alternative forms of nursing homes that need to be taken into consideration to get a better idea of the concept.

5.1.1 Nursing Homes

Nursing homes are a worldwide phenomenon. They originated in Western countries and spread on all continents. As a consequence, what is nowadays referred to as a nursing home may look quite different in every place of its existence. It would be beyond the scope of this book to provide a detailed description of the different kinds of institutions labelled as nursing homes that do exist worldwide. There are, however, three main characteristics that allow a broad distinction between them.

First of all, nursing homes are a housing option for older and sometimes also disabled people. Such housing options emerged in the Middle Ages from poorhouses that provided food and shelter for persons who were unable to care for themselves and had no source of income (Giarchi 2002). They were operated by the church or by charitable organizations and in some countries this charitable work became a matter of state regulations at the beginning of the seventeenth century—as, for example, in the UK with the provisions of the Elizabethan Poor Laws (Bright 2007).

In the twentieth century there was a growing awareness that residents of such housing facilities need more than just food and shelter. Residential facilities for older persons began to provide assistance in activities of daily living. At the same

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time the demand for specialized medical and nursing services became apparent. In reaction to this development countries began enacting laws to ensure care for older persons. In the USA, for example, homes for the aged run by philanthropically funded organizations were turned into modern nursing facilities after the 1965 enactment of Medicare and Medicaid and they became hospital-like in their design and physical operation (Wilson 2007).

One may therefore define nursing homes provisionally as residential facilities that provide personal care and nursing care. Some countries, however, differentiate between such facilities by the level of care they aim to provide. In the UK, for example, there are care homes (personal) and care homes (nursing) (Bright 2007; Hillcoat-Nalletamby 2014; Stevens et al. 2015). Care homes (personal) primarily offer personal and social care. The staff is mainly composed of care assistants. Medical and nursing care is only available up to a certain level that can be met by external general practitioners or district nurses (Bright 2007). Residents who require a higher level of nursing care have to move to care homes (nursing) where registered nurses are on duty 24 h. A similar distinction exists in the Netherlands, where older people with less complex problems receive care in residential care homes, while disabled people with chronic physical diseases or with progressive dementia who need continuing care and monitoring are accommodated in nursing homes (Oosterveld-Vlug et al. 2014). According to this distinction, only facilities that meet the criteria of care homes (nursing) should be referred to as nursing homes.

In the international context, however, the term nursing home is not univocally used. In some countries as, for example, in Germany the difference between personal care homes and nursing care homes does not exist and facilities referred to as nursing homes include all types of residents that would be treated separately in the UK or the Netherlands. In other countries there are even facilities labelled as nursing homes that refuse to admit sick and care dependent older persons. Andrews (2012) describes nursing homes in India where residents are expected to be sufficiently mobile to get to the dining room for meals and were not allowed to suffer from age-related dementia to any significant extent. Shrestha and Zarit (2012) report about similar homes in Nepal, and in his own investigation in Egypt the author heard about facilities labelled as nursing homes that forced residents to move out when they became too dependent on help (Boggatz 2011). If one accepts that personal care and nursing care are essential features of nursing homes, such facilities should not be labelled as nursing homes.

The boundary between simple residences and nursing homes is, however, not always clear as there are also mixed cases. These so-called nursing homes are partly residential facilities as they host independent older persons and partly care homes for personal care that deny admission only to those who suffer from serious illness. Hweidi (1999) reports about such a home in Jordan, and the author learned in his own investigation from managers of care homes in Egypt (Boggatz 2011) that homes initially intended to serve as simple residential facilities began to include personal care as part of their service in reaction to the increasing care needs of their residents which emerged over time.

In his meanwhile classical ethnographic study Gubrium (1997) describes a nursing home as it existed in the 1970s in the USA. It also had a mixed composition of independent and care dependent residents, but both groups stayed in separate units. For the independent older persons the nursing home served mainly as a residential facility. Although such mixed facilities may still exist, there is an ongoing debate about whether to admit independent older persons to care homes which—as the argument goes—are basically designed to serve those who have extensive care needs. In consideration of the costs of care, there was a policy shift in many Western countries. Governments want to enable people to receive support in their own homes. Hence, independent older persons or persons with low-care needs who used to be placed in care facilities now remain at home and nursing homes tend to accommodate only people with high care needs (Twenhöfel 2007; Thomas et al. 2013). This shift was a reason why a distinction between care facilities according to levels of care became obsolete in some countries. Persons who need only some assistance in activities of daily living are on the way to disappear from nursing homes.

In summary, the term "nursing home" may refer to different kinds of facilities as shown in Fig. 5.1. In some counties there exists a distinction between simple residential facilities, care homes (personal), and care homes (nursing) and the term nursing home should only be applied to the latter. Other countries, however, do not differentiate between these two kinds of care homes and distinguish only between residential facilities and nursing homes in general. There are also countries where the term nursing homes may refer to facilities that are restricted to provide personal care. Such facilities may serve partially as simple residential facilities and it would be more appropriate to label them as homes for the aged. In some cases, finally, the term nursing home may be misleadingly applied to simple residential facilities.

There are several reasons why facilities labelled as nursing homes have such different admission policies. Economic resources, professional knowledge, ownership, and state regulations are the most obvious. A lack of economic resources as it exists in developing countries may simply prevent facilities to respond to needs for personal or nursing care. Teka and Adamek (2014) provide an example of such a care home in Ethiopia that was run by the regional government. It housed impoverished older adults who had no family support. There was an insufficient supply of food and care and a single nurse was available to treat the residents, who struggled to get even basic medicines such as eye drops and pain reliever. Forced to live at a subsistence level, some of the residents were observed begging outside. Similar care homes are often run by charitable organizations. Although sometimes criticized for their poor quality, they save their residents from living the life of the destitute and provide at least a shelter for those who have been abandoned (Rugh 1981; Andrews 2012; Shrestha and Zarit 2012).

Residential Facility	Care homes (personal care)	Care homes (nursing care)
Residential Facility	Nursing homes	
Nursing homes/Home for the aged		-

Fig. 5.1 Different meanings of the term "nursing home"

A lack of economic resources is often associated with a lack of professional knowledge. Care homes in developing countries simply cannot afford to employ skilled nurses and are therefore afraid to accept physically and mentally ill individuals as they can only be treated by staff with no training in dealing with medical conditions (Shrestha and Zarit 2012). An own investigation gave the author some insight into the working conditions of such a home run by a convent of the Coptic church in Egypt (Boggatz 2011). The majority of the female caregivers was either illiterate or had just acquired basic skills in reading and writing. There was only one supervising nun who had absolved a three-month training course for care. Since they were unskilled workers, caregivers were not only in charge of personal care but also of all related household tasks including preparing meals, cleaning the home, and washing the residents' clothes. Paradoxically, this nursing home accepted older persons who had been rejected by the nearby governmental home due to their needs for personal care. Care was based on the ideal of charity and caregivers were expected to treat residents as if they were members of their own family.

Facilities in developed countries have better economic resources that allow the employment of nursing assistants and fully trained nurses who serve as supervisors. Their degree of service and comfort, however, may be quite different. High-end facilities may provide private rooms and other amenities like recreation rooms, a café (Andrew and Wilson 2014), a library (Fraher and Coffey 2011), or a garden (Raske 2010) for their residents, whereas low-cost facilities may be deprived of such amenities and residents are forced to stay in shared rooms. There are also nursing homes that offer different degrees of service and comfort and residents may choose to stay in a single room or a shared room according to their financial resources.

Such differences may be due to the ownership of the facilities. Ownership falls into either the public or the independent sector. In the public sector homes are run by governmental or local authorities, in the independent sector they are owned by charitable organizations or private organizations from large for-profit companies down to small, one-person businesses (Bright 2007; Giarchi 2002). Private for-profit organizations are likely to address older persons with high-end demands, whereas charitable organizations will take care of the more needy population. But there are also combinations of different kinds of ownership. Charitable homes, for example, may receive public funds (Giarchi 2002) or supplement their operating costs by also offering better service against private payments so that they work partly for profit (Boggatz 2011; Shrestha and Zarit 2012). Which kind of ownership is dominant depends on the orientation of the welfare system which varies between countries. In the UK, for example, the bulk of older people's long-term care provision moved into the independent sector due to changes in the funding policy (Bright 2007; Bowers et al. 2009). In other countries like Norway nursing homes are owned and run by the municipality, financed by taxes and resident payment (Nakrem et al. 2013).

State regulations are a further reason for differences between nursing homes. Many countries enacted laws that determine minimum standards of care and there are also independent commissions that carry out inspections to ensure quality of care. There is a variety of such rules and regulations that vary from country to country. Developing countries, however, may lack appropriate rules and regulations. In many Latin American countries, for example, there are no laws that regulate or facilitate financial oversight of care providing institutions (Figueredo-Borda and Zabalegui-Yárnoz 2015). Furthermore, the existence of laws does not guarantee their implementation. The registry of care facilities may be incomplete due to ineffective bureaucracy or because providers try to circumvent regulations that rather serve the purpose of bribery than the purpose of quality assurance (as the author had to learn during his work and investigation in Egypt). Due to a lack of "formal" inspection bodies and operational standards to monitor and evaluate care, care homes in Middle Eastern countries like Lebanon, Jordan, or Egypt are allowed "free reign" to set their own admission criteria, standards of care, and working practices (Hweidi 1999; Boggatz 2011; Adra et al. 2015).

5.1.2 Assisted Living

A description of long-term care facilities would be incomplete without taking into account alternatives to nursing homes that have emerged in some countries since the 1980s. Probably the best-known alternative is assisted living. It evolved as a response to a growing criticism of nursing homes that had a focus on medical care and were designed like hospitals. They were accused of subjecting residents to rigid control and depriving them of autonomy, privacy, and their individual way of life. Wilson (2007) who was among the pioneers of assisted living described the discontent of her mother with the nursing home and her vision of an alternative:

> Her vision was simple. She wanted a small place with a little kitchen and a bathroom. It would have her favourite things in it […] There would be people to help her with the things she couldn't do without help. In this imaginary place, she would be able to lock her door, control her heat, and have her own furniture. No one would make her get up, turn off her favourite soaps, or ruin her clothes. […] She could have privacy whenever she wanted, and no one could make her get dressed, take her medicine, or go to activities she did not like. She would be Jessie again, a person living in an apartment instead of a patient in a bed. (Wilson 2007)

Facilities that aimed to put this vision into practice mushroomed in the 1990s and at the beginning of this millennium there were about 11,500 assisted living facilities with more than half a million residents all over the USA (Hawes et al. 2003). Due to the rapid spread of assisted living, various types of facilities emerged that operated under this label. What was initially a specific model of care became a more generic term that referred broadly to housing and supportive services in a homelike environment (Zimmerman and Sloane 2007). In an attempt to clarify the concept, a national workgroup convened by the U.S. Senate Special Committee on Aging defined assisted living as residences that "provide or coordinate oversight and services to meet individualized scheduled needs, based on assessments and service plans, and unscheduled needs". Services were expected to include 24-h awake staff, provision and oversight of personal and supportive services, health-related services (excluding nursing care), social services, recreational activities, meals, housekeeping, laundry, and transportation (Assisted Living Workgroup 2003). Unfortunately, this definition was only accepted in parts by the majority of the workgroup attendees and due to this lack of a national consensus, states created their own definitions of assisted living (Zimmerman and Sloane 2007).

As a consequence, facilities that operate under the label of assisted living may look quite different. Some of them resemble rather nursing homes; others are similar to hotels and focus on concierge-type services such as housekeeping, laundry, meals, activities, and transportation, but view personal care and health-related services with reluctance. A third type is characterized by residential-style settings, a variable service capacity, a philosophy of consumer autonomy, and comes closest to the original idea of assisted living (Wilson 2007). All facilities, however, have in common that the main part of care and work is performed by aides who often just received on-the-job training (Ball et al. 2009). A qualified nurse may be employed in addition full- or part-time. This is the case in the majority of facilities but it is not obligatory (Hawes et al. 2003).

Due to the rapid growth of assisted living in the USA other countries took up the idea. Similar facilities, for example, were established in the UK where they were labelled as extra care housing. These were purpose-built housing schemes providing residents with a private flat, access to a range of nonmedical, low-level care, and support services, with communal facilities such as a dining area, organized social activities, and a 24-h support staff presence (Hillcoat-Nalletamby 2014).

Assisted living and extra care housing should not be confused with facilities that are known in the USA as independent living or congregate housing and in the UK as sheltered housing. The latter can be characterized as a simple “housing with support” that provides only limited service by a regular on-site “warden” or scheme manager, but no 24-h care on a regular base (Pannell and Blood 2012). In contrast, assisted living facilities are similar to care homes that provide personal care. In theory, the difference between these two kinds of facilities is that assisted living is oriented to support autonomy and privacy in a homelike environment. In practice, however, it may be difficult to distinguish both as there are also nursing homes that offer private rooms and are designed in a homelike style, whereas some assisted living facilities may look like nursing homes and accommodate residents in shared rooms.

It should be added that there are also combinations of nursing homes, assisted living, and independent living facilities. These so-called continuing care retirement communities are composed of separate sections each for a particular level of care dependency. They aim to allow for ageing in place so that residents may enter the independent living section and move with increasing care needs to the assisted living section until they reach the nursing home as their final destination.

5.1.3 Alternatives to Nursing Homes

The criticism of nursing homes did not only result in the emergence of assisted living that operated outside the framework for nursing homes (although in some states such facilities were eligible to receive funds from Medicaid). There were also attempts to change the nursing home culture from within. The best-known example is the Eden Alternative™ that was developed by Dr. Thomas, an American geriatrician who redesigned a nursing home in Upstate New York to make it a more human habitat. Integral to the Eden design was the introduction of plants, animals, and children into the nursing home to counteract boredom and loneliness among residents and to promote a "life worth living". Medical treatment became secondary to caring. The locus of decision-making was with the residents, and by interaction with plants, animals, and children they should have the opportunity to give care as well as to receive it (Hinman and Heyl 2009; Brownie and Horstmanshof 2012).

A recent development that grew out of Eden principles at the beginning of this millennium are The Green House homes™. These are small-house nursing homes that try to combat the negative effects of institutionalization by changing the architectonical and organizational structure of nursing homes (Zimmerman and Cohen 2010). Most Green House homes are built in clusters of two or three, and each accommodates 6–12 residents. Residents have private rooms and bathrooms that open onto a central living area. The physical environment resembles a family home (Zimmerman and Cohen 2010; Bowers and Nolet 2014).

Staff empowerment is a further cornerstone of this idea. The hierarchy is flattened. Caregivers at the level of certified nursing assistants work in self-managed teams and are responsible for direct resident care, cleaning, laundry, meal preparation, and social activities. They simulate the way how families might organize work (Rabig et al. 2006; Zimmerman and Cohen 2010; Bowers and Nolet 2014), and they are called "Shahbazim" (singular: "Shahbaz")—an expression derived from Persian language which literally means royal falcon and refers to a fabled bird in Iranian mythology. A nurse is available 24 h a day and the clinical care team is nearby and visits as needed, but according to the philosophy of "demedicalizing" the atmosphere they are rather in the background (Bowers and Nolet 2014).

Such small house homes had predecessors in other countries. The idea of group-living care emerged already at the beginning of the 1980s in Sweden with the foundation of a model project in Malmö (Annerstedt 1997). At the end of the same decade the Anton-Piekhofje in the Netherlands was established to accommodate small groups of people with dementia who live in private rooms and share a common recreational and dining room (Kennemerhart 2018). Since the 1990s similar group-living units evolved in Germany. All these units have in common that they protect privacy and promote at the same time social interaction because residents spent the majority of the daytime together in a central lounge and kitchen area (Simon et al. 2013).

Green houses and other small house homes are similar to assisted living with regard to the limited presence of qualified nurses. They aim to provide an environment where residents can feel at home and maintain their daily life. These are central goals of person-centred care. Ironically, they are pursued by facilities where few nurses are employed and these facilities were established because nursing homes were accused of being unable to provide such person-centred care. One is tempted to ask whether the nursing profession failed to achieve a goal which is central to the idea of holistic nursing. On the other hand, one may also ask whether assisted living and other alternatives to nursing homes are able to achieve these goals—given the lower qualification of staff and the ensuing lack of specialization. It should be noted that the idea to simulate family life in a care environment was similar to the ideal of care in Egyptian nursing homes that were described above. The underlying assumption seems to be that care does not require special expertise and that it occurs rather naturally when staff cooks and cleans for residents.

5.1.4 Long-Term Care and Quality of Life

Given this background the question arises: what are the experiences that residents make in these different kinds of long-term care facilities? How do nursing homes and their alternatives impact on older persons' quality of life? Composition and qualification of staff in long-term care facilities may be quite different, but from the perspective of residents all types of facilities have one thing in common: Persons who move in have to give up their old home. As a consequence, they have to deal with this change and their new environment will have a positive or negative influence on their quality of life.

This chapter will describe how such environments support or interfere with the older persons orientations of action. It is based on an extensive literature research in the databases Pubmed, CINAHL, and Embase as shown in Fig. 5.2. The research

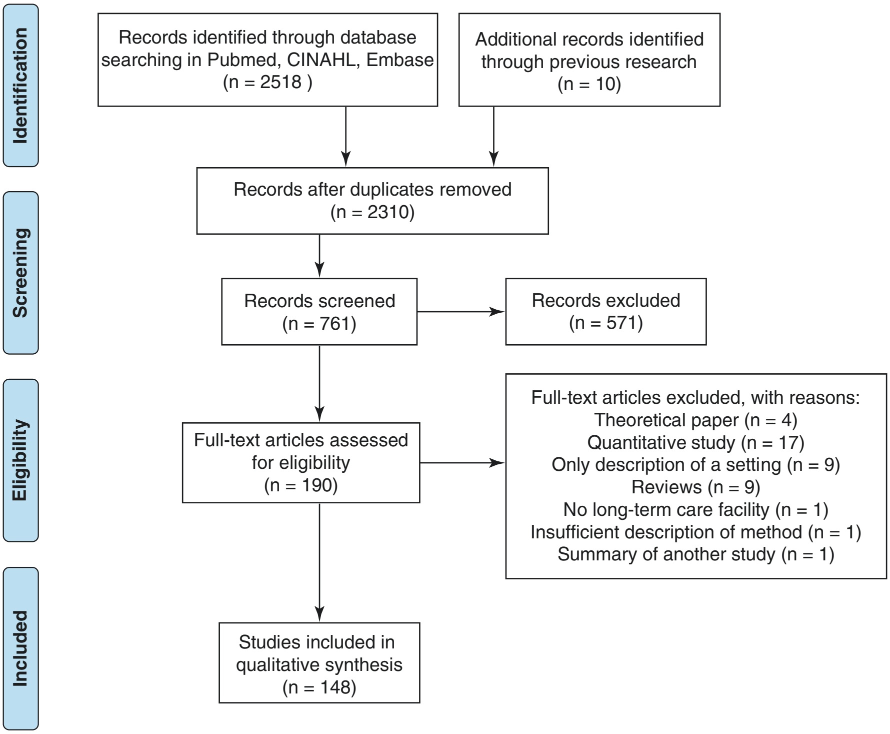

Fig. 5.2 Search strategy according to PRISMA (Moher et al. 2009)

was restricted to studies published in either English or German that were not older than 20 years. There was no restriction regarding place or kind of long-term care setting except for studies that described simple residential facilities with no staff available to provide personal care. Studies were included if they had a qualitative design and investigated the perceptions of residents in long-term care facilities by interviewing and/or observation. Since qualitative studies depend on the information provided by the participants, the perspective of older people with dementia could not be obtained unless they were included in observational studies. Studies that compared residents of long-term care facilities with home-dwelling older adults were included if the experiences of both groups were described separately. Because caregivers are in close contact to care recipients and exert a strong influence on their perceptions qualitative studies that investigated their point of view were also included. In several cases studies tried to capture both perspectives simultaneously. Research questions were allowed to have a broad focus on residents' experience in general or a narrow focus on a particular aspect of their experience like social contacts, independence, sexuality, etc. which was useful to shed some light on those aspects that may remain unnoticed if the study is concerned about experiences in general.

Altogether, 148 studies were included. Table 5.1 provides an overview over the places and settings, and Table 5.2 details their research questions, participants, and methods. 101 studies were conducted in facilities labelled as nursing homes, the others

Table 5.1 Studies by country and setting

	Nursing home	Assisted living	Total
USA	13	34	47
Canada	10	1	11
Australia	8	1	9
New Zealand	2	–	2
Norway	10	–	10
Sweden	10	4	14
Finland	2	–	2
Island	1	–	1
UK	11	2	13
Ireland	7	–	7
Germany	6	–	6
The Netherlands	3	–	3
Switzerland	1	–	1
Spain	4	–	4
Taiwan	5	–	4
China	2	–	2
South Korea	2	–	2
Indonesia	2	–	2
Middle East	4	–	4
Others	4	–	4
Total	106	42	148

Table 5.2 Investigated studies by authors and date of publication

Author(s)	Country	Facility	Research question	Participants	*n*	Data collection by	Research tradition
Adra et al. (2015)	Lebanon	NH	To explore the perspectives of quality of life for a sample of older residents, care staff, and family caregivers	Residents (65–91 years)	20	Interviews	Not specified
				Family members	8		
				Staff	11		
Al-Omari et al. (2005)	USA	AL	To describe the culture of an assisted living facility	Residents (77–83 years)	4	Interviews and participant observation	Ethnography
Andersson et al. (2007)	Sweden	NH	To describe older people's experiences of daily life at the care home after admittance	Residents (69–90 years)	13	Interviews	Not specified
				Family members	10		
				Staff	11		
Andrew and Wilson (2014)	New Zealand	NH	To explore the value of a café on the premises of an aged care facility for residents and their families	Residents (no age range specified)	11	Interviews	Interpretive description
				Family members	9		
Andrews (2012)	India and Australia	RCF	To identify characteristics of Anglo-Indian institutions and their residents' attitudes towards living in them	Residents (no age range specified)	40	Interviews and participant observation	Ethnography
Ball et al. (2000)	USA	AL	What represents quality in the lives of residents in assisted living	Residents (>65 years)	55	Interviews and participant observation	Grounded theory
Ball et al. (2004a)	USA	AL	To investigate the process of ageing in place in assisted living	Residents (no age range specified)	39	Interviews and participant observation	Grounded theory
				Family members	28		
				Staff	39		

Ball et al. (2004b)	USA	AL	To understand the meaning of independence for residents of assisted living	Residents (no age range specified)	55	Interviews and participant observation	Grounded theory
Ball et al. (2009)	USA	AL	How direct care workers in assisted living facilities interpret their relationships with residents	Staff (direct care workers)	38	Interviews and participant observation	Grounded theory
Barnes et al. (2013)	UK	NH	To describe individual residents' mealtime experience	Residents (no age range specified)	n. s.	Structured and unstructured observation	Not specified
Bauer et al. (2013)	Australia	NH	Residents' perceptions of needs and barriers to expression of sexuality in long-term care	Residents (79–101 years)	16	Interviews	Constructivism
Behr et al. (2013)	Germany	NH	How do residents experience situations that touch there intimate sphere	Residents (no age range specified)	42	Interviews	Not specified
Behr et al. (2014)	Germany	NH	To analyse mental fitness and mobility according to nursing home residents	Residents (no age range specified)	44	Interviews	Not specified
Bergland and Kirkevold (2006)	Norway	NH	Residents' perspective on what contributes to thriving in a nursing home	Residents (74–103 years)	26	Interviews	Phenomenology
Bennett et al. (2015)	USA	AL	To explore resident autonomy in assisted living and the effects visitors have on it	Residents (no age range specified)	68	Interviews and participant observation	Ethnography
				Family members	47		
				Staff	65		
Bland (2007)	New Zealand	NH	To explore the nature of comfort within the context of nursing homes	Residents (66–91 years)	21	Interviews and participant observation	Critical ethnography

(continued)

Table 5.2 (continued)

Author(s)	Country	Facility	Research question	Participants	*n*	Data collection by	Research tradition
Boggatz et al. (2009)	Egypt	NH	To identify the attitudes of Egyptian nursing home residents towards staying in a nursing home	Residents (Ø 72 years)	21	Interviews	Hermeneutics
Bollig et al. (2016)	Norway	NH	What nursing home residents and their relatives perceive as ethical challenges in nursing homes	Residents (66–100 years)	25	Interviews	Not specified
				Family members	18	Focus groups	
Bourrett et al. (2002)	Canada	NH	The meaning of mobility for residents and staff	Residents (>60 years)	20	Focus groups	Not specified
				Staff	15		
Bowers et al. (2001)	USA	NH	How nursing home residents define quality of care	Residents (64–104 years)	27	Interviews	Grounded theory
Bowers et al. (2009)	UK	NH AL	To learn from the experiences and aspirations of older people who currently live in care homes	Residents (no age range specified)	84	Participant observation and group discussion	Not specified
Canham et al. (2016)	Canada	NH	To explore meanings and experiences of "home" from the perspective of paid staff members	Staff	32	Interviews	Not specified
Carder (2002)	USA	AL	How daily operations in assisted living are affected by its central values	Residents (no age range specified) and staff	n.s.	Participant observation	Ethnography
Chang (2013)	South Korea	NH	To understand the experiences of life among nursing home residents	Residents (76–96 years)	11	Interviews	Descriptive phenomenology
Cheng et al. (2011)	China	RCF	To understand the well-being of residents and how the environment affects everyday activities and health	Residents (Ø 80 years)	27	Interviews	Not specified
				Family members	26		
				Staff	18		

Chin and Quine (2012)	Australia	RCF	Concern about residential aged care by older women in low-care facility	Residents (>65 years)	25	Interviews	Not specified
Cho et al. (2017)	South Korea	NH	To explore older adults' perceptions of their daily lives in South Korean nursing homes	Residents (65–94 years)	21	Interviews	Not specified
Christov (2016)	Germany	NH	To understand community and silence in a nursing home	Residents (no age range specified)	12	Interviews and participant observation	Ethnography
Chuang and Abbey (2009)	Taiwan	NH	To explore and understand the culture of nursing home life for older residents in Taiwan	Residents (no age range specified)	16	Interviews and participant observation	Ethnography
				Family members	17		
				Staff	4		
Chuang et al. (2015)	Taiwan	NH	To explore the older nursing home residents' care needs from their own perspectives.	Residents (Ø 81 years)	18	Interviews	Not specified
Cooney et al. (2009)	Ireland	NH	To identify the determinants of quality of life for older people living in residential care	Residents (>65 years)	101	Interviews	Grounded theory
Cooney (2011)	Ireland	NH	To understand older peoples' perceptions of "being at home" in long-term care settings	Residents (>65 years)	61	Interviews	Grounded theory
Coughlan and Ward (2007)	Canada	NH	Residents' experiences in a LTCF and their understanding of "quality of care"	Residents (Ø 84 years)	18	Interviews and participant observation	Not specified
Curle and Keller (2010)	Canada	NH	To investigate social interactions at mealtime in retirement homes	Residents (no age range specified)	n. s.	Participant observation	Ethnography

(continued)

Table 5.2 (continued)

Author(s)	Country	Facility	Research question	Participants	*n*	Data collection by	Research tradition
Dobbs (2004)	USA	AL	To explore the meanings of “home” and “care” for residents in assisted living	Residents (no age range specified)	n. s.	Participant observation and informal interviews	Ethnography
Dobbs et al. (2008)	USA	AL	To explored aspects of stigmatization for older adults in residential care or assisted living	Residents (no age range specified)	153	Interviews and participant observation	Ethnography
				Family members	76		
				Staff	80		
Donaldson et al. (2014)	USA	AL	To explore attitudes of heterosexual residents towards gay and lesbian peers	Residents (62–90 years)	13	Interviews	Interpretive phenomenology
Donnelly and MacEntee (2016)	Canada	NH	How do residents perceive care in LTC facilities purporting to offer person-centred care?	Residents (58–97 years)	23	Interviews	Grounded theory
Eckert et al. (2009)	USA	AL	To explore transitions in the life of residents in assisted living	Residents (no age range specified)	150	Interviews and participant observation	Ethnography
Eika et al. (2015)	Norway	NH	To explore nursing staff interactions during the older residents’ transition into long-term care facilities	Residents (no age range specified)	10	Interviews and participant observation	Ethnography
				Staff	17		
Falk et al. (2013)	Sweden	NH	To understand processes and strategies by which older people create a sense of home in residential care	Residents (Ø 82 years)	25	Interviews	Grounded theory
Figueredo-Borda and Zabalegui-Yárnoz (2015)	Uruguay	RCF	To explore the perception of care in long-term centres	Residents (74–99 years)	7	Interviews and participant observation	Ethnography
				Staff	15		

Fiveash (1998)	Australia	NH	Resident's experience of nursing home living	Residents (>65 years)	8	Interviews (2 or 3 times) and participant observation	Ethnography
Fraher and Coffey (2011)	Ireland	NH	To explore older people's decision to relocate to long-term care and their early experiences post-relocation	Residents (78–92 years)	8	Interviews	Interpretive phenomenology
Frankowski and Clark (2009)	USA	AL	How sexuality permeated the lives of assisted living residents, staff, and family members	Residents (no age range specified)[a]	150	Interviews and participant observation	Ethnography
Goddard et al. (2013)	UK	NH	To explore the views and experiences of care home resident's family on dignity therapy	Family members	14	Interviews	Not specified
Grando et al. (2000)	USA	NH	Reasons why elders with light-care needs reside in nursing homes	Residents (55–98 years)	98	Interviews	Not specified
Grant et al. (1996)	Canada	NH	Indicators of quality of care	Residents (25–99 years)	52	Interviews	Critical incidence technique
				Family members	58		
				Staff	37		
Grau et al. (1995)	USA	NH	To assess residents' best and worst experiences in the nursing home	Residents (Ø79 years)	46	Interviews	Grounded theory
Gustavsson et al. (2015)	Sweden	NH	To examine how residents and staff at a nursing home described the residents' everyday doings	Residents (69–97 years)	15	Interviews	Not specified
				Staff	6		

(continued)

Table 5.2 (continued)

Author(s)	Country	Facility	Research question	Participants	*n*	Data collection by	Research tradition
Hauge and Heggen (2006)	Norway	NH	How and to what extent the idea of the nursing home as a home has been realized	Residents (80–100 years)	24	Interviews and participant observation	Interpretive phenomenology
Harmer and Orrell (2008)	UK	NH	To explore concepts of meaningful activity, as defined by residents with dementia staff and family carers	Residents (72–99 years)	17	Focus groups	Grounded theory
				Family members	8		
				Staff	15		
Heid et al. (2016)	USA	NH	Preferences of residents and why they change	Residents (Ø79 years)	39	Rating scale and open questions	Cognitive interviewing
Heliker (2009)	USA	NH	To investigate the experience of participating in a story sharing intervention	Residents (>60 years)	54	Interviews	Interpretive phenomenology
				Staff	84	Focus group discussion	
Heliker and Scholler-Jaquish (2006)	USA	NH	To describe the experience of being admitted to and living in a nursing home	Residents (no age range specified)	10	Interviews (3 times)	Interpretive phenomenology
Hellström and Sarvimäki (2007a, b)	Sweden	AL	How residents in sheltered housing experience self-determination and how they are valued as human beings	Residents (73–93 years)	11	Interviews	Not specified
Herrmann and Flick (2011)	Germany	NH	To explore the nursing home residents' self-perceived resources for good sleep	Residents (66–101 years)	30	Interviews	Not specified
Hillcoat-Nalletamby (2014)	UK	NH AL[b]	To understand the meaning of independence for older persons in extra care housing and nursing homes	Residents (NH) (Ø 82 years)	29	Interviews	Not specified
				Residents (AL) (Ø 81,5 years)	29		

Hjaltadóttir and Gustafsdóttir (2007)	Island	NH	To disclose the characteristics of quality of life as perceived by frail but lucid residents in nursing homes	Residents (76–93 years)	8	Interviews	Interpretive phenomenology
Holmberg et al. (2013)	USA	NH	How the work environment supported or impeded caregiving to residents	Staff	150	Focus groups	Not specified
Holmgren et al. (2013)	Sweden	NH	To describe how nursing staff's routines and reasoning condition the involvement of relatives in nursing homes	Staff	42	Interviews and participant observation	Ethnography
				Residents (no age range specified)	n. s.	Participant observation	
				Family members	n. s.		
Hubbard et al. (2003)	UK	NH	To understand social interaction in institutional care settings	Residents (no age range specified)	n. s.	Participant observation	Ethnography
Hutchinson et al. (2011)	USA	NH	To investigate person and environmental factors that facilitate adaptation to nursing facilities	Residents (>60 years)	23	Interviews	Phenomenology
Hwang et al. (2013)	Taiwan	NH AL	To elucidate the nature of caring by describing the experience of elderly residents of Taiwan LTCFs	Residents (65–94 years)	12	Interviews	Not specified
Hweidi (1999)	Jordan	NH	To describe the culture of a nursing home in Amman, Jordan	Residents (no age range specified)	17	Interviews and participant observation	Ethnography

(continued)

Table 5.2 (continued)

Author(s)	Country	Facility	Research question	Participants	*n*	Data collection by	Research tradition
Iden et al. (2015)	Norway	NH	To explore residents' perceptions of their own sadness	Residents (>80 years)	12	Interviews and participant observation	Not specified
Iwasiw et al. (1996)	Canada	NH	Residents' perspectives of the first two weeks in LTC	Residents (no age range specified)	12	Interviews	Grounded theory
Iwasiw et al. (2003)	Canada	NH	To explore residents' perspectives of their first year in a nursing home	Residents (75–88 years)	7	Interviews (5 times)	Phenomenology
				Family members	3		
James et al. (2014)	Sweden	NH	To describe how residents develop a meaningful daily life	Residents (83–100 years)	25	Interviews (2 times)	Action research and hermeneutic
Jordan (2010)	USA	AL	How residents in ALF perceive nurses' caring behaviour	Residents (67–99 years)	51	Questionnaire and interviews	Mixed method
Karlsson et al. (2009)	Sweden	NH	To describe registered nurses' experiences of their work environment in residential care homes	Staff	12	Interviews	Not specified
Kemp (2008)	USA	AL	How married couples experience life in assisted living	Residents (66–94 years)	20	Interviews	Grounded theory
Kemp et al. (2012)	USA	AL	Social relationships in assisted living and their influencing factors	Residents (52–102 years)	27	Interviews and participant observation	Not specified
				Staff	16		
Kemp et al. (2016)	USA	AL	Relationships of married and unmarried couples in assisted living	Residents (59–100 years)	51	Interviews and participant observation	Grounded theory
Kennedy et al. (2005)	USA	AL	The experience of older adults in making everyday decisions in assisted living	Residents (63–76)	4	Interviews and participant observation	Case study

Koch-Straube (2003)[c]	Germany	NH	To describe everyday life in a nursing home	Residents (74–95 years)	41	Participant observation and informal interviews	Ethnography
				Staff	24		
Koppitz et al. (2017)	Switzerland	NH	To understand unplanned admissions to nursing homes and to explore its impact on adaptation	Residents	31	Interviews	Not specified
Koskenniemi et al. (2015)	Finland	NH	To describe how older patients in nursing homes and their kin experience the manifestation of respect	Residents (69–90 years)	40	Interviews	Not specified
				Family members	20		
Kuhn (2008)	USA	AL	To explore how the social world in assisted living is organized	Residents (no age range specified)	22	Interviews and participant observation	Ethnography
				Staff	17		
Lung and Liu (2016)	China (Hong Kong)	NH	To identify the types of daily interactions perceived by NAs and residents	Residents (71–96 years)	15	Interviews	Not specified
				Staff	18		
Mahrs Träff et al. (2017)	Sweden	AL	To explore how residents and staff understand the concept of physical activity	Residents (70–95 years)	13	Interviews	Phenomenography
				Staff	17		
Martinsson et al. (2013)	Sweden	NH	To illuminate older immigrants' experiences of moving to a residential care facility	Residents (67–87 years)	7	Interviews	Not specified
Melin-Johansson et al. (2014)	Sweden	NH	To explore experiences of ageing among residents based on the gerotranscendence theory	Residents (80–96 years)	14	Interviews	Not specified

(continued)

Table 5.2 (continued)

Author(s)	Country	Facility	Research question	Participants	*n*	Data collection by	Research tradition
Minney and Ranzijn (2016)	Australia	AL	Residents' perspectives on whether a "good life" is possible for older people living in residential aged care	Residents (77–95 years)	13	Interviews	Interpretive phenomenology
Mohammadinia (2017)	Iran	NH	To explore the older peoples' experiences of nursing homes	Residents (65–82 years)	15	Interviews	Descriptive phenomenology
Murphy (2007)	Ireland	NH	To explore nurses' perceptions of quality care in long-term care	Staff	20	Interviews	Interpretive phenomenology
Murphy et al. (2007)	Ireland	NH	To explore the quality of life in long-stay care from the perspectives of residents and staff	Residents (>65 years)	101	Interviews, focus groups, and survey	Mixed method
				Staff	48		
Nakrem et al. (2011)	Norway	NH	To describe nursing homes' residents experience with direct care	Residents (75–96 years)	15	Interviews	Not specified
Nakrem et al. (2013)	Norway	NH	To describe residents' experiences of living in a nursing home related to quality of care	Residents (75–96 years)	15	Interviews	Not specified
Nakrem (2015)	Norway	NH	To describe the nursing home culture from the staff's perspective and how the residents describe quality of care	Residents (75–92 years)	15	Interviews	Ethnography
				Staff	n. s.	Participant observation and informal interviews	
Nay (1992)	Australia	NH	The meaning of sexuality for older women in nursing homes	Residents (>50 years)	20	Interviews	Not specified

Naess et al. (2016)	Norway	NH	How different care practices affect nursing home residents' dignity and sense of self	Residents (no age range specified)	n. s.	Participant observation	Ethnography
				Staff	48	Interviews and participant observation	
Nord (2013)	Sweden	AL	Meaning of household possessions that residents brought with them when moving into assisted living	Residents (60–99 years)	11	Interviews	Not specified
Oakes and Sheehan (2012)	USA	AL	How employees in assisted living give meaning to the term autonomy	Staff (direct care workers)	18	Interviews	Not specified
Oosterveld-Vlug et al. (2013a)	The Netherlands	NH	To investigate if and how nursing home residents' personal dignity changes over the course of time	Residents (49–97 years)	22	Interviews (2 to 5 times)	Not specified
Oosterveld-Vlug et al. (2013b)	The Netherlands	NH	To gain insight how nurses and physicians view dignity of nursing home residents	Staff	28	Interviews	Not specified
Oosterveld-Vlug et al. (2014)	The Netherlands	NH	To gain insight how residents experience personal dignity and the factors that preserve or undermine it	Residents (49–102 years)	30	Interviews	Not specified
O'Shea et al. (2014)	Ireland	NH	To explore relatives' involvement in the care of older adults admitted to residential settings	Family members	9	Interviews	Not specified
Palacios-Ceña et al. (2013)	Spain	NH	To explore the significance of the mealtime experience among residents of nursing homes in Spain	Residents (62–95 years)	26	Interviews	Descriptive phenomenology

(continued)

Table 5.2 (continued)

Author(s)	Country	Facility	Research question	Participants	*n*	Data collection by	Research tradition
Palacios-Ceña et al. (2016a)	Spain	NH	To describe how Spanish nursing home residents experienced and made sense of meaningful activities	Residents (62–100 years)	38	Interviews	Descriptive phenomenology
Palacios-Ceña et al. (2016b)	Spain	NH	To describe the lived experience of sexuality in elderly Spanish women residing in nursing homes	Residents, only women (Ø 83 years)	20	Interviews	Descriptive phenomenology
Park et al. (2009)	USA	AL	How male residents interact with other residents and staff in assisted living	Residents (>65 years)	29	Questionnaire and interviews	Mixed method
Park et al. (2012)	USA	AL	To explore the experience of social engagement in assisted living	Residents (Ø 85 years)	29	Interviews	Not specified
Park et al. (2013)	USA	AL	To explore social relationships of African American and Hispanic assisted living residents	Residents (>60 years)	30	Interviews	Not specified
Perkins et al. (2012)	USA	AL	To develop a conceptual model of autonomy in assisted living	Residents (>65 years)	266	3 previous studies with interviews	Metasynthesis
Perkins et al. (2013)	USA	AL	To examine the relative importance of co-resident relationships and other network ties	Residents (42–102 years)	179	Questionnaire and open ended questions	Mixed method
Philpin et al. (2011)	UK	NH	To investigate factors that influenced nutritional care provided in residential care settings	Residents (>65 years)	16	Interviews, focus groups, and participant observation	Not specified
				Staff	19		
Pryce and Gooberman-Hill (2012)	UK	NH	To explore the factors affecting communicating with a hearing loss in residential care	Residents (76–99 years)	18	Interviews and participant observation	Ethnography

Raske (2010)	USA	NH	To evaluate the impact of an enabling garden on quality of life of nursing home residents	Residents (65–99 years)	16	Interviews	Not specified
				Family members	6		
				Staff	15		
Rahayu et al. (2018)		NH	To understand the experience of older persons living in a residential home	Residents	6	Interviews	Phenomenology
Rekawati et al. (2018)		NH	To determine the effect of a partnership model to increase quality of life of older people in nursing home	Residents	8	Interviews	Phenomenology
Roberts and Bowers (2015)	USA	NH	To explore the ways resident develops relationships with peers and staff in nursing homes	Residents (55–97 years)	15	Interviews and participant observation	Grounded theory
Robichaud et al. (2006)	Canada	NH	Quality of life indicators in LTC for residents and family members	Residents (Ø 82 years)	19	Interviews	Not specified
				Family members	8		
Rossen and Knafl (2003)	USA	AL	To explore the transition of elder women to assisted living	Residents (61–91 years)	31	Interviews (pre- and post-move)	Not specified
Sandhu et al. (2013)	USA	AL	To examine the influences of physical and mental function on co-resident relationships in assisted living	Residents (54–102 years)	24	Interviews and participant observation	Grounded theory
				Staff	16		
Saunders and Heliker (2008)	USA	AL	The experience of older women after admission to assisted living	Residents (63–91 years)	5	Interviews (7 times)	Not specified
Schenk et al. (2013)	Germany	NH	To identify dimensions of life that residents perceive as having particular impact on their overall quality of life	Residents (no age range specified)	43	Interviews	Not specified

(continued)

Table 5.2 (continued)

Author(s)	Country	Facility	Research question	Participants	*n*	Data collection by	Research tradition
Shaw et al. (2016)	UK	AL	To understand older adults' experiences of moving into extra care housing	Residents (66–85 years)	6	Interviews (3 times)	Interpretive phenomenology
Shin (2008)	USA	NH[b]	To explore older Korean Americans' preferences when they are bedridden	Residents (nursing homes) (63–92 years)	5	Interviews	Not specified
Shin (2015)	USA	CCRC	How residents interact with their physical and social environments	Residents (no age range specified)	17	Interviews and participant observation	Grounded Theory
Shippee (2009)	USA	CCRC	How residents define transitions between levels of care in a CCRC	Residents (76–99 years)	35	Interviews and participant observation	Not specified
Shrestha and Zarit (2012)	Nepal	RCF[b]	How older women define and assess their quality of life	Residents (73–91 years)	5	Interviews	Not specified
Sidenvall et al. (1994)	Sweden	NH	How residents experience the meal situation and the intentions of staff regarding this situation	Residents (Ø 81 years)	18	Interviews and participant observation	Ethnography
				Staff	18		
Slettebo et al. (2016)	Norway/ Sweden/ Denmark	NH	How nursing home residents experience dignity through the provision of activities that foster meaning and joy	Residents (62–103 years)	28	Interviews	Not specified
Speller and Tollee (2015)	Canada	AL	To determine the gaps and strengths in care related to safety in assisted living	Residents (no age range specified)	9	Interviews	Not specified
				Staff	13		
Stathi and Simey (2007)	UK	NH	To explore exercise experiences of residents who participated in an exercise intervention	Residents (86–99 years)	14	Interviews (before and after intervention)	Interpretive phenomenology

Stevens et al. (2015)	UK	NH	To explore the experiences of older people with minimal care needs admission to care homes with RN care	Residents (86–99 years)	12	Interviews	Grounded theory
Svidén et al. (2009)	Sweden	AL	How older persons experience moving to and living at sheltered housing.	Residents (no age range specified)	59	Interviews	Not specified
Taylor et al. (2014)	Australia	NH	To explore residents' perspectives of intrinsic factors influencing mobility and their associations	Residents (61–96 years)	15	Interviews	Ethnography
Teka and Adamek (2014)	Ethiopia	RCF	To explore psychosocial needs in a residential care centre from the perspective of both staff and residents	Residents (>60 years)	24	Focus groups	Not specified
				Staff	5	Interviews	
Thomas et al. (2013)	Australia	RCF	To investigate residents' perceptions and experiences of social interaction and leisure activity	Residents (Ø 84 years)	6	Interviews	Not specified
Timonen and O'Dwyer (2009)	Ireland	NH	Experiences and coping strategies of (older) people living in residential care	Residents (no age range specified)	12	Interviews and group meetings	Not specified
Tompkins et al. (2012)	USA	AL	To understand the perceived continuity of relationships with family and friends	Residents (>65 years)	29	Interviews	Not specified
Tsai and Tsai (2008)	Taiwan	NH	To the lived experiences of older nursing home residents in Taiwan	Residents (65–97 years)	33	Focus groups and interviews	Not specified

(continued)

Table 5.2 (continued)

Author(s)	Country	Facility	Research question	Participants	*n*	Data collection by	Research tradition
Tucket (2007)	Australia	NH	Residents and staff's perception of the nursing home	Residents (70–88 years)	19	Interviews, group discussion, participant observation	Grounded theory
				Staff	38		
Tuominen et al. (2016)	Finland	NH	To describe older people's experiences of free will, its actualization, promoters, and barriers in nursing homes	Residents (68–96 years)	15	Interviews	Descriptive phenomenology
Villar et al. (2014)	Spain	NH	To compare views of staff and residents about barriers to sexual expression in residential aged care facilities	Residents (71–96 years)	47	Interviews	Not specified
				Staff	53		
Walker and Curry (2007)	USA	NH	How do older adults experience moving from their primary residence to a long-term care facility	Residents (no age range specified)	8	Interviews	Not specified
		AL			8		
Walker and Paliadelis (2016)	Australia	NH	To investigate the lived experience of older people in residential aged care	Residents (77–96 years)	18	Interviews	Interpretive phenomenology
Warren and Williams (2008)	USA	AL	The experience of assisted living and common problems for residents	Residents (no age range specified)	21	Interviews	Grounded theory
Westin and Danielson (2007)	Sweden	NH	To illuminate the meaning of residents' experiences of encounters with nurses in nursing homes	Residents (78–99 years)	12	Interviews	Hermeneutic
Williams and Warren (2008)	USA	AL	Experiences of older women in assisted living	Residents (no age range specified)	21	Interviews and participant observation	Grounded theory

Williams and Warren (2009)	USA	AL	How staff communicates with residents in assisted living	Residents	8	Interviews	Not specified
				Staff	8	Focus group	
Wilson and Davies (2009)	UK	NH	How relationships between residents and staff develop	Residents (no age range specified)	16	Interviews, focus groups, and participant observation	Constructivism
				Family members	18		
				Staff	25		
Wright et al. (2010)	UK	AL	To explore tenants' experiences of living in a remodelled extra care scheme and staff views about working there	Residents	96	Interviews	Not specified
				Staff	56		
Wu et al. (2009)	Taiwan	NH	To understand the phenomenon of nursing home care for older people in Taiwan	Residents	40	Interviews	Grounded theory
				Family members	20		
Wu and Barker (2008)	USA	NH	To explore the mealtime experience of Chinese elders in American nursing homes	Residents (Ø 81 years)	7	Interviews and participant observation	Grounded theory
				Family members	9		
				Staff	19		
Zimmerman et al. (2016)	USA	CCRC	How structures and processes of care in CCRC result in stigma in assisted living and nursing homes	Residents (39–100 years)	113	Interviews	Ethnography
				Family members	40		
				Staff	101		

n.s. not specified

NH nursing home, *AL* assisted living (including Extra Care Homes), *RCF* residential care facility, *CCRC* continuing care retirement community

[a] Same participants as Eckert et al. (2009)

[b] Study included participants from other settings, but data from these settings were excluded from evaluation

[c] Revised edition of a study originally published 1997

in assisted living facilities. Regarding the location, 61 came from European countries (mainly Norway, Sweden, and the UK), 57 from North America (mainly the USA), 11 from Australia and New Zealand, 11 from the Far East (China, Taiwan, South Korea, and Indonesia), four from the Middle East (Egypt, Jordan, Lebanon, and Iran), and four from others countries (i.e. Ethiopia, India, Nepal, and Uruguay). The findings were analysed and synthesized by using the same method as described in Chap. 2.

5.2 Long-Term Care Facilities and Body-Related Orientations of Action

Moving into a long-term care facility is often a reaction to meet body-related needs. Due to functional limitations older persons may have difficulties to move around, to satisfy their need for food and drink, to take care of their hygiene, to use the toilet, or to protect their body against injuries. The facility is expected to safeguard their physical integrity. At the same time it will interfere with the way how older persons are used to care for these needs. Behaviour of staff, but also rules and regulations may either promote or impede the satisfaction of body-related orientations of action. Table 5.3 provides an overview over the different aspects of body-related orientations of action and their satisfaction, the factors that influence this satisfaction and the behavioural and attitudinal reactions that residents use to deal with their situation.

5.2.1 Physical Activity Versus Physical Rest

5.2.1.1 Physical Activity

Despite their functional limitations older persons in long-term care facilities expressed a *desire for physical activities*. Residents in assisted living facilities said that they wanted to exercise according to their abilities (Ball et al. 2004b; Minney and Ranzijn 2016; Mahrs Träff et al. 2017)

> I think you've got to be occupied—physically and mentally occupied—I would say. There's nothing worse than being idle. We've got the gymnasium, which I attend fairly regularly. (Minney and Ranzijn 2016)

But also those who stayed in nursing homes considered physical activity to be beneficial for their health and they tried at least to walk around in the home (Tsai and Tsai 2008; Hutchinson et al. 2011; Nakrem et al. 2011; Chuang et al. 2015; Slettebo et al. 2016)

> I stayed in bed one day, and I thought it was just terrible. Even if I'm not feeling 100% I get up, because I improve as the day goes on. (Bourrett et al. 2002)

The main motivation for their efforts to stay physically active was the *desire for mobility*, i.e. the ability to move around according to their own desire (Stathi and Simey 2007; Cooney et al. 2009; Nakrem et al. 2013; Schenk et al. 2013; Behr et al. 2014; Taylor et al. 2014)

Table 5.3 Body-related orientations of action, influencing factors, behavioural and attitudinal reactions

Orientations of action and their satisfaction	
Physical activity	Desire for physical activity
	Desire for mobility
Satisfaction of physical activity	Intrinsic pleasure
	Benefits for health
	Improved mobility
	Restricted opportunities for physical activity
	Decline of mobility and energy
Physical rest	Desire to rest and recover
	Need for improved sleep
Satisfaction of physical rest	Having a rest and nap
	Sleep disorders
	Overexertion
Body protection and regeneration	Avoidance of injuries
	Concern about hygiene
	Fear of deteriorating health
	Getting treatment and therapy
	Hoping to recover by staying at home
	Desire for pain relief
	Importance of physical comfort
	Desire for wellness
	Rejecting treatment or care believed to be risky
Satisfaction of body protection and regeneration	Improved health and well-being
	Experiencing a sense of wellness
	Decline of health
	Falls
	Pain
Negligence towards health	Ignoring minor ailments
	Limited desire for hygiene
Satisfaction of negligence towards health	Leaving minor ailments untreated
	Minimum of hygiene
	Inconvenience
Food consumption	Desire to eat well
Satisfaction of food consumption	Enjoyment of meals
	Gain in weight
	Less satisfied with food
	Bad quality of food
	Remaining hungry
Food abstinence	Avoidance of overeating
	Keeping a diet
	Loss of appetite
Satisfaction of food abstinence	Normal blood sugar
	Surfeit
Sexual desire	Desire for sexual contact
	Desire for intimacy

(continued)

Table 5.3 (continued)

Satisfaction of sexual desire	Sexual pleasure
	Sexual frustration
Sexual abstinence	Dislike of sexual duties
	Remaining abstinent as a widow
	Abandoned sexual desires
Satisfaction of sexual abstinence	Sexual harassment
	Marital rape
Influencing factors	
Physical conditions	Ill-health
	Functional limitations
	Sexual disability
Environmental factors	Accessibility for disabled persons
	Availability of assistive devices
	Security systems
	Inconvenient beds
	Noise
	Inappropriate room temperature
	Problems getting medication
	Distribution of clothes for the needy
	Quality and quantity of meals
	Unavailability of double beds for couples
	Private room for occasional use
Body-related care	Room cleaning
	Personal care
	Assistance for eating and toileting
	Treatment of wounds
	Monitoring of vital parameters
	Medication
	Health promotion
	Lack of hygiene
	Neglect of mobilization and sleep promotion
Behavioural and attitudinal reactions	Exercises
	Walking
	Using assistive devices
	Taking prescribed medication
	Taking a nap
	Acceptance of physical limitations
	Slowing down

> I'd like to be able to go out, to be more independent, to be able to go to the toilet myself. I'd like to be able eventually to go out to the shop – that's the one thing you miss terribly. (Cooney et al. 2009)

Some residents told how they struggled to regain or maintain mobility

> I've started walking down, almost down, to the kitchen every mealtime. I nearly get there I try and do as much as I can. It's will power really to get me to do it (Taylor et al. 2014)

5.2.1.2 Satisfaction of Physical Activity

Satisfaction of the desire for physical activity was associated with *intrinsic pleasure* (Bourrett et al. 2002; Slettebo et al. 2016; Mahrs Träff et al. 2017). As one resident of an assisted living facility put it:

> It's moving physically and feeling good (Mahrs Träff et al. 2017)

Other residents told about *benefits for their health* (Ball et al. 2004a; Herrmann and Flick 2011; Minney and Ranzijn 2016; Cho et al. 2017). Physical activity promoted sleep and helped to reduce functional limitations.

> One becomes tired because one walks a lot, is outside in the fresh air. (Herrmann and Flick 2011)

> I walk everyday. My old legs, they give me trouble on account of these veins, and that helps (Ball et al. 2004a)

As a consequence of exercising, residents experienced an *improved mobility* (Stathi and Simey 2007; Oosterveld-Vlug et al. 2013a; Mahrs Träff et al. 2017). Even if such improvement was small, it was still perceived to be a success:

> That I am able to move, even if it's slow going (Mahrs Träff et al. 2017)

There were, however, other residents who could not satisfy their desire to stay active. Some of them complained about *restricted opportunities for physical activities* (Tsai and Tsai 2008; Behr et al. 2014; Bollig et al. 2016; Heid et al. 2016)

> There are seldom any activities. I don't have anything to do. […] All I do here is eat. They don't even provide any space for us to take a walk. (Tsai and Tsai 2008)

Others reported about a *decline of mobility and energy* which was partly due to their health condition, but also partly due to such restricted opportunities (Cooney et al. 2009; Cheng et al. 2011; Falk et al. 2013; Thomas et al. 2013; Shaw et al. 2016; Cho et al. 2017)

> If I got better, I could be more hopeful, but I feel weaker day by day. The distance that took 5 minutes for me to walk [before] now takes 10 minutes, which makes me frustrated. (Cho et al. 2017)

> At first when I moved in, I could manage on my own and now I'm unable to even stand straight without my walker. (Falk et al. 2013)

5.2.1.3 Physical Rest

On the other hand, residents in long-term care facilities also expressed a *desire to rest and recover*. For some of them the favourite time was "lunch and nap" (Ball et al. 2000). They were content with their physical capacities and did not feel like improving them (Minney and Ranzijn 2016). This attitude was in particular explicit among residents who suffered from ill-health and frailty (Nakrem et al. 2013; Heid et al. 2016)

> When I was healthy I went. Now that I'm not healthy, I can't. I have to go with the flow so to speak. (Heid et al. 2016)

Furthermore, some residents complained about sleep disturbances and felt a *need for improved sleep* at night (Herrmann and Flick 2011; Schenk et al. 2013; Chuang et al. 2015).

5.2.1.4 Satisfaction of Physical Rest

The desire for physical rest was satisfied when residents were able *to have a rest and nap* (Thomas et al. 2013). Others, however, were not able to overcome their *sleep disorders* (Iwasiw et al. 1996; Timonen and O'Dwyer 2009; Herrmann and Flick 2011; Chang 2013; Chuang et al. 2015). As one of them told:

> I don't sleep, I just stare at the wall. (Iwasiw et al. 1996)

Such sleep disorders had a variety of reasons: a noisy environment in shared rooms, a lack of physical activity during the day, depression, or an inability to achieve inner calmness. Another disturbance of physical rest was an *overexertion* that occurred when residents had to engage in exhausting activities or therapies (Thomas et al. 2013; Gustavsson et al. 2015; Donnelly and MacEntee 2016). In reaction they refused to participate:

> I get dizzy and my legs start shaking and I don't want to fall down and break something. So I've had an argument with our physiotherapist [who said] 'you should walk, you should walk more'. Well … they're my legs and I know if I can stand up or not, and I told her 'get off my back', so she left me alone. (Donnelly and MacEntee 2016)

5.2.2 Body Protection and Regeneration Versus Negligence Towards Health

5.2.2.1 Body Protection and Regeneration

Physical activity could not only result in overexertion, it implied also risks for physical integrity that residents in long-term care facilities wanted to protect. They were concerned about the *avoidance of injuries* when they exercised or walked around (Fiveash 1998; Grando et al. 2000; Ball et al. 2004b; Stathi and Simey 2007; Falk et al. 2013; Speller and Tollee 2015). For this reason they appreciated a health protective environment with sufficient lighting and grab bars in the bathroom and around the home.

> To me [safety] means that everything is in its place and there is nothing around you can trip over… carpets are taped down where I walk, and everything is in its place. (Speller and Tollee 2015)

Some of them used assistive devices like walkers or canes, others asked for the assistance of caregivers to move around.

> I like it more for protection. If I'm a little bit wobbly, I feel more secure if I have something to push me along. (Ball et al. 2004b)

To protect their physical integrity some residents were also *concerned about hygiene* in order to prevent infections.

> The toilet is very clean, which is good for health. (Chuang et al. 2015)

Behind these particular concerns was the general fear of a deterioration in health, which, as one could observe when looking at other residents, seemed to be everyone's fate.

> I'm sick and there's sick people everywhere (Fiveash 1998)

When residents were ill they wanted *to get treatment and therapy* (Hjaltadóttir and Gustafsdóttir 2007; Hwang et al. 2013). Older persons who had been admitted to a nursing home because of ill-health sometimes *hoped to recover by staying in the home* (Bland 2007; Tsai and Tsai 2008; Chuang and Abbey 2009). They considered the long-term care facility to be a place of treatment and not a place of living.

> I came here after my stroke. My sons have to work and have no time to take care of me, so they sent me here. This place is like a hospital, with nurses and doctors. I can have better care than if I stay home…. The important thing to me now is to improve my health. (Tsai and Tsai 2008)

Residents who were ill had above all a *desire for pain relief* (Nakrem et al. 2011; Schenk et al. 2013; Chuang et al. 2015). Those who suffered from impairments told about the *importance of physical comfort* that could be achieved with the help of caregivers by small changes of their body position (Bowers et al. 2001; Cooney et al. 2009; Iden et al. 2015).

> It is of great importance for me that I am in a good sitting position […] if I am not sitting well, I feel sad. (Iden et al. 2015)

Some residents were not only concerned about the relief of physical discomfort, they also had a *desire for wellness* and asked for care that actively promoted comfort, such as being offered a refreshing shower on a hot summer's day (Bland 2007) or getting food similar to or higher than the body temperature because—as residents in Taiwanese nursing homes told—it was better for health (Chuang et al. 2015). Sometimes, however, residents *rejected treatment or care they believed to be risky* for their health (Nakrem et al. 2011). One resident, for example, who had injured her knee was offered knee prosthesis, but she did not dare to be operated. Another resident refused to be showered because he became exhausted and dizzy:

> I can't shower anymore. Just have to wash myself here (in the room). I did it (shower) at first but just had to give up. I would just fall, you know. It was my decision; I just said I couldn't do it. (Nakrem et al. 2011)

5.2.2.2 Satisfaction of Body Protection and Regeneration

Some older persons could satisfy their need for physical regeneration. They told about their *improved health and well-being* since their admission to the facility because the new environment was clean and healthy or because they received an appropriate therapy (Cheng et al. 2011; Minney and Ranzijn 2016).

> I'm able to concentrate on the physical side with the help of the gymnasium program, the masseur which I have once a month - I have a full body massage. I've got physiotherapists who look after my back and leg problems. (Minney and Ranzijn 2016)

Others told about moments when they *experienced a sense of wellness*, for example, when they felt like a new-born person after getting a bath (Koch-Straube 2003).

On the other hand there were residents who felt that their health was somewhat under threat due to a lack of hygiene:

> I often watch [the nurses] when they are doing the medication. They can be awful running their hand through their hair. And another thing very few of them have in their possession handkerchiefs. They just use the back of their hand but I am sorry to have to bring this up but it is true and another thing yeah they don't bring handkerchiefs for their nose or anything, it is not good enough. (Timonen and O'Dwyer 2009)

More serious, however, was the *decline of health* experienced by many residents (Hutchinson et al. 2011; Shrestha and Zarit 2012; Heid et al. 2016)

> How old age becomes difficult that as the body is attacked by diseases, the body becomes weak and frail, and life becomes troublesome. (Shrestha and Zarit 2012)

Their health condition sometimes worsened due to *falls* (Chang 2013; Shaw et al. 2016) which could be triggered by inappropriate furniture.

> If I want to get out of the bed, my legs must go down completely first. The other day, after I happened to miss this side rail, I fell down. (Chang 2013)

For these reasons it is not surprising that residents complained about *pain* that apparently could not be alleviated in several cases (Bergland and Kirkevold 2006; Timonen and O'Dwyer 2009; James et al. 2014; Mohammadinia et al. 2017)

> When you are in pain there is nothing done about it… I am sometimes in a lot of pain—for months in pain. (Timonen and O'Dwyer 2009)

> But there is evil everywhere in the body, the skeleton, and the belly. I have huge problems… It is quite unnecessary to have to live like this. (James et al. 2014)

5.2.2.3 Negligence Towards Health

Not every resident, however, was seriously concerned about the protection and regeneration of his body. Some of them tended to *ignore minor ailments* and did not seek medical treatment in these cases.

> Well if I had a headache it's unimportant or if I had a cold it's unimportant. […] It depends on the severity of the condition. (Heid et al. 2016)

Some male residents also had a *limited desire for hygiene* and were reluctant to take a bath—partly because they did not like it, partly because it had become inconvenient due to functional limitations (Koch-Straube 2003; Martinsson et al. 2013; Heid et al. 2016).

> Nobody understands me! I do not want to take a shower so often. (Martinsson et al. 2013)

> At the present time I do not take a tub bath or shower bath because I cannot stand up. So my choices are really confined to what I can do at the present time. I guess it was [more important] when I was at home and was able to take a shower every day. But since it's not possible, it's not as important right now. (Heid et al. 2016)

5.2.2.4 Satisfaction of Negligence Towards Health

As the quotations above suggest, negligence towards health was met when residents could *leave minor ailments untreated* and felt comfortable with a *minimum of hygiene*. More care for their health seemed to involve *inconvenience* for them and they only showed signs of worry when they were suffering from serious health problems.

5.2.3 Food Consumption Versus Food Abstinence

5.2.3.1 Food Consumption

Physical activity and rest were not only related to residents' attitudes regarding body protection, they also interacted with their balance between food consumption and abstinence. Meals were an important event in the daily life and residents had a *desire to eat well* (Tsai and Tsai 2008; Hutchinson et al. 2011; Palacios-Ceña et al. 2013; Chuang et al. 2015: Iden et al. 2015).

> I have nothing to do here [nursing home] but eat. Therefore it [eating] is very important in my daily life. (Tsai and Tsai 2008)

Some residents appreciated good meals because they had gone through hardships like war or economic crises in their life.

> I have experienced much hunger… Being able to eat four times a day is a privilege… (Palacios-Ceña et al. 2013)

For others food was an integral part of their family tradition and remembered them to the good old times when they had joy and pleasure in their life.

> Well, the culture of New Orleans is known for their red beans and rice, they gumbo, they jambalaya. I keep all that in my head that I can remember. (Hutchinson et al. 2011)

5.2.3.2 Satisfaction of Food Consumption

The desire for good food was met to varying degrees. Several residents told how they *enjoyed the meals* provided by the facility (Raske 2010; Wright et al. 2010; Cheng et al. 2011; Palacios-Ceña et al. 2013; Andrew and Wilson 2014; Figueredo-Borda and Zabalegui-Yárnoz 2015; Koppitz et al. 2017; Rekawati et al. 2018)

> They cook a different, tasty meal here every day, they […] feed us well. (Figueredo-Borda and Zabalegui-Yárnoz 2015)

> They provide the meals and we get to choose what we want… I would give the meals four stars. (Koppitz et al. 2017)

Enjoyment of meals depended to some extent on the expectation of residents. If expectations were low, they were easily satisfied. Facilities for better-off had to offer more to satisfy their residents.

> Well we had fresh salmon, was it Thursday, one day last week? It was beautiful. And we had turkey at the weekend. What more can we want? (Wright et al. 2010)

Some residents who enjoyed their meals reported about a *gain in weight* (Cheng et al. 2011; Chang 2013).

> [Before coming to the nursing home,] I was so skinny and weighed only 33 kg. I ate nothing at the hospital and stayed at home for 10 days, but now I eat well without overeating. That's how I get better. I gain weight and get better… (Chang 2013)

Others, however, were *less satisfied with the food*. Some were disappointed because meals were ready-made and not homelike (Nakrem et al. 2013); others said that they were not healthy because they lacked fresh fruits and vegetables (Bollig et al. 2016). Whereas these residents found meals at least acceptable, others openly complained about *bad quality of food* as it was not according to their taste or did not meet their cultural habits and some did not eat the food offered to them (Wu and Barker 2008; Timonen and O'Dwyer 2009; Cheng et al. 2011; Chuang et al. 2015).

> …the food is still just the same, sometimes you can't even eat the meat. Especially the so-called lamb, I think he died before he was killed! (Timonen and O'Dwyer 2009)

> The rice is cold. The vegetables are cold… This is not good for the elderly to eat. (Chuang et al. 2015)

Sometimes, complaints did not concern the quality but the quantity of food and residents reported that they *remained hungry* (Sidenvall et al. 1994; Tsai and Tsai 2008; Teka and Adamek 2014). This was an issue for facilities in developing countries where scarcity of resources prevented the provision of adequate meals. One resident in an Ethiopian nursing home, for example, complained:

> I eat to survive. But, I don't think we are receiving a balanced diet that is needed for older adults. (Teka and Adamek 2014)

Surprisingly, however, similar complaints were sometimes also raised in industrialized countries:

> There are smaller portions here than at home, where you get your plate filled. And at home you can take a little more… As a rule, I eat everything I get here, and it's not much. I am not fed very well. (Sidenvall et al. 1994)

Koch-Straube (2003) argues that meals in nursing homes are one of the rare sources of pleasure and entertainment for residents, but quite often they do not satisfy these needs. Hence, residents feel hungry despite a sufficient quantity of food.

5.2.3.3 Food Abstinence

The desire for a good meal was counterbalanced by a tendency *to avoid overeating* (Sidenvall et al. 1994; Cohen-Mansfield et al. 1995; Tuominen et al. 2016). Some residents felt uncomfortable when they were offered a standard portion and requested to get half of it. Others left what they could not eat on the plate. They had adapted their food intake to their lower consumption of energy which was consequence of their restricted opportunities for physical activity. Others wanted to restrict the intake of calories and *to keep a diet* because they suffered from diabetes (Cho et al. 2017). There were, however, also residents who were no longer interested in eating at all. If they ate, it was for them just an intake of calories, but nothing that was associated with pleasure. This *loss of appetite* was not only a reaction to food that did not satisfy their needs but also a sign that they did not enjoy their life (Koch-Straube 2003).

5.2.3.4 Satisfaction of Food Abstinence

Residents who kept their diet were satisfied when they succeeded in maintaining a *normal blood sugar*.

> Since I came here, I've been living in a regular pattern and eating whatever is given to me; so, my diabetes has been better, and I've been healthier. If I were home, I would have eaten whatever I wanted. (Cho et al. 2017)

If residents, however, ate more than they could they suffered from *surfeit* (Sidenvall et al. 1994; Cohen-Mansfield et al. 1995). This happened because they felt obliged to empty their plate since they had grown up during war times and had been taught that it was a sin to waste food.

5.2.4 Sexual Desire Versus Sexual Abstinence

5.2.4.1 Sexual Desire

Body-related orientations of actions also concerned sexuality. As we saw in Chap. 2, older persons do not like to talk about this issue because it does not conform to cultural norms they had learned when they had grown up. This does, however, not mean they do not have such desires. In contrast to home-dwelling older persons, residents in long-term care facilities have limited opportunities to hide such desires due to restrictions of their privacy. Staff sometimes could not avoid witnessing sexual activities of residents. Intimate relationships of varying degrees and manifestations occurred among couples, but there were also instances of solo masturbation (Frankowski and Clark 2009). Sexual relationships were not restricted to assisted living facilities that allow for more privacy, they were also observed in nursing homes (Naess et al. 2016). Some residents of long-term care facilities openly described a *desire for sexual contact* (Nay 1992; Frankowski and Clark 2009; Bauer et al. 2013)

> You don't lose your feelings as you age. I don't feel old. You never lose the need for love and intimacy. Sex is funny. It isn't just for younger people; it's for old people too. Just because you've suddenly got old, you've still got the same feelings. (Nay 1992)

> I always look under the bed for a man. (Bauer et al. 2013)

Sexual desire did not necessarily imply intercourse. Several residents expressed a *desire for intimacy* that just consisted of physical touch (Frankowski and Clark 2009; Bauer et al. 2013; Palacios-Ceña et al. 2016b)

> To snuggle up together is lovely you know… you don't have to have intercourse but you can have a cuddle. I miss that. (Bauer et al. 2013)

5.2.4.2 Satisfaction of Sexual Desire

To some extent residents were able to satisfy their sexual desire and they had *sexual pleasure*—either as couples or alone by masturbation (Nay 1992; Frankowski and Clark 2009). For others, however, sexual desires remained unsatisfied and they experienced *sexual frustration* (Nay 1992; Bauer et al. 2013; Villar et al. 2014). One reason was the lack of privacy that prevented them from fulfilling their desire.

> I used to masturbate once a month, but the worse off (more dependent) I got … (the less I masturbated). I don't feel private. (Bauer et al. 2013)

Another reason was a lack of appropriate partners as it was told by an older woman:

> It's complicated, firstly because here most people are women and… you know, there are few men and most of them are too old! (Villar et al. 2014)

As a consequence they missed the pleasures they had when they were younger.

5.2.4.3 Sexual Abstinence

Not all residents, however, shared such sexual desires. Some women spoke about their *dislike of sexual duties* they had to perform for their husband when they had been married.

> Many times I didn't want to do it, but I repeated to myself that it was my duty and his right… (Palacios-Ceña et al. 2016b)

For other older women, who had a more pleasurable sex-life, sexuality was only allowed in a marriage, and hence they wanted *to remain abstinent as a widow*.

> Having sexual relations with another person, even remarrying, feels as if I am betraying my beliefs, my Church, the vow I made when I got married (Palacios-Ceña et al. 2016b)

Finally, there were those residents who had *abandoned sexual desires*, because they perceived themselves to be too old (Frankowski and Clark 2009; Bauer et al. 2013)

> It's finished [sex and intimacy], you don't think about it, or you try not to think about it. (Bauer et al. 2013)

5.2.4.4 Satisfaction of Sexual Abstinence

Given the fact that many residents were not inclined to be sexually active, older persons in long-term care facilities had no problem to satisfy their desire for sexual abstinence. There were, however, instances that female residents felt *sexually harassed* by male residents who made attempts to satisfy their sexual desire.

> When a man gets right into bed, sits down, and goes under the covers, it's sexual harassment and it has gone too far. (Frankowski and Clark 2009)

In the described incidence the female resident finally had to call the police because caregivers and the administrator of the assisted living facility had ignored her complaints about the male resident. In another case, a caregiver assumed that *marital rape* was occurring in the relationship of a couple under her care (Frankowski and Clark 2009).

5.2.5 Influencing Factors

The satisfaction of body-related orientations of action depended on the residents' physical condition, environmental factors, and the care they received from staff members. In response, residents tried of course to cope with their situation.

5.2.5.1 Physical Condition

Physical activities of residents in long-term care facilities were restricted by *ill-health* and ensuing *functional limitations* which were often a reason for their admission to the long-term care facility (Sidenvall et al. 1994; Hweidi 1999; Andersson et al. 2007; Tsai and Tsai 2008; Chuang and Abbey 2009; Curle and Keller 2010; Chang 2013; Thomas et al. 2013; Hillcoat-Nalletamby 2014; Oosterveld-Vlug et al. 2014; Heid et al. 2016; Rekawati et al. 2018). Mobility impairments increased the risk of falling and prevented residents from walking and exercising. In serious cases, residents lost the ability to clean and dress themselves and to eat independently. A further consequence was *sexual disability* which contributed to a loss of sexual desire:

> Many people here are not independent enough to go to the toilet by themselves. So they can't get involved in sexual matters; they would even need help to masturbate. (Villar et al. 2014)

5.2.5.2 Environmental Factors

Environmental factors could alleviate or aggravate the impact of functional limitations. Facilities that were *accessible for people with disabilities* gave residents who suffered from functional limitations a sense of safety and allowed them to move around independently (Bourrett et al. 2002; Ball et al. 2004a; Cooney 2011; Speller and Tollee 2015). They had grab bars and non-skid surfacing in bath areas, electric doors, handrails on stairways and hallways, ramps and large doors for wheelchair accessibility. Facilities without such a design impeded residents' mobility and sometimes prevented the admission of disabled persons (Ball et al. 2004a, b). The *availability of assistive devices* like power wheelchairs or just walkers and canes also improved residents' mobility (Bourrett et al. 2002; Oosterveld-Vlug et al. 2013a). *Security systems* with door code numbers were intended to prevent residents from unauthorized leaving and restricted their mobility (Bourrett et al. 2002; Tuominen et al. 2016). In some facilities, *inconvenient beds* caused physical discomfort and increased the risk of falling due to their height (Chang 2013). *Noise* and *inappropriate room temperature* (i.e. either to warm or to cold) were a reason for sleep disturbances (Herrmann and Flick 2011; Heid et al. 2016).

Due to lack of financial resources facilities in developing countries were often not accessible for people with disabilities. They even had *problems getting medication* to treat their residents (Hweidi 1999; Teka and Adamek 2014). As a physician in a Jordanian nursing home told:

> Our financial capabilities can't allow us to buy all the medicine we need. Sometimes the Ministry of Health covers a part of our pharmaceutical needs, while other times they don't have them. (Hweidi 1999)

Some facilities that cared for the poor and needy were at least able to *distribute clothes* once a year (Teka and Adamek 2014).

A factor that influenced the satisfaction of food consumption was the *quality and quantity of meals* (Timonen and O'Dwyer 2009; Wright et al. 2010; Teka and Adamek 2014; Bollig et al. 2016). Facilities for the poor could only provide bare necessities. In the Ethiopian home, for example, meals consisted of "dabe" (a kind of bread) for breakfast, and "injera" (a sourdough-risen flatbread) at lunch time and dinner, while meat was served only three times per year (Teka and Adamek 2014). In contrast, the residents in wealthier countries had more choice and could enjoy better food - especially when their clients were affluent. An assisted living facility in the US, for example, offered regularly dishes like fresh salmon and turkey (Wright et al. 2010). Raske (2010) described a facility with an enabling garden that allowed residents to get fresh vegetables. Other nursing homes established a café that allowed residents to get snacks and cakes beside their regular meals (Andrews 2012).

An obstacle for the satisfaction of sexual desires was the *unavailability of double beds for couples* (Frankowski and Clark 2009; Bauer et al. 2013). Some facilities, however, offered married couples a *private room for occasional use* so that they could meet their desire (Bauer et al. 2013).

5.2.5.3 Care for Body-Related Needs

In case of functional limitations body-related needs had to be satisfied with the help of care. *Room cleaning* and washing of clothes and bedding in order to meet the need for hygiene were part of the basic services that some of the residents considered worth mentioning (Hweidi 1999; Rekawati et al. 2018). *Personal care* was provided by caregivers and included washing, dressing, and grooming (Grant et al. 1996; Hweidi 1999; Ball et al. 2004a; Hwang et al. 2013; Figueredo-Borda and Zabalegui-Yárnoz 2015; Koskenniemi et al. 2015). In case of severe limitations residents also needed *assistance for eating and toileting* (ibid.). Whereas these tasks were often performed by nursing assistants or even caregivers who had just received an on-the-job training, nurses were in charge of the *treatment of wounds* (Grant et al. 1996; Figueredo-Borda and Zabalegui-Yárnoz 2015; Gustavsson et al. 2015), the *monitoring of vital parameters* (Rekawati et al. 2018), and the distribution of *medication* (Hweidi 1999; Gustavsson et al. 2015). Some facilities were also concerned about *health promotion* and they offered exercises and educational programs about health and nutrition for their residents (Ball et al. 2004a, b; Stathi and Simey 2007; Rekawati et al. 2018).

Sometimes, however, residents observed also deficiencies of body-related care. They complained about a *lack of hygiene*, for example, when nurses distributed medication (Timonen and O'Dwyer 2009), and felt that staff *neglected mobilization and sleep promotion* (Bourrett et al. 2002; Herrmann and Flick 2011).

> It's a heck of a thing to say, but outside you may get more people to offer to help than in here. (Bourrett et al. 2002)

5.2.6 Behavioural and Attitudinal Reactions

Despite their declining health and functional limitations some residents made efforts to cope with this situation by activities. They participated in *exercises* if such a program was offered by the facility or they even tried to exercise alone (Ball et al. 2004b; Stathi and Simey 2007; Tsai and Tsai 2008; Behr et al. 2014; Cho et al. 2017; Rekawati et al. 2018)

> Every morning after breakfast, I go to the third floor to exercise, especially exercise appropriate for older people! (Cho et al. 2017)

Quite often, such exercises consisted of *walking* either inside the facility or—if permitted by physical abilities—outside of it (Cooney et al. 2009; Herrmann and Flick 2011; Taylor et al. 2014; Gustavsson et al. 2015). To prevent falls residents *used assistive devices* (Ball et al. 2004b). To protect their health residents were eager to comply with medical treatment and *took prescribed medication* (Ball et al. 2004a, b).

> I am very careful about taking my heart medicine. I'm gonna survive. (Ball et al. 2004b)

To satisfy their desire for physical rest and recovery, several residents said that they were *taking a nap* (Ball et al. 2004b).

Although residents made efforts to maintain their physical capacities, they were aware that on the long run their health was declining. In response, many of them told about their *acceptance of physical limitations* (Hjaltadóttir and Gustafsdóttir 2007; Walker and Curry 2007; Hutchinson et al. 2011; Nakrem et al. 2011; Falk et al. 2013; Behr et al. 2014; Taylor et al. 2014). "You just have to live with it" was a typical expression on dealing with this situation (Nakrem et al. 2011). Such acceptance allowed for a certain degree of satisfaction despite experienced limitations:

> You should be grateful for the degree of health you have, and you should also point it out to others that it's certainly something to be grateful for, to be able both to hear and see and not to be all that confused. (Hjaltadóttir and Gustafsdóttir 2007)

In order to protect their remaining health and to continue physical activities, some residents consciously *slowed down*, and avoided risky movements.

> I've got a sort of Ten Commandments which I tell myself, never hurry, never rush, never stretch for anything in case it's not there. (Hillcoat-Nalletamby 2014)

5.3 Long-Term Care Facilities and Social Orientations of Action

Moving into a long-term care facility meant a change of social relationships for older persons. Receiving care did not only concern the satisfaction of body-related needs, it also implied social relationships with the persons who provided care. Older persons had to find a new balance between their desire for self-reliance and their need to be cared for, but also between their tendencies to exert influence on others and to pay attention to their needs. Staying in a long-term care facility meant furthermore getting into close contact with other residents. At the same time contacts to family, neighbours, and friends outside became more difficult due to increased distance. These circumstances required them to establish a new balance between their desires for closeness and distance, but also between their tendencies to social adjustment and unconventionality. Table 5.4 provides an overview over the social orientations of action, the various degrees of their satisfaction, the factors that influence this satisfaction, and the behavioural and attitudinal reactions of the residents.

5.3.1 Self-Reliance Versus Being Cared for

When older persons experienced functional limitations they could either try to remain self-reliant or they could develop a desire to be cared for.

5.3.1.1 Self-Reliance

Despite their functional limitations, several residents still had a *desire for self-reliance* (Bourrett et al. 2002; Ball et al. 2004b; Murphy et al. 2007; Stathi and Simey 2007; Bradshaw et al. 2012; Oakes and Sheehan 2012; Behr et al. 2014;

Table 5.4 Social orientations of action, influencing factors, behavioural and attitudinal reactions

Orientations of action and their satisfaction	
Self-reliance	Desire for self-reliance
	Hesitantly accepting some help
	Ready to give up self-reliance
Satisfaction of self-reliance	Maintaining self-reliance
	Regain of self-reliance
	Loss of self-reliance in unfamiliar environment
	Learned helplessness
	Gradual loss of abilities
Being cared for	Selective compensation of limited abilities
	Seeking for comprehensive attention
	Desire for hands-on care
	Concern about getting medical treatment
	Desire to feel safe and protected
	Desire for family care
	Expecting to get additional support from families
Satisfaction of being cared for	Availability of service
	Attentiveness to residents' needs
	Comfort and relief from burden
	Getting medical care
	Receiving little extras
	Receiving care for medical needs
	Feeling supported and protected by roommates
	Receiving support from the family
	Gratefulness for receiving care
	Feeling neglected
	Inattentiveness to care recipients' needs
	Minimal care
	Independent against their will
	Fear of remaining without help
	Lack of medical care
	Fear of threats
	Lack of support by the own family
Exerting influence on others	Maintaining control
	Demanding attitude
	Desire to participate in decisions
	Having some choice
	Being informed over health condition
	Expecting the obedience of own children
	Expecting roommates to comply with social norms
	No objections to decisions
	Desired paternalism

(continued)

Table 5.4 (continued)

Satisfaction of exerting influence on others	Being in control of care
	Having choices
	Participating in decisions about care
	Exceptions of control
	Allowed to act according to own will under supervision
	Being exposed to surveillance
	Institutional fear
	Restricted by rules and routines
	Lack of choice
	Powerlessness
	Loss of control over family
	Being annoyed by roommates
Attention to the needs of others	Fear to be a burden on family
	Wanting to reduce burden on caregivers
	Showing tolerance
	Avoidance of conversation to prevent conflicts
Satisfaction of attention to the needs of others	Reduced burden on families
	Feeling to be a burden on caregivers
	Feeling guilty for neglecting marital duty
Social adjustment	Adaptation to unwritten rules
	Hiding sexual desires and inclinations
	Being polite and well-mannered
	Observance of table manners
Satisfaction of social adjustment	Feeling normal and in tune with social environment
	Sense of structure and inner order
	Feeling ashamed
Unconventionality	Reduced interest to conform to social standards
	Striving for individual liberty
	Searching a temporary escape
	Tendency to socially undesirable behaviour
	Aggressive self-assertion
Satisfaction of unconventionality	Gain of an individual lifestyle
	Allowed to do what they liked
	Having to suppress own needs
Closeness	Desire for social participation
	Maintaining contacts to friends outside
	Desire for contact with the family
	Interested in contacts with roommates
	Preference for close contacts
	Preference for shared rooms
	Searching for a female partner
	Contacts according to inclination
	Desire for positive relationship to staff

Table 5.4 (continued)

Satisfaction of closeness	Social participation
	Loss of social participation
	Succeeding in maintaining old contacts
	Loss of old contacts
	Positive relationship to family
	Limited or no contact to family
	Separated from spouse
	Grief due to loss of significant others
	Couples who enjoy their company
	New partnerships
	Restricted contacts between the sexes
	Positive relationships with roommates
	Sense of community
	New contacts as a substitute
	Gain of contact
	Experiencing relationships as friendly but superficial
	Lack of contacts with roommates
	Decline of social contacts
	Loneliness
Distance	Maintaining privacy
	Desire for temporary withdrawal
	Restricted desire for contact with other residents
	Distanced relationship with caregivers
	Inclined to complete disengagement
Satisfaction of distance	Protected privacy
	Intrusion of privacy by caregivers
	Disturbance of privacy by roommates
Influencing factors	
Physical condition	Functional limitations
	Loss of hearing
	Cognitive decline
Circumstances of life	Moving in by own decision
	Financial resources
	Forced to move in
Environmental factors	Type of accommodation
	Communal spaces
	Noise
	Privacy policy
	Visitation rules
	Connection between facility and environment
	Access to the internet
	Family influenced social relationships

(continued)

Table 5.4 (continued)

Care for social needs	*Task-orientation*
	Formal assessment
	Informal monitoring
	Planning care without the resident
	Discussing about the resident instead of with him
	Excluding residents from participation in decisions
	Imposing day structure and routines
	Repeated task performance
	Care as prescribed
	Lack of communication with residents
	Dominance of medical care
	Overprotection
	Safety regulations
	Education and control
	Bossy and rude behaviour
	Rough treatment
	Inattentiveness
	Reluctance to provide help
	Keeping distance
	Person-centred care
	Planning care with residents
	Agreements on care and safety rules
	Offering choices
	Adapting to wishes and needs
	Becoming familiar with personal routines
	Attentiveness to the residents
	Care in time
	Small favours
	Chat and small talk
	Reducing distance
	Developing a relationship of trust
	Persuading the resident
	Searching the dialogue
	Promoting self-reliance
	Respecting and protecting privacy
	Influencing social contacts between residents
	Attempts to select residents
	Discharge of residents
	Promoting the integration of newcomers
	Arranging contacts
	Facilitating communication
	Simulating real life situations
	Common meals
	Family-style service
	Seating arrangements
	Organizing joint activities

Table 5.4 (continued)

	Inviting residents
	Expectations to participate and socialize
	Restrictions on mutual visits
	Involving significant others
	Restricting visits from families and friends
	Preventing intimate relationships
	Providing discreet environments for intimate relationships
Behavioural and attitudinal reactions	*Towards caregivers*
	Asking for help
	Expressing appreciation
	Engaging in small talk
	Sharing private matters
	Demanding and complaining
	Racism
	Hiring additional staff
	Rejecting help
	Rejecting well-meant advices
	Resisting against care
	Giving in
	Subordination
	Avoiding complaints
	Towards roommates
	Engaging in conversation
	Showing affection
	Assistance and emotional support
	Forming groups
	Gossip
	Reprimanding
	Shunning persons with dementia or other impairments
	Quarrel
	Avoiding contact with all roommates
	Formal politeness
	Leaving sometimes the facility

Hillcoat-Nalletamby 2014; James et al. 2014; Taylor et al. 2014; Shin 2015; Speller and Tollee 2015; Tuominen et al. 2016). They did not want to receive help from others as they felt that such help restricted the independence and self-determination they had been used to throughout their life.

> I like to do things for myself. If I can do it myself, I'll do it myself. They're supposed to come in, in the morning and make me tea and make me toast and things like that, if I want it. But I'd much rather do it myself. (Hillcoat-Nalletamby 2014)

This attitude was particularly strong in assisted living facilities, but also nursing home residents expressed this desire. However, when the functional limitations increased, these residents *hesitantly accepted some help* (Nakrem et al. 2011; Shaw et al. 2016).

> I have health issues which are a little bit personal and I don't know that I can handle at the moment somebody doing what I might need help with and I would rather struggle on. Now that might sound like pride, it's not, it's embarrassment. […] So I'm at a bit of a crossroads I think. I would like not to have to change anything because I fiercely want to keep my independence anyway. But I feel worried about that, if I am going to deteriorate anymore and I do need some help, erm, coming to terms with having what feels a little bit invasive. (Shaw et al. 2016)

At the end, they were *ready to give up self-reliance* and to receive help from caregivers.

> You push your pride aside and come to the realisation that you do need it [assistance] and do not object to it. That's the first thing. Once you've done that I'd say you'd be prepared to go, accept the type of assistance they [staff] think desirable (Taylor et al. 2014)

5.3.1.2 Satisfaction of Self-Reliance

At least for some time, several residents succeeded in *maintaining their self-reliance* (Bourrett et al. 2002; Ball et al. 2004b; Murphy et al. 2007; Wright et al. 2010; Cooney 2011; Martinsson et al. 2013; Oosterveld-Vlug et al. 2013a; Palacios-Ceña et al. 2013; Hillcoat-Nalletamby 2014; Minney and Ranzijn 2016).

> I basically look after myself. I can do everything myself. I'm not like some of the people here; I am capable of looking after myself. (Hillcoat-Nalletamby 2014)

Self-reliance, however, could have different meanings, depending on the capabilities of the older persons. Residents in nursing homes were already satisfied, if they were still able to move around independently—even if they had to use assistive devices (Oosterveld-Vlug et al. 2013a). For others, self-reliance implied the ability for self-care despite difficulties. One older woman, for example, told how she spent "four hours just trying to get myself clean and cutting my fingernails and rolling my hair and just things like that" (Ball et al. 2004b). Others were satisfied if they could eat without help (Palacios-Ceña et al. 2013). Some residents in assisted living facilities even enjoyed performing household task in their own room.

> I've got macular degeneration as I said, but I'm still fairly independent. I don't require help to do anything - I even make my own bed every morning, and I don't need any help of that nature. I've got a lot of independence and that's one of the main things here that I'm enjoying (Minney and Ranzijn 2016)

Sometimes residents in nursing homes even reported a *regain of self-reliance* if they had a chance to exercise and were encouraged to do so (Stathi and Simey 2007; Oosterveld-Vlug et al. 2013a):

> When I came here, I couldn't walk. But being left in my own, in my own room, I was determined to walk round the room and then the corridor, and things like that. (Stathi and Simey 2007)

Others, however, told about a certain *loss of self-reliance in the unfamiliar environment* of the facility after they moved in (Shaw et al. 2016). They felt anxious about leaving the place because they did not know their way around and preferred to stay inside.

More often residents felt *incapacitated by security rules* that restricted their independence and range of activities (Bourrett et al. 2002; Ball et al. 2004b; Dobbs 2004; Cho et al. 2017; Timonen and O'Dwyer 2009; Oakes and Sheehan 2012; Palacios-Ceña et al. 2016a). This occurred not only in nursing homes but also in assisted living facilities which emphasized resident's autonomy and self-responsibility.

> They won't let me shower by myself, but I can shower by myself. They won't let me go in there and shower just alone. (Ball et al. 2004b)

> I feel confined here. I really want to go out, but staff don't let me out because it's cold out there now. I understand that. They may worry about any possible injuries, but I am still disappointed with the fact that we need their permission to get out. (Cho et al. 2017)

Overprotective care even induced *learned helplessness* and residents gave up performing self-care because they were given no chance to do so (Koch-Straube 2003; Ball et al. 2004b; Hellström and Sarvimäki 2007a, b; Murphy et al. 2007; Behr et al. 2013; Hillcoat-Nalletamby 2014). Their attitudinal change became sometimes apparent in the interviews:

> *Interviewer:* So, you don't have the option of getting yourself washed and dressed?
> *Respondent:* Oh no, no.
> *Interviewer:* Do you think you could?
> *Respondent:* I'd have to have help, I think, especially to get dressed but I think I could wash myself, the way they do. (Hillcoat-Nalletamby 2014)

As a result of overprotective care residents experienced a *gradual decline of independent self-care* until they became completely care-dependent (Saunders and Heliker 2008; Hutchinson et al. 2011; Falk et al. 2013; Iden et al. 2015; Shaw et al. 2016; Cho et al. 2017).

> It's hard for me to move [by myself]. I need others' help to stand up and [sit] down or go to [the] hospital. (Cho et al. 2017)

> I am often sad because I have to wear diapers and need help to use the bathroom. But I don't like it when my diapers are wet and I'm completely dependent on care. (Iden et al. 2015)

5.3.1.3 Being Cared for

Other residents were less inclined to maintain their self-reliance and did not hesitate to accept care when they experienced functional limitations. Some of them just wanted to get a *selective compensation of limited abilities* (Ball et al. 2004b; Bergland and Kirkevold 2006; Falk et al. 2013; Hillcoat-Nalletamby 2014; Melin-Johansson et al. 2014; Taylor et al. 2014; Speller and Tollee 2015; Koppitz et al. 2017). A relief of burdensome activities made life easier and allowed them to focus on other things of more importance. They wanted to remain independent to some extent while receiving care and support at the same time:

> The arrangements are better for me, like take shopping. I can do it independently… the energy that I used to waste with trying to shop and cook, it's taken from me now, I don't

> have to do that, I only have to think about breakfast or tea and that's easy (Hillcoat-Nalletamby 2014)

Others were *seeking for comprehensive attention* (Ball et al. 2004b; Josat 2005; Robichaud et al. 2006; Hjaltadóttir and Gustafsdóttir 2007; Oakes and Sheehan 2012; Bollig et al. 2016; Christov 2016; Heid et al. 2016). They wanted to rely on their caregivers and expected them to have time and to be attentive to their needs. As a family member said in place of the residents:

> A good caregiver is the one who pays attention to the resident's needs, listens, gives exclusive time to the resident (Robichaud et al. 2006)

Some even tried to absorb the attention of others by monotonous complaints (Christov 2016). Seeking for attention implied a *desire for hands-on care* (Grando et al. 2000; Ball et al. 2004b; Hwang et al. 2013; Chuang et al. 2015). Residents wanted caregivers to respond promptly to their needs of daily living like eating, toileting, or hygiene.

> I appreciate nurses giving me my medicine, food, desserts, and soft drinks regularly…and changing my diaper as soon as possible (Hwang et al. 2013)

Some residents also mentioned their *concern about getting medical treatment* (Grando et al. 2000; Nakrem et al. 2011; Hwang et al. 2013).

> When I am sick, they should take action….such as checking my blood pressure and temperature, helping me to relax, or taking me to see a doctor. (Hwang et al. 2013)

Beside such concrete help residents had a *desire to feel safe and protected* (Ball et al. 2004b; Robichaud et al. 2006; Hjaltadóttir and Gustafsdóttir 2007; Stathi and Simey 2007; Nakrem et al. 2011; Falk et al. 2013; Schenk et al. 2013; Taylor et al. 2014; Chuang et al. 2015; Shin 2015; Koppitz et al. 2017). Being aware of certain risks for their health they just wanted someone to be there and look after them in case of any trouble.

> That you feel more secure, you know, I feel, I'm calmer inside […] That I'm um, well, looked after, let's say, or protected […] Because when, because I often get palpitations (Schenk et al. 2013)

This desire was one of the reasons for moving into a long-term care facility:

> I'm all alone, and my people live an hour each ride in a car away. Can't expect to call on them, and things don't happen in the day, they happen in the night when you cannot get a doctor outside to come and visit you. (Stathi and Simey 2007)

Older persons from more traditional cultures where care was perceived to be a duty of the family did not want to receive such support and security in long-term care facilities. They had instead a *desire for family care* (Shin 2008; Chuang and Abbey 2009; Andrews 2012; Shrestha and Zarit 2012; Chang 2013). As one older Korean woman said:

> It is natural for old people to live with their first son's family and be cared by them. It is natural. (Shin 2008)

In Western countries where institutional care was culturally more acceptable residents in long-term care facilities nevertheless *expected to get additional support from their families* like occasional shopping or transportation (Park et al. 2012; Tompkins et al. 2012; Hillcoat-Nalletamby 2014).

5.3.1.4 Satisfaction of Being Cared for

The satisfaction of the desire for being cared for had several aspects. It referred to the *availability of service* (Andersson et al. 2007; Bland 2007; Tsai and Tsai 2008; Wright et al. 2010; Nakrem et al. 2011; Figueredo-Borda and Zabalegui-Yárnoz 2015; Koppitz et al. 2017; Rekawati et al. 2018) and to *caregivers' attentiveness to residents' needs* (Ball et al. 2004a; Bergland and Kirkevold 2006; Bland 2007; Jordan 2010; Wright et al. 2010; Nakrem et al. 2011; Hwang et al. 2013; Donnelly and MacEntee 2016; Lung and Liu 2016; Koppitz et al. 2017).

> They wash and dress me in the morning. They clean my flat. They do my laundry. If I need them to sort of open a window or close a window, they will come and do that. I can't reach some of them, you see. I have my breakfast, but they do all my ironing, washing, that type of thing. And they look after me; make sure I've taken my insulin. (Wright et al. 2010)

What residents appreciated most was that caregivers met their needs without having to tell them:

> They make every attempt; I can't imagine what else they can do. They make every attempt to meet my needs and to even anticipate my needs. (Jordan 2010)

> We do not have to talk so much, because she knows exactly how I want to be helped. I am so glad I do not have to explain (Bergland and Kirkevold 2006)

Such care provided *comfort and relief from burden* (Iwasiw et al. 1996; Iwasiw et al. 2003; Walker and Curry 2007; Tsai and Tsai 2008; Cheng et al. 2011; Nakrem et al. 2013; James et al. 2014; Teka and Adamek 2014; Minney and Ranzijn 2016; Shaw et al. 2016; Cho et al. 2017).

> This place is better than my house … here, I just eat and sleep! Everything is done by staff, so I feel very relaxed (Cho et al. 2017)

At the same time, these residents felt protected and safe because there was always someone there to help them in case of problems. (Iwasiw et al. 1996; Andersson et al. 2007; Tsai and Tsai 2008; Jordan 2010; Cooney 2011; Oakes and Sheehan 2012; Nakrem et al. 2013; Hillcoat-Nalletamby 2014; Melin-Johansson et al. 2014; Oosterveld-Vlug et al. 2014; Teka and Adamek 2014; Chuang et al. 2015; Shin 2015; Minney and Ranzijn 2016; Shaw et al. 2016)

> It is very safe to live in this place. There are a lot of nurses to take care of me. There was nobody at my home during the day. My son was afraid of me falling again at home and sent me here. I have good care in this place. (Tsai and Tsai 2008)

Some residents also told how their feeling of being cared for was increased when they *received little extras* (Thomas et al. 2013; Lung and Liu 2016)

> I feel that the nursing assistants care about me.… Sometimes I say I'd love to have some ginger…. I get a small pack of ginger the next day from the nursing assistants …. They know what I like to eat… because they see what I eat daily…. Also, I have to eat something before I go to sleep because our dinner is early. So I eat bread, biscuits, etc. Since they know this, they always drop some food off for me. (Lung and Liu 2016)

Others were satisfied because they *received care for their medical needs* and were treated according to the prescriptions of physicians (Wu and Barker 2008; Boggatz et al. 2009). If they suffered from chronic illness, staying in a nursing home could imply ease access to necessary treatment as in the case of an older woman in Cairo who needed haemodialysis and would have been unable to reach the medical centre due to lack of suitable transportation (Boggatz et al. 2009). Residents in assisted living facilities mentioned sometimes that they also *felt supported and protected by their roommates* because they provided occasional help and checked on each other:

> My eyesight is so bad. A lot of time I ask her [a female resident], when I'm going to church on Sunday…. I have to ask her, you know, do I need to wear this? Or do I need to wear something else or whatever. (Park et al. 2013)

> Today, someone asked for me why I was not here. […]You notice who is missing and then you worry because you don't know that he is missing because he is sick or in the hospital or something. (ibid.)

Furthermore, the desire to be cared for was met when residents *received support from their family* (Iwasiw et al. 1996; Ball et al. 2000; Ball et al. 2004a; Kennedy et al. 2005; Bland 2007; Williams and Warren 2009; Cheng et al. 2011; Tompkins et al. 2012; Martinsson et al. 2013; Thomas et al. 2013; Hillcoat-Nalletamby 2014; Adra et al. 2015; Gustavsson et al. 2015). Family members provided financial support, took residents out for social activities, and were engaged in a range of care tasks such as laundering, shopping, and sometimes even personal care.

> I'm very low care because I have some of my family who help me when needed …. My daughter helps me sometimes I might want my back washed … she helps with cleaning as well (Hillcoat-Nalletamby 2014)

Beside such direct support, family members also provided indirect support by giving advices to staff on how to care for the resident. They informed them, for example, about the resident's preferences regarding food—especially when caregivers were not familiar with the cultural background and habits of the older person:

> No yogurt or ice cream. She doesn't like cold foods. She is afraid of cold food. The box milk [carton] she doesn't like. I think it's a habit. The elderly Chinese people, they don't like cold. Mom will spit it out. (Wu and Barker 2008)

In sum, a number of residents expressed their *gratefulness for receiving care* (Heliker and Scholler-Jaquish 2006; Nakrem et al. 2011, 2013; Oosterveld-Vlug et al. 2014; Bollig et al. 2016)

> I have a place to lay my head down at night and three meals a day, and a van gets me to church on Sunday, and so I'm just thankful. (Heliker and Scholler-Jaquish 2006)

Some authors, however, point out that such gratefulness should not be confused with satisfaction (Sidenvall 1999), because basic care needs may be met, while other social and identity-related needs remain unsatisfied, and residents may respond according to social desirability knowing that they depend on the care provided by the facility—even if it was less satisfying. Many other residents in fact reported that their desire to be cared for was not satisfied and they *felt neglected* by their caregivers (Grau et al. 1995; Bowers et al. 2001; Coughlan and Ward 2007; Timonen and O'Dwyer 2009; Jordan 2010; Cooney 2011; Nakrem et al. 2011; Falk et al. 2013; Oosterveld-Vlug et al. 2013a, b; James et al. 2014; Taylor et al. 2014; Bollig et al. 2016; Tuominen et al. 2016). Having to wait when they asked for help because the staff did not listen, was not concerned, or had no time was a common complaint.

> We do have much waiting time… if there is something [you need] … they tell you that you just have to call, just call … so everything will be done, but it is not like that … it takes time. For example, if I sit here and eat breakfast, I just need to call when I am done. Then you may sit a long time… a very long time before they think that I am done, and I have to wait for them to come… (Bollig et al. 2016)

This was particularly embarrassing when residents had urgent needs:

> I tell them I have to go to the bathroom and I can't wait and they still don't come. It's cruel to make someone wait when they know it'll mean an accident. Sometimes I can't go and they get so disgusted, and even if they don't, I feel bad. I'm taking up their time. (Bowers et al. 2001)

> Often in our day room, a person becomes unwell and there's no nurse available […] I'm not able to get up and walk and go out for a nurse and I keep shouting for a nurse and a nurse can't come. (Timonen and O'Dwyer 2009)

If, however, caregivers performed their tasks, they did so in a hurry and were *inattentive to the care recipient's needs* (Andersson et al. 2007; Westin and Danielson 2007; Jordan 2010; Cheng et al. 2011; Hwang et al. 2013; Donnelly and MacEntee 2016)

> They approach you in such a way that you feel you are actually being ignored – yes, you do not exist – you are just like a ghost, nothing else…It is awful, I tell you. It is so cruel. (Westin and Danielson 2007)

Lack of attention was associated with *minimal care* that avoided effort and left basic needs unsatisfied (Grau et al. 1995; Nakrem et al. 2013; Donnelly and MacEntee 2016; Bollig et al. 2016; Heid et al. 2016):

> I've always got pads on … To begin with, I thought it was absolutely foul … In the hospital they gave you the bedpan, but they don't give you that here. They don't approve of that, so what can I do … you lie in your own filth, but then they come and take the dirty pad off, put a clean one on, and away they go again. (Donnelly and MacEntee 2016)

In some facilities the restricted number of baths per week were a reason for complaints by residents:

> I don't know any woman who wants to go without a bath for one week. I was quite horrified that we were only going to get it once a week. (ibid.)

Such minimal care seemed to accelerate the physical decline of the residents. Regarding her roommates one older woman observed:

> I think they lay in bed too much. There aren't enough people and it occurs to me that they should be giving more help to them. (Nakrem et al. 2013)

In some assisted living facilities, the desire to be cared for was not satisfied, when residents were forced to remain *independent against their will*. As they were told, it was part of the institutions philosophy to provide care as minimal as possible (Wright et al. 2010; Oakes and Sheehan 2012).

> I was going to have a carer to put me to bed and they wouldn't help me. I said to one of them, 'Rita will you help me?' She says: 'We're here to make you independent.' (Wright et al. 2010)

Residents in extra care houses that had no night-time staff also told about their *fear of remaining without help* at night in case there should be any trouble (Wright et al. 2010). Residents in nursing homes complained sometimes about a *lack of medical care* (Chang 2013; Falk et al. 2013; Teka and Adamek 2014). While such complaints are understandable for facilities in developing countries which lack financial resources, this is all the more surprising for homes in developed countries:

> Well, since I've been here, everybody has told me: 'This is not a hospital but only a nursing home', when I feel sick and ask for help. Of course, I know I'm in a nursing home. But I really feel pain… (Silence) When I'm in pain and exhausted, I should have an injection… When I feel bad, I want to have an injection, but they seem to neglect me. (Chang 2013)

Another issue that prevented the satisfaction of the desire to be cared for was the *fear of threats* that allegedly or actually existed in the facility. Sometimes this fear was rather unspecific and due to the unfamiliar environment (Iwasiw et al. 1996; Timonen and O'Dwyer 2009). Others were afraid of a rude treatment by caregivers (Fiveash 1998; Bland 2007). But also roommates were a source of threat if they showed disruptive behaviour (Fiveash 1998; Hjaltadóttir and Gustafsdóttir 2007; Frankowski and Clark 2009) or were supposed to steal other residents' properties (Koch-Straube 2003; Tsai and Tsai 2008).

> I was frightened. I awoke one night and this man was standing at the end of my bed, looking at me. He had scars and sores in his face, a bandage over his ear. I'd never seen him before. I don't like to complain, but it's very frightening. (Fiveash 1998)

A final problem that had a negative impact on the feeling of being cared for was the *lack of support by the own family* (Shin 2008; Shrestha and Zarit 2012; Chang 2013;

Schenk et al. 2013; Teka and Adamek 2014; Mohammadinia et al. 2017). Some residents received only occasional visits from their relatives, whereas others felt that their family wanted to get rid of them and forced them to stay in a long-term care facility. This feeling was particularly strong among residents who had grown up in a culture that valued family care:

> My children didn't let me stay at their home. That's why I am here. This is not what I wanted. They forced me to come here. I said nothing. I was dragged like the dead when they wanted me to go. What should I do? So, I have been suffering until now… (Chang 2013)

> My daughter's husband is dead, and we could live together but as she is very wicked, she relocated me here, and I think she has forgotten me. (Mohammadinia et al. 2017)

5.3.2 Exerting Influence on Others Versus Attention to the Needs of Others

When older persons needed care and moved into a long-term care facility they could either try to influence or even control caregivers and roommates in order to enforce their will and maintain their self-determination, or they could pay attention to the needs of others and refrain from demands.

5.3.2.1 Exerting Influence

Since they were used to determining their own lives residents understandably had a *desire to maintain control* over persons they depended on (Shin 2008; Tuominen et al. 2016). Some of them had a *demanding attitude* regarding care (Ball et al. 2004b, 2009; Bowers et al. 2001; Iwasiw et al. 2003; Dobbs 2004; Williams and Warren 2009; Cooney 2011; Oosterveld-Vlug et al. 2014; Roberts and Bowers 2015). They perceived care as a service that had to be delivered according to their expectations.

> I'm really used to directing my own care … And that doesn't always go over real well with people in a place like this because I'm used to telling people what to do and having it done when I tell them to do it. (Roberts and Bowers 2015)

> To stay like in a hotel, they should serve me. (Boggatz et al. 2009)

Since they paid for the care they received they evaluated it according to what they believed to be the value of its price. If caregivers failed to meet their expectations they started complaining about the lack of service and their inabilities.

> When I'm paying so much I should have more to say. I'm paying good money to stay here, I should have better service. I pay $3000 a month and I can't even get a glass of water when I want it. (Bowers et al. 2001)

> I don't know why they don't train them better…[they] can't even figure out the simplest things (ibid.)

> [They are] so unorganized, I mean, [they] use 100 steps to do something that would take someone with more common sense only 10. (ibid.)

To enforce their will they reprimanded their caregivers or they complained about them to their supervisors (Bowers et al. 2001; Oosterveld-Vlug et al. 2014). Such a demanding attitude was found in some nursing homes (Iwasiw et al. 2003), but it mainly existed in assisted living facilities for upper-class residents that subscribed to a philosophy of consumer autonomy. In such a facility researchers observed how caregivers were treated like waitresses in a restaurant when they served the meals (Dobbs 2004) and caregivers complained about the bossy behaviour of the residents (Ball et al. 2009; Williams and Warren 2009). As one worker said, "Some of them won't open up at all. They are like, 'Get the trash and go.'"(Ball et al. 2009).

Other residents had a less demanding attitude and were willing to accept some restrictions due to care, but they nevertheless had the *desire to participate in decisions* regarding their own care (Murphy et al. 2007; Nakrem et al. 2013; Behr et al. 2013; Falk et al. 2013; Schenk et al. 2013). One resident recalled an event where she had to express this desire:

> 'So, Mrs A, today, today we're going to have a shower'. I look, and say what, why today? I say, no, I say, not with me. I [laughing] I say, not today, I'm not showering. I say, I'd like to be told at least one day in advance that we're having a shower tomorrow, and at about what time. (Schenk et al. 2013)

Despite their readiness to comply with the necessities of care, these residents wanted to *have some choice* and decide about certain aspects of their daily life that were of importance for them (Iwasiw et al. 1996; Murphy et al. 2007; Bowers et al. 2009; Cooney et al. 2009; Chin and Quine 2012; Oosterveld-Vlug et al. 2013a; Palacios-Ceña et al. 2013; Tuominen et al. 2016). Desired decisions were mainly about small things like how they can spend their day and have their meals, where they can walk around, or with whom they can talk and interact.

> Sometimes I feel like eating in my room, being able to choose what to eat…It makes me feel like I am at the wheel. (Palacios-Ceña et al. 2013)

Another aspect regarding control concerned their *desire to be informed over their health condition* because it allowed understanding why a certain treatment was required (Schenk et al. 2013; Chuang et al. 2015)

> It is very important to know my present conditions and the disease I have now (Chuang et al. 2015)

Residents' tendency to exert control also concerned the relationship to their family. In cultures where care for older persons was considered to be a duty of the family they *expected the obedience of their children* and wanted to be cared for by them instead of staying in a nursing home:

> When one begets a son, one expects the son to grow, be loving and disciplined. One also expects the daughter-in-law, too, to be disciplined. (Shrestha and Zarit 2012)

The desire to maintain control became furthermore apparent in the relationships to roommates. Older persons *expected them to comply with social norms* and good manners (Sidenvall 1999; Hubbard et al. 2003; Koch-Straube 2003; Behr et al. 2013; Nakrem et al. 2013; Palacios-Ceña et al. 2013; Christov 2016; Naess et al. 2016). Some were annoyed if someone dirtied the toilets. Others felt disturbed by residents who were messing with their food, burping, yelling, or crying out in pain and reprimanded them for such misbehaviour. In some cases they made staff to sanction what they considered to be inappropriate behaviour as it was experienced by one older woman who had just moved into a facility.

> I got here 2 months ago and sat where I was told. A lady said that I was rude because I didn't pray before eating…She and her friends talked to the nurse assistant and the next day I was moved. (Palacios-Ceña et al. 2013)

Some residents even became aggressive if a roommate got on their nerves. Hubbard et al. (2003) report an incidence where a female resident repeatedly asked to go to the toilet until another resident shouted: "You're not needing the toilet at all; go and give her a slap in the mouth". Several residents were also not inclined to tolerate an open expression of sexuality by others, especially by homosexuals, as this contradicted their idea of morality (Donaldson et al. 2014).

Not every resident, however, wanted to stay in control and to exert influence on others. Some were of the opinion that care was not their business, but the job of the caregivers. Consequently, they had *no objections to their decisions*, did what they were told, and did not feel like they were losing control (Murphy et al. 2007; Nakrem et al. 2011; Taylor et al. 2014)

> At my age I don't bother I do whatever the girls tell me to do. (Murphy et al. 2007)

> 'I'll say if they want to [assist], that's their business, not mine' (Taylor et al. 2014)

Others showed an attitude that might be labelled as *desired paternalism* (Bowers et al. 2009; Nakrem et al. 2011; Oosterveld-Vlug et al. 2013b; Melin-Johansson et al. 2014). They believed that it was best to let caregivers make decisions about daily matters such what to eat or how to care for their body, since they thought others were more knowledgeable on these matters. Some were even convinced that they did not have to tell caregivers their wishes because they would know them anyway.

> Staff know what I like and don't like. (Bowers et al. 2009)

This renouncement of exerting influence was associated with the desire for being cared for.

5.3.2.2 Satisfaction of Exerting Influence

Some residents were able to exert influence on the care received. *Being in control of care* meant that they were allowed to decide by themselves to move into a long-term care facility (Koppitz et al. 2017) and that they could determine their life although they were dependent on the help of others (Ball et al. 2004b; Falk et al. 2013).

> Oh no, I'm not sorry one bit that I'm in a wheelchair and can't cope on my own. I'm still the captain of this ship, and I do whatever I want… I just need a little bit of support. (Falk et al. 2013)

The feeling of being in control implied that residents actually *had choices* (Murphy et al. 2007; Cooney et al. 2009; Cheng et al. 2011; Philpin et al. 2011; Raske 2010; Oosterveld-Vlug et al. 2013a; Palacios-Ceña et al. 2013; Andrew and Wilson 2014; Gustavsson et al. 2015; Minney and Ranzijn 2016; Tuominen et al. 2016). Such choices concerned the time to eat or sleep or the activities during the day. Flexible routines allowed accommodating residents' wishes.

> I can go to bed anytime that I like but after 10 suits me, I come in and look at my own television. (Cooney et al. 2009)

> I can do my own things leisurely – I don't have to stop my tasks suddenly. They (nurses) come to me and tell that it's coffee time and you can come to the living room when you are ready. I don't have to go there immediately. (Koskenniemi et al. 2015)

The choice was satisfactory if the facilities could offer a wide range of recreational activities (Cooney et al. 2009; Raske 2010). It was further enhanced if there was a café on the grounds that allowed for a certain variety of food (Andrew and Wilson 2014). The range of choice was, however, determined to some extent by the financial resources of the residents as not everybody could afford to move into facilities offering such amenities (Bowers et al. 2009).

Having choices depended furthermore on the actual possibility to *participate in decisions about care* (Murphy et al. 2007; Oosterveld-Vlug et al. 2013a; Koppitz et al. 2017).

> That has got better over time, them respecting your wishes. For example, how I want to be washed, the fact that I don't always want to take a shower, that I don't always want to eat in the dining room. (Oosterveld-Vlug et al. 2013a)

Other residents felt that there were some *exceptions to their independence* that seemed, however, to be acceptable. As one of them told:

> I can decide almost everything here – except… watching the time… the meals and such (Nakrem et al. 2013).

Residents with a risk to fall were only *allowed to act according to their own will under supervision*:

> I go out. Sometimes in the summer time I go down to the shops, but I'm not allowed out on my own. I have to get a nurse to come with me and she goes with me down to do the shopping and then we come back home again. (Cooney et al. 2009)

Other residents had a less favourable perception of such safety rules. They rather *felt exposed to surveillance*. In some facilities they were expected to wear an alarm (Andersson et al. 2007), in others they needed permission to go outside (Hweidi 1999). Some residents were annoyed by the permanent observation even in the night and they felt restricted in their freedom:

> They have some idiots running around at night checking out [the residents]… I had a man [staff] come in here about 2 o'clock in the morning. I said, 'What do you want?' He said, 'I wanted to make sure you're breathing.' It's so idiotic. I don't know who runs this place, but there isn't much brains attached to it as far as I'm concerned. They do silly things like that. If you're dead, you're dead and that's all there is to it. (Iwasiw et al. 2003)

In assisted living facilities such close monitoring of the residents could result in an atmosphere of *institutional fear* (Kuhn 2008; Warren and Williams 2008; Williams and Warren 2008, 2009; Zimmerman et al. 2016). Those who were still able to live independently were aware that staff was monitoring the development of their physical limitations and had the power to decide who should be transferred to a nursing home where they would eventually lose their self-determination. To avoid this loss, residents tried to hide their conditions, pretended to be healthy and even *participated in activities against their liking* because they were afraid that non-participation would be interpreted as a loss of abilities:

> I do what they ask me to do. […] If you can't do it you gotta get out of here (Williams and Warren 2008)

Paradoxically, assisted living, which was supposed to support independence, became a place where this very independence was subject to control with the intention of promoting it.

Residents in nursing homes who were due to their functional limitations more dependent on care felt *restricted by rules and routines* of the facility (Fiveash 1998; Iwasiw et al. 2003; Bourrett et al. 2002; Heliker and Scholler-Jaquish 2006; Bland 2007; Murphy et al. 2007; Tucket 2007; Tsai and Tsai 2008; Cooney et al. 2009; Timonen and O'Dwyer 2009; Chin and Quine 2012; Hwang et al. 2013; Martinsson et al. 2013; Nakrem et al. 2013; Oosterveld-Vlug et al. 2014; Villar et al. 2014; Tuominen et al. 2016; Chuang and Abbey 2009; Gustavsson et al. 2015; Bollig et al. 2016; Donnelly and MacEntee 2016; Heid et al. 2016; Naess et al. 2016; Cho et al. 2017; Mohammadinia et al. 2017; Koppitz et al. 2017; Rahayu et al. 2018). They felt that everything was regulated: the time to awake, to eat, and to sleep, the amount of their food, their daily activities, and their hygiene. Their own wishes were overruled by standards of care and if they wanted to complain staff simply would not listen.

> Well, they are limited by the ways things are organized, by the rules. You have to follow what others do, now it's time for lunch, now it's time to go to the bathroom… You're not free, it's not like being at home. (Villar et al. 2014)

> In the dining room, they like you to have your own place. You can't change places, and they have rules. You can't do this; you can't do that. (Heliker and Scholler-Jaquish 2006)

> My opinions are not heard, and nothing has been fixed… the staff [members] just follow their rules… even though I say something to them, they don't listen. (Cho et al. 2017)

Due to these imposed rules and routines, residents felt that there was a *lack of choice*, except for small details that depend on the consent of their caregivers (Dobbs 2004; Chin and Quine 2012; Heid et al. 2016).

> I'm not satisfied because I do not have any choice. That's what I mean, if they ask you first, then we talk then I would be satisfied. Don't come and say: 'This is what I am going to do.' Of course I would say: 'Why? Do we have any other options beside this?' (Heid et al. 2016)

In the long run, such lack of choice resulted in a feeling of *powerlessness* (Grant et al. 1996; Fiveash 1998; Bourrett et al. 2002; Iwasiw et al. 2003; Koch-Straube 2003; Andersson et al. 2007; Bland 2007; Hellström and Sarvimäki 2007a, b; Tucket 2007; Westin and Danielson 2007; Svidén et al. 2009; Timonen and O'Dwyer 2009; Hutchinson et al. 2011; Nakrem et al. 2011, 2013; Hwang et al. 2013; Oosterveld-Vlug et al. 2014; Iden et al. 2015; Tuominen et al. 2016; Bollig et al. 2016; Donnelly and MacEntee 2016).

As they perceived it, they were forced to obey to their caregivers, and because they saw no chance to change this situation they felt imprisoned.

> I am a victim. I can't decide anything for myself. I don't have any influence … everything goes according to my contact person's schedule. (Hellström and Sarvimäki 2007a, b)

Some residents even described how they were intimated by the rude behaviour of caregivers.

> If the mean nurse is on duty, I don't dare to call for help. (Iden et al. 2015)

The feeling of powerlessness was sometimes reinforced by regulations that aimed to protect the rights of the residents:

> There's quite a few things that need to be straightened out … We have a Residents' Council … that's phony … nothing happens from it. (Iwasiw et al. 2003)

If caregivers abused their power they could even drive residents into isolation and emotional decline as observed by one study participant:

> There is a lady here who sat at my table for lunch. She had one leg and was blind & deaf …. One day she started using her hands to feed herself instead of using the spoon …. I started to feed her …. One day a Sister (registered nurse) saw this happening and said she'd have to be a complete feed, so they moved her …. She (resident) hasn't spoken to any of us since … she has gone right back into herself and won't speak to anyone any more even the nurses. A sad case I think. We asked for her to be moved back to our table, but were told, "No can do". We (residents) have to do as we are told. (Tucket 2007)

Such feelings of powerlessness were aggravated if residents had been forced to move into the facility by their family (Iwasiw et al. 1996; Boggatz et al. 2009; Wu et al. 2009; Chang 2013; Walker and Paliadelis 2016: Koppitz et al. 2017) and lost control over their possessions and money (Shin 2008). For older persons from traditional cultures, where care was perceived to be a duty of the children, such a forced move into a long-term care facility also meant a *loss of control over their family* (Boggatz et al. 2009; Shrestha and Zarit 2012; Mohammadinia et al. 2017; Wu et al. 2009). They felt expelled from their own home and accused their children of being selfish since they apparently rejected to care for their parents as they had once cared for them when they were children. An older woman from Egypt, for example, expressed her anger about her “ungrateful” daughter-in-law:

> The problem was she doesn’t like anyone else to share with her the flat. She wants to be in the flat with her children only. She said to me, there is no room. (Boggatz et al. 2009)

In her anger, she added that the only benefit of staying in the nursing was to “get rid of her”. Older women from Taiwan told how they were taken to the nursing home without being informed what was going to happen, so that they had no choice but to accept the decision their children had made:

> I didn’t know what was happening! He (the son) said he would like to take me for a ride… I didn’t know it before I came here. My son brought me here and he told me to take a rest and relax here. (Wu et al. 2009)

With regard to their roommates, residents were often unable to assert their expectations of compliance with social standards. As a consequence, they felt *annoyed by roommates*. Sometimes such annoyance was caused by inappropriate manners and caused disgust (Sidenvall et al. 1994; Iwasiw 1996; Fiveash 1998; Hubbard et al. 2003; Ball et al. 2004a; Dobbs 2004; Shin 2008; Behr et al. 2013; Chang 2013; Nakrem et al. 2013; Naess et al. 2016; Palacios-Ceña et al. 2013; Tuominen et al. 2016).

> The man in front of me spat in his hand and smeared it out on the table in front of me. They cough up and just smear it on the table..,. lt is rather terrible, in fact. (Sidenvall et al. 1994)

> Look at him! He poops m the bed and eats in bed. Just watching him makes me sad. (Shin 2008)

> When she was having a meal, she wanted to go to the toilet. See, you have to go before or after. She got up one day and said: ‘You don’t let me go now.’ She said: ‘I’ll piss on the floor’. (Fiveash 1998)

In other cases the behaviour of roommates violated others residents’ privacy (Walker and Paliadelis 2016) or it was disruptive, openly aggressive, and resulted in conflicts (Fiveash 1998; Hubbard et al. 2003; Boggatz et al. 2009; Curle and Keller 2010; Nakrem et al. 2013; Teka and Adamek 2014; Roberts and Bowers 2015; Cho et al. 2017).

> One day I had her dancing here, happy as Larry. She went over there and pulled the plugs out of the TV set. She threw everything off the chair and I had my bandages in the end of my bed ‘cause it had been tea time and I put them down there. She threw them all on the floor. (Fiveash 1998)

> At times, residents in front of me who have dementia have asked me: ‘Why are you still alive?’ I answered: ‘How can I die? It’s beyond my control.’ Then, they said: ‘Die’ and ‘You need to die.’ It’s so hard to hear that from others. (Cho et al. 2017)

Sometimes, such conflicts resulted in open violence:

> While I was sitting like now on the chair, she took off one of my slippers, and beat me with it on my face. She doesn't have morals or good manners. (Boggatz et al. 2009)

For some residents, a further source of annoyance was that sometimes roommates openly showed their gay or lesbian sexuality (Donaldson et al. 2014).

5.3.2.3 Attention to the Needs of Others

If residents refrained from exerting control it was not always a reaction to the experience of powerlessness. They also did so out of an attention to the needs of others which could be restricted if they put too high demands on them. Some residents had moved into a long-term care facility and agreed to stay there because they *feared to be a burden on the family* (Bradshaw et al. 2012; Chang 2013; Nakrem et al. 2013; Hillcoat-Nalletamby 2014; Cho et al. 2017; Rahayu et al. 2018). They wanted their children to have a happy and independent life, so they refrained from demanding to be cared for by them:

> My daughter said at the beginning, you come with us, and I said, Jane you and your husband and child, that's your life. And I said, you've got your life, I'll have my life I said. And I would never, never do that. I said no. All that matters to me is that my children are happy. And so I said, Jane I'm happy and quite happy with this. So that's good. (Hillcoat-Nalletamby 2014)

For the same reason, they did not expect family members to visit as often as they secretly wished (Park et al. 2012; Tompkins et al. 2012). At the same time, several residents *wanted to reduce burden on their caregivers* (Iwasiw et al. 1996; Bowers et al. 2001; Ball et al. 2004b; Hellström and Sarvimäki 2007a, b; Chuang and Abbey 2009; Nakrem et al. 2011, 2013; Behr et al. 2013, 2014; Oosterveld-Vlug et al. 2014; Roberts and Bowers 2015; Speller and Tollee 2015; Rekawati et al. 2018). Being aware of staff shortage and caregivers' work overload they tried to minimize unnecessary work for them, withheld from demands, did as much as they could for themselves, and avoided complaining as they did not wish them to get into trouble with their superiors.

> I try not to be unnecessarily calling on them all the time because they have enough to do as it is. (Ball et al. 2004b)

> Well to be honest, I would hate to get the girl in trouble by complaining so I do put up with things that I don't really agree with… I don't want the girl to lose her job or anything because I said something (Speller and Tollee 2015)

Some residents also made efforts to pay attention to their roommates needs. They tried to *show tolerance* even if they disliked their behaviour (Grau et al. 1995; Nakrem et al. 2013; Melin-Johansson 2014), and if any other measure failed they *avoided conversation to prevent conflicts* (Curle and Keller 2010; Christov 2016).

> They are not so easy to deal with, you know. It's the same with me, sometimes I just have to pull myself together and be a little more flexible if you know what I mean. (Nakrem et al. 2013)

5.3.2.4 Satisfaction of Attention to the Needs of Others

Several residents claimed that moving into a long-term care met their desire to pay attention to the needs of others because this *reduced the burden on their families*—a burden that was partly due to their worries about the fact that the older person had previously been living alone (Iwasiw et al. 1996; Walker and Curry 2007; Shin 2008; Cheng et al. 2011; Nakrem et al. 2013; Minney and Ranzijn 2016; Cho et al. 2017).

> They (family) come and visit and they are glad that I'm safe. They don't have to worry anymore. They worried when I was by myself and that something would happen to me (Minney and Ranzijn 2016)

If residents were unable to pay attention to the needs of others, they felt guilty. By moving into a long-term care facility, they could avoid such feelings with regard to their family. Regarding their relationship to staff members, however, there were care dependent residents who actually *felt to be a burden on their caregivers* (Ball et al. 2004b; Saunders and Heliker 2008: Falk et al. 2013; Hwang et al. 2013; Oosterveld-Vlug et al. 2014). They felt guilty and embarrassed by having to ask for help and if possible they tried to avoid it—even if their own needs remained unmet. The same was true for older women who felt unable to take care of her care dependent spouse. They *felt guilty for neglecting their marital duty*:

> I've got the guilt feeling all the time. […] I'd feel guilty if I wasn't looking after Edgar. But I do know that if I couldn't, I would be absolutely sensible and pay for whatever we could afford to have. (Shaw et al. 2016)

5.3.3 Social Adjustment Versus Unconventionality

Staying in a long-term care facility required an adjustment to social norms and expectations. Older persons were inclined to adjust since they wanted to avoid conflicts with caregivers and other residents. However, since social norms can be perceived as restrictive, residents also searched for opportunities to satisfy their need for unconventionality.

5.3.3.1 Social Adjustment

Residents had an often unspoken tendency towards social adjustment and conformity. They wanted to behave in a socially appropriate way and complied with social norms because they had been brought up that way. Disregarding social rules and standards seemed to be wrong to them. Conformity meant *adaptation to unwritten rules* (Iwasiw et al. 1996; Iwasiw et al. 2003; Chuang and Abbey 2009; Cheng 2013; Nakrem et al. 2013; Rekawati et al. 2018). It allowed to lead an orderly life and to feel normal.

> This is what you have to do – fit in – and be flexible. (Iwasiw et al. 1996)

> I go to bed at a normal time at night and get up at a normal time in the morning. One has to follow the routines in the nursing home, and that is just fine. Have no problems with that. (Nakrem et al. 2013)

One of these unwritten rules concerned the expression of one's own sexuality. Many older persons had grown up in a conservative climate in which sexuality was only acceptable among married heterosexual couples and if it served reproductive purposes. Therefore, any sexual relationship for mere pleasure, whether between people of the same sex or between people who had lost the ability to procreate, was morally unacceptable and those who were inclined to have such relationships tried to *hide their sexual desires and inclinations* (Nay 1992; Walker and Curry 2007; Frankowski and Clark 2009; Bauer et al. 2013; Donaldson et al. 2014; Villar et al. 2014)

> I and many like me, keep a check on behaviour… I know that those things [sexual expression] can't be done openly because they're not proper. I feel that the correct thing is to behave as if some impulses didn't exist. In my case, I've been influenced a bit by religion… sex is for procreation, you know, so, if there's nothing to procreate, then the right thing is to control yourself and retire. (Villar et al. 2014)

Conformity also meant to *be polite and well-mannered* (Ball et al. 2009; Chuang and Abbey 2009; Christov 2016; Heid et al. 2016). Residents made efforts to behave friendly and respectful and tended to avoid behaviours that others might consider inappropriate, such as gambling or drinking.

> They will think I'm an alcoholic if I say drinking is very important (Heid et al. 2016)

Some authors (Chuang and Abbey 2009) claim that politeness is a particular trait of Chinese culture with its tradition of collectivism where compromise for the sake of harmony is seen as a kind of virtue. According to them Chinese nursing home residents may be more cooperative, self-suppressive, and non-confrontational. However, findings from nursing homes in Western countries, which are said to have a more individualistic culture, suggest that at least some older persons there have similar tendencies towards conformity and social adjustment. Hence, differences between older persons from China and Western countries are more likely to be a matter of extent to which this trait is expressed.

An important aspect of social adjustment and conformity concerned the *observance of table manners* and appropriate behaviour with regard to elimination. These manners are the product of a particular culture and its members have been brought up to adhere to them. Non-adherence would make them feel ashamed of their behaviour (Sidenvall 1999). Residents therefore made an effort to eat decently and—if they were incontinent—not to bother roommates with the smell of their excrements (Nakrem et al. 2011).

5.3.3.2 Satisfaction of Social Adjustment

Residents, who were able to adjust to social norms and to behave accordingly, *felt normal and in tune with their social environment.*

> Being able to feed ourselves, without help, means we are normal. We don't need to be supervised in case we cause trouble or need help. (Palacios-Ceña et al. 2013)

In addition, adapting to rules gave some residents a *sense of structure and inner order* (Hjaltadóttir and Gustafsdóttir 2007; Cooney 2011; Philpin et al. 2011;

Palacios-Ceña et al. 2013; Gustavsson et al. 2015). For them, fixed schedules and routines were not a constraint but a guidance that prevented inner disintegration. The passage of time got clear contours that allowed orientation. Especially, mealtimes served as a compass.

> My schedule is determined by the meals…you have to organize yourself so that everything you do fits in between breakfast, lunch and dinner (Palacios-Ceña et al. 2013)

> I don't need a clock, when we are called for breakfast it is 9 o'clock, lunch is around one, and in the evening when the noise of carts is heard in the kitchen it's eight o'clock. (ibid.)

Residents, however, could not always meet their desire for conformity—even if such recognition was granted by others. If they were unable to adhere to social standards and good manners, it made them *feel ashamed*. Such feelings aroused when residents suffered from incontinence, needed help to use the toilet (Hweidi 1999; Koch-Straube 2003; Coughlan and Ward 2007; Behr et al. 2013; Perkins et al. 2013; Iden et al. 2015), had to be undressed in order to get personal care (Behr et al. 2013; Oosterveld-Vlug et al. 2014), or were unable to eat in a decent way (Sidenvall et al. 1994). All these situations had in common that they required skills that had been trained in early infancy. Their inabilities made the residents feel like a little child who could not assume the role of an adult person and behave in an appropriate way.

> I am often sad because I have to wear diapers and need help to use the bathroom. (Iden et al. 2015)

> You must undress…very unpleasant. And then you think 'Ok, now I'm even going to pull my underwear down in front of this person' (Oosterveld-Vlug et al. 2014)

> Now one is so old and crazy that one can't eat - now I need a bib… and they put it on if you ask, I'm afraid of spilling. I usually put a serviette on my knees because I take care of my clothes. I learnt that from my mother when I was a child. (Sidenvall et al. 1994)

Such failures to meet social standards made residents feel ashamed in front of their caregivers and prevented them from socializing with roommates because they considered themselves to be an unsuitable member of the community. As one resident in an assisted living facility who suffered from incontinence told:

> I don't have any [friends] because I'm very unattractive. I'm physically unattractive. (Perkins et al. 2013)

5.3.3.3 Unconventionality

Since adaptation to social norms can restrict spontaneity, a degree of unconventionality was needed to establish a healthy inner balance. Hence, there were also residents who told about their *reduced interest to conform to social standards* (Melin-Johansson et al. 2014). In men, this manifested as not shaving as often as they used to or not caring much about what clothes to wear. Grooming was not that important any more, and they showed a more relaxed attitude. But also some women became less concerned about their physical appearance.

> I am less particular about what clothes or hairstyle to wear, and whether the make-up is perfect. (Melin-Johansson et al. 2014)

Another resident explained that in old age it became less important to care about what people thought of one's behaviour. For example, one did not have to worry about the room being untidy or leaving the toilet door open, even if there were people around (ibid.).

Instead of just observing social norms residents wanted to be themselves and live out their peculiarities. For this reason, some of them had refused to stay with their children where they would have to adapt to their way of life. They *strove for their individual liberty* and the long-term care facility was perceived to be a place where they could find it (Boggatz et al. 2009; Chang 2013; Cho et al. 2017). During his own research in Egypt, the author met female residents who moved to a nursing home because they wanted to escape from restricting gender norms. In one case, the resident had been visually impaired all her life. This prevented her from marrying and she had to remain under the supervision of her family. An independent life for a woman living alone with a disability was hardly imaginable in Egyptian society and for her such a life became in part possible because her relatives finally brought her to a nursing home. In the other case, the resident had been married and raised her own children but after the death of her husband she did not want to stay with her son. She moved into a nursing home and openly rejected his expectation that according to the Egyptian tradition a mother had to be cared for by her son.

> I tricked him, I told him that I'm going to a friend and I had a small bag, so he drove me here. While he was coming in here… he told me that this is an older peoples' home. I said to him, yes and he got angry and asked me, did I make you upset? Is there anything that I'm not doing for you? I told him, no…and so, he cried and got really sad. He told me… that he cannot, when he wants to get married, tell his wife or her family that his mom is in an older peoples' home. This would mean that he is not a good boy. (Boggatz et al. 2009)

Such a perception of a long-term care facility was, however, only present if family life was perceived as restrictive. More often, life in the facility was experienced as restrictive since it required adjustment to rules and regulations the older persons were not used to. Not surprisingly, residents who were still able to do so *searched for a temporary escape*:

> I get the hell out of here … go down to the pub [in the facility] … talk to somebody. (Iwasiw et al. 2003)

In some cases, the desire for individual liberty could result in a *tendency to socially undesirable behaviour*. Instead of hiding their sexual desire some residents openly showed it by kissing or fondling each other in the public areas or by advocating the enjoyment of sexuality in old age (Nay 1992; Naess et al. 2016). Instead of adhering to decent manners, they consumed alcohol and even got drunk sometimes (Koch-Straube 2003; Slettebo et al. 2016). If residents felt that they could not do spontaneously what came into their mind because others reminded them to observe good manners, they sometimes showed an *aggressive self-assertion* as in the incident reported above by Fiveash (1998), in which one resident did not observe what others considered to be appropriate table manners and insulted her roommate by responding to a reprimand: “I’ll piss on the floor.”

5.3.3.4 Satisfaction of Unconventionality

For some residents, moving into a long-term care facility actually meant a *gain of an individual lifestyle*, as they did not have to adapt to their children’s way of life (Iwasiw et al. 1996; Boggatz et al. 2009; Bradshaw et al. 2012; Chang 2013; Cho et al. 2017).

> Here, I can do whatever I want to do, but if I stayed with my children, it would be awful [because they wouldn’t let me do things] (Cho et al. 2017)

> Since I’ve been here, I’ve begun to get my own self-esteem back. I love it. Now, I’m just beginning to live… I’m beginning to get my own world. (Iwasiw et al. 1996)

Other residents told about opportunities when they were *allowed to do what they liked*. One older man, for example, who attended ceramic classes, began to enjoy this work since “the guy down there [i.e. the occupational therapist] lets me do what I want” (Iwasiw et al. 2003).

Quite often, however, residents felt that they had to comply with social norms that existed in the facility. These norms made them feel that they *had to suppress their own needs* and prevented them from doing what they liked (Dobbs 2004; Falk et al. 2013; James et al. 2014; Palacios-Ceña et al. 2016b). Sometimes they were directly reprimanded by their roommates, but mainly they were just aware of their gossip and preferred to adapt to what they felt others perceived as social standards. Social standards concerned not only table manners or appropriate behaviour with regard to elimination but also the dress code. In assisted living facilities, where older persons had moved in to feel at home, residents felt urged to “dress up” because they were constantly on public display—although being at “home” would normally imply that one can dress however one chooses (Dobbs 2004). For example, when someone was sitting in the lobby in his pyjamas because he found it more relaxing, he was questioned by his roommates as to why he was ready for bed already. Conservative norms also prevented the wearing of outfits that were perceived as too erotic:

> I would like to show my cleavage or wear colourful clothes, but I prefer not to give them reasons to speak. Many people in the home can’t avoid gossiping about you and I don’t want my family to think badly of me. (Palacios-Ceña et al. 2016b)

Not surprisingly, such a climate constrained the free expression of one’s sexuality.

> Once, I commented what I liked with my friends, and they considered me to be a whore. I was only expressing what I liked or what I would have liked just out of curiosity. I never spoke [about it] again (ibid.)

5.3.4 Closeness Versus Distance

Social relationships of residents mainly depended on their desire for closeness and distance. The need to be cared for often implied a desire for closeness and social contacts which was also the reason why older persons adjusted to social norms and paid attention to the needs of others. Social distance on the other hand was facilitated by self-reliance and allowed for some non-conformity. Both tendencies, however, needed to be in balance in order to achieve social well-being.

5.3.4.1 Closeness

Even after moving into a long-term care facility, older people still felt the need for contact with the outside world and had a *desire for social participation* (Murphy et al. 2007; Cooney et al. 2009; Schenk et al. 2013; Behr et al. 2014; Teka and Adamek 2014). They wanted to feel connected to what was going on in the world outside, to stay up to date, and to get news about major events but also about their families and friends.

> So we keep in touch all the time, follow the government, see how they're going…if I couldn't keep in contact with the outside world, where would I be? (Cooney et al. 2009)

If possible, residents wanted to *maintain contacts to their friends outside* (Iwasiw et al. 1996; Murphy et al. 2007; Thomas et al. 2013; Walker and Paliadelis 2016; Shaw et al. 2016). Those who were still able to do so occasionally went out to visit them. The others depended on their friends to come to them. Most important for everybody was, however, the *desire for contact with the family* (Iwasiw et al. 1996, 2003; Bergland and Kirkevold 2006; Bland 2007; Hjaltadóttir and Gustafsdóttir 2007; Murphy et al. 2007; Stathi and Simey 2007; Harmer and Orrell 2008; Saunders and Heliker 2008; Cooney et al. 2009; Hutchinson et al. 2011; Nakrem et al. 2011; Park et al. 2012; Shrestha and Zarit 2012; Tompkins et al. 2012; Chang 2013; Hwang et al. 2013; Martinsson et al. 2013; Schenk et al. 2013; Thomas et al. 2013; James et al. 2014; Teka and Adamek 2014; Chuang et al. 2015; Gustavsson et al. 2015; Walker and Paliadelis 2016). Because of their lifelong relationship, residents were strongly attached to their children, who were therefore their main source of social well-being. They expected them to visit, to keep them up to date about what happened in the family, and to pick them up for outings

> I feel happy only if my family comes to see me. Otherwise, living here is very boring, and nothing is meaningful to me (Hwang et al. 2013)

The desire for closeness also referred to other residents. Many older persons were *interested in contacts with their roommates* (Ball et al. 2000; Grando et al. 2000; Rossen and Knafl 2003; Bergland and Kirkevold 2006; Robichaud et al. 2006; Andersson et al. 2007; Bland 2007; Stathi and Simey 2007; Wright et al. 2010; Nakrem et al. 2011; Andrews 2012; Kemp et al. 2012; Falk et al. 2013; Schenk et al. 2013; Thomas et al. 2013; Oosterveld-Vlug et al. 2014; Teka and Adamek 2014; Chuang et al. 2015; Bollig et al. 2016; Christov 2016; Minney and Ranzijn 2016;

Shaw et al. 2016; Rekawati et al. 2018). Some even had moved into a facility to find some company. They wanted to have someone to talk to who shared their joy and interests, and whom they could trust.

> When I signed up for this place I thought that I'd meet like-minded people and that we all could have a nice time together the last days or years of our lives. I hoped that it at least was someone here that I could make friends with, go for walks with, and talk about books with. (Falk et al. 2013)

> It is necessary to have friends here. (I) feel more cheerful, much happier and valued. (Chuang et al. 2015)

Residents made efforts to establish contacts and especially those who lived in single rooms searched for opportunities to meet other persons. Mealtimes were welcome as they provided such opportunities.

> I go down to dinners a lot. Talking to yourself all day long. So I'd rather go down to dinner. I just love going down with people, 'cos otherwise you're sat alone in this flat. (Wright et al. 2010)

Some residents wanted more than just occasional contacts in common rooms. They had an explicit *preference for close contacts* and did not mind an intrusion into their privacy (Thomas et al. 2013; Shin 2015). The company of roommates was rather welcome and the residents left their doors open for others to come in if they wished.

> They come in every night and visit me and we sit and watch the television from 6pm to 8.30 pm and we sit, the 3 of us together. We have supper in here also. It is so lovely having friends close by and at hand. (Thomas et al. 2013)

Some residents even had a *preference for shared rooms* which seemed to promote their sense of well-being and security (Fraher and Coffey 2011, Andrews 2012; Nakrem et al. 2013; Oosterveld-Vlug et al. 2013a). Surprisingly, this attitude was not restricted to traditional societies where people had a strong sense of community. It was also found in Western countries where people are said to be rather distanced and individualistic.

> At home I also slept on my own since my husband died 14 years ago. In here I share with four others, but they are all very nice. They all welcomed me, and we are all good to each other. (Fraher and Coffey 2011)

For some older men the desire for closeness was related to *searching for a female partner*. They had even moved into a long-term care facilities in the hope of finding someone suitable (Iwasiw et al. 2003; Boggatz et al. 2009).

The desire for closeness, however, did not extend to every roommate. Rather, the residents made *contacts according to their inclination*. This inclination was sometimes determined by feelings of sympathy.

> When you first meet people, you can kind of tell if that's the kind of person you want to build a friendship with. And then as it progresses and you find you have more and more things in common, it grows and grows. (Kemp et al. 2012)

Shared interests around music, sports, gardening, books, art, travel, and even pornography provided another foundation for relationships (Kemp et al. 2012; Park et al. 2012, 2013).

> I specifically like to select people that talk about things that I have an interest in. Because sometimes the conversation is not interesting. It's not about things that you have an interest in. (Park et al. 2013)

Quite often, however, the background for sympathy and shared interests was commonality based on race, class, gender, functional ability, culture, regional ties, religion, and even age (Kemp et al. 2012; Park et al. 2013; Perkins et al. 2012, 2013). As one resident put it:

> There's nothing like being with your own [race]. (Perkins et al. 2012)

Although relationships based on such commonalities are an understandable trait of human behaviour, they also implied the rejection of other persons considered unsuitable to fit into a particular community. A 92-year-old resident, for example, explained why he did not include some roommates in his network:

> They are all old, over 90, a bunch of old people. (Perkins et al. 2013)

Such rejection could also concern prospective residents who came to have a look on the facility. A manager who showed such an older person around told how she was approached by one of the residents who informed her: "We have already decided, she's not a candidate" (Kuhn 2008). Especially residents in assisted living facilities tried to exert some influence on the admission of new persons in order to maintain a social climate that corresponded to their lifestyle. Providers were aware of these preferences and made efforts to select residents who fitted well with the culture of their homes, but because they had to avoid vacancies all facilities also included residents viewed by the larger collective as outsiders, misfits, or troublemakers (Perkins et al. 2012).

More than any other contact, however, contacts with caregivers were of particular importance and residents expressed their *desire for a positive relationship to staff* (Bowers et al. 2001; Josat 2005; Bland 2007; Bergland and Kirkevold 2006; Coughlan and Ward 2007; Westin and Danielson 2007; Harmer and Orrell 2008; Hauge and Heggen 2008; Cooney 2011; Nakrem et al. 2011, 2013; Chang 2013; James et al. 2014; Teka and Adamek 2014; Gustavsson et al. 2015; Bollig et al. 2016; Lung and Liu 2016; Walker and Paliadelis 2016). Caregivers were perceived to be a central source of their well-being. They were those they could talk to even if they had no more contacts to roommates, family, or friends. Hence, they wanted to obtain their empathy and in return they took part in their private affairs.

> I treat the nursing assistants like my friends, which means that we share what has happened here and comfort each other. (Lung and Liu 2016)

5.3.4.2 Satisfaction of Closeness

Residents in long-term care facilities could satisfy their desire for closeness to various degrees. They had several ways to attain *social participation*. For some of them reading, listening to the radio, or watching TV was sufficient to feel connected to the world outside (Thomas et al. 2013). Others, who were still mobile, participated in activities arranged by the community, such as meetings for seniors (Falk et al. 2013). Those who were less able to leave the facility were satisfied with sitting inside and watching people on the street or at a nearby supermarket through a window as it gave them the feeling of taking part in other persons' lives (Bollig et al. 2016). Observing what was going on in the entrance hall or in a café inside the facility had the same effect and provided some entertainment (Andrew and Wilson 2014). Others, however, complained about a *loss of social participation* (Oosterveld-Vlug et al. 2014; Canham et al. 2016). Staying inside a facility meant for them that they were no longer part of the society. They felt far away from their community, lacked social ties, and had a sense of being abandoned.

A sense of social participation was reinforced if residents *succeeded in maintaining old contacts*. Some received visits from friends outside (Ball et al. 2000; Al-Omari et al. 2005; Kennedy et al. 2005; Park et al. 2012; Koppitz et al. 2017), stayed in contact via telephone and sometimes the internet (Williams and Warren 2008; Svidén et al. 2009; Minney and Ranzijn 2016), or went outside to meet them (Park et al. 2009; Svidén et al. 2009; Martinsson et al. 2013; Shaw et al. 2016).

> When they [outside visitors]'re here, we have very good visits. Quality time. We just chat for an hour … when he comes in at nine-thirty, I know at ten-thirty he'll be leaving. And the other one comes in and he just stays an undetermined length of time. And we just talk. I don't know much to talk about, but we pass quality time for an hour or so. (Park et al. 2012)

Although such contacts were more frequently reported in assisted living facilities, they were also found to some extent in nursing homes. More often, however, residents reported about a *loss of old contacts* (Ball et al. 2000; Rossen and Knafl 2003; Dobbs 2004; Shippee 2009; Svidén et al. 2009; Cheng et al. 2011; Chang 2013; Oosterveld-Vlug et al. 2013a, 2014; Thomas et al. 2013; Martinsson et al. 2013; James et al. 2014; Bennett et al. 2015; Canham et al. 2016; Koppitz et al. 2017). They were yearning for old times they had spent with their friends. All that remained now was some memories. Their friends had died or were sick and unable to visit them and they felt lost and abandoned.

> We used to get together often and have some meals with a little humble vegetable dish. I used to live like that, but now I feel like I live in exile (Chang 2013)

> We have called each other in the last years because we do not meet. As it was, she was gone when she could not talk on the phone anymore, but she is still alive — 101 years she is — but we are losing each other. (James et al. 2014)

In this situation contacts to the family became even more important and the desire for closeness was satisfied if residents had a *positive relationship to their family*

(Iwasiw et al. 1996; Murphy et al. 2007; Tsai and Tsai 2008; Wu et al. 2009; Nakrem et al. 2011; Tompkins et al. 2012; Hwang et al. 2013; Martinsson et al. 2013; Thomas et al. 2013; O'Shea et al. 2014; Oosterveld-Vlug et al. 2014; Adra et al. 2015; Bennett et al. 2015; Gustavsson et al. 2015; Bollig et al. 2016; Minney and Ranzijn 2016; Tuominen et al. 2016). Beside the already mentioned practical support and feeling of being cared for, visits from their children provided the opportunity to talk with a close person and to have someone who listened and showed his empathy.

> My son is a very filial child. He comes to visit me every day. He also brings food for me such as fruit or cookies. He says, 'Mom, all you have to do here is to nurture your health. You don't have to think too much' (Tsai and Tsai 2008)

Others, however, complained about *limited or even no contact to their family* (Ball et al. 2000; Saunders and Heliker 2008; Boggatz et al. 2009; Chuang and Abbey 2009; Timonen and O'Dwyer 2009; Cheng et al. 2011; Tompkins et al. 2012; Chang 2013; Schenk et al. 2013; Thomas et al. 2013; Bennett et al. 2015; Gustavsson et al. 2015; Mohammadinia et al. 2017). Their children lived far away, were too busy to visit them regularly, or had broken off their relationship with their parents. In some cases, they were non-existent.

> When I moved into here it has become too hard to see them because none of them can drive to come and see me because it's too hard. (Thomas et al. 2013)

> Since I have been here, nobody has visited me, even my children do not reply to my phone calls. Nobody understands me here; there is neither sympathy nor talking. (Mohammadinia et al. 2017)

This experience was aggravated when they had to witness how their roommates received love and attention from their children.

> When I see them celebrating their birthdays, and in come the relatives, sisters, brothers, and all the aunts and uncles, and yet I have nobody. I have nobody, not a single person. (Schenk et al. 2013)

There were also some residents who had been *separated from their spouse* when they had to move into a nursing home (Coughlan and Ward 2007; Iden et al. 2015).

> We have been married for ages. Moving into nursing home was like getting a divorce. It was very sad, even though she visits me every day. (Iden et al. 2015)

Others were in an even worse situation because they suffered from *grief due to the loss of significant others* (Coughlan and Ward 2007; Nakrem et al. 2011; Martinsson et al. 2013; Melin-Johansson et al. 2014; Teka and Adamek 2014; Kemp et al. 2016). One older women told, how she experienced the loss of her son:

> I discussed everything with him; he was nearby to me at any situation. He used to visit me frequently. Unfortunately, he died 7 years back; starting from those days for me life is meaningless; no happiness; I feel severe headache. When I am thinking about him I do not want to talk with anyone. (Teka and Adamek 2014)

In contrast to these residents, there were occasionally *couples who enjoyed their company* after they had moved in together. Their close relationship made them less dependent on contact with their roommates and they felt sorry for those who were in a less fortunate situation:

> We have companionship that they don't have. It's very, very difficult for most of the people here because […] they've lost their spouse. (Kemp 2008)

In some cases, residents also found *new partnerships* that satisfied their desire for closeness.

> I just fell in love with that man. You know, I didn't even love my husband like I love him. (Kemp et al. 2016)

Such relationships did not necessarily involve sexuality, but like their married counterparts, unmarried couples spent most of their time together although they did not share a room. In nursing homes with a lack of privacy romantic relationships could be restricted to showing love and affection by holding hands or taking care of one another. Whereas such relationships were tolerated to some extent in Western countries, *contacts between the sexes were rather restricted* in cultures where gender segregation was a predominant value. Hweidi (1999), for example, reported about a Jordanian nursing home that social interaction between male and female residents seemed to be non-existent except for some meetings which occurred at the entrance or in the club hall when both genders happened to be there at the same time. But also long-term care facilities in Western countries did not always offer the possibility to find new partners and those who had moved in in search of someone remained sometimes unsatisfied and began to complain about loneliness or as one of them summarized his experience: "There is no love here" (Iwasiw et al. 2003).

Besides families, old friends, or new partnerships, roommates were of particular importance in meeting the desire for closeness. Quite often residents reported about *positive relationships with their roommates* (Iwasiw et al. 2003; Cooney et al. 2009; Curle and Keller 2010; Cooney 2011; Bradshaw et al. 2012; Thomas et al. 2013; Andrew and Wilson 2014; Hillcoat-Nalletamby 2014; James et al. 2014; Lung and Liu 2016; Koppitz et al. 2017; Rahayu et al. 2018). Spending their time together and knowing that there was always someone available to talk to saved them from feelings of loneliness.

> I can just make a short walk to the dining room and there are always people sitting around in the dining room. I just go and talk to them (Thomas et al. 2013)

> There's no feeling of loneliness about it, you know it's a companionable place. (Cooney 2011)

Some facilities apparently managed to establish a positive social climate as researchers could observe how residents mutually expressed their friendship and appreciation (Curle and Keller 2010). In such places, residents told how they developed a *sense of community* and a feeling of belonging to the facility (Saunders and Heliker 2008; Eckert et al. 2009; Cooney 2011; Kemp et al. 2012). As one of them put it: others became "just like family" (Kemp et al. 2012)

> We have a good rapport with each other … it's not like your own family but you make them your family. (Cooney 2011)

For some residents, their *new contacts in the facility became a substitute* for old but lost relationships to families and friends (Westin and Danielson 2007; Bennett et al. 2015; Canham et al. 2016).

> Yes, it means almost everything, when you do not have any relatives, but you feel that in some way you belong here in this home, that you are one among the others and you always have someone to turn to. (Westin and Danielson 2007)

For others, moving into the facility even meant a *gain of contact* because they were widowed or childless and had less opportunity to socialize when they were still living at home (Iwasiw et al. 1996; Saunders and Heliker 2008; Bowers et al. 2009; Cheng et al. 2011; Falk et al. 2013; Nakrem et al. 2013; Oosterveld-Vlug 2013a; Schenk et al. 2013; Oosterveld-Vlug et al. 2014; Teka and Adamek 2014; Adra et al. 2015; Minney and Ranzijn 2016).

> I didn't socialize much, only with my husband [who died], but I knew if I came here I would need to change and I did and it's been good. (Bowers et al. 2009)

Social interaction mainly occurred in public areas of the facility. Residents regularly met at meals, which for this reason meant more than just the intake of food and calories (Sidenvall et al. 1994; Iwasiw et al. 1996; Wu and Barker 2008; Curle and Keller 2010; Hweidi 1999; Philpin et al. 2011; Barnes et al. 2013; Thomas et al. 2013; James et al. 2014; Gustavsson et al. 2015; Canham et al. 2016; Slettebo et al. 2016). Sharing food allowed for conversation and created bonds between residents as they became familiar with each other.

> Nice fellows, we sit there at the table joking and teasing each other, children of the same spirit as I am. (Sidenvall et al. 1994)

Another occasion to socialize was participation in joint activities organized by the staff (Iwasiw et al. 1996; Raske 2010; Pryce and Gooberman-Hill 2012; Oosterveld-Vlug 2013a; Schenk et al. 2013; James et al. 2014; Adra et al. 2015; Gustavsson et al. 2015). Besides these arranged possibilities, contacts were made in the common room (Koch-Straube 2003; Hubbard et al. 2003; Nakrem et al. 2011; Thomas et al. 2013; Christov 2016) or—if available in the facility—in the café (Andrew and Wilson 2014) or while waiting for the hairdresser (Thomas et al. 2013).

Such contacts, however, did not result for every resident in the formation of close ties with other roommates. There were also those who *experienced their relationships as friendly but superficial,* because their contacts remained restricted to occasional conversation in public areas (Ball et al. 2000; Koch-Straube 2003; Dobbs 2004; Hutchinson et al. 2011; Kemp et al. 2012; Park et al. 2012; Bennett et al. 2015; Roberts and Bowers 2015).

> I have acquaintances here, but don't get too involved. (Kemp et al. 2012)

> I mean they're all friends [but] I don't confide in them, you know what I mean. We're all separate. It's not like when you're younger. (Park et al. 2012)

For these residents, relationships labelled as friendships were rather "artificial" as they did not develop out of mutual understanding but occurred "simply because they live in the same place" (Park et al. 2012). Some residents, however, would not generalize such statements. They rather developed *individual friendships* with some roommates when there was mutual sympathy (Ball et al. 2000; Coughlan and Ward 2007; Tucket 2007; Kuhn 2008; Williams and Warren 2008; Svidén et al. 2009; Kemp et al. 2012; Park et al. 2012; Falk et al. 2013; Andrew and Wilson 2014; Gustavsson et al. 2015; Roberts and Bowers 2015; Bollig et al. 2016)

> I have a friend that's a real good friend of mine. When I came in the door, she said, 'That's gonna be my friend.' Me and her turned out to be best friends that ever was. We still are. (Ball et al. 2000)

However, close contact did not always mean familiarity. For some, it was just acceptable and better than loneliness.

> I've got two women here, (Margaret) and another one (Joan), I don't know her surname … they come into my room invariably, sit and talk to me… They're patients – inmates… They're not good friends or anything like that. I realize I can talk to them. We lend each other books and things like that. (Tucket 2007)

Quite often, however, residents felt that there was no suitable person available to establish closer contacts or friendship and they suffered from a *lack of contacts with roommates* (Sidenvall et al. 1994; Fiveash 1998; Andersson et al. 2007; Hjaltadóttir and Gustafsdóttir 2007; Tucket 2007; Hauge and Heggen 2008; Tsai and Tsai 2008; Wu and Barker 2008; Bowers et al. 2009; Chuang and Abbey 2009; Cooney et al. 2009; Timonen and O'Dwyer 2009; Cooney 2011; Philpin et al. 2011; Nakrem et al. 2011; Andrews 2012; Bradshaw et al. 2012; Pryce and Gooberman-Hill 2012; Barnes et al. 2013; Chang 2013; Falk et al. 2013; Martinsson et al. 2013; Nakrem et al. 2013; Schenk et al. 2013; Thomas et al. 2013; James et al. 2014; Melin-Johansson et al. 2014; Oosterveld-Vlug et al. 2014; Iden et al. 2015; Roberts and Bowers 2015; Shin 2015; Stevens et al. 2015; Bollig et al. 2016; Christov 2016; Tuominen et al. 2016; Slettebo et al. 2016; Cho et al. 2017; Mohammadinia et al. 2017). This was reported to some extent from assisted living facilities, but it was a more common complaint in nursing homes where residents had higher levels of care dependency. Some older persons felt that their roommates did not share their interests or that they had a different social background. Others felt restricted by a cold social climate.

> I just didn't get on with the people there. It was – you know, it was like a wall. Yes. There was just no, no connection among the residents, and so I said to myself, the first opportunity I get, I'm getting out of here. (Schenk 2013)

> I do nothing. I sit in the living room in my own stress-less chair. I have tried to involve other residents in a conversation but I get no response, so I have stopped doing that. (Slettebo et al. 2016)

Because the majority of residents were women, men sometimes felt restricted by the dominance of female topics and interests.

> At the dinner table, there's 10 people *(women) and* one man… With a woman, you know, sewing and cooking and that don't interest me. (Bauer et al. 2013)

The most common complaint, however, was that roommates were unable to communicate due to dementia or hearing impairments.

> There are no normal people here. Almost every person has dementia or is wheelchair-bound… it's hard to communicate with them (Cho et al. 2017)

> It's so sad that I can't talk to any of the others. They're all in a world of their own – old and silly. (Hauge and Heggen 2008)

There were also residents who had been lucky enough to find some friends when they had moved in, but they eventually experienced a *decline of their social contacts* because roommates that had become their friends left or died (Park et al. 2009; Bennett et al. 2015).

Others lost social contacts due to declining cognitive abilities and being in the initial stage of dementia they were aware of this loss.

> There's probably half a dozen people who've come within the last few months that I've never met and some of them, if I get close enough, are peering at me and they're 'why doesn't he say anything?' You can see their thoughts on their faces. Because they expect the men to introduce themselves first, don't they. (Shaw et al. 2016)

Due to their work, staff members were the most important source of social contacts for the residents. Quite often, residents told about the *attention and friendliness of staff*, which met their desire for closeness (Iwasiw et al. 1996; Iwasiw et al. 2003; Bland 2007; Cho et al. 2017; Murphy et al. 2007; Westin and Danielson 2007; Tsai and Tsai 2008; Svidén et al. 2009; Williams and Warren 2009; Wu et al. 2009; Jordan 2010; Hutchinson et al. 2011; Nakrem et al. 2011; Hwang et al. 2013; Park et al. 2013; James et al. 2014; Oosterveld-Vlug et al. 2014; Gustavsson et al. 2015; Rekawati et al. 2018). They described caregivers as kind, pleasant, and helpful, and they recounted how they took their time, listened to them, showed their compassion, and did small favours to them.

> The nurses listen to whatever I say, and we laugh together (Cho et al. 2017)

> The staff are wonderful, I can talk about anything I like … the girls are exceptional, always helpful and in a good mood. Not even in my dreams could I have expected it would turn out so well. (Svidén et al. 2009)

Not surprisingly, many older persons told that they developed *close relationships to their caregivers* that made them feel loved and less lonely (Grant et al.1996, B78; Ball et al. 2000, 2004a, 2009; Al-Omari et al. 2005; Bland 2007; Coughlan and Ward 2007; Westin and Danielson 2007; Eckert et al. 2009; Jordan 2010; Cooney 2011; Nakrem et al. 2011; Philpin et al. 2011; Park et al. 2012; Adra et al. 2015;

Shin 2015; Stevens et al. 2015; Canham et al. 2016). For many of them, caregivers became like friends or even family members and some of them welcomed being called grandma or grandpa by the staff.

> I know that I am comfortable in here and that the employees are so sweet. They love me and they treat me as if I were their mother or grandmother. (Adra et al. 2015)

> So caring is treating me as a family such as by calling me grandma, holding or touching me, greeting me actively every day, and accompanying me for a while. (Hwang et al. 2013)

For residents who had only limited contacts to family, friends, or roommates, *contact to caregivers became a substitute* for their lack of relationships, and they were to some extent dependent on their attention (Hauge and Heggen 2008; Park et al. 2009, 2013; Hwang et al. 2013; Mohammadinia et al. 2017).

> Here, older people rarely talk to each other or walk outside. I like having staff inquiring about me… (Hwang et al. 2013)

Not every resident, however, experienced a close relationship to caregivers. There were also those who described their *contact to staff as friendly but superficial*—at least when certain caregivers were concerned (Heliker and Scholler-Jaquish 2006; Jordan 2010; Nakrem et al. 2013; James et al. 2014; Iden et al. 2015; Donnelly and MacEntee 2016; Lung and Liu 2016). According to these residents there was nothing "wrong" with such staff members, but they lacked the affection that had been shown by others (James et al. 2014). According to Lung and Liu (2016), who investigated nursing homes in Hong Kong, such polite but formal relationships helped avoiding conflict and maintaining a harmonious atmosphere that is valued in Chinese culture. Although this type of relationship may be particularly pronounced in Chinese facilities, a friendly tone, which lacks authenticity, is by no means unknown in other countries, as it is shown by the following quote:

> They're too pleasant. (laughter), They come in here with a big smile on their face but I don't know how they leave when they turnaround. They're always nice to you, you know. But, you never know if they really mean it. I mean that's just my feeling. (Jordan 2010)

Others did not report about a lack of authenticity in their relationship to caregivers. They rather told that they had only *limited contact to staff* (Dobbs 2004; Heliker and Scholler-Jaquish. 2006; Martinsson et al. 2013; Gustavsson et al. 2015; Bollig et al. 2016). Caregivers were perceived to be distanced or too busy to spend time with residents. In some facilities, residents rarely knew the names of the staff even after 3 months (Heliker and Scholler-Jaquish. 2006).

> I miss the contact. They do not have time (Gustavsson et al. 2015)

Furthermore, older persons who were immigrants reported a language barrier that prevented them from establishing closer relationships to staff:

> It would be nice if someone here could speak my language so I can feel secure … There is one person on the staff who can speak my language, but when she is not here, I do not want to talk. (Martinsson et al. 2013)

If residents lost contact to family and friends outside and felt that they could not establish new contacts to roommates and caregivers inside the facility, they eventually suffered from *loneliness* (Iwasiw et al. 1996; Fiveash 1998; Ball et al. 2000, 2004a; Coughlan and Ward 2007; Westin and Danielson 2007; Saunders and Heliker 2008; Tsai and Tsai 2008; Warren and Williams 2008; Chuang and Abbey 2009; Shippee 2009; Timonen and O'Dwyer 2009; Cheng et al. 2011; Cooney 2011; Hweidi 1999; Kemp et al. 2012; Tompkins et al. 2012; Chang 2013; Martinsson et al. 2013; Schenk et al. 2013; Behr et al. 2014; Hillcoat-Nalletamby 2014; James et al. 2014; Melin-Johansson et al. 2014; Oosterveld-Vlug et al. 2014; Teka and Adamek 2014; Adra et al. 2015; Chuang et al. 2015; Nakrem 2015; Walker and Paliadelis 2016; Cho et al. 2017). This experience was not restricted to nursing homes where residents suffered from disabilities that prevented them from developing relationships. Loneliness was also found in assisted living facilities, where social contacts seemed to be better. Some residents were just excluded from the social networks in the facility and they became outsiders.

> I don't know where I am, I'm isolated. This isn't the place for me I'm so lonely (Hillcoat-Nalletamby 2014)

> I can't communicate with the people here. There's nobody to talk to at all. I feel absolutely terrible, don't I? I have no one to talk to! I want a friend… I like talking. I'm dying to have a friend to talk to. (Chang 2013)

To some extent, loneliness seemed to be the reason for unusual behaviours that could be observed among residents. For those who could not describe their feelings, crying out for help for no obvious purpose was the only way to attract some attention (Ball et al. 2004a).

5.3.4.3 Distance

The desire for closeness, however, was counterbalanced by a desire for distance. First of all, distance was ensured by *maintaining privacy*. Privacy meant to have one's own space that was surrounded by a personal boundary. The extent of personal space, however, could vary. Whereas many older persons wanted to have a single room (Hjaltadóttir and Gustafsdóttir 2007; Hauge and Heggen 2008; Chin and Quine 2012; Nakrem et al. 2013) and expected caregivers to knock before entering (Oakes and Sheehan 2012; Chuang et al. 2015; Bollig et al. 2016), others did not mind shared rooms due to their desire for closeness. They nevertheless insisted on a private sphere as they had their own area in a shared room that others were not allowed to step in without permission (Murphy et al. 2007). Gubrium (1997) observed how privacy was enacted in public areas, for example, by claiming an exclusive right to use a certain place. Such rights were tacitly acknowledged by other roommates in order to avoid conflicts. Some residents also wanted to have their privacy to perform their own activities without being disturbed by others. Iwasiw et al. (2003), for example, observed a resident who filled his day by playing the piano and avoided in this way the interaction with others. As he said, "I'm busy with…music.… You just block yourself right off from what's around you" (ibid.).

Maintaining privacy was associated with a *desire for temporary withdrawal* (Harmer and Orrell 2008; Hauge and Heggen 2008; Nakrem et al. 2011; Melin-Johansson et al. 2014; Stevens et al. 2015; Christov 2016). Residents wanted to balance their need for company and their need to be alone by choosing how much time they spent in the common room and in their private space.

There were also residents who had just a *restricted desire for contacts with other residents* due to a variety of reasons. Some had reservations about their roommates and since they believed that they still had enough contacts to friends outside they felt no need to establish closer contacts inside (Perkins et al. 2013; Shaw et al. 2016)

> I don't want to get tied into anyone here, particularly because living here with them if they're not my cup of tea […] So I'm very much making a conscious decision that I will be friendly with everyone but not to sort of forge a great relationship because I'm in the position that I don't feel lonely that I've got a good circle of friends that I don't need to look for another friendship really. (Shaw et al. 2016)

In nursing homes such reservations about roommates were due to their impairments or dementia (Oosterveld-Vlug et al. 2014). This made even those who felt a need for closeness less inclined to search for new contacts. For men, lack of shared interests with predominantly female roommates was a reason to remain distant (Park et al. 2009; Williams and Warren 2009). For others, dislike of gossip as it occurred in long-term care facilities was a reason not to get too involved in their social networks (Perkins et al. 2013; Roberts and Bowers 2015; Kemp et al. 2016).

> Well, a lot of times it's gossip. And I don't like that. Not very much. I like to know what's going on but I don't like to, I don't like the gossip part of it. (Roberts and Bowers 2015)

Others perceived themselves to be loners by nature and were satisfied when they were left alone and could pursue their individual activities and interests (Ball et al. 2000; Eckert et al. 2009; Williams and Warren 2009; Kemp et al. 2012; Martinsson et al. 2013; Roberts and Bowers 2015; Stevens et al. 2015).

> I have never been fond of socializing so I am used to taking care of myself and entertaining myself. I can always pass the time reading, watching television and listening to the radio, solving crosswords and so on. So I am pretty much alone. In a way, I don't care for the entertainment they offer here. (Slettebo et al. 2016)

Shyness and feelings of shame (for example, due to incontinence) were other motives for social distance (Iwasiw et al. 1996; Rossen and Knafl 2003; Jordan 2010; Cheng et al. 2011). Some residents, finally, avoided close contacts because they had been hurt by the loss of friends and were afraid of having to repeat this experience.

> Yeah, I don't want [friends] anymore. I don't want to see the friend die. Or, eat supper and be dead by breakfast time. (Park et al. 2009)

There were also residents who wanted to have a *distanced relationship to caregivers* (Andersson et al. 2007; Nakrem et al. 2011; Lung and Liu 2016). They felt that they were too young to understand older persons and had interests they could not share. Because caregivers were no real substitute for family and friends, residents preferred that they just fulfilled their function without establishing any closer relationship with them.

> There is not much chatting between the nursing assistants and me because, as a resident here, and the nursing assistants are the workers, so we lead different lives…. There is nothing to talk about … I mean, we do not interact like friends; there is not much joking, or chatting.… These things are all on me, and are none of their business […]. We, residents are those who need to be taken care of… they are care workers…. Our relationships can't go beyond this…. I mean, there is no way for us to be friends at all. (Lung and Liu 2016)

There were also residents who were *inclined to complete disengagement* (Koch-Straube 2003; Shippee 2009; Williams and Warren 2009; Curle and Keller 2010; Pryce and Gooberman-Hill 2012; Christov 2016). Being forced to move into a long-term care facility and dissatisfied from life they withdrew out of inner protest.

> I just made up my mind that things had to change, so I just erased from my mind these other relationships. (Shippee 2009)

For them, the facility and their roommates were a permanent annoyance. If they could not avoid their presence because they suffered from impaired mobility and had been taken out of their rooms by caregivers, they preferred not to communicate with others. Their silence created a barrier that protected what was left of their privacy.

5.3.4.4 Satisfaction of Distance

The desire for distance was satisfied when residents had a single room or apartment that *protected privacy* (Murphy et al. 2007; Cooney et al. 2009; Bauer et al. 2013; Falk et al. 2013; Nakrem et al. 2013; Hillcoat-Nalletamby 2014; Shin 2015). This demand was particularly met in extra care housing and assisted living facilities which had been established for this purpose, but also nursing homes fulfilled this requirement if residents had single rooms and caregivers respected their privacy.

> You have a carer coming in the same, but here you've got a little bit more privacy, you've got your bedroom, you've got your bathroom, you've got your kitchen, you can have your visitors in. (Hillcoat-Nalletamby 2014)

Privacy, however, was fragile and some residents complained about an *intrusion of privacy by caregivers* (Nakrem et al. 2011; Chuang and Abbey 2009; Oakes and Sheehan 2012; Falk et al. 2013; Schenk et al. 2013; Chuang et al. 2015; Nakrem 2015). They felt disturbed when caregivers entered their room without knocking on the door and they disliked monitoring, especially night checks, which staff performed in the interest of their health and safety. If residents, however, were care dependent, an intrusion of their privacy was unavoidable as caregivers had to provide personal care. Another source of annoyance was the *disturbance of their privacy by roommates* who entered unannounced their room and sometimes even took away their private possessions (Bradshaw et al. 2012; Behr et al. 2013; Koskenniemi et al. 2015).

> When I want to be alone, some residents always come to my room… and I have to drive them away. It is horrible…I want to be alone - there is so much noise in the living room. (Koskenniemi et al. 2015)

Lack of privacy also meant that there was no or only limited place for private belongings due to risk of theft (Timonen and O'Dwyer 2009; Cooney et al. 2009; Cooney 2011). Furthermore, it restricted the opportunities for social contacts according to residents' desires. Due to the constant presence of roommates, there was no place where residents could retreat to meet with others for private reasons. It also made visitors feel unwelcome as everybody could observe their private encounter (Timonen and O'Dwyer 2009; Cooney et al. 2009; Fraher and Coffey 2011; Nakrem et al. 2011, 2013).

> In the day room there's a certain lady and she listens to every word that those people… I think it's very wrong. It's very embarrassing for the visitors to have someone listening. (Timonen and O'Dwyer 2009)

As mentioned above, the lack of private space also restricted the satisfaction of sexual desires (Bauer et al. 2013; Villar et al. 2014).

5.3.5 Influencing Factors

The balanced satisfaction of social needs depended on the one hand on the residents' physical condition and their circumstances of life. On the other hand, it was influenced by environmental factors and the way how caregivers dealt with their social needs. In response, residents showed a variety of coping reactions.

5.3.5.1 Physical Conditions

Functional limitations prevented residents from participation in joint activities (Andersson et al. 2007; Nakrem et al. 2011; Chang 2013; Thomas et al. 2013; Gustavsson et al. 2015; Cho et al. 2017):

> When I hear and see others laugh and enjoy [themselves], I desperately want to join them … but now it takes a lot longer than before for me to walk … anywhere, so it's hard for me to join others… I'm very disappointed. (Cho et al. 2017)

Those who were wheelchair-bound depended on their caregivers to get in touch with others and to return to their privacy. *Loss of hearing* was a serious obstacle to establish communication (Hubbard et al. 2003; Andersson et al. 2007; Chuang and

Abbey 2009; Curle and Keller 2010; Philpin et al. 2011; Pryce and Gooberman-Hill 2012; Melin-Johansson et al. 2014; Gustavsson et al. 2015; Stevens et al. 2015). Residents could not understand what the others said and were afraid to annoy them because those who spoke complained about having to repeat what they had already told them:

> My hearing is so difficult and a number of the people here have hearing and speech difficulties and I haven't been able to sort out those who are speaking clearly and those who don't. I don't want to embarrass them or me. (Stevens et al. 2015)

Cognitive decline was another obstacle for social contacts (Ball et al. 2004a; Curle and Keller 2010; Nakrem et al. 2011; Andrews 2012; Sandhu et al. 2013; Chang 2013; Schenk et al. 2013; Behr et al. 2014; Oosterveld-Vlug et al. 2014; Cho et al. 2017). Those who suffered from it either could not understand what others were talking about or they deterred them with disruptive behaviour.

> We have a lot here, (…) who go crazy sometimes, don't they? (…) if you now talk to the lady and say, we go to the room (…) no, she doesn't (…) then sometimes they get really angry (…) because she insults them with crazy words (…) Because she beats her – gives her a blow. Well, that can't be true, is it? (….) the next day they are quite fine and normal again? (Behr et al. 2014)

At the same time, cognitive integrity was a prerequisite for remaining independent and self-reliant.

> If you don't have Alzheimer's yet or Parkinson's and the confusion isn't there, then you can still decide for yourself where to get out and where to go.(Schenk et al. 2013)

Residents were afraid of getting dementia, and they saw it as a disease that could strike them without their being able to do anything about it.

5.3.5.2 Circumstances of Life

The satisfaction of social needs was furthermore affected by the life circumstances of the residents. There were those who had *moved in by own choice* (Iwasiw et al. 1996; Rossen and Knafl 2003; Andersson et al. 2007; Walker and Curry 2007; Cooney et al. 2009; Svidén et al. 2009; Cooney 2011; Nakrem et al. 2013; Stevens et al. 2015). This allowed them to maintain control over their life as they were able to anticipate and prepare for the move. Since the long-term care facility was only possible option for them, they also could realize some advantages of moving in. One advantage was the feeling of being cared for.

> After my wife died, I was alone out on the island and that just wouldn't work. Got this here thing with my foot and I just couldn't be out there alone on the island, under any circumstances, without home healthcare. (Nakrem et al. 2013)

The opportunity to establish new contacts was another advantage and they were ready for some social engagement. Consequently, they entered the "home" with a mind-set of "giving it a go" or "making it work" (Cooney 2011). In some cases, their decision had been influenced by family members, but since these only gave them advice but did not impose anything on them, they finally considered the decision to be their own (Stevens et al. 2015).

Financial resources increased resident's possibilities of choice and thus their amount of control (Ball et al. 2004a; Bowers et al. 2009; Eckert et al. 2009). They were particularly important when moving into assisted living, as accommodation there usually had to be paid for privately. Older persons were considered to be customers and their financial capacity thus determined the extent and level of the service that could be called upon. This encouraged a demanding attitude, but it also meant that they had to move out when their money was depleted.

A deliberate choice to move in, however, was rather rare. Many residents had been *forced to move in* (Iwasiw et al. 1996; Fiveash 1998; Hweidi 1999; Andersson et al. 2007; Bland 2007; Bowers et al. 2009; Cooney 2011; Shrestha and Zarit 2012; Chang 2013; Falk et al. 2013; Martinsson et al. 2013; Oosterveld-Vlug et al. 2013b; Teka and Adamek 2014; Stevens et al. 2015; Canham et al. 2016; Mohammadinia et al. 2017). In some cases, they had suddenly lost their functional abilities due to an accident or an acute disease, in other cases they had experienced a gradual decline of self-care abilities, but all of them had had no choice but accept the decision of others. Some older persons were even overrun by such a decision and experienced it as a shock.

> They called my daughter and said that I needed to make up my mind about moving to this place by following Monday at the very latest. This was a Friday afternoon, and I felt unsure… but then I decided to say no, I didn't want to leave my home. My daughter called early that Saturday morning saying that she and her husband were on their way and that I needed to get ready. I didn't understand a word she was saying, and asked what they in God's name were up to? We're moving your furniture today and everything is arranged at the residential care facility for you to move in by Monday, my daughter said. That night my heart was pounding and I couldn't stop crying. (Falk et al. 2013)

Some authors (Eckert et al. 2009; Bowers et al. 2009) even doubt that older people who claimed that it was their own decision to move into a long-term care facility actually had a chance to make a conscious choice, as in most cases they had little time to evaluate a variety of options and to anticipate the consequences of a potential selection. In any case, an involuntary move into a facility did not only mean the loss of control over one's life, it also produced an inner resistance that prevented older persons from recognizing the benefits of staying there, and they were less inclined to make contact with their fellow residents. Some of them needed some time to adapt and to decide to make the best out of their situation while others tended to withdraw although this reinforced their feeling of loss and loneliness.

> My body is like that; my children didn't let me stay at their home. That's why I am here. This is not what I wanted. They forced me to come here. I said nothing. I was dragged like the dead when they wanted me to go. What should I do? So, I have been suffering until now… (Chang 2013)

In cultures where parents expected to be cared for by their children, the move into a nursing home against their will could be a traumatic experience from which older persons did not recover—as it was observed in a residential facility in Nepal:

> During meal time, she did not eat; she only wanted her son. She did not eat. She did not sleep at night. She would just sit there. She did not stay in her room upstairs. … what is the use of to have a son? (Shrestha and Zarit 2012)

Being in such a way abandoned meant to lose control over one's children and not to receive the care that was desired.

5.3.5.3 Environmental Factors

Besides these person-related factors, environmental conditions influenced the satisfaction of social needs. The satisfaction of the desire for distance depended on the *type of accommodation*. Privacy was more or less protected when residents had single rooms or double rooms for couples (Ball et al. 2000; Dobbs 2004; Bergland and Kirkevold 2006; Andersson et al. 2007; Cheng et al. 2011; Bradshaw et al. 2012; Thomas et al. 2013; Shin 2015). However, when such rooms were small, they were more like a prison cell and the residents were forced to spend their time outside (Bright 2007; Murphy et al. 2007). Lack of a private bathroom also restricted privacy (Bergland and Kirkevold 2006). Shared rooms or dormitories, however, meant that privacy was lost—except for some residents who preferred this kind of accommodation (Fiveash 1998; Murphy et al. 2007; Cooney et al. 2009; Cheng et al. 2011; Cooney 2011; Fraher and Coffey 2011; Andrews 2012; Oosterveld-Vlug et al. 2014).

The satisfaction of the desire for closeness, on the other hand, was supported by the existence of *communal space* that allowed for socializing. Dining halls permitted shared meals and created a sense of community (Philpin et al. 2011). A spacious lobby with comfortable seats, recreation rooms, or a café inside the facility were conducive to interaction between residents (Dobbs 2004; Fraher and Coffey 2011; Cheng et al. 2011; Kemp et al. 2012; Sandhu et al. 2013; Andrew and Wilson 2014; Zimmerman et al. 2016). Unfortunately, several facilities had only limited or no communal space (Wu et al. 2009; Cheng et al. 2011; Cooney 2011; Kemp et al. 2012; Canham et al. 2016) and if no common meals were served, residents had less opportunity to socialize (Wright et al. 2010). If common rooms were available, *noise* levels from music or television, from other residents or from staff raising voices or singing along to music made it difficult for residents to hear each other and could cause a communication breakdown (Pryce and Gooberman-Hill 2012). When residents were transferred to a hospital or another facility, *privacy policy* prevented their former friends to stay in contact because staff was not allowed to give information about their whereabouts (Kemp et al. 2012; Zimmerman et al. 2016). *Visitation rules* influenced the contact of residents to friends and family outside. Open visiting hours facilitated their access, whereas restricted time limits for visitations could prevent them from coming (Murphy et al. 2007). Some assisted living facilities had conflicting rules, as information packages indicated that "visiting times are flexible" because the facility was "the home of the resident", while the same documents stated that the residents were "subject to reasonable restrictions on visiting times and places"—a description that remained vague and allowed individual interpretation (Bennett et al. 2015). Obviously, such regulations could have a deterring effect for visitors from outside.

Residents' contact with the outside world also depended on the *connections between facility and environment*. This connection could be facilitated by an open house policy, for example, by inviting neighbours from the surrounding area to participate in joint events (Murphy et al. 2007). If a facility was composed of several buildings, the spatial distance between them resulted in limited contact between their residents (Kuhn 2008; Kemp et al. 2012). Long distances and lack of transportation prevented residents from going out to visit their family or friends and they depended on their visits (Kuhn 2008; Bennett et al. 2015). Some residents, however, told that *access to the internet* would allow them to maintain contacts to families and friends outside (Thomas et al. 2013). Given the increasing diffusion of digital technologies this opportunity is likely to become more important when future generation who grew up with the internet move into long-term care facilities.

In some cases, the *family influenced the social relationships* of the residents. Their children either encouraged them to participate in joint activities (Kemp et al. 2012) or they interfered with contacts they disliked. Sometimes they instructed staff about people who should be prevented from visiting the resident (Bennett et al. 2015), but more often they were concerned about newly formed relationships between couples and tried to separate them (Frankowski and Clark 2009; Villar et al. 2014). As one facility manager observed, some children "become very upset with their mom because Mom was never like this and it's embarrassing for them" (Frankowski and Clark 2009). One reason for the disruption of intimate contacts was the fear of adult children that they might lose their inheritance to the late lover of a parent (Nay 1992).

5.3.5.4 Care for Social Needs

The most influential factor for the satisfaction of social needs, however, was the way how caregivers addressed these needs. Due to their function they held a key position in the social network of the residents. Caring for their social needs depended first and foremost on how they established their own relationship with the residents. Besides they also exerted some influence on the social contacts between the residents.

The relationship of caregiver to residents was often determined by their function and dominated by the performance of certain tasks. It therefore tended to be more task-oriented than person-centred. Task-orientation began with a *formal assessment* to determine to what extent the condition of the residents met required criteria of health and functionality. This was a standard procedure at admission in nursing homes and assisted living facilities (Ball et al. 2004a, b; Kuhn 2008) and it was deemed to be necessary in order to plan the care that was required.

The assessment of care needs was furthermore an ongoing process because care plans could always need a revision due to a deteriorating health condition of the resident. This issue was of particular importance in assisted living facilities, as a certain amount of care needs could exceed the capacity of the facility and the resident had to move into a qualified nursing home. However, since residents in these facilities were officially entitled to autonomy, they could not be subjected to a permanent repetition of such assessments and fearing that they would be transferred to a nursing home against their will, they tried to pretend more self-reliance than they actually had. In reaction, staff members resorted to an *informal monitoring* that could take the character of spying on residents (Kuhn 2008; Williams and Warren 2009: Oakes and Sheehan 2012; Zimmerman et al. 2016). Zimmerman et al. (2016), for example, reported about one staff member, who was aware of the likelihood that his white uniform would make residents pretend to be self-reliant, and who used "tricks" like standing outside and watching through the reflection of the glass door in order to observe residents secretly, and always disappeared quickly so they would not know they are being watched.

Theoretically, decisions about care should be discussed and agreed upon with care recipients—especially in assisted living facilities where residents were considered to be customers who should have choices. In practice, however, staff members *planned care without the resident* based on their observations—even in assisted living. One resident, for example, told about his experiences with care conferences that were standard in many long-term care facilities:

> I will tell you this, I mean no circumstances should they have a meeting about the patient and just have the doctor and the social worker, and the head nurse there and not the patient. Or, someone form the patient's family, that's fine too. But, if the patient's not there, they can say anything or anything and whether it's true or not. And, like the last meeting they had here, I was nowhere to be seen because they never told me they were having anything. (Jordan 2010)

Although intended to obtain a better idea of the needs of residents, such conferences tended in practice to assess these needs without taking their views into consideration. It was in line with this attitude that nurses or caregivers while being on duty rather *discussed about the resident instead of with him* (Koskenniemi et al. 2015), and that the organization *excluded residents from participation in decisions* regarding who was in charge of them and how they could spend their day.

> Well, there would be a lot to do or say, if you could do it your own way. Many times people think it could be otherwise, but it is difficult, and of course it has to be their way. (ibid.)

"Their way" meant that staff *imposed day structure and routines* on the residents (Fiveash 1998; Ball et al. 2000; Koch-Straube 2003; Dobbs 2004; Al-Omari et al. 2005; Bland 2007; Hellström and Sarvimäki 2007a, b; Murphy et al. 2007; Hauge and Heggen 2008; Tsai and Tsai 2008; Williams and Warren 2008; Timonen and O'Dwyer 2009; Cooney 2011; Park et al. 2012; Chang 2013; Hwang et al. 2013; Gustavsson et al. 2015; Bollig et al. 2016; Heid et al. 2016; Naess et al. 2016; Tuominen et al. 2016). Long-term care facilities had a fixed schedule that set the time for waking up, meals, therapies, and participation in joint activities and residents were expected to adapt to it. Such schedules could also determine the day when residents had to take a shower and the amount of time that was available for a particular activity. Even in assisted living facilities that intended to ensure self-determination such schedules existed and gave residents a feeling of being imprisoned as rules and schedules determined their daily life (Park et al. 2012).

> Although I don't want to wake up in the morning, I have to wake up and have breakfast, because it's one of the rules of communal life. (Chang 2013)

> They clean the table before the meal is finished…. [You need] a respectable time to eat your meals…. You feel like you are in school. (Timonen and O'Dwyer 2009)

In such a framework, care was reduced to the *repeated performance of tasks* (Bland 2007; Chuang and Abbey 2009; Wilson and Davies 2009; Fraher and Coffey 2011; Koskenniemi et al. 2015; Naess et al. 2016). The caregivers were mainly concerned with doing their job in a fast and effective way. As one of them told:

> Right after you begin to work, you just want to finish the assigned tasks as soon as possible. That's your job (Chuang and Abbey 2009)

Routine procedures offered a way to reduce the workload by diminishing the necessity to adapt to changing circumstances. At the same time, they should ensure that duties were carried out thoroughly. As one caregiver explained:

> Well if you didn't have a routine, you wouldn't get the jobs done, like getting them washed and dressed in the morning and getting them to breakfast for a certain time or making sure the pads are changed because if they get into that routine and if it is a certain time then you don't forget. (Wilson and Davies 2009)

The residents were, of course, aware of the time pressure under which care was provided and felt forced to adapt accordingly.

> The nurses are too quick for me, and I am not able for it. It's probably their age; they would be dressing me too quick. I suppose they have so much to do. (Fraher and Coffey 2011)

Under these circumstances, no consideration could be given to the special requests of particular residents. Care assistants, who had been sent to support them, provided *care as prescribed*, but nothing more:

> One day she come in, cleaned me and washed my clothes, everything. And I'd had to use a bedpan. So I said to her, 'Would she empty it?' 'I haven't come here to empty your pot, I've come here to get your tea,' she says. 'You want to ring the warden if you want her to empty it or ring the Careline'. (Wright et al. 2010)

This attitude was associated with a *lack of communication with the resident* which prevented them from establishing a closer relationship with their caregivers that allowed them expressing their wishes (Coughlan and Ward 2007; Westin and Danielson 2007; Bowers et al. 2009; Hwang et al. 2013; Taylor et al. 2014)

> They approach you in such a way that you feel you are actually being ignored – yes, you do not exist – you are just like a ghost, nothing else. (Westin and Danielson 2007)

In nursing homes, there was a tacit *dominance of medical care* underlying this task-oriented attitude. Some researchers (Wu and Barker 2008: Nakrem 2015) observed that the nursing staff focused on treating the medical diagnoses of the residents and that they defined the quality of care in terms of biomedical results. For example, during meals they were mainly busy administering medication and ensuring sufficient food intake, and at meetings they emphasized physical problems, such as pain, difficult breathing, defecation, problems in getting up from bed, the amount of food eaten, etc.

Task-oriented care was associated with *overprotection* (Koch-Straube 2003; Wilson and Davies 2009; Wright et al. 2010; Oakes and Sheehan 2012; Barnes et al. 2013; Naess et al. 2016). Caregivers, for example, restricted the mobility of residents in order to prevent accidents that would also cause more work for them.

> We have four staff on constantly watching the residents. You have to be thinking about it (safety) at all times. So if a resident gets up and you know they're prone to falls you'll sit them back down, that way there's less accidents. (Wilson and Davies 2009)

This attitude increased residents dependency as caregivers provided unnecessary support that on the short run saved some time:

> But there is the cost thing, about how much longer it takes to sort of encourage someone to walk down to the restaurant for lunch, rather than sticking them in a wheelchair and wheeling them down. (Wright et al. 2010)

On the long run, however, such unnecessary care increased their workload as residents unlearned their self-reliance. Overprotection was embedded in *safety regulations* that restricted the self-determination of residents (Hweidi 1999; Ball et al. 2004b; Al-Omari et al. 2005; Dobbs et al. 2008; Williams and Warren 2008; Eckert et al. 2009; Oakes and Sheehan 2012). Even in assisted living facilities, despite their agreed upon independence, residents had to accept supervision over their self-care activities and they were not allowed to consume alcohol or to smoke in their rooms—although these were considered their private homes.

> Do you know that [facility staff] saw me—I bought an extra thing of Tylenol at the grocery store— and she said, 'you have to put that in the nurse's office. (Dobbs et al. 2008)

To enforce compliance with rules and directives caregivers tried to *educate and control* the residents (Koch-Straube 2003; Dobbs 2004; Hellström and Sarvimäki 2007a, b; Williams and Warren 2008, 2009; Oakes and Sheehan 2012; Zimmerman et al. 2016). They told them when to get up (in one facility they even gave instructions via loudspeakers (Williams and Warren 2008)), prevented them from going to bed when time did not seem appropriate, reprimanded them for inappropriate behaviour in front of others, and threatened to transfer them to a nursing home. Education and control of residents was often associated with a *bossy and rude behaviour* (Jordan 2010; Oosterveld-Vlug et al. 2014; Roberts and Bowers 2015). One resident, for example, described a nurse in the following way:

> There's an older [nurse] and she comes at night and all I can think of is the description of her was an army nurse. (Roberts and Bowers 2015)

And another resident recalled an incident that occurred when he asked a nurse to get his medication earlier than scheduled:

> I had to catch an 8 o'clock bus, I knew that. So, I went to her and uh I told her, I says I have to catch an 8 o'clock bus, can I have my medication […] And, they usually give it to us about 8 o'clock so I wanted my medication early. Well, she didn't understand my feelings of it and she uh-she lost her cool. So, she did in a very, very loud voice, she did speak up really harshly to me. And, this didn't-this didn't just uh-didn't last for just a minute or so, this continued on and on and on for I don't know how-a definite time anyway. (Jordan 2010)

Some residents also complained about a *rough treatment* when they received care, and some even feared to be abused one day (Fiveash 1998; Tsai and Tsai 2008; Hwang et al. 2013; Gustavsson et al. 2015).

> Some are a bit rough, they don't always understand that you are 97 and fragile (Gustavsson et al. 2015)

Caregivers were not always rough in their treatment of the residents, more often they were only *inattentive* and did not realize that there were unspoken needs (Grau et al. 1995; Sidenvall 1999; Andersson et al. 2007; Coughlan and Ward 2007; Williams and Warren 2009; Jordan 2010; Chang 2013; James et al. 2014; Bollig et al. 2016; Cho et al. 2017). They overlooked the pain someone was suffering from, and they disregarded his emotional condition.

> They ain't no concern how you feel or nothing else. They don't know if you had a bad day or not. […] They ignore that in the conversation, it doesn't matter. (Jordan 2010)

Sometimes caregivers were distracted by other, apparently more attractive activities like watching TV while providing care. One resident complained:

> These are young girls who are not used to this … and if the television is on… they concentrate on the film and forget to feed me. (Bollig et al. 2016)

Others, however, were rather annoyed by having permanently to pay attention to the demands of the residents. Residents believed that they were *reluctant to provide help* and that they made them wait on purpose (Grau et al. 1995; Bowers et al. 2001; Coughlan and Ward 2007; Cooney et al. 2009; Timonen and O'Dwyer 2009; Falk et al. 2013; Taylor et al. 2014; Bollig et al. 2016)

> It's not that they're so busy…you know…sometimes they're just standing around…they want to make sure we know our place…[and] know who's in charge (Bowers et al. 2001)

> They do it on purpose, you know… [making us wait] gives them a feeling of power.(ibid.)

Caregivers sometimes justified the rejection of requests by arguing that these were not legitimate as residents were still capable of performing the required tasks (Oakes and Sheehan 2012). However, there were also situations when the behaviour of the residents caused the caregivers to *keep their distance*. Sometimes they felt the resistance of the residents which caused them to hold back (Ball et al. 2009). Female caregivers also had to take precautions not to give the perception of impropriety when caring for male residents (ibid.) since this could provoke sexual adavances that were shocking and embarassing for them (Nay 1992).

Besides a task-orientation, there was also person-centred care which had a positive effect on the social well-being of the residents. Some facilities managed to plan care together with residents so that they could express their own needs and expectations.

> They have a plan laid out. I would assume that applies to people who are sick differently one from another. And, I know in my case, at a meeting and I was there. And it was a matter of preparing for bed or getting up in the morning. And I said: 'Well, I', I explained the things I can't do and I would like covered. And they drew up a statement from the R.N. to the effect that when you get up in the morning you can wash your face and hands, and they would bring the water to you. (Grant et al. 1996)

In order to reach *agreements on care and safety rules*, assisted living facilities negotiated service contracts that described in detail the services to be provided and risk agreements in which residents who engaged in risky practices indicated their understanding of risks and agreed to take responsibility for negative outcomes (Carder 2002; Al-Omari et al. 2005).

Besides such formal agreements, there were also attempts to provide person-centred care in daily practice. Some facilities *offered small choices*, for example, by bringing a variety of desserts into the dining room on a trolley enabling residents to make their selection on the spot (Barnes et al. 2013). Some caregivers had flexible routines to *adapt to the wishes and needs* of the residents (Grant et al. 1996; Barnes et al. 2013; Hwang et al. 2013; Koskenniemi et al. 2015; Tuominen et al. 2016). They postponed, for example, meals or washing times if residents asked for it or they consulted them about the portion sizes when plating food.

> I can do my own things leisurely – I don't have to stop my tasks suddenly. They (nurses) come to me and tell that it's coffee time and you can come to the living room when you are ready. I don't have to go there immediately. (Koskenniemi et al. 2015)

Some facilities also showed *flexibility in the applications of rules* (Al-Omari et al. 2005: Palacios-Ceña et al. 2013). They allowed, for example, that residents changed assigned seats in the dining room or that they left without signing the sign-out book as it was required according to the regulations of the facility.

Flexibility allowed caregivers to *become familiar with the personal routines* of the residents and to adapt to them so that after some time residents no longer had to communicate their needs as the caregivers already knew them (Murphy et al. 2007; Ball et al. 2009; Wilson and Davies 2009; Jordan 2010) As one caregiver explained:

> Well everyone has a personal routine and you get to know when they like to get up or go to bed, or if they need a rest in the afternoon. Like now, it's getting near 10 so I know that James will need to go to the toilet, so I'll take him next. (Wilson and Davies 2009)

Prior to such tacit understanding, *attentiveness to the residents* was required (Al-Omari 2005; Jordan 2010; Oosterveld-Vlug et al. 2013b). This did not only mean to listen to their desires, it also implied to look after them in order to discover their unmet needs:

> Oh yeah, I had another one of the nurses last night. I didn't go to supper, she came walking right here. I didn't go to eat supper at all because I was still in bed. She comes in and asks Mr. XXX is something wrong. I said no. I said they ain't had anything I wanted to eat so I didn't go. She said will I didn't know, I thought you were sick. (Jordan 2010)

A further aspect of person-centredness was to provide *care in time* and helping residents as soon as they were in need (Tsai and Tsai 2008; Hwang et al. 2013; Tuominen et al. 2016). Not having to wait gave residents a feeling of being cared for while exerting some control at the same time. *Small favours* by the staff like bringing a little present also contributed to a feeling of being cared for (Al-Omari et al. 2005; Murphy et al. 2007; Wilson and Davies 2009; Schenk et al. 2013; Thomas et al. 2013). One resident recalled such an instant.

> There was the maintenance man who said one day, 'I have a comfortable chair you can have because you always sit here'. I thought he was joking… but then one day, it was there…it looked new….when I saw the man again I told him thank you. (Thomas et al. 2013)

Such favours were also useful to establish a closer relationship to the resident. Caregivers used a variety of strategies to achieve this aim. *Chat and small talk* promoted a positive social climate and indicated that caregivers were interested in the personality of the resident (Coughlan and Ward 2007; Murphy et al. 2007; Cooney et al. 2009; Hwang et al. 2013; Oosterveld-Vlug et al. 2013b; Nakrem 2015; Cho et al. 2017).

> I've visited nursing homes before we came in you know, visiting neighbours and there was all, there was nobody talking to anybody… It's different here, the nurses come up there, they just come up for a bit of slag… (Murphy et al. 2007)

Making jokes created a more open and relaxed atmosphere. Small talk while providing personal care also helped to mask feelings of shame. Such close contact entailed that several caregivers *reduced their distance* to the residents and became involved in a more private relationship (Murphy 2007; Hauge and Heggen 2008; Heliker 2009; Cooney 2011; Nakrem et al. 2011; Nakrem 2015). They called them by their first names, if the residents desired, took their lunch in the common room, and shared with them their private affairs. Some of them also visited the residents in their private room to spend time by talking (Naess et al. 2016) and one caregiver even brought her own children into the facility to join a celebration of Halloween (Murphy 2007). Such incidents gave residents the feeling that they had forged a special relationship with their caregivers and if one of them told about her personal troubles they were able to reciprocate and give some advice. Closeness could be reinforced when caregivers *showed their empathy* by approaching the resident with affection, speaking kind words, maintaining eye contact, and by establishing physical contacts through holding hands or giving a kiss or a hug, provided the resident accepted it (Grant et al. 1996; Bland 2007; Coughlan and Ward 2007; Murphy 2007;

Nakrem et al. 2011; Figueredo-Borda and Zabalegui-Yárnoz 2015; Koskenniemi et al. 2015; Nakrem 2015). In this way, caregivers *developed a relationship of trust* that also allowed residents to share their private affairs with them and to establish a family like relationship that satisfied their desire for closeness (Al-Omari et al. 2005; Coughlan and Ward 2007; Bradshaw et al. 2012; Oakes and Sheehan 2012; Behr et al. 2013; Hwang et al. 2013; Adra et al. 2015).

If caregivers succeeded in establishing a personal relationship with residents, they could influence them without exerting pressure and control. Mutual sympathy allowed them to *persuade the residents* to co-operate should they be unwilling to do so.

> Usually, we try to be more than just staff working here. We try to be their friends. We try to comfort them a lot. We try to sit one-on-one with them, you know, make eye contact, and let them know we care about them, and like, the way we care… So we hardly have days where people refuse. We always get them to do it…somehow. (Oakes and Sheehan 2012)

For the same reason, some caregivers *searched the dialogue* with the so-called difficult residents who tended to be non-compliant or demanding.

> Sometimes, just sometimes by talking to them, there are often some patients, sometimes they're difficult, they can be very difficult, but you usually find with difficult patients if you sit down and talk to them then they tend to become less sort of difficult and they start to trust you I suppose as well (Murphy 2007)

Caregivers also made efforts to *promote the self-reliance* of the residents by encouraging their self-care (Ball et al. 2004a; Murphy et al. 2007; Koskenniemi et al. 2015). At the same time, however, they had to pay attention to their needs so that they did not feel neglected:

> We will not do anything for them they can do on their own. If they need us we're there. If they need assistance with bathing, we'll assist, but I tell the staff if all they need is for you to run the water for them and you assist them in the tub, let them bathe themselves. Don't make them more dependent than they have to. (Ball et al. 2004b)

Procuring assistive devices like shower stools or special dishes supported these attempts. Caregivers also made efforts to *respect and protect the privacy* of the residents (Bauer et al. 2013; Oosterveld-Vlug et al. 2013a, b; Oosterveld-Vlug et al. 2014; Figueredo-Borda and Zabalegui-Yárnoz 2015). At least some of them got used to knock at their door before entering and to prevent others from watching how they provided personal care.

> I think you should do everything you can to safeguard privacy. So if you are busy washing someone, keep the door closed. And when you come in you cover them with a sheet. (Figueredo-Borda and Zabalegui-Yárnoz 2015)

In addition to establishing their own relationship with the residents, the caregivers also influenced the relationships that existed between the residents. This influence began at the admission. As already mentioned above, assisted living facilities made *attempts to* *select residents* who fitted well with the culture of the home in order to meet expectations of those who already stayed there (Kuhn 2008; Perkins et al. 2012). Selection criteria were the degree of functional limitations and social status. This produced a certain homogenization of the residents that facilitated relationships among them. However, since vacancies had to be avoided, older persons who were deemed less suitable also had to be accepted. Social harmony, of course, could be restored by the *discharge of residents* who were perceived as disturbing (Kemp et al. 2016).

After admission, it was necessary to *promote the integration of newcomers* (Al-Omari et al. 2005; Heliker and Scholler-Jaquish 2006; Kemp et al. 2012; Shaw et al. 2016). There was a variety of ways to achieve this. New residents were introduced and welcomed in meetings and—if existing—in the newsletter of the facility. In some facilities, they were also paired with "buddies" to make them familiar with new place, and caregivers interfered sometimes on their behalf if other residents were reluctant to accept them. To some extent, staff also *arranged contacts* among individual residents by encouraging interaction between those they considered to be like-minded (Cooney et al. 2009; Wilson and Davies 2009; Kemp et al. 2012; Sandhu et al. 2013). One caregiver, for example, told:

> I try to group them where they'll be with their own kind, a little group of people that they can have something in common together. (Kemp et al. 2012)

Caregivers also tried to *facilitate communication* in larger groups of residents, by gathering them in common areas and starting a conversation (Hauge and Heggen 2008; Cooney 2011; Kemp et al. 2012; Gustavsson et al. 2015; Zimmerman et al. 2016). However, such attempts could also fail, when the caregivers left them to themselves and the residents felt that they had nothing to talk about. Those who were still mobile then went back to their rooms, while those who suffered from impaired mobility had no choice but to stay and retreat into silence (Koch-Straube 2003; Hauge and Heggen 2008; Gustavsson et al. 2015; Christov 2016). In order to avoid such reactions, one nursing home tried to elicit social contacts by *simulating real life situations*. A rolling kiosk gave residents the opportunity to purchase candy and cookies that they could share with their roommates, which created a situation that prompted conversation (Naess et al. 2016).

However, the most important way to promote social contacts was to arrange social events. *Common meals* were an integral part of long-term care facilities and ensured that their residents met regularly (Sidenvall et al. 1994; Fiveash 1998; Al-Omari et al. 2005; Wright et al. 2010; Philpin et al. 2011; Andrews 2012; Kemp et al. 2012; Park et al. 2012; Perkins et al. 2013; Zimmerman et al. 2016). Eating together created social bonds between residents. The impact of common meals on social relationships depended, however, on the way how they were organized. In some facilities, participation was optional (Al-Omari et al. 2005). This gave residents a feeling of independence, but it could also reinforce social withdrawal that resulted in isolation. In most facilities, however, participation was rather compulsory. This could result in the establishment of relationships, but also force residents to make contacts they did not want.

Social contacts at mealtimes were stimulated by an appealing atmosphere. Philpin et al. (2011) described an arrangement they labelled as "family-style" where "residents ate at small, four-seater dining tables, pleasantly laid with linen cloths and napkins, pretty china and flowers" which was conducive to communication. *Family-style service* at mealtimes could also increase the sense of self-reliance and control by offering some choice. Barnes et al. (2013) observed two ways of such family-style service: Food was presented in serving dishes and placed on each table so residents could either help themselves, with staff supporting those who were not able to self-serve, or a chef was present in the dining room with the available choices on a hotplate and served food for each person individually as desired.

Contact opportunities at mealtimes depended furthermore on *seating arrangements* made by caregivers. In many facilities, residents were not allowed to choose their place. The personnel decided where and with whom each resident had to sit. Such arrangements should ensure social harmony. Quarrelsome residents were separated and calm residents were placed in tables where conflicts existed in order to reduce tensions (Palacios-Ceña et al. 2013; Naess et al. 2016). As one resident told:

> Since I am calm, they place me where there is trouble, to cool things down. (Palacios-Ceña et al. 2013)

In this way seating arrangements promoted positive relationships, but they also prevented residents from establishing contacts of their own choice. Another purpose of these arrangements was to separate self-reliant residents from those who were unable to observe table manners due to their impairments. The idea behind this separation was that it might be annoying for able-bodied residents if they had to witness the incompetence of others (Sidenvall et al. 1994; Kemp et al. 2016; Naess et al. 2016).

Besides the arrangement of common meals caregivers were also involved in the *organization of joint activities* (Ball et al. 2000; Koch-Straube 2003; Al-Omari et al. 2005; Kennedy et al. 2005; Murphy 2007; Williams and Warren 2008; Eckert et al. 2009; Svidén et al. 2009; Bradshaw et al. 2012; Kemp et al. 2012; Park et al. 2012; Hwang et al. 2013; Sandhu et al. 2013; Teka and Adamek 2014; Gustavsson et al. 2015; Naess et al. 2016). In order to ensure participation there were different ways of *inviting residents* like distribution of daily activity schedules at breakfast, daily postings on boards in the lobbies, phone calls to residents, hand-delivered invitations, and friendly reminders (Iwasiw et al. 2003; Al-Omari et al. 2005; Kemp et al. 2012; Gustavsson et al. 2015; Naess et al. 2016). One staff member described his way to get residents to the program:

> Knock on the doors, give them a warm smile and tell them 'come for a little while you might have fun'. (Al-Omari et al. 2005)

Some residents felt welcomed and respected if they were personally invited (Iwasiw et al. 2003). Others, however, felt that such well-meant *expectations to participate and socialize* compelled them to participate in activities they actually disliked (Hjaltadóttir and Gustafsdóttir 2007; Hauge and Heggen 2008; Warren and Williams 2008; Williams and Warren 2008; Jordan 2010). There were older persons in assisted living facilities who believed that joint activities were a means of assessing their functional capacities and as they feared to be transferred to a nursing home they complied with such expectations. In any case, participation meant that they had to observe a certain dress code and to adapt to a programme that suited the average resident but did not meet their individual needs.

> And also there is a lack of many or most of getting to know the individual person and they try to treat you as a group. Instead of treating you as individuals and that's something they have to be trained in and they have to learn. Everybody is different. […] You have to be able not to treat people as a group. (Jordan 2010)

One reason for the failure to meet individual needs was a limited knowledge about the residents and their preferences. Another reason was that activity staff included short-term volunteers or part-time staff with limited experience (Kemp et al. 2012).

In some facilities, contacts between residents seemed to be welcome only if staff was able to control them, and there were residents who complained about *restrictions on mutual visits*.

> I wish it was just open where we could walk in each other's room and talk. But it's not! Everyone has their room. And they [staff] don't want you— they tell us not to open 'em. Or knock on them. (Park et al. 2012)

Staff also had an influence on the social relationships between residents and their families and friends outside the facility. Some facilities *involved significant others* in the care of their residents (Grant et al. 1996; Holmgren et al. 2013; O'Shea et al. 2014; Koskenniemi et al. 2015). Significant others were able to provide information about the preferences and lifestyle of the older persons and to advocate for them. Interfering in the process of care allowed them to maintain a positive relationship with the residents and to take care of them. Such interference, however, was not always welcome. Some caregivers perceived it as an intrusion into their work and tried to reduce their influence:

> My God, they can be involved in what the residents should wear or what they should eat for dinner… but somehow the relatives forget that we are experts in caring and they are not. But then again, they think that they know their mom or dad for whom we are caring and I can understand that. But that was when they were healthy, not now… (Holmgren et al. 2013)

There were also facilities that *restricted visits from families and friends* (Bennett et al. 2015). If these were viewed as some sort of burden or as an impediment to medical or institutional routine, they became unwanted guests in the minds of the staff. Unspoken rules about guests and what they were permitted to do created an uncomfortable atmosphere and kept outsiders away. For example, visitors were expected to register and staff could disturb the privacy of their visit by observing it. Staff also *prevented intimate relationships*, even among married couples, by criticizing the behaviour of the residents or simply by forbidding it (Dobbs et al. 2008; Frankowski and Clark 2009; Bennett et al. 2015). Others facilities, however, tried to *provide a discreet environment for intimate relationships* so that residents remained undisturbed and did not offend others (Naess et al. 2016).

5.3.6 Behavioural and Attitudinal Reactions

If the residents were unable to satisfy a certain orientation of action, they tried to cope with this situation. This concerned, on the one hand, their relationship with the caregivers, on the other hand, their relationship with the roommates. Their relationship with the caregivers was mainly based on their care needs. Residents who lacked self-reliance *asked for help*. Underlying this care seeking behaviour was an increasing *acceptance of care dependency* which was an expression of a critical self-perception that we will take a closer look at when describing the identity-related orientations of action (Grau et al. 1995; Walker and Curry 2007; Fraher and Coffey 2011; Oosterveld-Vlug et al. 2013a; Taylor et al. 2014).

To receive the care and support they desired some residents made efforts to establish a close relationship to their caregivers. They engaged in *small talk* with them (Cooney 2011) and *expressed their appreciation* (Bland 2007; Jordan 2010; Roberts and Bowers 2015).

> I know I make it a point to know them al by their first names and I make efforts-some little thing, I may offer them a piece of candy or some little treat. I try to keep little treats in my room that I offer because I appreciate them so much. (Jordan 2010)

Sharing private matters with caregivers gave residents a sense of familiarity and satisfied their desire for closeness (Grau et al. 1995; Nakrem et al. 2011; Adra et al. 2015). For this purpose they liked to choose a confidant whom they saw as having their best interest at heart, and acting on their own initiative:

> I like all of the nurse aides and I have some favourites that I talk about everything with – out families, our friends, what we like to do… it's like getting to know family. (Grau et al. 1995)

Not all residents, however, were inclined to establish a positive relationship with staff. Some tried to satisfy their need to be cared for by exerting control. These residents were *demanding and complaining* (Dobbs 2004; Ball et al. 2009; Williams and Warren 2009; Speller and Tollee 2015). They viewed caregivers as incompetent and treated them like servants. Dobbs (2004), for example, observed residents in assisted living who claimed that the food was always horrible, and that the staff was always late with dinner; that caregivers did turn the thermostats too high or too low in rooms, and did just care about getting a pay check. In some cases white residents in assisted living facilities even showed open *racism* against their black caregivers (Ball et al. 2009; Williams and Warren 2009; Kemp et al. 2012; Park et al. 2013). Some refused to be bathed by them (Park et al. 2013), while others insulted them with racial expressions like "coloured girl" or the "nword" (Ball et al. 2009).

> This one … kept on telling me, 'What are you doing in this country? … you know you are abusing our money. We don't want you here. Go back to your country' (Williams and Warren 2009)

Such behaviour reflected also the gulf of social status between working, poor staff and upper middle to middle class older persons who could afford to pay for staying in a hotel-like facility where residents had to be treated as customers. It was mainly observed in assisted living which was made for residents who were less care dependent and had a higher socio-economic status that enabled them to dominate staff to some extent. As one caregiver explained:

> But [they were] still financially better than we were. And they think they pay a lot of money to live here, they have a right to treat you the way they want to. (Williams and Warren 2009)

In some cases, upper-class residents perceived care in nursing homes as inadequate and *hired additional staff* to meet their expectations:

> I have someone especially for me, I give her a salary and pay her extra, they [the management of the nursing home] gave me the permission that she stays with me. (Boggatz et al. 2009)

An agreement as in the above example from Egypt was based on the common practice in this country that care dependent person had to be cared for by relatives or privately paid caregivers as their substitutes when they were in a hospital—a practice that also could be applied to receiving care in nursing homes.

In contrast to these residents, there were also those who wanted to maintain their self-reliance and *rejected help* even if the staff was worried about them and willing to help (Ball et al. 2004b; Hillcoat-Nalletamby 2014). Out of a desire to remain in control other residents *rejected well-meant advices* for their well-being and health, ignored regulations of the facilities and did as they liked (Koch-Straube 2003; Oakes and Sheehan 2012; Martinsson et al. 2013; Palacios-Ceña et al. 2016a).

The attempt to exert control could result in a power struggle where caregivers in turn tried to impose care on the residents. In such situations, the residents tried to *resist against care* (Grau et al. 1995; Koch-Straube 2003; Al-Omari et al. 2005; Ball et al. 2009; Cooney 2011; Tuominen et al. 2016). Some reacted with open aggression which consisted of verbal abuse and sometimes also physical violence such as kicking or biting in order to defend themselves. Others resorted to passive resistance and refused to eat or talk.

> There are days I decide I'm not getting up. (Staff ask) me 'are you getting up today?' No. … I defy anyone to move me when I make up my mind. (Cooney 2011)

With diminishing strength, however, residents were doomed to lose this power struggle and as they saw no opportunity to change anything they finally *gave in.*

The ensuing experience of powerlessness made residents abandon their desire for control and resulted in *subordination* to their caregivers (Grau et al. 1995; Fiveash 1998; Sidenvall 1999; Iwasiw et al. 1996; Koch-Straube 2003; Hellström and Sarvimäki 2007a, b; Tucket 2007; Wu and Barker 2008; Chuang and Abbey 2009; Timonen and O'Dwyer 2009; Chang 2013; Falk et al. 2013; Hwang et al. 2013; Taylor et al. 2014; Bollig et al. 2016; Donnelly and MacEntee 2016; Tuominen et al. 2016). They adapted to imposed schedules and routines, showed no interest in having choices, and withheld complaints in case of substandard care—sometimes because they felt that complaints would be useless, and sometimes out of fear from negative consequences.

> I don't want to say anything to make trouble and make the relationships worse. If it is not gone too far and I still can tolerate it, I will make no complaint (Chuang and Abbey 2009)

> Just keep quiet and that's it … the fear of causing trouble … that is what it is, isn't it. Fear of causing trouble and there is a backlash on you. (Timonen and O'Dwyer 2009)

One resident was even worried that complaints might prompt the owners to close the facility "and sell us all to somebody else" because they might feel that "it is not worth it for the bits and pieces that they get out of it" (Donnelly and MacEntee 2016).

Some nursing home residents believed that the only way to get caregivers to comply with some of their wishes was to be humble and polite or obedient (Iwasiw et al. 1996; Tuominen et al. 2016). Their subordination also became apparent when they expressed their gratitude for a care they actually found unsatisfactory (Nakrem et al. 2013; Bollig et al. 2016). Knowing to be dependent on their help made them avoid criticism of caregivers and respond in a socially desirable way during interviews (Christov 2016). The same tendency was observed in assisted living facilities where fear to be moved into a nursing home made residents comply with imposed care (Warren and Williams 2008). For this reason some authors warn against interpreting residents' statements of gratefulness as a satisfaction of their desire to be cared for (Sidenvall 1999). Other authors, however, interpret the *avoidance of complaints* as a way to pay attention to the needs of caregivers who were under time pressure and suffered from high workload (Hellström and Sarvimäki 2007a; Speller and Tollee 2015). In this sense, compliance was a strategy to build a positive relationship with caregivers in the hope that this would be reciprocated.

The relationship between residents and roommates was mainly based on the desire for closeness and distance. To establish relationships, the residents *engaged in conversation* with each other (Hweidi 1999; Hubbard et al. 2003; Heliker and Scholler-Jaquish 2006; Hauge and Heggen 2008; Curle and Keller 2010; Kemp et al. 2012; Roberts and Bowers 2015). Topics were often superficial including the weather or how one was doing. They also spoke about other people, including their families, other residents, and staff, or they discussed about the past, television, sports, religion, and politics. At mealtimes food was a common topic. Joking, flirting, and teasing were often part of such conversations. Koch-Straube (2003) observed conversations that seemed to be trivial but had a hidden meaning. For example, a dialogue between a male and a female resident about who might be the owner of some glasses lying on a table nearby was also an attempt by the male resident to make closer contact which was rejected by the female resident by claiming that these glasses originally belonged to her late husband.

To gain the sympathy of their roommates, they passed compliments and *showed their affection* by smiling, giving thanks, or shaking hands (Hubbard et al. 2003; Curle and Keller 2010). To some extent residents also gave each other *assistance and emotional support* (Iwasiw et al. 1996; Williams and Warren 2009; Curle and Keller 2010; Philpin et al. 2011; Kemp et al. 2012; Park et al. 2013; Thomas et al. 2013; Behr et al. 2014). They helped others to sit down or stand up, moved obstacles like walkers out of their way, passed items out of reach, or encouraged others to finish their meal. Some made efforts to involve roommates who suffered from impaired hearing or from dementia into a conversation. They also encouraged others and comforted those who experienced losses and were grieving.

However, the residents did not show the same affinity to each of their roommates. They rather tended to *form groups* whose members felt connected while at the same time excluding others from their circle (Hubbard et al. 2003; Nakrem et al. 2011; Philpin et al. 2011; Kemp et al. 2012; Park et al. 2012; Perkins et al. 2012; Palacios-Ceña et al. 2013; Sandhu et al. 2013; Thomas et al. 2013; Zimmerman et al. 2016). In this way, their closeness to some residents created at the same time a distance to others. Therefore there was also communicative behaviour by which they tried to exclude and control others. *Gossip* was a way to subject others to a critical evaluation (Perkins et al. 2012). It forged closer ties among those engaged in it and made them feel superior to those who were exposed to it who in turn felt excluded. When the residents felt disturbed by others, they either *reprimanded* them directly or they expressed their annoyance non-verbally to enforce their adjustment to social norms (Dobbs 2004; Christov 2016). Some demanded that disturbing residents should be separated from "normal people" and transferred to a higher level of care. In any case, most residents *shunned persons with dementia or other impairments* (Hweidi 1999; Hauge and Heggen 2008; Kemp et al. 2012; Perkins et al. 2012). Sometimes, residents felt annoyed by others and began to *quarrel* (Kemp et al. 2012; Perkins et al. 2013; Sandhu et al. 2013). Kemp et al. (2012), for example, observed the following situation that occurred at a joint activity: "Irving said something to Hillary and she told him, 'Get away you slob!' A staff person [told him] to go on the other side of the room … Irving started aggravating Hillary from across the room. He yelled out to Hillary, 'Hey Chubby.'" Some conflicts were rooted in interethnic tensions as they were observed in American facilities with a mixture of ethnic groups (Park et al. 2013). As mentioned above, conflicts sometimes involved physical violence by residents against each other (Boggatz et al. 2009).

Due to such conflicts and dislikes, it was not surprising that there were residents who *avoided contact with all their roommates*, with whom they had to live together without wanting it. In some facilities, these residents were rather outsiders, as the majority was inclined to socialize. In other facilities this behaviour was so pervasive that the main feature of communal life was silence (Koch-Straube 2003; Christov 2016). In some cases, this avoidance was not due to dislike but due to feelings of shame because the resident suffered from incontinence or diarrhoea and felt unable to adjust to standards of acceptable behaviour (Jordan 2010). Some of these residents tried at least to uphold social manners and their behaviour was characterized by *formal politeness*.

> Right now I really have no relationships other than greeting them. (Kemp et al. 2012)

Those who were still mobile *left sometimes the facility* (Park et al. 2009; Svidén et al. 2009; Shaw et al. 2016). This allowed them maintaining contacts to persons outside and—if they felt uncomfortable in their social environment—escaping for a short time from a place they disliked.

5.4 Long-Term Care Facilities and Identity-Related Orientations of Action

Long-term care facilities frame the entire life of their residents. They influence not only the satisfaction of body-related and social needs but also the way in which residents can unfold their identity. They may or may not offer opportunities for work or relaxation, diversion or reflection, self-centredness or concern for others, self-presentation or self-concealment, and for a positive or a critical self-perception. Table 5.5 provides an overview over these identity-related orientations of action, their satisfaction, their influencing factors, and the behavioural and attitudinal reactions of the residents.

5.4.1 Work Versus Relaxation

5.4.1.1 Work

Living in their own home necessitated older persons to perform a variety of activities. They had to care for themselves and their household. Although they were retired, they still had to work. This could be strenuous, but it also gave them something to do and filled their time. These tasks, however, were lost by moving to a long-term care facility. As residents they nevertheless had a *desire to be busy* and active (Bland 2007; Stathi and Simey 2007; Chin and Quine 2012; Adra et al. 2015; Slettebo et al. 2016). Some residents remained unspecific about the kind of activity they wanted to perform, others showed a clear *desire to work* and to be productive—even if this just meant that they contributed somehow to the work that had to be done in the facility (Ball et al. 2004b; Hutchinson et al. 2011; Chang 2013, Falk et al. 2013; Palacios-Ceña et al. 2016a).

> I asked them to give me some work for the home, to fix things. (Palacios-Ceña et al. 2016a)

> I would like to find something that I can do. Why can't I bring a pot and boil soybeans this fall? I wish I could make soybean paste and red pepper paste… I think there must be skilful people here. (Chang 2013)

Another resident gave a rationale for this desire:

> I have worked all my life. I have always had responsibilities, and suddenly I find myself here, with my wife, I feel useless, I need to do something. (ibid.)

If these residents had no chance to do something in the facility, they engaged in domestic chores within their private sphere, such as dusting bookshelves, polishing old photographs or silverware, and doing some light housework—provided they had a room they could furnish themselves. Beside this desire for practical work, there was also a *desire for productive leisure activities* that facilitated self-expression through mental and physical engagement (Harmer and Orrell 2008; Hutchinson

Table 5.5 Identity-related orientations of action, influencing factors, behavioural and attitudinal reactions

Orientations of action and their satisfaction	
Work	Desire to be busy
	Interest to work
	Desire for productive leisure activity
	Desire for mental challenge
	Easy activities that match abilities
Satisfaction of work	Enjoying being active
	Having nothing to do
	Having achieved nothing
Mental relaxation	Desire for idleness
	Calming down the mind
Satisfaction of mental relaxation	Rest and relaxation
	Enjoyment of nature
	Feeling overburdened
	Unable to relax because of rumination
Diversion	Desire for collective amusement
	Desire for an increased stimulation
	Desire for individual entertainment
Satisfaction of diversion	Pleasure in social activities
	Joy through music
	Entertainment through excursions
	Lack of stimulation
Reflection	Inclined to reflection
Satisfaction of reflection	Intellectual satisfaction
	Displeased with superficial conversations
	Entertainment is trivial
Concern for others	Desire to care for the family
	Showing hospitality
	Desire to help others
	Desire to reciprocate
	Contributing to the common good
Satisfaction of concern for others	Feeling of being needed
	Serving a higher purpose
	Feeling of being useless
	Feeling unable to reciprocate
Self-centredness	Rejecting social commitments
	Putting oneself and one’s needs first
	Struggle between duty and self-concern
	Reduced selfishness
Satisfaction of self-centredness	Satisfying self-interest
	Self-neglect

(continued)

Table 5.5 (continued)

Self-presentation	Creating a positive impression by dressing and grooming
	Leaving a positive impression on staff
	To be in the focus of attention
	Desire to be respected
Satisfaction of self-presentation	Feeling comfortable with attractive appearance
	Being appreciated by others
	Being respected as a person
	Afraid of co-stigmatization
	Not being respected as a person
	Being completely ignored as a person
Self-concealment	Protection of the intimate sphere
	Desire to remain unnoticed
Satisfaction of self-concealment	Content to remain unnoticed
	Being exposed to the criticism from others
	Being exposed to the gossip of others
	Feeling permanently exposed to public
Positive self-perception	Focussing on the past
	Looking at present achievements
	Downward comparisons
	Trying to feel superior to others
	Forgetting the unpleasant self
Satisfaction of positive self-perception	Positive memories
	Recognizing remaining strength
	Negative image of present self
	Plagued by negative memories
Critical self-perception	Making efforts
	Lowering expectations
Satisfaction of critical self-perception	Acceptance of ageing
	Loss of self-recognition
Influencing factors	
Physical condition	*Same as in Table 5.4*
Circumstances of life	*Same as in Table 5.4*
Environmental factors	Access to nature
	Gift shop
	Shared TV
	Female dominance

Table 5.5 (continued)

Identity-related care	Getting acquainted with residents
	Showing empathy and respect
	Active listening
	Stimulating memories
	Dignity therapy
	Strength spotting
	Story sharing
	Assistance in self-presentation
	Tactful dealing with mishaps
	Creating a protective environment
	Allocation of tasks
	Encouraging residents to continue preferred activities
	Simulating real life situations
	Organizing joint activities Gender specific activities
	No concrete idea about likes and dislikes
	Sessions detached from the lifeworld
	Preventing residents from helping
	Lack of respectful treatment
	Discrimination
	Privileged treatment of higher status residents
Behavioural and attitudinal reactions	Individual activities
	Participation in joint activities
	Social engagement
	Cultivating memories

et al. 2011; Chuang et al. 2015; Shaw et al. 2016; Slettebo et al. 2016). Depending on their interests and abilities, as well as the opportunities of the facility, residents tried to keep themselves busy by drawing, writing, doing woodwork, gardening, solving crosswords or puzzles. Some of these activities were solitary and residents performed them according to their own abilities. Group activities, however, were tailored to the average level of interests and abilities and residents had to adapt to this level. Some residents had a *desire for mental challenge*, and they felt bored if tasks were not demanding (Thomas et al. 2013; Minney and Ranzijn 2016). For example, they lost interest in preparing a certain food if they were only allowed to help with part of the process like mixing or adding ingredients. Others, however, disliked too much challenge and preferred to participate in rather *easy activities that matched their abilities* (Murphy et al. 2007; Cooney et al. 2009).

5.4.1.2 Satisfaction of Work

Residents, who were allowed to assume tasks in the facility or found opportunities for productive leisure activities, *enjoyed being active* (Ball et al. 2004b, Cooney et al. 2009; Cooney 2011; Chuang et al. 2015). Older persons who stayed in assisted living facilities described their satisfaction:

> Every morning I clean the bathroom; I pick up any towels; I pour Lysol in the tank, in the tub. (Ball et al. 2004b)

> I may chop things, like celery, onions, whatever she [the owner] wants me to do. I like to be busy. I don't like to just sit and watch TV. (ibid.)

Others, however, were prevented from performing such activities, because staff said that such tasks were only for workers. As a consequence, they *had nothing to do* and to fill their time (Fiveash 1998; Ball et al. 2000, 2004b; Andersson et al. 2007; Coughlan and Ward 2007; Murphy et al. 2007; Stathi and Simey 2007; Tsai and Tsai 2008; Chuang and Abbey 2009; Timonen and O'Dwyer 2009; Cooney 2011; Chang 2013; Martinsson et al. 2013; Nakrem et al. 2013; Hillcoat-Nalletamby 2014; Gustavsson et al. 2015; Bollig et al. 2016; Palacios-Ceña et al. 2016a; Slettebo et al. 2016; Mohammadinia et al. 2017; Koppitz et al. 2017). Being condemned to inactivity, they could not use and exhaust their mental energy. All they could do was take care of themselves or do nothing.

> I get so tired of not doing anything […] four hours just trying to get myself clean and cutting my fingernails and rolling my hair and just things like that. (Ball et al. 2004b)

> When I was in my home and busy 24 h, I didn't have time for anything, and now. I don't know what to do, time eats me (Palacios-Ceña et al. 2016a)

The same occurred if facilities provided no opportunities for productive leisure activities. One resident, for example, complained that a sewing room had been closed.

> This offer does not exist anymore. They cannot afford it anymore. It has been removed from all nursing homes: there is nothing. We just sit in the chair … that is what we do. (Bollig et al. 2016)

If residents had no opportunity to be productive in one way or another they felt that they *had achieved nothing.*

> One does not have the feeling of having accomplished work and deserving sleep. (Herrmann and Flick 2011)

5.4.1.3 Relaxation

Not everybody, however, complained about inactivity. To some extent, residents also had a *desire for idleness* (Andersson et al. 2007; Williams and Warren 2008;

Raske 2010; Schenk et al. 2013; Behr et al. 2014; Slettebo et al. 2016). Being released from the duties of independent life, they wanted to relax, to “take it easy” at times, and not always having to be “doing something” (Schenk et al. 2013). As a consequence they could reject the participation in joint activities that were meant to keep them busy. Some even said that they had become phlegmatic (Behr et al. 2014). Such disinterest in activity may, of course, result in boredom and lack of stimulation. To some extent, however, *calming down the mind* was a counterbalance for mental engagement and residents considered it to be a useful way of reducing inner stress and promoting sleep and recovery. Some residents even used purposeful strategies to achieve this goal.

> One can calm down by reading or a conversation in the evening. One should try to have nothing exciting. […] You know what I mean. Exciting or appealing books or reading material of this type or that type. One should instead take something calm or gentle. (Herrmann and Flick 2011)

5.4.1.4 Satisfaction of Relaxation

By sitting there and doing nothing, the residents found *rest and relaxation* (Raske 2010; Herrmann and Flick 2011; Schenk et al. 2013; Behr et al. 2014; Slettebo et al. 2016).

> During the weekdays, nothing happens. I only sit here looking out the windows. But I like to do this. (Slettebo et al. 2016)

According to them, a well dosed phlegmatism showed a positive effect on the mind

> Well, that I can relax. You know? That nothing bothers me, that nothing is on my mind. You know? (Herrmann and Flick 2011)

This recreational effect could be increased by a quiet, natural environment. It was promoted by easy access to outdoor areas with fresh air and sun, and residents told about their *enjoyment of nature*—especially when the facility had a garden (Tsai and Tsai 2008; Raske 2010; Nakrem et al. 2013; James et al. 2014).

> To me, the most luxurious thing that I can do is to be wheeled into the sunshine outside. (Tsai and Tsai 2008)

Sometimes, however, residents could not fulfil their desire for mental relaxation because joint activities were too strenuous in relation to their abilities or because they had too many of them. As a consequence, they *felt overburdened* (Koch-Straube 2003; Williams and Warren 2008; Thomas et al. 2013; James et al. 2014; Minney and Ranzijn 2016). Some residents also said that their minds were so busy that they were *unable to relax because of their rumination.*

> And I don’t fall asleep. That is the problem. Then it’s that one thinks about some things and ruminates about some things. However, I guess there is nothing to do about it. (Herrmann and Flick 2011)

5.4.2 Diversion Versus Reflection

5.4.2.1 Diversion

Work and productive leisure activities kept residents busy and relaxation allowed them to recover. Both, however, could also become monotonous and had to be supplemented by some kind of diversion that stimulated the mind of the residents. Until retirement, the desire for productive work and the desire for diversion were met separately in either work or leisure time. After retirement older persons maintained this distinction because they perceived some activities as duties and others as pleasure. Furthermore, the absence of labour constraints enabled them to realize their desire for productive work more freely and independently. As residents in long-term care facilities, however, they were often deprived of the opportunity to work—either due to lack of physical abilities or due to institutional regulations. Hence, participation in activities that were rather meant for their diversion became a substitute for activities they had performed to satisfy their desire for productive labour. As a consequence, the difference between diversion and work became blurred. Some joint activities like handicrafts were meant to meet both needs simultaneously, whereas others like parlour games were mainly of an entertaining character, and since they kept the residents busy, they became a substitute for work.

Under these conditions, many residents expressed a *desire for collective amusement* (Josat 2005; Bergland and Kirkevold 2006; Murphy et al. 2007; Hjaltadóttir and Gustafsdóttir 2007; Harmer and Orrell 2008; Bowers et al. 2009; Cooney et al. 2009; Hutchinson et al. 2011; Falk et al. 2013; Schenk et al. 2013; James et al. 2014; Slettebo et al. 2016). They wanted to be entertained by activities according to their taste.

> My best hobby of all is playing cards, I play four times a week with four other ladies. (Cooney et al. 2009)

Parlour games like playing cards or bingo were a welcome means to find entertainment. Excursions were another source of diversion, but also simple get-togethers and drinking coffee. Some residents, in fact, did not want anything else but to have a conversation in order to meet their need for diversion (Andersson et al. 2007; Nakrem et al. 2013). Others had a *desire for an increased stimulation* (Bergland and Kirkevold 2006; Harmer and Orrell 2008). They preferred events with dance or singing.

> Singing, for example that's important, that's, yes, and what else is it they do, oh we do gymnastics and, goodness, all sorts and memory training that's really important too… And above all for the folks who can't walk anymore, so that they're looked after too and that they get out and aren't just sitting in their rooms all the time. (Schenk et al. 2013)

There were also those who mentioned a *desire for individual entertainment* that they satisfied by listening to the radio or watching TV (Hutchinson et al. 2011; Hwang et al. 2013; Nakrem et al. 2013; Slettebo et al. 2016).

5.4.2.2 Satisfaction of Diversion

The desire for diversion was met when residents found *pleasure in social activities*. Mealtimes provided entertainment through conversation with tablemates (Grau et al. 1995; Wu and Barker 2008; Chuang and Abbey 2009; Curle and Keller 2010; Philpin et al. 2011; Chuang et al. 2015; Bollig et al. 2016). They were the social event of the day, and residents perceived it to be its highlight—in part due to a lack of other distractions. Joint activities organized by staff provided additional pleasure. Especially bingo and other parlour games were a source of delight (Cooney et al. 2009; Slettebo et al. 2016). Occasionally, residents even made jokes and were hilarious (Koch-Straube 2003). A café inside the facility was another source of distraction (Andrew and Wilson 2014). Some residents told how they experienced *joy through music* (Harmer and Orrell 2008; Nakrem et al. 2013; Adra et al. 2015; Slettebo et al. 2016). Singing together could even show an effect on their physical well-being:

> All the music's going through your head with it and it makes you more appetizing. (Harmer and Orrell 2008)

Some residents were also fond of dancing. They were, however, not able to share their pleasure with their roommates as it required physical abilities. So they had to attend events outside the facility and needed transportation for this purpose (Slettebo et al. 2016). One way of making this pleasure available to residents with physical disabilities was to offer sit dance (Nakrem et al. 2013). Since residents spent most of their time indoors and always saw the same environment they also enjoyed an *entertainment through excursions* (Hjaltadóttir and Gustafsdóttir 2007; Park et al. 2009; Falk et al. 2013; Thomas et al. 2013; Minney and Ranzijn 2016).

> Oh, I just love when they (nursing staff) wake me up in the morning and I know that today is the day we're going for a trip to Denmark, or have a day in the country. (Falk et al. 2013)

If no excursion was possible, they wanted to spend at least some time outside the facility to get distracted (Hwang et al. 2013). Quite often, however, their desire for diversion remained unsatisfied and the residents complained about a *lack of stimulation* (Fiveash 1998; Hweidi 1999; Hjaltadóttir and Gustafsdóttir 2007; Murphy et al. 2007; Chuang and Abbey 2009; Cooney et al. 2009; Timonen and O'Dwyer 2009; Cooney 2011; Park et al. 2012; Chang 2013; Thomas et al. 2013; James et al. 2014; Nakrem 2015; Mohammadinia et al. 2017). The daily routine was monotonous and repetitive and the institution-like atmosphere at the nursing home was depressing and stifling.

> …just the same thing, the same day in and day out…it's boring. (Cooney et al. 2009)

On the long run, even means of entertainment turned out to be insufficient.

> We're sitting down all day doing nothing in the unit. Sitting on the bed, looking at television. I'd like something else. It drives me nuts at times. (Timonen and O'Dwyer 2009)

> Although the place has a green and pretty courtyard, our days are so repetitive and monotonous and this green space is of no avail to us. Even some days I do not like to come here and see the yard. (Mohammadinia et al. 2017)

5.4.2.3 Reflection

To some extent, diversion needed to be counterbalanced by reflection, so that residents did not get tired of it. There were also those who were generally more *inclined to reflection* and disliked the entertainment through joint activities.

> I feel better walking and reflecting than dancing or singing. Nothing is wrong with me, but they don't stop telling me that I must socialize in order to improve my quality of life. (Palacios-Ceña et al. 2016a)

These residents often preferred solitary activities like thinking or reading.

> I am very fond of reading. I have always read a lot. So it is actually reading that keeps me going. I have a lot of books myself. (Slettebo et al. 2016)

Some of them, however, also liked to join together and tried to form a study circle where they could discuss their reading (Hutchinson et al. 2011; James et al. 2014).

5.4.2.4 Satisfaction of Reflection

Those who were able to read and discuss derived *intellectual satisfaction* from these activities (Shaw et al. 2016; Slettebo et al. 2016).

> All of my books that I'd never read. When I moved here, I read all of them. (Shaw et al. 2016)

The topics for intellectual engagement did not have to be complicated. It was enough to gain new insights. One resident, for example, described how he experienced the talks that a staff member gave in the afternoon.

> … these talks in the afternoons, which I've found very informative […] the talks are aimed at us 80 years plus, puts me in context, gives me an understanding of what other people are talking about. I want a better understanding of what goes on […] It was fascinating really. […] Knowledge is what makes you more comfortable, knowing what the hell is going on (Shaw et al. 2016)

Quite often, however, social events were less satisfying for residents with an intellectual inclination. They were *displeased with the superficial conversations* of their roommates (Koch-Straube 2003; Roberts and Bowers 2015):

> They […] have the same things in mind. Flowers and grass and … And I don't like that […] I never did. I never went to uh, the neighbours with coffee klatches. (Roberts and Bowers 2015)

They were also tired of joint activities as they perceived this kind of *entertainment to be trivial* or "babyish" (Ball et al. 2000; Tucket 2007; Dobbs et al. 2008; Chang 2013; Sandhu et al. 2013; Stevens et al. 2015; Christov 2016; Palacios-Ceña et al. 2016a; Koppitz et al. 2017)

> Every program consists of sitting around and talking about the old days, not discussion. Sometimes it really gets on my nerves, yes… Is it interesting for the elderly? They are ridiculous… (Chang 2013)

> Most of the activities are very childish, like those nursery rhymes. (Sandhu et al. 2013)

> …I don't like it — they have musical thing… Like sing old songs and they make you miserable… But I think they are trained to do it… It's a 'Long Way to Tipperary' — if I hear that again I'll *scream* ….Yes. I tell them that (these songs upset me) and *they* laugh. They say others love them. (Tucket 2007)

5.4.3 Concern for Others Versus Self-Centredness

Although residents in long-term care facilities had limited abilities and facility staff took care of them, they were not only driven by self-interest. They still had a concern for others. This concern was not motivated by an adjustment to social standards. It was rather a spontaneous feeling regarding other persons to whom they felt attached.

5.4.3.1 Concern for Others

Although they lived away from their children, residents in long-term care facilities still had a *desire to care for their family*. As parents they were concerned about the well-being of their offspring:

> My Irene's a good daughter and she's got a good husband so I feel content. When they're happy, I'm happy. (Minney and Ranzijn 2016)

As grandparents they wanted to give presents to their grandchildren or—if they were able to do so—to produce something for them. One female resident, for example, was busy with knitting socks for them (Nakrem et al. 2013). If they had assets, they liked to distribute their money and possessions to their offspring (Melin-Johansson et al. 2014). The minimum they wanted to do for their visiting friends and relatives was to *show them hospitality*—for example, by inviting them to cake and coffee (Andrew and Wilson 2014).

The residents also had a *desire to help others* (Bowers et al. 2001; Iwasiw et al. 2003; Ball et al. 2004b; Kennedy et al. 2005; Robichaud et al. 2006; Harmer and Orrell 2008; Williams and Warren 2009; Kemp et al. 2012; Park et al. 2012; Sandhu et al. 2013; Schenk et al. 2013; Hillcoat-Nalletamby 2014; Adra et al. 2015; Minney and Ranzijn 2016), for example, by caring about newcomers (Robichaud et al. 2006; Iwasiw et al. 2003) or by supporting roommates with dementia in meeting their individual needs (Minney and Ranzijn 2016).

> In my eyes, quality of life is when you do something, something meaningful, especially when you can make others happy, that's, that's the meaning of life after all, when you do some- especially do something that makes you happy and that can also make others happy. (Schenk et al. 2013).

> I worry about [my neighbour] and I'll mention something to [the staff] if I think it needs [their] attention. I have nothing in common with her other than I worry about her. (Kemp et al. 2012)

Contributing to the social life in the facility according to their individual abilities, for example, by playing music, was another way to show concern for the community.

> I play the piano because nobody else seems ready to play round here. I'm not wonderful at it but I play and enjoy it. And some of the older folk ask for certain songs … and I know that, so it gives me pleasure to think I'm helping them. (Hillcoat-Nalletamby 2014)

Others wanted to perform housekeeping roles knowing that their work was for the benefit of their roommates (Ball et al. 2004b). Concern for others was important to the residents, because they did not want to be selfish and to receive only favours from them. They had instead a *desire to reciprocate* (Bowers et al. 2001; Ball et al. 2004b; Robichaud et al. 2006; Wu and Barker 2008; Heliker 2009; Jordan 2010; Chang 2013; Oosterveld-Vlug et al. 2014; Lung and Liu 2016). This concerned mainly their caregivers who provided the support they needed. Residents tried to reciprocate by giving them small presents, by comforting them when they were in sorrow, and by helping them in order to reduce their workload.

> Sometimes my friends come and visit me with fruit or biscuits, etc., and I would give the nursing assistants some. (Lung and Liu 2016)

> A nursing assistant didn't feel well, I attempted to comfort her… and I would also ask her if she was feeling better the next day.… We know, you care about me, and so do I (ibid.)

> They do so much and work so hard. I try to find little ways to take some of the burden off. (Bowers et al. 2001)

Residents in a facility for the poor in Ethiopia who could hardly provide for themselves wanted at least to *contribute to the common good*—even if this contribution consisted only of praying.

> Our aim is to serve the Ethiopian people and our country through praying and to be blessed. (Teka and Adamek 2014)

5.4.3.2 Satisfaction of Concern for Others

Satisfying their desire to show concern for others gave the residents a *feeling of being needed*. Helping others by encouraging or providing practical support gave them a sense of purpose in life (Dobbs et al. 2008; Timonen and O'Dwyer 2009; Kemp et al. 2012; Park et al. 2012; Perkins et al. 2012; Park et al. 2013; Behr et al. 2014; Hillcoat-Nalletamby 2014; Slettebo et al. 2016).

> My activities are very limited. Now I will try to—the best I can—assist other people here. […] You know, it makes me feel useful! It gives me a sense of well-being, that I'm helping my neighbour. (Park et al. 2012)

> If I can help somebody as I pass along, if I can cheer somebody with a word or song, if I show somebody he is shrouded in wrong, then my living shall not be in vain. (Park et al. 2013)

Helping in the facility by contributing to the work that had to be done had the same effect. (Ball et al. 2000, 2004b; Williams and Warren 2008; Cooney et al. 2009; Perkins et al. 2012; Minney and Ranzijn 2016)

> Yesterday we were short of staff and I was in the kitchen and I was a carer, you know, I did everything. They all said, 'oh, you did work so hard!' I felt needed, do you know what I mean? It felt like the old times and that was really good (Minney and Ranzijn 2016)

The above-mentioned residents in Ethiopia felt that by praying for the welfare of their country they *served a higher purpose* they had been chosen for.

> Our purpose is not enjoyment. To pray and to live in the will of God is our main leisure activity that makes us happy. (Teka and Adamek 2014)

> Most of us were wounded with our past life. I think when God has chosen you for a special purpose he did everything you do not like it. Finally I am here to pray and to be happy. God will not leave you idle. (ibid.)

Other residents, however, did not find that they could contribute to the lives of others and expressed their *feeling of being useless*. Some of them had this feeling due to the way they were treated by the society:

> You notice that when you get old, people stop taking you seriously: 'That person's so old, we'll just park him in a corner then he won't bother us any more'. That's often what happens…. Yes, you no longer count, you know. (Oosterveld-Vlug et al. 2014)

Others felt that their frailty prevented them from contributing to the society as they desired (Shin 2008; Heliker 2009; James et al. 2014). Their existence was reduced to a satisfaction of their own needs and this forced self-centredness gave them the feeling of having no purpose in life. If they were only able to receive care from others they *felt unable to reciprocate*. They could do them no favours in return. Koch-Straube (2003) notes that it was common in German nursing homes for residents not to have their own money and therefore not to receive bills. Being unable to pay for the services they received they had no visual proof that they gave something in return.

5.4.3.3 Self-Centredness

To some extent, residents also told about their self-centredness which was a necessary counterbalance to their concern for others. Most of them, however, did not go into detail because self-concern is a natural part of life and inherent in most activities without people thinking about it. Furthermore, self-interest is often at the expense of others and is therefore not socially desirable. Residents with such an exaggerated self-interest were not likely to talk about it in interviews, but their self-centredness became apparent in their behaviour as it was experienced by their caregivers and as it could be observed by researchers in observational studies. For example, the expectation to be in command and to control care, which was for some residents a central motive of their social orientations of action, was also a clear sign of self-centredness. It was motivated by the desire to satisfy their own needs at will—at the expense of their caregivers, whom they expected to comply with their wishes, and at the expense of their roommates, who were expected to wait for these caregivers until their own needs had been satisfied.

In some interviews, selfishness became apparent when the residents *rejected social commitments*. One older woman told, for example, why she gave up caring for others:

> When I think about what I would never do again - this is - to work for the Red Cross again - I saw too much blood over there - now I just think about myself. (Whispering) You can kiss my ass. (Christov 2016)

Others admitted that they were still self-centred and *put themselves and their needs first* (Melin-Johansson et al. 2014). As they told, their focus had always been on the well-being of their family. They had had no time to think about themselves, because there was always someone else who needed their attention and took priority. Being released from their duties they now wanted to get some compensation. Others still had a care dependent spouse, and moving into a long-term care facility offered them the chance to take care about their own needs because professional support relieved them from parts of their duties. At the same time, however, they still felt indebted to the marital obligation and experienced a *struggle between their duty and their self-concern* (Shaw et al. 2016). Whereas these older persons learned to increase their self-interest, others were on the way to unlearn it and they told about their *reduced selfishness*. As they said, they became less interested in material possessions and it was easy for them to give away their assets for the benefit of others.

> I'm not that interested in money, but I think it is nice to give it away to my grandchildren and children. (Melin-Johansson et al. 2014)

5.4.3.4 Satisfaction of Self-Centredness

To some extent, residents were able to *satisfy their self-interests*. This was the case when caregivers obeyed and complied with their wishes or when roommates gave them the attention they desired when they tried to dominate the conversation. However, as we saw in the previous section, such desires remained quite often unmet because they had to subordinate to their caregivers or to wait until they received the help they required. An exaggerated concern for others could also prevent the satisfaction of their own needs, as it was the case when a resident had to take care of a spouse. Due to a feeling of marital duty their concern for the needs of the other led to *self-neglect* (Melin-Johansson et al. 2014; Shaw et al. 2016). Women, in particular, were prone to such self-neglect as they had been taught to take care more for others than for themselves.

> No, I've never experienced myself as important, not now or in the past. Other people have always been more important – parents, employer, my husband, my daughter – I was never important. I never thought of myself. (Melin-Johansson et al. 2014)

5.4.4 Self-Presentation Versus Self-Concealment

Although residents in long-term care facilities were largely excluded from social participation they still wanted to get the attention of others and to be respected as a person. For this reason, they were interested in their self-presentation. Since any self-presentation may attract too much or even unwanted attention, residents were also inclined to conceal themselves at least to some extent. Self-concealment was, in fact, a necessary counterbalance to achieve a respectable self-presentation.

5.4.4.1 Self-Presentation

The tendency to attract the attention of others could be observed at mealtimes where residents wanted to *create a positive impression by dressing and grooming* (Dobbs 2004; Murphy et al. 2007; Cooney et al. 2009; Nakrem et al. 2011; Bauer et al. 2013; Falk et al. 2013; Melin-Johansson et al. 2014; Oosterveld-Vlug et al. 2014, Naess et al. 2016). They prepared themselves for social gatherings and tried to hide aspects of their bodies that could be perceived as negative by others.

> I would still really like to look good and I want to smell nice, that kind of thing. I think that does have to do with dignity, so that they don't come up to you and think 'Oh, she stinks,' and so on. I would hate that (Oosterveld-Vlug et al. 2014).

This self-presentation was in accordance with social norms, but it also implied a desire for some social distinction. As Dobbs (2004) observed at mealtimes in assisted living, there seemed to be at times a competition of dressing better than anyone else in the setting. By "dressing up" for the public eye the women tried to show their beauty. Another way to attract the attention of others was to demonstrate one's capabilities. In this sense, some residents made efforts to *leave a positive impression on the staff* and were eager to get the recognition of their caregivers.

> It feels good to be appreciated by the staff, when they see that, I can still do something (James et al. 2014)

An exaggerated desire to get attention was sometimes observed at mealtimes or at social gatherings where some residents wanted *to be in the focus of attention*. Curle and Keller (2010) observed how such residents tried to dominate social interactions and described them as "dominant leaders who impeded interactions as they did not encourage positive responses from others, spoke primarily about their own interests and issues, and maintained little attentive behaviour. Sometimes dominant leaders existed in pairs and would control table conversation by excluding or rebuffing other tablemates from their conversation, providing little opportunity for others to interact verbally" (Curle and Keller 2010).

But also those who were less eager to attract the attention of their social environment had the *desire to be respected* (Bergland and Kirkevold 2006; Robichaud et al. 2006; Andersson et al. 2007; Schenk et al. 2013; Oosterveld-Vlug et al. 2014; Teka and Adamek 2014; Chuang et al. 2015; Bollig et al. 2016; Naess et al. 2016). This expectation concerned the treatment they wanted to receive from their caregivers:

> They need to be polite to older persons. More polite. Respect us. (Chuang et al. 2015)

> Actually, greeting is not a big deal, but the feeling is good. (ibid.)

Or, as the residents of the Ethiopian facility for poor older persons put it:

> We prefer greeting rather than eating (Teka and Adamek 2014)

Such treatment was a question of dignity that had to be bestowed on them as persons, irrespective of whether they made efforts to attract the attention of others or not.

5.4.4.2 Satisfaction of Self-Presentation

To some extent, residents were able to present themselves and to satisfy their desire for attention. Women who dressed up nicely at mealtimes apparently *felt comfortable with their attractive appearance*, which allowed for some social distinction (Falk et al. 2013).

In some cases, activities to meet the desire for work or for diversion could result in the *appreciation by others*. Some residents, for example, explained that singing was not only a source of individual joy, it also gave them a feeling of being seen and heard as an important member in the social life of the nursing home (Slettebo et al. 2016). Another resident told how her passion for cooking earned her the recognition of the other residents:

> They like my tossed salad. They call it 'Mamie's salad'. (Ball et al. 2004b)

The desire for respect—irrespective of attempts to attract the attention of others—was met when the residents were *respected as persons* and treated as acceptable members of the community (Hjaltadóttir and Gustafsdóttir 2007; Harmer and Orrell 2008; Cooney et al. 2009; Wu et al. 2009: Cooney 2011; Falk et al. 2013; Goddard et al. 2013; Hwang et al. 2013; Oosterveld-Vlug et al. 2014; Lung and Liu 2016). Such recognition was granted when caregivers treated them in a respectful way, respected their privacy, paid attention to their wishes, showed interest in their lives, and gave them tasks that allowed residents to contribute to life in the facility. What was experienced as respectful treatment depended on the social status of the resident and on cultural manners.

> Nurse X is very good. Every time she sees me, she always calls me 'grandma'. It is enough. I am very happy. It makes me feel more comfortable to live here… (Wu et al. 2009)

> I really love to hear the nursing assistant calling me 'teacher'… because I was a teacher for my whole career. […] Because at least they know I was a teacher, not someone ordinary, but an intellectual…. The way they call me that, it feels like they are showing respect. (Lung and Liu 2016)

> They usually call me 'big sister' and I call them 'little sister.'… I feel happy we call each other 'sister' … it seems that they all familiar with me and treat me well. (ibid.)

Cultural habits also determined how the residents were called. In some countries it was customary to use the first name, in others the surname was preferred.

> All the nurses on this floor know me by my-by my first name. Of course, they always address me by mister, but they all know me. Yes indeed. So, I know that they have a personal interest in the individual. (Jordan 2010)

Quite often, however, the desire to get attention from others and to receive their respect was not satisfied. For some residents, the mere fact of living in a long-term care facility was a threat to being perceived as a respectable member of society. Living together with disabled persons made them fear of getting a bad reputation and they were *afraid of co-stigmatization* (Dobbs et al. 2008; Christov 2016). Staff members, for example, observed how some residents did not like to go on outings because they did not want to be seen with other residents using wheelchairs (Dobbs et al. 2008).

Apart from this fear of losing one's social reputation, there was also the direct experience of *not being respected as a person* (Grant et al. 1996; Dobbs et al. 2008; Timonen and O'Dwyer 2009; Williams and Warren 2009; Falk et al. 2013; Chuang et al. 2015; Teka and Adamek 2014; Stevens et al. 2015; Donnelly and MacEntee 2016; Rahayu et al. 2018). Residents complained about a lack of esteem and a disrespectful treatment, which manifested itself in ageism and infantilizing and sometimes even rude behaviours by others.

> It's like they think we're children…at least they give the attitude. So I think they should recognize people here are elderly but they aren't stupid and they aren't three years old (Williams and Warren 2009)

> The diminutives! The endearments! The idiotic we's. Hello dear, how are we today? What's your name dear? Shall we go to the dining room Eve? Hi hon… Don't we look nice today!… Chirpy singsong voices. Who thinks we want to be talked to this way? (ibid.)

> When care giver growled at me, I felt hurt, I wanted to weep… (Rahayu et al. 2018)

Others did not complain about such apparent disrespect, they rather told how they were *completely ignored as a person* (Iwasiw et al. 1996; Heliker and Scholler-Jaquish 2006; Hellström and Sarvimäki 2007a, b; Westin and Danielson 2007; Cooney 2011). They felt that they were just a mere number to others, while their true self remained unknown to them.

> They don't know the meaning of me! They don't know the meaning of me. (Heliker and Scholler-Jaquish 2006)

5.4.4.3 Self-Concealment

The desire to attract attention was counterbalanced by a tendency to self-concealment. Self-concealment was ensured by maintaining privacy which kept others, who were rather strangers, out of one's own affairs and *protected the intimate sphere* (Iwasiw et al., 2003; Bergland and Kirkevold 2006; Hjaltadóttir and Gustafsdóttir 2007; Murphy et al., 2007; Hauge and Heggen 2008; Shin 2008; Chin and Quine 2012; Falk et al. 2013; Schenk et al. 2013; Nakrem et al. 2013; Chuang et al. 2015; Bollig et al. 2016).

> I've made a system of not letting anyone in my room. I don't want unfamiliar people running around in here, and I want to feel that this is mine and that I can do whatever I want in here. (Falk et al. 2013)

> To go to the toilet at night, that, I think, is very inappropriate here. Imagine if I could have a little toilet that was only mine (Bergland and Kirkevold 2006)

Self-concealment was also apparent in a *desire to remain unnoticed* (Curle and Keller 2010; Christov 2016) as it was observed by some researchers. While some residents tried to be in the focus of attention and dominated discussions at mealtimes, most residents were just silent spectators of such self-presentations (Curle and Keller 2010). Christov (2016), who investigated the question why residents in many nursing homes remain silent, observed that they behaved with caution when they participated in joint activities since some group members liked to reprimand others for what they considered to be inappropriate behaviour. Since older people could not avoid the attention of others while in the public sphere, they tried to be as inconspicuous as possible to hide aspects of their personality that could contribute to an unpleasant self-portrayal in the eyes of others.

5.4.4.4 Satisfaction of Self-Concealment

If residents could retreat and were not exposed to the criticism of their roommates, they were *content to remain unnoticed*. There were, however, situations when they could not avoid the attention of others. Christov (2016) describes how they were *exposed to the criticism of others* when they participated in joint activities—even if they behaved with caution and tried to be inconspicuous. In case of mishap, other group members made their comments and sometimes it even provoked criticism if they remained silent. There were also occasions when residents were *exposed to gossip*. Christov (2016), for example, describes an incident in which a resident who returned from her husband's grave was degraded to an object of conversation by her roommates who talked about her while she was present and made even jokes about her situation. Likewise situations that made older persons feel ashamed like having to undress in front of a caregiver violated their desire for self-concealment. Their inability to adapt to social standards gave them at the same time the feeling of being an object of curiosity that one could dispose of without showing any sign of respect.

Similar feeling arose when others invaded the privacy of the residents. This was the case when they were monitored by staff, especially during night checks, or when other residents entered their private rooms without permission. For residents who lived in single rooms, such incidences were an occasional nuisance. Those, however, who stayed in shared rooms had no chance to withdraw and *felt permanently exposed to the public* (Iwasiw et al., 1996; Fiveash, 1998; Bland, 2007; Murphy et al., 2007; Chuang and Abbey, 2009; Cooney et al., 2009; Fraher and Coffey, 2011; Hutchinson et al., 2011; Chin and Quine, 2012; Oosterveld-Vlug et al., 2014). As one of them put it:

> The biggest thing that worries me is the lack of privacy… your life is like an open book. (Iwasiw et al. 1996)

The same was true for residents who were wheelchair-bound and had been left in the common room by their caregivers so that they were forced to spend their whole day there (Hauge and Heggen 2008; Koch-Straube 2003). In some facilities, residents had to live in large open plan wards and they hardly had a chance to conceal themselves, as there were only curtains around their beds that visually protected them from the eyes of others, and they knew that even when the curtains were closed, everyone knew what was going on (Cooney et al. 2009).

5.4.5 Positive Self-Perception Versus Critical Self-Perception

Residents did not only strive for a balance between attracting attention and self-concealment, they also had to gain a balanced self-awareness that allowed them accepting both their strengths and weaknesses. The awareness of their strengths could give them an embellished self-image, while the awareness of their weaknesses was a necessary counterbalance that enabled them to obtain a realistic idea of themselves. To some extent, older persons gained a positive self-image when they got attention and acknowledgement from others. On the other hand, lack of acknowledgement made older persons aware of their reduced abilities and diminished their self-esteem. Their self-perception, however, was not completely determined by the feedback of their social environment. An awareness of own strengths could boost their self-consciousness even if they were not acknowledged by others.

5.4.5.1 Positive Self-Perception

Naturally, older persons were more inclined to perceive their strengths. To obtain a positive self-image they used strategies of selective self-awareness. Some *focused on the past* and tried to remember their accomplishments (Koch-Straube 2003; Hjaltadóttir and Gustafsdóttir 2007; Melin-Johansson et al. 2014; Oosterveld-Vlug et al. 2014). Others *looked at their present achievements*. Instead of mourning their lost abilities, they prided themselves on what they could still do or what they had regained after recovering from an illness (Oosterveld-Vlug et al. 2013a: Adra et al. 2015). Another way of obtaining self-acceptance was to compare oneself with others who were worse of. Such *downward comparisons* could boost the self-esteem of the residents (Oosterveld-Vlug et al. 2013a; Nakrem et al. 2013; Behr et al. 2014; Oosterveld-Vlug et al.2014; Christov 2016). Some residents *tried to feel superior to others* by devaluating their roommates, for example, by criticizing them or commenting their behaviour while they were present (Koch-Straube 2003; Christov 2016). It also occurred in the form of gossip about other residents when they were absent and it could result in the above-mentioned exclusion of others. Confronted with their physical decay, some residents completely withdrew in memories in order to *forget their unpleasant self*. Koch-Straube (2003) assumes this to be a reaction to protect the natural sense of self-worth.

5.4.5.2 Satisfaction of Positive Self-perception

Despite their losses and their physical decline, some residents were able to maintain their self-esteem by dwelling on *positive memories* (Hjaltadóttir and Gustafsdóttir 2007; Hutchinson et al. 2011; Goddard et al. 2013; Melin-Johansson et al. 2014; Oosterveld-Vlug et al. 2014; Iden et al. 2015).

> Well, I've always been successful, I've had to build up everything myself. I never had any friends giving me a leg-up, so yes, I don't owe anyone anything fortunately. (Oosterveld-Vlug et al. 2014)

Having something accomplished in life was of course a prerequisite for positive memories. What was perceived as an accomplishment, however, depended on everybody's own value system. It could just be the fact of having lived a long life.

> Being 97 (age), oh I think it kind of makes you feel good; in general (people) kind of honour you for that. (Hutchinson et al. 2011)

Residents could also gain a positive self-image by focusing on the present and *recognizing their remaining strength* (Oosterveld-Vlug et al. 2013a; Adra et al. 2015). Some of them told about their satisfaction of being still able to participate in age appropriate exercises, while others were glad about a successful recovery from a disease:

> Well, it [sense of dignity] was worse then [six months ago]. Yes, much worse. Yes, well not any more - you get your feeling of dignity back after a bit, don't you? Because now I go home on my own in the minibus. And then I go upstairs on my own, along the access balcony, I go back down, get the minibus at seven o'clock, it's all those little things that I'm able to do again. Yes, I've been able to get a little bit of grip back on my life again. (Oosterveld-Vlug et al. 2013a)

More often, however, residents told of a *negative image of their present self* (Fiveash 1998; Ball et al. 2004b; Coughlan and Ward 2007; Saunders and Heliker 2008: Nakrem et al. 2011; Bauer et al. 2013; Falk et al. 2013; Oosterveld-Vlug et al. 2014; Iden et al. 2015; Shaw et al. 2016; Cho et al. 2017). They compared themselves to the person they once were, and with the loss of their abilities and strengths and the traces of ageing in their appearance they felt incapable and unattractive. One older man felt that he “went from a strong man to a nothing” (Shaw et al. 2016), and a female resident considered herself to be “just a numb nitwit” and added:

> I think. I was smart, but I think I lost it all’cause I just don’t do like I used to. (Ball et al. 2004b)

Being dependent on the help of others was for them a humiliating experience which sometimes caused a complete loss of their self-esteem:

> I don’t feel like a human being because it’s hard for me to move [by myself]. I need others’ help to stand up and [sit] down or go to [the] hospital. Other residents assist me all the time. This is why I say I don’t feel like a human being. (Cho et al. 2017)

Some residents were also unable to resort to positive memories. They were instead *plagued by negative memories*, remembered their mistakes and wrong decisions and felt guilty (Hjaltadóttir and Gustafsdóttir 2007; Melin-Johansson et al. 2014; Minney and Ranzijn 2016; Mohammadinia et al. 2017)

> More often than I wish, I reflect on my past life and things that have been unhappy. Some of the things that I’ve done one way, and wish I’d done another. Yeah, there are a few regrets. (Minney and Ranzijn 2016)

Some even considered the fact that they had to stay in the nursing home as a kind of punishment for bad deeds.

> Why I am here? I do not know; I say maybe I was not a good daughter to my father. (Mohammadinia et al. 2017)

5.4.5.3 Critical Self-Perception

Although such critical self-awareness could result in discouragement and loss of self-esteem, it was to some extent a necessary counterbalance to a one-sided perception of own strengths. It confronted residents with their weaknesses and made them aware of the difference between their desired and their actual condition. In response, some began *to make efforts* (Ball et al. 2004b; Mahrs Träff et al. 2017) to bring their current state closer to their desired state (for example, by exercising in order to improve their functionality). Others, however, were aware of their limitations and *lowered their expectations* (Ball et al. 2004b; Timonen and O’Dwyer 2009; Shaw et al. 2016). As one resident put it:

> You’ve just got to learn to put up with things (Shaw et al. 2016)

And another added:

> I don’t expect too much from the time I have left… . I’ve done pretty good to go as far as I have. (Timonen and O’Dwyer 2009)

5.4.5.4 Satisfaction of Critical Self-Perception

As the last quotation suggests, an adequate degree of self-criticism could result in an *acceptance of ageing*. It gave older persons a realistic sense of themselves that enabled them to become aware of their weaknesses without undue feelings of negativity. One couple told how they adapted to the idea of being old and care dependent like residents in a nursing home:

> My husband said, 'No.' He said, 'It's all old people.' I said, 'You looked in the mirror lately?' [laughter] I said, 'What do you think we are?' Then, all of a sudden, he started realizing, too, that it was getting harder for us. That's why he said, 'OK. We'll move in there.' (Shin 2015)

In this way, a critical self-perception led to a real self-acceptance which implies both the acceptance of strengths and weaknesses.

Others, however, did not achieve such a self-acceptance. Koch-Straube (2003) observed residents who were unable to recognize themselves when they were shown a photo of themselves. She argues that this *loss of self-recognition* was not simply a sign of mental confusion, but rather a mechanism of self-defence against the awareness of their progressive decay which was a violation of the natural self-love and narcissism. According to her, these residents forgot their current condition and retreated to a world of their own imagination, which allowed them to maintain an illusionary perception of themselves.

5.4.6 Influencing Factors

Just like body-related and social orientations of action, identity-related orientations of action were influenced by physical conditions, circumstances of life, environmental factors, and the care the residents received. Physical impairments resulted in care dependency and a loss or self-reliance which in turn reduced the ability to find satisfaction through work and increased the awareness of one's own weaknesses. Hearing impairments restricted the participation in joint activities that provided diversion, whereas visual impairments prevented residents from reading which contributed to entertainment or reflection (Thomas et al. 2013). Financial resources and a voluntary entry into the facility did not only strengthen the sense of control, but also facilitated the satisfaction of self-centredness. The absence of such circumstances could have the opposite effect.

5.4.6.1 Environmental Factors

The features of the facility provided a framework for the satisfaction of identity-related needs. An easy *access to nature* fostered mental relaxation (Raske 2010; Cheng et al. 2011; Fraher and Coffey 2011; Nakrem et al. 2013). A garden that belonged to the facility offered a chance to work for those who felt this need and were still able to do so. A *gift shop* as it existed in some facilities provided an opportunity to go shopping and to get some entertainment also for those who could not leave the facility due to impaired mobility (Thomas et al. 2013). In some facilities, however, *shared TV* was the main source of entertainment (Rekawati et al. 2018). Furthermore, all the features of a facility that promoted social contacts, like communal spaces or access to the internet, also contributed to the entertainment and activity of the residents. One factor that negatively affected entertainment for male residents was *female dominance* in the facilities (Park et al. 2009). Since women were in the majority, their interests naturally prevailed and men had to adapt or to avoid joint activities. For example, the passion that women showed for bingo did not arouse much enthusiasm among men. On the other hand, male topics such as world war stories or football did not attract the interest of women.

5.4.6.2 Identity-Related Care

More important than the features of the facility was the attention to the identity-related needs that residents received from the staff. *To get acquainted with the residents* and their individual inclinations was a precondition for person-centred care (Heliker and Scholler-Jaquish 2006; Wilson and Davies 2009; Koskenniemi et al. 2015). Caregivers gained knowledge about the personalities of the residents by spending time with them, observing their reactions during care, and talking with them. By *showing empathy and respect* they encouraged their feeling of being respected, promoted their self-acceptance, and promoted their willingness to engage in communication (Jordan 2010; Figueredo-Borda and Zabalegui-Yárnoz 2015; Koskenniemi et al. 2015). *Active listening* encouraged residents to disclose themselves—as one nurse recalled her experience:

> I feel … I've done something good one day when I get to talk to the residents about various things, learn about them … things that might be a big deal to them but not to us … So, there are so many things that are intertwined here that it's difficult to explain. I feel like I've done the best I can if I've brought out a smile in the residents … to bring them back. If you manage to say the right things, you can create little moments, and it's amazing what we have managed to get the residents to think about for one, two, five minutes. (Naess et al. 2016)

Stimulating memories was enjoyed by residents as it reminded them of their achievements in life and of the things they cherished (Harmer and Orrell 2008). Some facilities also made attempts to stimulate story-telling for therapeutic purpose. Goddard et al. (2013) investigated the effects of such a project where residents received *dignity therapy*. This approach comprised an interview by a nurse or other trained healthcare professionals, which was recorded and transcribed. The interview was subsequently edited and transformed into a coherent narrative, which was returned to the residents, who could pass the resulting document on to people of their choice—provided they were satisfied. One health care professional told how she perceived the effect of dignity therapy on the social well-being of a nursing home resident:

> She loved the attention, you know, sort of, mum was a great chatter and she likes to talk about the old times. (Goddard et al. 2013)

There were also other methods to promote the self-acceptance of the residents and to give them a feeling of being respected. Minney and Ranzijn (2016) reported about a residential care facility where staff taught residents *strength spotting* which is a technique for maintaining a positive attitude that allows to overcome health setbacks and to remain resilient. Heliker (2009) reported on a project in long-term care facilities where caregivers were encouraged to share stories with residents. Such *story sharing* did not only provide an insight into the personality of the residents, it was also a reciprocal give and take process of respectful telling and listening that focused on what matters to the individual.

Assistance in self-presentation promoted the satisfaction of the need for a self-presentation that was at the same time in line with social standards (Murphy 2007; Naess et al. 2016). For this purpose, the caregivers paid attention to the hygiene and appearance of the residents. They took care that residents groomed their hair, shaved their beard, got on the make-up they wanted, were dressed appropriately and in a way that matched their personality, and they checked their clothes to make sure there were no stains on them. A *tactful dealing with mishaps* served the same purpose (Oosterveld-Vlug et al. 2013a; Koskenniemi et al. 2015). If caregivers behaved naturally and politely when residents accidentally lost urine and were discreet when they needed help in using the toilet, they diminished the feelings of shame of those concerned. Seating arrangements at mealtimes were intended to produce a similar effect for those in need of feeding assistance as they *created a protective environment* (Naess et al. 2016). At the same time, however, this exclusion of residents with disabilities could entail discrimination (Sidenvall 1999).

If residents were still self-reliant, an *allocation of tasks* could meet their desire for work and concern for others, which also fostered their self-acceptance (Ball et al. 2004b; Cooney et al. 2009; Koskenniemi 2015). *Encouraging residents to continue preferred activities* had the same effect (Oosterveld-Vlug et al. 2013b). The above-mentioned *simulation of real life situations* did not only promote social contacts, it was also a source of entertainment (Naess et al. 2016). Even if they had only limited resources, all facilities tried to promote the diversion and entertainment of their residents through *organizing joint activities* which also fostered social contacts as mentioned above (Ball et al. 2000; Koch-Straube 2003; Al-Omari et al. 2005; Kennedy et al. 2005; Murphy 2007; Williams and Warren 2008; Eckert et al. 2009; Svidén et al. 2009; Bradshaw et al. 2012; Kemp et al. 2012; Park et al. 2012; Hwang et al. 2013; Sandhu et al. 2013; Teka and Adamek 2014; Gustavsson et al. 2015; Naess et al. 2016). Some facilities had special staff members called "live enrichment coordinators" who were in charge of organizing such events (Al-Omari et al. 2005), others employed occupational therapists for this purpose (Naess et al. 2016).

There was a broad range of possible joints activities that provided entertainment. First of all, mealtimes had this effect. Delicious food was furthermore a kind of self-reward and a sign of self-acceptance as the residents of a Taiwanese nursing home said with reference to a Chinese saying: "While you are eating, you are the same as an emperor" (Chuang and Abbey 2009). In addition to the meals, there were a number of common activities that provided entertainment. These included parlour games, musical events, performances, excursions, pet therapy, visits from and activities with children, exercises, festivities, and celebrations (Iwasiw et al. 1996; Fiveash 1998; Hweidi 1999; Bergland and Kirkevold 2006; Coughlan and Ward 2007; Tsai and Tsai 2008; Wu and Barker 2008; Cooney 2011; Fraher and Coffey 2011; Philpin et al. 2011; Andrews 2012; Falk et al. 2013; Nakrem et al. 2013; Thomas et al. 2013; Teka and Adamek 2014; Adra et al. 2015; Gustavsson et al. 2015; Naess et al. 2016; Rekawati et al. 2018). In some institutions there were also group discussions to meet the need for reflection (Teka and Adamek 2014), while other facilities tried to satisfy the need for work and productivity through opportunities such as cooking, gardening, crafts, and creative design (Iwasiw et al. 1996; Fiveash 1998; Cooney 2011; Fraher and Coffey 2011; Philpin et al. 2011; Thomas et al. 2013; Chuang et al. 2015). Mainly, however, these activities were tailored to meet the needs of the average resident. As a consequence, residents with a higher level of capabilities felt insufficiently challenged and those with an individual interest felt homogenized (Tucket 2007; Chang 2013; Stevens et al. 2015). In order to meet the different needs of male and female residents, some facilities tried at least to offer *gender specific activities* like men-only luncheons with speakers and topics on men's issues or bingo which attracted mainly women (Al-Omari et al. 2005; Kemp et al. 2012).

There were, however, not always efforts to meet identity-related needs. A closer investigation of staff's knowledge about the personalities of residents revealed that despite good intentions to provide person-centred care staff members had *no concrete idea about their likes and dislikes* and how to respond to them. As one participant replied:

> Specifically, just for him? Well, I think it's always a question of giving somebody attention and taking somebody seriously. Behave nicely to someone, respond to what someone says… Really, I think it's mainly the kind of things that apply to anyone. (Oosterveld-Vlug et al. 2013b)

In some cases, organizing joint activities was not meant to create a meaningful event for residents but to produce an outcome that was believed to have therapeutic value. Koch-Straube (2003), for example, describes music therapy sessions aimed at improving the mood of the participating residents, but since these sessions were not related to their individual needs, they had a rather manipulative character. In his meanwhile classical study about an American nursing home, Gubrium (1997) provides an example of a reality orientation therapy session which was similarly outcome-oriented and manipulative. In such sessions participating residents were asked to read items on a chart and then they were quizzed on the content. Correct answers were those that corresponded to the chart and they indicated that the resident was oriented. An excerpt from one such session illustrates this approach.

> Aide: [pointing to the weather on the RO board that reads 'raining'] What's the weather like today, Emma?
> *Emma turns her head slightly and quickly looks out the window*
> Emma: Well, it looks like the sun is shining kinda bright.
> *The sun happens to be shining at the moment*

> Aide: Are you sure? It says, it's raining. Doesn't it? [Finger still pointing to the board]
> Emma: Well, it doesn't look like it from here.
> Aide: What does it say here, Emma? [Directing Emma's attention to the board]
> Emma: It says it's raining.
> Aide: [Warmly] That's correct. Very good. (Gubrium 1997)

With their exclusive focus on the improvement of cognitive function, such *sessions were detached from the lifeworld* of the residents and their concerns (in this particular case reality orientation was even detached from reality). Not surprisingly, residents felt reminded of school and disliked to participate. While in this case the residents were kept busy with activities that were meaningless to them, in other cases they were denied activities they wanted to do. Some residents complained that staff *prevented them from helping* in the facility (Koskenniemi et al. 2015; Palacios-Ceña et al. 2016a; Zimmerman et al. 2016)

> I asked once or twice let me help to clean the table, but they (nurses) said that they don't need help. (Koskenniemi et al. 2015)

> They said that they couldn't because I was a resident and not a worker. (Palacios-Ceña et al. 2016a)

Worse than the disregard of such needs was the *lack of respectful treatment* that was experienced by many residents (Grant et al. 1996; Hellström and Sarvimäki 2007a, b; Dobbs et al. 2008; Tsai and Tsai 2008; Williams and Warren 2008; Timonen and O'Dwyer 2009; Falk et al. 2013; Teka and Adamek 2014; Chuang et al. 2015; Stevens et al. 2015; Donnelly and MacEntee 2016; Lung and Liu; Zimmerman et al. 2016). Letting them wait, showing no interest in their concerns and opinions, and talking to them in a derogatory way did not only create feelings of powerlessness, it also had a negative impact on their self-esteem and prevented the satisfaction of their desire for self-presentation in order to gain the respect of others. Underlying such a lack of respect was an ageism that perceived older people as senile and incapable of making their own decisions, and often manifested itself in an infantilizing treatment.

> I find it insulting; they talk above you like you are a mute, deaf and dumb … They think we're all retarded and about to wet our pants at any moment and not having a brain in our heads … It is true that there is such a stereotype about old age … They talk to you like you are a child: 'oh that was so clever of you to tie your shoe like that, good boy'. (Donnelly and MacEntee 2016)

Some residents also reported about *discrimination* due to their race or their social status (Shin 2008; Hutchinson et al. 2011). Ethnic minorities like African Americans had experienced racism throughout their life and were also exposed to it in long-term care by the behaviour of caregivers and roommates. This behaviour was stood in marked contrast with the *privileged treatment of higher status residents* that made the others aware of their lower status (Dobbs et al. 2008; Zimmerman et al. 2016).

> They treat me pretty well because of my husband; he was a judge. Doctors and judges and their wives are treated differently. (Dobbs et al. 2008)

5.4.7 Behavioural and Attitudinal Reactions

Despite their restricted opportunities residents tried to satisfy their identity-related needs. A good deal of their time was spent on *individual activities* (Fiveash 1998; Hweidi 1999; Ball et al. 2000; Bergland and Kirkevold 2006; Andersson et al. 2007; Coughlan and Ward 2007; Svidén et al. 2009; Tsai and Tsai 2008; Hauge and Heggen 2008; Williams and Warren 2009; Andrews 2012; Park et al. 2012; Falk et al. 2013; Martinsson et al. 2013; Nakrem et al. 2013; Thomas et al. 2013; James et al. 2014; Teka and Adamek 2014; Gustavsson et al. 2015; Minney and Ranzijn 2016; Slettebo et al. 2016; Rekawati et al. 2018). Self-care, household tasks (if they had a single room equipped with own furniture), needlework, or crosswords gave them the feeling of having something to do and to be productive. Reading and in some cases the use of a computer kept their mind busy or provided some entertainment. Diversion was also found by listening to the radio, watching television, observing other residents, receiving visits from volunteers, or participating in excursions with the family. Relaxation was found when residents withdrew to have a rest or spent time with contemplation or watching the nature. Beside this, residents *participated in* the above-mentioned *joint activities* that were organized by the staff.

To some extent residents also showed *social engagement*. If they were able and allowed to do so, they helped in the facility, for example, by contributing to the preparation of meals or festivities, caring for facility pets, or working in the garden provided these options were available (Ball et al. 2004b; Williams and Warren 2008; Herrmann and Flick 2011; Perkins et al. 2012; Teka and Adamek 2014; Figueredo-Borda and Zabalegui-Yárnoz 2015). Others helped care dependent residents by providing practical support like pushing their wheelchair or bringing them something to drink, or by cheering them up and giving emotional encouragement (Hweidi 1999; Kennedy et al. 2005; Dobbs et al. 2008; Kemp et al. 2012; Park et al. 2012, 2013; Perkins et al. 2012; Sandhu et al. 2013; Minney and Ranzijn 2016). If it was a part of the organizational structure, some residents could act as representatives of the interests of their roommates (Svidén et al. 2009). Some facilities also edited an internal newspaper that allowed residents to submit contributions, and in a Chinese facility residents were also engaged in the education of young people of the surrounding communities by organizing symposia for them (Cheng et al. 2011). Beside these activities, older persons *cultivated their memories* in order to maintain or regain their self-esteem (Harmer and Orrell 2008; Goddard et al. 2013). This was particularly suitable for those who were less able to be active and was supported by dignity therapy in some facilities.

5.5 Long-Term Care Facilities and Development-Related Orientations of Action

Moving into a nursing home creates a new framework for the satisfaction of identity-related needs. It is a change that threatens the established balance between maintaining old habits and searching for new perspectives. In contrast to younger persons who tend to search for new perspectives and suffer from feelings of stagnation that may result in a midlife crisis if they fail to do so, older persons are naturally more inclined to the preservation of their past. Losing their past poses a serious threat to their identity, which is further aggravated by the fact that their future perspective consists of their approaching death. Moving into a long-term care facility is thus an end life crisis, and older persons may respond to this situation by attempts of denying the closeness of their death or by facing it. At the same time they have to find a balance between scepticism and hope that allows them to deal with their situation without succumbing to despair or deceptive expectations. Table 5.6 provides an overview over these development-related orientations of action and their satisfaction, their influencing factors, and the behavioural and attitudinal responses of the older persons.

Table 5.6 Development-related orientations of action, influencing factors, behavioural and attitudinal reactions

Orientations of action and their satisfaction	
Attachment to the past	Attachment to the old home
	Maintaining old lifestyle
	Cultivation of memories
	Desire for cultural continuity
	Insisting on routines of care
	Abandoning old habits
	Efforts to forget the old home
Satisfaction of attachment to the past	Initial fear and uncertainty
	Shock at admission
	Sadness about loss of home
	Sadness about loss of previous identity and life
	Not at home in the new home
	Feeling betwixt and between
	Finding some continuity
	Homelike atmosphere
Searching new perspectives	Inclined to learn something new
	Desire to re-establish a feeling of being at home
	Developing new routines
	Resistance to adapt
Satisfaction of searching new perspectives	Discovering a new life
	Getting a new sense of belonging
	Stagnation
Denial of adversities	Avoidance of confrontation with mortality and death
Satisfaction of denial of adversities	Life without undue worries and fears
	Sudden fear of death
Facing adversities	Preparing themselves and others for own death
Satisfaction of facing adversities	Enabled to deal with the approaching end
Scepticism	Downsizing expectations
	Restricted expectations for an improvement

Table 5.6 (continued)

Satisfaction of scepticism	Gradual adaptation
Hope	Making the best out of it
	Religious expectations
Satisfaction of hope	Satisfied despite limitations
	Enjoying the moment
	Well-being in spite of illness
	Religious comfort
	Peace and solace in the face of death and dying
	Being hopeless and resigned
Influencing factors	
Environmental factors	Homelike environment
	Impersonal and institutional atmosphere
	No match with cultural background
Development-related care	*Same as in Tables 5.4 and 5.5*
	Religious ceremonies
	Allowing to grieve
Behavioural and attitudinal reactions	Cultivating memories
	Religious practices

5.5.1 Attachment to the Past Versus Searching New Perspectives

5.5.1.1 Attachment to the Past

A motive of central importance for residents in long-term care facilities was their *attachment to their old home* (Hutchinson et al. 2011; Chin and Quine 2012).

> I like to have my own spot where I can be still, where I can enjoy my home, where I can be on my own. (Chin and Quine 2012)

Their old home was the place they had shaped all their lives. It was a material expression of their personality and enclosed their identity like a protective shell. It secured their privacy and provided a connection to a familiar environment. At the same time, residents sought to *maintain their old lifestyle* (Harmer and Orrell 2008; Cooney 2011; Philpin et al. 2011; Palacios-Ceña et al. 2013; James et al. 2014; Roberts and Bowers 2015). They wanted to continue their usual routines, pursue their old hobbies, and keep up their old contacts with families and friends. If this was not possible, they resorted to the *cultivation of their memories* which also served to promote their self-acceptance (Koch-Straube 2003; Hjaltadóttir and Gustafsdóttir 2007; Harmer and Orrell 2008; Melin-Johansson et al. 2014; James et al. 2014; Oosterveld-Vlug et al. 2014). Members of ethnic minorities had an explicit *desire for cultural continuity* since living away from their homeland made them feel that the culture of their host country stood in contrast to their familiar way of life (Shin 2008; Hutchinson et al. 2011; Andrews 2012; Martinsson et al. 2013; Park et al. 2013). They longed for the kind of food they had been used to since childhood, preferred to watch television from their home country, wanted to talk to residents of the same cultural background, and favoured to have caregivers who spoke their own language. Some residents were explicitly concerned about *staying in connection to their cultural roots* (Hutchinson et al. 2011; Martinsson et al. 2013). They were eager to celebrate the festivities of their homeland or wanted to learn more about its history and traditions.

> I have always been interested in history …but my eyes get so tired … I wish they could find something they could read to me about my native country. (Martinsson et al. 2013)

Residents who had become used to life in the facility tended to maintain their habits by *insisting on routines of care* (Koch-Straube 2003). They wanted to keep their seat at mealtimes, which had once been allocated to them, and insisted on the timing and procedure of their personal care. However, not everybody was concerned to the same extent about preserving the past. Some residents told that they had *abandoned old habits*. Everyday routines, such as caring for hygiene, had become less important to them, which increased their readiness to accept care as it was (Heid et al. 2016), and there were also those who felt no sadness about leaving their old homes since they were no longer attached to their habits and belongings (Iwasiw et al. 1996). Some residents even made *efforts to forget their old home* and forced themselves not to look back (Cooney 2011; Chang 2013).

> I said to my daughter, 'Don't leave my stuff, even my spoon. Throw all of my stuff away. I will wait for my passing here from now on. I am going to think of this place as my home. Throw it all away.' I have forgotten everything, since I didn't go home. (Chang 2013)

5.5.1.2 Satisfaction of Attachment to the Past

Some older persons reacted to the loss of their familiar environment with an *initial fear and uncertainty* when they entered the facility that had to become their new home (Iwasiw et al. 1996; Cooney et al. 2009). They felt overwhelmed by the newness of everything, and were shy to establish contacts to other residents.

> There's a lot of fearfulness because you leave a world that you've known all your life. (Iwasiw et al. 1996)

> You've got to learn the ropes. Nobody tells you anything. (Heliker and Scholler-Jaquish 2006)

For many residents, however, losing their old home resulted in a *shock at admission*—especially when they had been forced to move in against their will since this was a blow against their self-determination (Iwasiw et al. 1996; Hweidi 1999; Falk et al. 2013; Teka and Adamek 2014).

> A very big shock. A younger person wouldn't understand it. I can't say that I ever felt worse in my whole life time. (Iwasiw et al. 1996)

> I can't remember my own feelings the day I moved in. It's just a blank. Whether I just wanted it wiped out, maybe that's what happened. (ibid.)

Out of this shock evolved a permanent *sadness about the loss of their home* (Iwasiw et al. 2003; Dobbs 2004; Bergland and Kirkevold 2006; Heliker and Scholler-Jaquish 2006; Bland 2007; Hjaltadóttir and Gustafsdóttir 2007; Walker and Curry 2007; Cooney et al. 2009; Cooney 2011; Fraher and Coffey 2011; Martinsson et al. 2013; Nakrem et al. 2013; Teka and Adamek 2014; Stevens et al. 2015; Canham et al. 2016; Shaw et al. 2016; Koppitz et al. 2017).

These residents felt uprooted and homeless and their sorrow could be exacerbated by the knowledge of what happened to their previous home.

> I want to go back to my apartment; it's a whole house full of memories. The only thing I've regretted is falling and being where I am now [nursing home]. (Heliker and Scholler-Jaquish 2006)

> We left it immaculate […] They've ripped everything up, the garden, everything. Edgar said to me 'leave it, gone, it's gone, leave it.' But I can't. […] And he said 'done, it's finished.' That's our life gone, that's part of our life gone. But that was my life. I mean, I've been there fifty four years, my husband was there since he was about eight. (Shaw et al. 2016)

These feelings were associated with *sadness about the loss of their previous identity and life* since they lost contacts to their old friends and were unable to continue their habits and routines (Iwasiw et al. 1996; Koch-Straube 2003; Dobbs 2004; Bergland and Kirkevold 2006; Heliker and Scholler-Jaquish 2006; Svidén et al. 2009; Andrews 2012; Chang 2013; Nakrem et al. 2013; Palacios-Ceña et al. 2013; Oosterveld-Vlug et al. 2014; Cho et al. 2017; Koppitz et al. 2017).

> You don't know what it's like…you lose your identity for being able to do what you want to do when you want to do it. (Heliker and Scholler-Jaquish 2006)

> So at the end of my life you had to settle for this – not that I lay awake about this, but I do think it gets you very much down. (Iwasiw et al. 1996)

Residents from ethnic minorities experienced at times some *cultural alienation* since their roommates did not speak their own language and caregivers did not understand the cultural background of their habits and routines (Martinsson et al. 2013). In sum, many residents did *not feel at home in their new home* and wanted to return. Some of them believed that their stay was only temporary and their hope to return was nourished by the fact that their old home was still existent:

> I just brought the essentials… my furniture is still at home and I've been here for 6 months now. My daughter is taking care of my apartment while I'm here. (Falk et al. 2013)

Others were aware of the advantages they had from staying in the facility but they could not get accustomed to institutional life. Hence, they *felt betwixt and between* the old and the new way of life and remained ambivalent in their feelings for the long-term care facility (Iwasiw et al. 1996; Bergland and Kirkevold 2006; Heliker and Scholler-Jaquish 2006; Bland 2007; Bollig et al. 2016). In the interviews, these residents expressed their views on the facility in statements such as: "I wouldn't say anything against it…." (Iwasiw et al. 1996), but what remained unsaid was an objection like: "It is possible to stay here, but I would rather have lived at home" (Bergland and Kirkevold 2006).

There were also residents who could satisfy to some extent their desire to maintain old habits since they *found some continuity*. Some of them were able to maintain old contacts since the facility was located in their familiar environment (Iwasiw et al. 1996; Falk et al. 2013; Schenk et al. 2013; Minney and Ranzijn 2016).

> Mhm. Well. As I said, the whole environment to start with, yes, the, the feeling of being at home yes [clears throat] then, as I said, a mate here, a mate there, just off- off the cuff I could name you three… three… um um… three men who um live on the premises here yeah, or um acquaintances, and women too, it's not like that, no - but the feeling of being at home is definitely worth a lot. (Schenk et al. 2013)

Another resident told how she found comfort in being still able to visit her old home.

> I can go out to my home from here; it was very strange when I went out first but I feel more relaxed now. I am glad to come back to the company. (Fraher and Coffey 2011)

Residents from ethnic minorities sometimes found a caregiver from their own cultural background and his or her presence increased their sense of familiarity (Martinsson et al. 2013). The most important thing for gaining some sense of continuity was the possibility of personalizing one's own space by bringing own furniture and other belongings to the facility (Iwasiw et al. 2003; Bergland and Kirkevold 2006; Hjaltadóttir and Gustafsdóttir 2007; Murphy et al. 2007; Cooney et al. 2009; Cooney 2011; Falk et al. 2013; Nord 2013; Hillcoat-Nalletamby 2014; Shin 2015)

> I am very grateful that my room is big enough, so that I have space for some private furniture. It is important to have my own furniture. In a way I feel more at home when I can sit among this furniture (Bergland and Kirkevold 2006)

Several residents were also *able to continue old habits*—even if this was only possible to a lesser extent (Ball et al. 2004b; Bland 2007; Harmer and Orrell 2008; Philpin et al. 2011; Chin and Quine 2012; Andrew and Wilson 2014; Hillcoat-Nalletamby 2014; Minney and Ranzijn 2016). This was the case when they had the opportunity to work or to pursue a valued hobby. The desire for continuity was also satisfied when the facility had a *homelike atmosphere* that brought back old memories. Such feelings could be evoked by a café inside the facility or a garden that reminded residents to pleasures they had experienced in their previous life.

> It is nice and cozy in front of the fireplace 'cause in the winter time that fire's going and it's beautiful sitting around on the comfy suite there and having a cup of coffee. (Andrew and Wilson 2014)

> I love the feeling when I'm out in the garden. It takes me back to my childhood. (Raske 2010)

First and foremost, however, the feeling of being at home depended on the social atmosphere, i.e. residents' familiarity with roommates and staff (Ball et al. 2004a; Cooney 2011):

> It's real homely … it feels just right … there's an atmosphere of home about it that you don't feel you're in a strange place at all… There's no feeling of loneliness about it, you know it's a companionable place. (Cooney 2011)

5.5.1.3 Searching New Perspectives

Despite their old age and the losses they had experienced some residents were still *inclined to learn something new*. For them, life was a continuous process of learning.

> If you learn to accept things as they are, use time that otherwise would be empty and listen to tapes, then you can go on learning until you die. (Hjaltadóttir and Gustafsdóttir 2007)

> I just love to learn. Ever since I left school I wanted to learn things. I just love it and now, heaven forbid, I'm trying to teach myself to play the mouth organ! I've bought lessons from the Internet. I'm doing a two year Diploma course. I've got time to focus on that now. (Minney and Ranzijn 2016)

However, the search for new perspectives was more often concerned with a *desire to re-establish a feeling of being at home* and to make the unfamiliar familiar. In this sense residents searched for new contacts and tried to discover pleasant aspects in their new home. For the same reason, several residents tried to learn the rules of their new environment and to *develop new routines* (Iwasiw et al. 1996; Hutchinson et al. 2011). Residents, however, who were strongly attached to the past and could not overcome the loss of their home were reluctant to discover something positive in their new environment and showed a *resistance to adapt* (Dobbs 2004).

5.5.1.4 Satisfaction of Searching New Perspectives

A minority of residents were able to *discover a new life* in their long-term care facility (Iwasiw et al. 1996; Boggatz et al. 2009; Bradshaw et al. 2012; Shaw et al. 2016). These were those who were inclined to life-long learning and those who had voluntarily moved in to free themselves from social constraints and attain an individual way of life. More commonly, however, the residents found something familiar in the unfamiliar and *developed a new sense of belonging* to the new place (Iwasiw et al. 1996; Bergland and Kirkevold 2006; Heliker and Scholler-Jaquish 2006; Bowers et al. 2009; Jordan 2010; Cooney 2011; Chin and Quine 2012; Oosterveld-Vlug et al. 2013a; Bollig et al. 2016; Canham et al. 2016).

> I think differently [about being in the nursing home] than I did in the beginning when I came here … because I now feel more connected [to the nursing home] than I did when I came here. I do feel more at home. (Bollig et al. 2016)

> I consider this my home now, but not a home the way I am used to. I have a totally different attitude towards my surroundings now. (Bergland and Kirkevold 2006)

Residents, however, who were unable to adapt had a feeling of *stagnation* despite their efforts to find some entertainment and diversion (Fiveash 1998; Coughlan and Ward 2007; Tucket 2007; Oosterveld-Vlug et al. 2014).

> I feel that my life has no future at the moment …. I watch the tennis and I watch the football and that — on TV, and that just fills in time. (Tucket 2007)

5.5.2 Denial of Adversities Versus Facing Adversities

That staying in a long-term care facility would mean a loss of the old home was apparent to many older people even before they moved in. As we saw in Chap. 2, many of them avoided to think about this possibility and denied care needs that might force them to move in. Those who already lived in a long-term care facility could not ignore this situation, but they had to respond to the fact that this was most probably the last stop in their lives. They had to find a balance between a denial of their approaching death which to some extent was necessary to maintain a future perspective and the tendency to face their unavoidable end in order to be prepared for it.

5.5.2.1 Denial of Adversities

Staying in a long-term care facility implied a threat to be confronted with death. Witnessing other residents' physical decline and their process of dying reminded the older persons to their own, final destiny. To maintain a positive attitude required the *avoidance of a direct confrontation with mortality and death* (Tsai and Tsai 2008; Walker and Paliadelis 2016). This denial was necessary to protect a vulnerable state of mind. As one resident put it:

> It is upsetting to see people decline. I don't allow myself to get close. (Walker and Paliadelis 2016)

As we will see in the following chapter, this denial was rooted in a culture where confrontation with death was avoided and where families and caregivers sought to reinforce this attitude in the older persons.

5.5.2.2 Satisfaction of Denial of Adversities

As long as residents could avoid the unwanted confrontation with death, they could continue their *life without undue worries and fears*. However, there were always situations where a confrontation with death was unavoidable and such encounters triggered a *sudden fear of death*. A resident in a Taiwanese nursing home, for example, described his anxiety when he had to share his room with a dying person:

> I was scared when I had to live with an unconscious person. It [seeing that person] made me feel that I could be in his situation in the future. I was also afraid that he would pass away in this room. You know it is not good for Chinese people to see someone die in the same room. This would make me feel the soul or ghost is surrounding the room, which is a symbol of misfortune. And maybe I would be the one following him soon. (Tsai and Tsai 2008)

5.5.2.3 Facing Adversities

Not everybody, however, was scared of the approaching end of life. Instead, these residents tried to *prepare themselves and others for their own death* (Hjaltadóttir and Gustafsdóttir 2007; Shrestha and Zarit 2012; Falk et al. 2013; Chuang et al. 2015). They had a desire to say goodbye to family and friends and took precautions about their funeral.

> I have told my daughter (about my death) and wanted to say a nice goodbye. She doesn't want to listen to me. She becomes angry when I mention it. I want to talk, but she doesn't want to listen. (Chuang et al. 2015)

> I have told my son that I want to be buried beside my wife. I don't want to be cremated. (ibid.)

5.5.2.4 Satisfaction of Facing Adversities

Residents who faced their approaching death were devoid of self-delusion. This saved them from undue fears that were experienced by those who were inclined to a denial of death and *enabled them to deal with their approaching end*. If there was something they desired in the face of the unavoidable end of life, it was not an extension of life or an improvement of health but a fast and painless process of dying:

> It's just a part of life, I guess. We'll all end up like this if you live long enough graced with a long life. Having that said… for my own part I really hope that when it starts going downhill it will be fast. The worst thing that could happen is if I end up like one of those in need of incontinence pads and feeding tubes. I hope that I'll manage independently all the way to the end. That's really my only wish for the future. (Falk et al. 2013)

5.5.3 Scepticism Versus Hope

Staying in a long-term care facility and dealing with the loss of the old home required also a balance between scepticism and hope. On the one hand, residents had to come to terms with things as they were and not to indulge in deceptive hope. However, a one-sided scepticism could result in hopelessness and despair. Therefore, it had to be balanced by a tendency towards hope which enabled older persons to discover something positive even in negative circumstances.

5.5.3.1 Scepticism

In view of their frailty, which had resulted in the loss of their old homes, many older persons tended to accept the situation as it was. They made the decision to be satisfied with less and this *downsizing of expectations* was an attempt to adapt to the loss of a positive future perspective (Grau et al. 1995; Ball et al. 2004a; Bergland and Kirkevold 2006; Walker and Curry 2007; Timonen and O'Dwyer 2009; Fraher and Coffey 2011; Bradshaw et al. 2012; Chin and Quine 2012; Nakrem et al. 2011; Nakrem et al. 2013; Falk et al. 2013; Oosterveld-Vlug et al. 2013a; Oosterveld-Vlug et al. 2014; Taylor et al. 2014; Iden et al. 2015; Donnelly and MacEntee 2016; Walker and Paliadelis 2016).

> You don't need more when you are so old (Nakrem et al. 2013)

Although they were not pleased about their situation, they tried to convince themselves that staying in a long-term care facility was still the best that could have happened to them:

> You are more likely to resign yourself to those things, because there's no alternative. I should be pleased I'm here at all. (Oosterveld-Vlug et al. 2013a)

Downsizing expectations implied that residents accepted a loss of control, adapted to routines of care, got satisfied with limited opportunities for work or entertainment, and remained aware of their own mortality.

> You can't do anything. You sit in your room on your own… I knew I had to get used to it because I knew I'd be here till they cart me out. Likewise Leo said: It's a part of it now… But, no, you know beforehand when you get here, that it's the last stop. (Walker and Paliadelis 2016)

Not surprisingly, these residents had only *restricted expectations for an improvement* in their own condition when facilities made attempts to promote their health. One resident, for example, who participated in an exercise program said:

> I'm very old. You can't expect to be made new when you're old. I mean, everything else is wearing out on us, they can't give you new things, so that's the way to look at it, isn't it? (Stathi and Simey 2007)

> At my age, I just have to accept the health decline. So I don't spend much time reflecting on this. (Iden et al. 2015)

5.5.3.2 Satisfaction of Scepticism

Residents who tended to be sceptical and downsized their expectations experienced a *gradual adaptation* to life in the long-term care facility (Andersson et al. 2007; Andrews 2012; Cooney 2011; Kemp et al. 2012). They had no hopes that could be disappointed and simply got used to stay there. In the course of time they became familiar with their new environment, established some social contacts and found some opportunities for shaping their life. One resident described his adaptation after some period of time:

> I feel closer to those people that I see, those people who are closer to me in the dining area, those people that are closer to me in the hallway, that I pass more often going to and fro. (Kemp et al. 2012)

Although this statement does not suggest any real closeness to the roommates, it shows a certain degree of habituation which rendered the stay in the facility at least bearable.

5.5.3.3 Hope

A one-sided downsizing of expectations, however, did not necessarily produce a degree of satisfaction. It also required a tendency to hope that implied the ability to discover something positive even in negative situations. A common way to find something positive while staying in a long-term care facility was to think in a positive way and the attempt to *make the best out of it* (Iwasiw et al. 1996; Ball et al. 2000; Bourrett et al. 2002; Dobbs 2004; Bergland and Kirkevold 2006; Heliker and Scholler-Jaquish 2006; Bland 2007; Stathi and Simey 2007; Cooney et al. 2009; Cooney 2011; Bradshaw et al. 2012; Chin and Quine 2012; Falk et al. 2013; Oosterveld-Vlug et al. 2013b, 2014; Stevens et al. 2015; Bollig et al. 2016; Shaw et al. 2016; Slettebo et al. 2016; Koppitz et al. 2017):

> That should be one's aim: to lead a reasonably happy existence. It is no great fun in being unhappy all the time and revelling in your unhappiness saying, 'Oh goodness me, life is a bore', one can say that, I say that getting old is a bloody awful thing, but, ah! There you are! You've got to make the most of it. (Stathi and Simey 2007)

According to these residents adaptation to losses and finding a new perspective was a matter of mind:

> I made up my mind to go ahead with what I can do. We have to play the cards we are dealt (Heliker and Scholler-Jaquish 2006)

> I sat down and reasoned with myself and decided that I wanted to move here and that would feel at home, that the food would taste great and that all the people here were kind-hearted. If I didn't set my mind to it, it would be impossible for me to live like this… so that is what I did and that have worked out just fine. Does that sound crazy to you? (Falk et al. 2013)

This attitude allowed them to overcome their initial rejection of staying in a long-term care facility. A strategy that facilitated these attempts to think positive was the above-mentioned comparison of one's own situation with the situation of others who were worse of—a strategy which also helped to promote a positive self-perception.

A way to find something positive even in the face of mortality and death was to have *religious expectations* (Hweidi 1999; Bland 2007; Hutchinson et al. 2011; Shrestha and Zarit 2012; Chang 2013; Oosterveld-Vlug et al. 2014; Adra et al. 2015; Chuang et al. 2015; Iden et al. 2015; Heid et al. 2016). Residents, who had such expectations, read the scriptures of their religion and spent their time in prayer hoping to soothe and overcome their sorrow.

> When you truly put your faith in God and let him direct you in your life you will be able to face any difficulties you find yourself going through. I have confidence that his almighty can guide me. Thank God, I am a strong believer and I love praying. I love to be honest and tell the truth all the time and this is very important for my quality of life. (Adra et al. 2015)

> What is required for happiness? I just sing and recite the hymn of God. That is main thing… Singing hymn of the God is required to experience and enjoy happiness permanently […] we must console our mind by remembering the Almighty. (Shrestha and Zarit 2012)

5.5.3.4 Satisfaction of Hope

When older persons were inclined to make the best out of their situation, they became *satisfied despite limitations* (Bland 2007; Walker and Curry 2007; Hutchinson et al. 2011; Iden et al. 2015; Walker and Paliadelis 2016)

> So I haven't got that much longer to live so… so I'll be alright. Yes, that's what I mean, so I don't worry about that. It's as good as I'll get. (Walker and Paliadelis 2016)

Since they had no far-reaching goals for the future, wishes and hopes were temporarily satisfied when residents found pleasure in small things and *enjoyed the moment* (Walker and Curry 2007; Tsai and Tsai 2008; Nakrem et al. 2011; Melin-Johansson 2014; Oosterveld-Vlug et al. 2014; Minney and Ranzijn 2016; Shaw et al. 2016). Sitting in the sun and doing nothing or playing with a pet could be a source of joy. One resident described how he enjoyed a trip on houseboat:

> Oh that's great fun! It's most relaxing and the staff look after us really well. The food's lovely and it's just relaxing just to sit there. I wander around the deck looking at everything I can see (which is not that much), but what I can see, I enjoy. (Minney and Ranzijn 2016)

Such positive experiences could produce a *well-being despite illness* (Bergland and Kirkevold 2006; Nakrem et al. 2011; Behr et al. 2014; Minney and Ranzijn 2016). This was more than the above-mentioned satisfaction despite limitations, since it involved an inner thriving that outweighed these limitations. A male resident with paraplegia, for example, claimed that his health was "darn good" (Nakrem et al. 2011) and a female resident explained how she achieved well-being despite her arthritis by engaging in joyful activities:

> One thing that stops me from doing a lot of things is my arthritis, yeah that can hold you back a bit. But luckily I've got my daughter here and she comes and picks me up and we go out for coffee and we have lunch out sometimes and I'm quite happy with that. And I like to read, you know, books. I'm really quite content living (Minney and Ranzijn 2016).

Beside this temporary joy and pleasure many residents found hope in *religious comfort*. Religious rituals and practices provided spiritual well-being that helped overcome mental and even physical suffering. A resident in a Jordanian nursing home, for example, told how he got rid of his nightmares since he put the Koran under his pillow:

> I'm an illiterate man who can't read or write. I see frightful nightmares while sleeping every night. The presence of a text of the Holy Koran ensures that I'm not going to see nightmares again. (Hweidi 1999)

Christian residents in an Ethiopian care facility for the poor described how they compensated the lack of medication:

> Why should we seek medical service rather than God's support? Holy water is our medicine. (Teka and Adamek 2014)

In the same way, the Hindus found comfort in their own religion:

> When one hears Lord Krishna's flute music, one does not recall sufferings and troubles. (Shrestha and Zarit 2012)

> Where is peace? To mutter the name of God repeatedly gives much more peace and happiness. He has created the world. If one is naked and hungry, he is kind to him. He resides in the heart of everyone. (ibid.)

A satisfaction of hope could also help to find *peace of mind in the face of death and dying* (Hjaltadóttir and Gustafsdóttir 2007; Melin-Johansson et al. 2014; Shin 2015; Shaw et al. 2016). These residents appreciated life and enjoyed its moments, but were not worried about prolonging it since they felt no fear of death.

> I'm not keen on this long life that everyone is striving for, on the other hand I admire life, it has given me many things, both hard work and also happiness. (Hjaltadóttir and Gustafsdóttir 2007)

Residents in facilities run by a religious congregation described how they found hope and solace in ceremonies for the dying that helped them to overcome their own fear of death and to await an afterlife.

> Because… when you die, nuns all gather together around the deathbed. They pray, they sing… beauuuuuuutiful songs… They accompany you to the doorstep of the heaven… (Shin 2015)

Others, however, were unable to overcome their suffering. After being abandoned by their family, they felt that they had lost their purpose in life, and they became *hopeless and resigned* (Ball et al. 2000; Koch-Straube 2003; Andersson et al. 2007; Coughlan and Ward 2007; Tsai and Tsai 2008; Hutchinson et al. 2011; Melin-Johansson et al. 2014; Cho et al. 2017; Mohammadinia et al. 2017). The only wish they had was to die as soon as possible

> My sons don't want to care for me, so they sent me to this place. I can't do anything. All I can do is eat; [I am a] useless person. I hope to pass away as soon as possible. (Tsai and Tsai 2008)

> I don't look forward to anything. I don't think much about the future. I just live day-to-day and expect it to end up very shortly. In fact I hope it does. (Ball et al. 2000)

5.5.4 Influencing Factors

5.5.4.1 Environmental Factors

Since physical decline was the main reason for an admission to a long-term care facility, it disrupted the balance between maintaining old habits and searching for new perspectives and triggered the crisis that had to be resolved by finding a new balance between scepticism and hope. This process could be facilitated or hampered by the environmental factors that also influenced the satisfaction of body-related, social, and identity-related orientations of action. Of particular importance for the balance between maintaining old habits and searching a new perspective was the atmosphere of a facility. A *homelike environment* that reminded residents to places of their previous life enabled them to find something familiar in the unfamiliar and promoted their sense of belonging (Bergland and Kirkevold 2006; Murphy et al. 2007; Hauge and Heggen 2008; Cooney 2011; Bradshaw et al. 2012; Barnes et al. 2013; Andrew and Wilson 2014; Adra et al. 2015; Nakrem 2015). This could be further enhanced if they were allowed to furnish their own space with private belongings that were memories of their past. In contrast, an *impersonal and institutional atmosphere* that imposed schedules and routines on residents and did not provide opportunities for recreation and the establishment of social contacts deprived older persons of their sense of home (Canham et al. 2016). Furthermore, the atmosphere and style of a facility could *not match the cultural background* of immigrants—even if it was homelike for the majority of their roommates (Andrews 2012; Martinsson et al. 2013).

5.5.4.2 Development-Related Care

The treatment of the residents also had an influence on the satisfaction of their development-related needs. Care related to social and identity-related orientations of action played a key role for the failure or success to find a new balance between maintaining old habits and searching for new perspectives. Getting acquainted with a residents' biography, active listening, and supporting reminiscence did not only satisfy older persons' desire for respect and self-esteem, as mentioned above, it also helped them to establish a connection to their past. Allocation of tasks, promotion of social contacts and organisation of common activities, did not only satisfy social and identity related needs, but also offered the possibility to discover new perspectives if they were tailored to the preferences and interests of the older persons. *Religious ceremonies* helped to satisfy their need for hope (Iwasiw et al. 1996; Bergland and Kirkevold 2006; Fraher and Coffey 2011; Andrews 2012; Falk et al. 2013; Nakrem et al. 2013), and *allowing them to grieve* (Heliker and Scholler-Jaquish 2006) could alleviate their sorrow if they became hopeless and resigned.

5.5.5 Behavioural and Attitudinal Reactions

Since an admission to a long-term care facility meant a major change in the life and was often experienced as a crisis, older persons had to react with a readjustment of their development-related orientations of action which was also reflected in their behaviours. Cut-off from their homes and their previous lives they could try to some extent to search for new perspectives. Another way of staying connected to the past was *cultivating memories*, which also helped them to maintain their self-esteem, as mentioned above (Harmer and Orrell 2008; Goddard et al. 2013). If they were confronted with the death of roommates, they could try to face this final adversity. To the awareness of their approaching end, they could react by downsizing their expectations, which also helped them to cope with the loss of physical abilities and self-reliance. As a counterbalance, many tried to strengthen their hope, mainly with the help of *religious practices* (Hweidi

1999; Ball et al. 2000; Al-Omari et al. 2005; Bergland and Kirkevold 2006; Bland 2007; Hutchinson et al. 2011; Park et al. 2012; Shrestha and Zarit 2012; Chang 2013; Adra et al. 2015; Iden et al. 2015; Rekawati et al. 2018).

> I tell myself that I mustn't be sad. I say a silent prayer. It makes me calm. (Iden et al. 2015)

5.6 Discussion

The aim of this metasynthesis was to describe how long-term care facilities influence the quality of life of their residents and to identify the similarities and differences between nursing homes and their alternatives in this respect. In a global context, however, there is no clear demarcation between these different kinds of facilities. Some assisted living facilities may have rather an institutional character and remind their residents to nursing homes and some nursing homes may have such a homelike atmosphere that they could be labelled as assisted living. The difference between concrete facilities as they are experienced by their residents seems to be only gradual. It may be more appropriate to consider both types of facilities as endpoints of a continuum of care that allows concrete facilities to be positioned according to their proximity to one of these two endpoints. At one end of this continuum, there are facilities that accommodate residents with less severe physical limitations who enjoy more independence. These residents tend to establish social contacts in the form of individual relationships and group building that include some of their roommates and exclude others. Within a system where such facilities are a preliminary stage to facilities for a higher level of care dependency, the independence of the residents is, however, under threat as they are constantly monitored with regard to their fitness and may be transferred to a nursing home in case they should fail to meet the criteria to stay.

At the other end of this continuum there are facilities to meet higher levels of care dependency. The restricted self-reliance of their residents can be associated with severe loss of choice and control. Residents are subjected to routines of care and live in a forced community where they tend to retreat into silence. Their lives seem to be reduced to sheer physical existence and they suffer from a loss of purpose in life. In countries, where no distinction between levels of institutional care exists, facilities may accommodate residents with all degrees of care dependency, but a policy that aims to delay or prevent admission to long-term care facilities can turn nursing homes into places where persons with the highest level of care dependency are concentrated. Since quality of life depends to some extent on the physical condition, it is under such circumstances not surprising that facilities for lower levels of care needs seem to ensure a higher level of quality of life.

It is, however, doubtful that such differences in quality of life can be captured by an objective measurement. The findings of this metasynthesis indicate that older persons tend to reduce unmet needs and compensate them by others in order to maintain their inner balance. Hence, unfavourable conditions do not necessarily affect their perceived satisfaction of needs. Attempts to measure quality of life aim to identify deficiencies that should be remedied. They may create awareness for a loss of quality of life that older persons have compensated by a change of attitudes and needs. Unintentionally, such measurements counteract these attempts to maintain the subjectively perceived quality of life. It is therefore not surprising that study participants tend to depict their own condition in a positive way. In other words, their responses may be biased, since such bias helps to maintain their quality of life. Ignoring deficiencies corresponds to the tendency to obtain a positive self-image and to deny adversities which are both orientations of action of every human being. Consequently, there is no quality of life as such that could be adequately measured if one would succeed in avoiding bias. Bias cannot be removed since it is an essential aspect of being a person and of every person's quest for quality of life. In part, quality of life results from a self-perception where the needs are adapted to the conditions of life. This does, however, not mean that such self-perception produces a stable state of well-being. Well-being is rather a fragile condition. It results from an inner balance of the opposite orientations of action that can be easily disturbed by external circumstances such as the loss of health or old home. Older persons than have to struggle to overcome these losses and to regain an inner balance. Such disturbances of the inner balance cannot be captured by a fast assessment, but they can be observed by caregivers if they engage in an individual care relationship that is based on trust and allows intimate knowledge of the care recipient. In other words, person-centred care is the way to recognize disturbances in quality of life with the aim of enabling older persons to overcome them.

The attempt of this metasynthesis was to identify the orientations of action that are of importance for the inner balance of older persons. It has of course some limitations. To some extent, the distinction between the different orientations of action remains vague. On the one hand, this is due to the fact that the different orientations of action affect each other. Thus, for example, the satisfaction of being cared for also conveys a certain feeling of closeness, or the satisfaction of self-reliance also promotes a sense of control and a positive self-image. In addition, orientations of action can often only be identified by the behaviour of residents. A particular behaviour, however, can serve several needs. Reading, for example, can meet the desire for diversion or reflection, depending on the kind of literature. Unfortunately, many of the investigated studies just listed a variety of behaviours and activities without specifying the underlying needs. In such cases, the interpretation had to rely on assumptions, which were of course prone to errors.

Some orientations of action may have been inappropriately understood or some may even be missing. For example, one would have expected to find a desire for creativity that was counterbalanced by an orientation towards destruction. The investigated data, however, did not justify the identification of these orientations of action. Since their existence is at least plausible, one has to assume that the model derived from this metasynthesis is still preliminary. Likewise, the needs for elimination and protection of body temperature, which play a role in everyday nursing practice, were not mentioned in any study. One reason might be that for the residents the issue of elimination is related to feelings of shame, and hence, they avoid mentioning this issue. In contrast to this, caregivers expect to hear about it since they have been trained to focus on possible problems in this area. The regulation of body temperature may not have been mentioned since residents did not perceive this to be any problem.

Moreover, the findings of this metasynthesis mainly apply to residents without cognitive impairments, since persons who suffer from dementia have only limited abilities to provide a clear idea of their needs. What matters to them has to be reconstructed by observations and remains necessarily fragmentary. The findings of this metasynthesis, however, may serve as a framework to understand also the concerns of those who cannot speak for themselves. They offer an orientation scheme for the assessment of their personality, and even if an understanding is doomed to remain fragmentary and incomplete, it is still a step forward in identifying and responding to their needs.

5.7 Conclusion

In summary, quality of life in long-term care facilities seems to be ambivalent. On the one hand, facilities can promote a feeling of safety and being cared for. Relieved from the burden of self-care, older persons can even enjoy a sense of independence as they can focus on activities that are more important to them. Living together with peers may also promote social contacts, which are a source of entertainment and an opportunity to find acknowledgement from others. Staying in a care facility may allow them to discover new perspectives and to find new hope. On the other hand, routines of care and rules of social life may result in a loss of self-reliance and control over one's life with ensuing feelings of powerlessness, boredom, and a loss of self-esteem. As a consequence, admission to a long-term care facility may result in a serious crisis—especially if older persons are forced to move in against their will. They can feel cut off from the past and lose hope, which ultimately reduces the will to live on. Although many studies confirm this rather negative picture, the findings also provide opposite examples. Long-term care facilities can prevent but also promote the satisfaction of older persons' orientations of action. Table 5.7 summarizes the key points of these findings.

Whether quality of life after admission to a long-term care facility develops in a positive or a negative way depends on a variety of factors. Most important seem to be the older persons' physical condition, the influence they can exert on the decision to move in, the support they receive from family and friends, their attitude to life in general, and of course the care they receive in the facility. The investigated studies describe a variety of care interventions that may have an either positive or negative impact. However, there is no care that is always appropriate. Well intended actions may counteract the needs of residents if the focus of their orientations of action is on the opposite. Providing personal care may produce a feeling of being cared for, but can also result in a loss of self-reliance. Enforcing self-reliance by refusing to help can on the other hand produce feelings of being neglected. The company of

Table 5.7 Long-term care facilities and satisfaction of the orientations of action

Body-related orientations of action	
Physical activity *Satisfied* if residents maintain and enjoy mobility according to their capacities *Not satisfied* if residents have no opportunities for physical activity and experience a decline of mobility	*Physical rest* *Satisfied* if residents can have a rest and nap *Not satisfied* if residents suffer from sleep disorders or overexertion from physical activities
Body protection and regeneration *Satisfied* if residents experience physical wellness through receiving personal care *Not satisfied* if residents experience injuries, pain, and a decline of health	*Negligence towards health* *Satisfied* if residents are allowed to reduce hygiene and health care according to their needs *Not satisfied* if residents feel inconvenient due to exaggerated care for their health
Food consumption *Satisfied* if residents enjoy their meals *Not satisfied* if residents remain hungry or dislike the taste of food	*Food abstinence* *Satisfied* if residents could avoid satiety *Not satisfied* if residents suffered from satiety since they felt obliged to empty their plates
Sexual desire *Satisfied* if residents had sexual pleasure that was not disturbed by others *Not satisfied* if residents experienced sexual frustration due to lack of privacy or appropriate partners	*Sexual abstinence* *Satisfied* if residents remained undisturbed from sexual desires of others *Not satisfied* if residents experienced sexual harassment or marital rape
Social orientations of action	
Self-reliance *Satisfied* if residents maintain self-reliance *Not satisfied* if residents feel incapacitated by overprotective care and gradually lose their abilities	*Being cared for* *Satisfied* if residents feel comfort and relief of burden since caregivers are attentive to their needs and provide little extras *Not satisfied* if residents feel neglected, have to wait to get desired help
Exerting influence on others *Satisfied* if residents have choices and can participate in decisions about their own care *Not satisfied* if residents feel powerless since they had to move in against their own will, feel subjected to routines of care, and are annoyed by their roommates	*Attention to the needs of others* *Satisfied* if residents feel that they are no burden to their family and their caregivers *Not satisfied* if residents feel to be a burden to their family and their caregivers
Social adjustment *Satisfied* if residents feel normal and in tune with their social environment *Not satisfied* if residents feel shame for failures to meet social standards	*Unconventionality* *Satisfied* if residents can be spontaneous and feel unrestrained by social norms *Not satisfied* if residents have to suppress own needs
Closeness *Satisfied* if residents gain social contacts in the facility and maintain contacts to family and friends *Not satisfied* if residents lose old contacts and find no suitable person to talk to in the facility	*Distance* *Satisfied* if residents have their own room and others respect their privacy *Not satisfied* if residents stay in shared rooms and lack privacy

Table 5.7 (continued)

Identity-related orientations of action	
Work *Satisfied* if residents enjoy to be active and productive *Not satisfied* if residents have nothing to do to fill their time	*Relaxation* *Satisfied* if residents find mental relaxation *Not satisfied* if residents feel exposed to overburdening activities
Reflection *Satisfied* if residents find intellectual pleasure *Not satisfied* if residents are displeased by trivial entertainment and superficial conversation	*Diversion* *Satisfied* if residents feel entertained through social activities, music, or excursions *Not satisfied* if residents lack entertainment and stimulation
Self-centredness *Satisfied* if residents were able to meet their own interests by being in command, getting attention from others, and having their own pleasure *Not satisfied* if residents suffer from self-neglect	*Concern for others* *Satisfied* if residents have a feeling of being needed *Not satisfied* if residents feel useless and unable to reciprocate
Self-presentation *Satisfied* if residents attract the attention of others and are appreciated and respected by others *Not satisfied* if residents were not respected or ignored by others	*Self-concealment* *Satisfied* if residents remain unnoticed and undisturbed by undue attention of others *Not satisfied* if residents feel exposed to gossip and undue criticism of others
Positive self-perception *Satisfied* if residents have positive memories and were able to recognize their own strengths *Not satisfied* if residents have a negative self-image and were plagued by negative memories	*Critical self-perception* *Satisfied* if residents are able to recognize their weaknesses and to downsize their expectations *Not satisfied* if residents have no realistic idea about themselves and withdraw in an imaginary identity
Development-related orientations of action	
Attachment to the past *Satisfied* if residents find some continuity and experience a homelike atmosphere *Not satisfied* if residents suffer from the loss of their home and experience cultural alienation	*Searching new perspectives* *Satisfied* if residents discover a new life in the facility or develop a new sense of belonging *Not satisfied* if residents experience stagnation
Denial of adversities *Satisfied* if residents can live with undue worries and fears *Not satisfied* if residents suffer from fear due to their confrontation with death	*Facing adversities* *Satisfied* if residents are aware of and feel enabled to confront their approaching death *Not satisfied* if residents are not aware of their approaching death
Hope *Satisfied* if residents are enabled to enjoy the moment and to find religious comfort *Not satisfied* if residents resign and become hopeless	*Scepticism* *Satisfied* if residents are aware of their situation and adapt gradually *Not satisfied* if residents are attached to illusionary beliefs

roommates may promote social well-being but can also disrupt privacy. Too much privacy, however, can result in a lack of social contacts and loneliness. Joint activities may create diversion but can also produce feelings of triviality. Lack of diversion, on the other hand, may result in boredom. The list of examples could be extended further. It shows that care has to be adapted to the individual inclinations of the residents. For this reason, the findings of this metasynthesis do not allow establishing a fixed standard for appropriate care. They highlight, however, some principles of central importance that need to be observed by caregivers since they represent the core of person-centred care.

- First of all, caregivers should establish a relationship of trust. Quite often they become a substitute for social contacts that have been lost. If residents find someone to turn to, it reduces their sense of loneliness and makes them feel at home. Since residents want continuity in care relationships, every one of them should find a reference person in the care team who is primarily responsible for meeting his or her needs. To establish trust, caregivers need to have communicative skills. These include the ability to small talk, which serves no purpose except entertainment. Establishing trust is not a task that can solved in a time- and cost-efficient manner. It rather takes time to be spent with the resident.
- In such a relationship of trust, caregivers should be attentive to unspoken needs, as residents often follow habits and routines that go unreflected and are therefore not expressed. Moreover, older persons will not always tell their conscious needs since persons do not like to disclose their inner world to everybody. Having secrets is an essential aspect of being a person. They belong to the private sphere, and their protection represents a dimension of quality of life. Caregivers must therefore carefully identify unspoken needs without violating privacy. Such attention will also enable them to better understand the needs of those who cannot speak for themselves—even if only approximately.
- When caregivers enter in a dialogue with residents, active listening is of central importance. It enables residents to recognize their current resources and needs and to reflect on their biography. Reminiscence may allow them to gain self-acceptance by rediscovering their own strengths and to maintain a connection to their past.
- Active listening is also the way to learn about the residents' own concerns. Instead of identifying deficits according to some predetermined standards, caregivers should become aware of what really matters to the older persons. They should not determine what residents should achieve, but understand what residents want to achieve, since this enables them to be self-determined and to unfold their personality.
- Finally, to ensure self-determination, residents should be allowed to participate in the planning of their care and to have choices. In this way they can maintain a sense of control despite their loss of abilities and self-reliance.

Of course, it will be impossible to meet this ideal at all times. Individual interests must sometimes be neglected since caregivers have to meet the needs of more than one care recipient. Furthermore, residents must adapt to some extent to the rules of the community to which they belong. It seems, however, that in many facilities incidences that contradict this ideal are not the exception to the rules of person-centredness. The dominant understanding of care that exists in long-term care facilities rather disregards this idea. Care is mainly understood to be manual work which serves to produce some specified outcomes in a fast and effective way. Within such a framework of task-orientation, communication and active listening are not perceived to be interventions, since they show no immediate and measurable results. They rather seem to be an end in themselves and therefore without real value. However, quality of life is not a product that can be fabricated in a working process. A balanced satisfaction of orientations of actions emerges from within the individual and caregivers have to work like gardeners who can stimulate but not enforce the growth of plants. Such an enabling care would meet the needs of care recipients, but it requires that caregivers gain a new understanding of their own work. The understanding of care, however, depends not only on the individual caregiver but also on the social system in which they work. Therefore, it seems necessary to develop a new nursing culture that is focused on listening and dialogue if residents in long-term care facilities shall receive person-centred care.

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