2018

Exploring the Lived Experiences of Female Retirement Living Seniors and Their Social Relationships

Kathy Procyk
proc7090@mylaurier.ca

Exploring the Lived Experiences of Female Retirement Living Seniors and Their Social Relationships

by

Kathy Procyk

Wilfrid Laurier University, 2018

THESIS

Submitted to the Department of Kinesiology and Physical Education

in partial fulfillment of the requirements for

Master of Kinesiology

Wilfrid Laurier University

Acknowledgements

First and foremost I would like to thank my supervisor, Dr. Paula Fletcher. I am so grateful for the amazing opportunity she provided me by taking me on as a student. The countless hours she spent reading, editing, and sharing her knowledge with me have been invaluable in the success of this project. Her unwavering support, mentorship, and belief in me over the last two years have greatly contributed to my growth both as a student and as a person.

To my thesis advisory committee, Drs. Jennifer Robinson-Wilson and Pam Bryden - thank you for always finding time in your busy schedules to provide direction and feedback for my thesis. Their willingness to help in any way they could was greatly appreciated.

To my parents, family, and friends- thank you for your encouragement towards my academic undertakings and for understanding when they took priority. Thank you to my Mama, Tato, and partner Roman, for their unconditional love and always being a phone call away ready to celebrate all my milestones. They have kept me grounded and reminded me I can achieve anything I put my mind to. I could not have done this without their support.

And, lastly, to my participants- I am forever indebted to all the individuals who took the time to share their experiences with me. I am grateful for your honesty, insights, and helping me better understand what it means to live in a retirement home. You are some of the most resilient, kind-hearted, and selfless people I have ever met. This project is just as much yours as it is mine. Thank you from the bottom of my heart.

Abstract

Objective

This research examines the lived experiences of seniors living within a retirement home (RH) and their social relationships with friends, family, and RH peers. The phenomena is explored through two perspectives (the senior and their support person) in order to better understand how retirement home living affects individuals' social patterns and social well-being.

Methods

The theoretical orientation used to guide this study was phenomenology. After completing a background questionnaire, one-on-one semi-structured interviews were conducted with 11 women living in a retirement home and 7 primary support persons. Interviews were transcribed verbatim for further data analysis. Field notes, member checks, and triangulation were used to enhance the credibility of the research.

Results

Four key themes emerged: (1) It's all in the attitude; (2) Barriers to friendship; (3) Life beyond the RH; (4) The bigger picture. The following themes and their respective subthemes highlighted the various factors that influenced social life and relationships within a retirement home. Despite the challenges associated with RH living, all participants recognized the RH was the best place for the seniors to be.

Conclusions

Participants' narratives revealed the realisms of making and maintaining social relationships while living in a RH. The dual perspective from seniors and their support persons provided insights into effective methods of keeping seniors socially active, as well as suggestions on how to foster meaningful social participation and interactions.

Definition of Terms

For the purpose of the current study, terms commonly used are defined as follows:

Primary Support Person (PSP): A person who supports a senior predominantly, but not exclusively, through the provision of social support. This involves regular communication, which helps the senior feel cared for, important, and connected (Cobb, 1976).

Retirement Home (RH): "A privately owned building or a part of a building with one or more rental units of living accommodation that meets the following criteria: (1) occupied by persons who are 65 years or older; (2) occupied or intended to be occupied by at least six persons who are not related to the operator of the home; (3) makes at least two care services as set out in the Act available to residents" (Retirement Homes Act, 2010, S.O. 2010, c. 11).

Retirement Living Senior (RLS): A senior who has been living in either an independent or assisted living unit within a retirement home for 1-3 years. ("Senior Living Options-ORCA" 2013)

Social Network: "The web of social relationships surrounding an individual, in particular, structural features, such as the type and strength of each social relationship" (Umberson & Montez, 2010, p. 55).

Social Relationship: "Connections that exist between people who have recurring interactions that are perceived by the participants to have personal meaning. It excludes social contacts and interactions that are fleeting, incidental, or perceived to have limited significance (e.g., time-limited interactions with formal care providers)" (August & Rook, 2013, p. 1838).

Social Support: An intimate social relationship which involves one person providing some form of emotional, instrumental, and/or informational support to a senior, intended to help better the senior's social, mental, and/or physical well-being (Umberson & Montez, 2010).

TABLE OF CONTENTS

CHAPTER 1: REVIEW OF THE LITERATURE

1.1 INTRODUCTION

For the first time in Canadian history, the number of seniors in Canada exceeds the number of children, with 5.9 million Canadians over age 65 and 5.8 million under 14 (Statistics Canada, 2017). Not only is the proportion of seniors increasing, these seniors have a longer life expectancy than the generations before them. In 2016, the average life expectancy in Canada was 81, compared to 78 in 1990 (Statistics Canada, 2017). Further increased life expectancy is accompanied by a myriad of issues such as increased risk of disease development and physical disabilities, cognitive decline (e.g,. memory loss, dementia), difficulties with daily activities, and fewer social interactions (Wister & McPherson, 2014). Nevertheless, as with any age group, a central goal for Canada's aging population is for seniors to be as healthy as possible.

Health is a multidimensional construct including physical, mental, emotional and social well-being, which affect a person's quality of life (Centers for Disease Control and Prevention, 2010). One very important, but often overlooked construct is how social involvement and relationships integrate to shape one's overall health in later life (Ashida, 2008). Recent studies show that social participation has a positive influence on both self-perceived and actual health of seniors (Gilmour, 2012; Leone & Hessel, 2016). Still, the role that social relationships and the social environment play in healthy aging is not well understood (Adams, Leibbrandt, & Moon, 2011; Berkman, Glass, Brissette, & Seeman, 2000).

While it is unclear whether social relationships lead to good health, or vice versa, there is evidence of a reciprocal relationship between the two factors. As seniors age, they have reduced social networks due to various life circumstances (Charles & Carstensen, 2010). A report examining senior women in Canada found that 3% of women aged 65 to 74, and 6% aged 75 and over reported having no close family members. Further, 9% of women aged 65 to 74, and 13%

aged 75 and over reported having no close friends (Hudon & Milan, 2016). When asked what constitutes successful aging, seniors often identified engagement with life and social activity was of utmost importance (Carver & Buchanan, 2016; Reichstadt, Sengupta, Depp, Palinkas, & Jeste, 2010). Moving into a retirement home has the potential to positively influence seniors' social well-being through expanding their social networks and providing opportunities to be involved. To capture the all-encompassing nature of retirement living seniors' (RLSs') social well-being, this study will examine RLSs and their primary support persons' (PSPs') social experiences within and beyond the four walls of the retirement home. A deeper look into the social networks, familial bonds, expectations, and involvement of seniors and their PSPs will reveal the intricacies of RLSs' social well-being. The concepts of Canada's senior population, their social relationships, PSPs, and retirement home living will be discussed in turn.

1.2 AGING POPULATION

1.2.1 Demographic Shift

Seniors are most often defined as men and women aged 65 years or older. In 2016, seniors comprised 17% of Canada's population. Population projections predict that by 2031, seniors will account for one quarter of our population (Statistics Canada, 2017). The aging of the baby boom cohort (individuals born between 1946-1964) is driving much of the demographic shift towards an older population. When studying the aging population, it is important to remember seniors are a very diverse group of people with varying cultures, identities, values, abilities, and socioeconomic standing (Public Health Agency of Canada, 2011).

Due to their longer life expectancies, females currently dominate the senior population with 55% of Canadian seniors being women (Statistics Canada, 2017). Independent of age, women have unique experiences of aging compared to their male counterparts. For example,

senior women are more than twice as likely to live alone. Senior women also report higher satisfaction with life as a whole, feeling closer to more family members and friends, and engaging in more frequent contact with these members (Milan & Vézina, 2011). From a health perspective, senior women are more likely to receive daily informal care assistance, be formally diagnosed with more than one long-term health condition, and more likely to report feeling pain (Milan & Vézina, 2011). In the coming years, Canada will face an increase in the number of senior women requiring support and a decline in the number of people able and willing to provide this support (Knickman & Snell, 2002). Society will need to accommodate this shift and the resulting increased demands.

1.2.2 Supporting Seniors

Though the type and frequency may vary, most people will receive some kind of support or care throughout their lives. Sinha (2013) contends that in Canada the most common reason individuals require support from caregivers are age-related needs. Providing support to seniors comes in many different forms, including housework or yard maintenance, scheduling and coordinating appointments, providing transportation, helping with personal care, offering companionship, and managing finances among many other tasks (Sinha, 2013). These forms of support are often referred to as caregiving and can be further broken down into formal and informal care. Formal care refers to paid "home care and community support services provided to older persons by a mix of providers, including personal support workers, nurses, occupational therapists…" (Williams et al., 2010, p. 6). In contrast, informal care is unpaid, ranges from emotional to instrumental supports, and is provided by social networks, friends, families, or volunteers (Williams et al., 2010). For the purpose of this thesis, informal caregiving will be conceptualized as a type of support, and the two terms (informal caregiving and support) will be

used interchangeably to describe an individual providing any form of informal assistance to another individual.

As a result of the demographic shift, the number of Canadian seniors requiring support from informal and formal networks is expected to double in the next 30 years (Keefe, 2011). This increasing demand has been recognized at all levels of the Canadian government, generating various reports with recommendations and strategic plans on how to deal with the aging population. Based on reports released by the World Health Organization (World Health Organization, 2015), Public Health Agency of Canada (Public Health Agency of Canada, 2014; The National Seniors Council, 2014), and the Ontario Government (The Ontario Seniors' Secretariat, 2013), the main focus for policy makers moving forward is to ensure the healthcare system is able to support the growing number of seniors, namely in areas of long term care, home care services, and hospital admissions. In addition to healthcare, investing in social wellness is essential to healthy aging, as social well-being is closely linked to better physical and mental health (Thoits, 2011). As such, reducing social isolation among seniors has also been identified as a priority area by a number of aging research groups across the country. While recommendations for age-friendly communities include increasing social participation, helping seniors maintain independence, and reducing risks of social isolation in seniors, there is little information on how to achieve this (The Ontario Seniors' Secretariat, 2013). Current services offered to support seniors' social health include senior centers that offer social, learning, and recreation programs, and various senior-based organizations that provide volunteer and community engagement opportunities (Aging With Confidence: Ontario's Action Plan for Seniors, 2017). Unfortunately these community-based programs do not necessarily reach the 25% of senior women who report desires to participate in such social activities, but face barriers

of accessibility and availability of services (Gilmour, 2012). In short, there is a need for alternative, more practical means to support seniors' social and overall health.

1.3 SOCIAL ASPECTS OF AGING

There is no single universally accepted definition for social networks, social relationships, or social support. These concepts are widely used in the literature; however the lack of consistency and consensus of these definitions has made it difficult to compare studies both within and between areas of research. Williams and colleagues (2004) critically appraised existing literature on social support and argued that in order for social support and related concepts to be relevant, they must be defined contextually. Based on the literature, they found that the concept of social relationships is most often categorized by structure, type, and strength. Further, social relationships are necessary for social support to occur. According to the authors, the concept of social support can be broken down into emotional resources, intimate resources, material resources, time resources, cognitive resources, and skill or labour resources (Williams, Barclay, & Schmeid, 2004). Using these definitions as a framework, this study will define social networks as the broadest type of social structure, followed by social relationships, and then the most intimate structure, social support. For the purpose of this study, social networks include groups of people that seniors are affiliated with, such as church groups, residents in the RH, or extended family networks. Social relationships will then refer to connections seniors have with people within their social networks that are reoccurring and perceived as meaningful. These ties have the potential to make seniors feel connected, and provide a sense of belonging. Finally, social support will refer to intimate relationships that are valued most by seniors, and have positive effects on the seniors social, mental, and/or physical well-being (Umberson & Montez, 2010). The concept of social networks and social support will be described below.

1.3.1 Social Networks

Understanding the complexity of seniors' health is a matter that involves more than just what goes on under the skin or in the mind. Precipitants to good health include environmental factors, such as support networks of friends, family, and neighbours. The term social network refers to "the web of social relationships surrounding an individual, in particular, structural features, such as the type and strength of each social relationship" (Umberson & Montez, 2010). As people age, the composition of their social network changes. Contrary to the preconception that seniors' social networks remain stable in later life, findings from The National Social Life, Health, and Aging Project (NSHAP) suggest otherwise. Longitudinal data from 3000 community-dwelling American seniors found that 93% of respondents reported changes in their social networks, most of them having both lost and gained at least one confidant in the last five years (Cornwell, Schumm, Laumann, Kim, & Kim, 2014). With age, seniors' networks also tend to decrease in size due to a decline in health, retirement, relocation, passing of loved ones, and departure of children (McPherson, Smith-Lovin, & Brashears, 2006).

Social networks play an important role in seniors' health because they provide seniors with a personalized system of access to information, resources, and social support. Some of the literature on seniors' social networks suggests that people with larger support networks tend to have better health outcomes, as having more contacts increases the chance of receiving support when needed (Cornwell et al., 2014; Waite & Das, 2010). However, the quality of one's social networks is arguably more important than mere size. Subsequently, existing research also supports the notion that it is not the size of the social networks that is associated with health and well-being, but rather the quality of the relationships within the networks (Adams et al., 2011; Fiori, Antonucci, & Cortina, 2006; Routasalo, Savikko, Tilvis, Strandberg, & Pitkala, 2006).

Seniors place the greatest emphasis on emotional satisfaction and support in their social relationships, so good quality relationships are perceived positively by seniors (Charles & Carstensen, 2008). As such, seniors' social networks are mainly kin centered as family relationships tend to provide unconditional support and strong, reliable ties (Cornwell et al., 2014). In discussing social networks, it is important to note that having social networks does not necessarily mean that seniors receive adequate support via the networks. For example, some relationships within their networks can potentially be sources of stress rather than support (Walen & Lachman, 2000). Thus, the positive health effects of having social networks are strongly influenced by seniors' perceptions of the relationships with their social networks. For example, according to the Canadian Community Health Survey, 62% of seniors who reported a strong sense of belonging also reported good health, whereas only 49% of seniors who felt less connected reported good health (Shields & Laurent, 2006). Nevertheless, the literature shows that social networks, regardless of size, typically are positive for seniors and their health.

1.3.2 Social Support

Berkman (1983) was the first to differentiate between the concepts of social networks and social support. Whereas social networks refer to the web of relationships that surround a person, social support is an interactive process, from which emotional, instrumental, and financial support is obtained. Seeman and Berkman (1988) examined the structural characteristics of seniors' social support systems, as well as the availability and perceived adequacy of the emotional support being received. Structured interviews with 2806 community-dwelling seniors revealed that neither network size nor the geographic proximity of support was significantly related to perceived adequacy of support. This meant that adequate social support could be provided from close, or afar and in various forms (ie. telephone, letters, visits, etc.) Interestingly,

the presence of a spouse did not significantly increase seniors' perceived adequacy of emotional support, while intimate ties with a confidant, close friends, and children did. Recent research in the field of social gerontology continues to find that family members provide the most social support to senior family members, but seldom consider the perceived adequacy of this support (Cranswick & Thomas, 2005; Silverstein & Giarrusso, 2010; Sinha, 2013).

Undoubtedly social support plays a critical role in the overall health of seniors (Cheng, Lee, Chan, Leung, & Lee, 2009; Public Health Agency of Canada, 2006; Stoller & Wisniewski, 2003). In addition to increasing seniors' perceived health and quality of life, social support has also been shown to have positive effects on morbidity, mortality, mental health, as well as cognitive and physical abilities (Barnes, Mendes de Leon, Wilson, Bienias, & Evans, 2004; Cacioppo & Hawkley, 2003; Heikkinen & Kauppinen, 2004; Wilson et al., 2007). Early work by Berkman and Syme (1979) analyzed the relationships between social ties and mortality in 4775 adults aged 30 to 69. During a 9 year follow up, they found that compared to individuals with strong social support, those with low social support were almost twice as likely to die prematurely, even after controlling for self-reported physical health, socioeconomic status, smoking, alcohol consumption, physical activity, obesity, race, life satisfaction, and use of preventive health services. These findings are comparable in Canada, as illustrated in Health Canada's Report on Social Participation and the Health and Well-being of Canadian Seniors, which also found social relationships to be significantly associated with health and well-being, independent of socio-demographic and health factors (Gilmour, 2012). Using data from 25,000 community-dwelling seniors collected through the General Social Survey on Aging and Social Support, the researchers analyzed the relationships between three dimensions of social support (positive interaction social support, tangible social support, and emotional or informational social

support) and three health and well-being outcomes (positive self-perceived health, loneliness, and life dissatisfaction). Based on these measures, as the level of social activity increased, the likelihood of reporting positive self-perceived health increased, while loneliness and life dissatisfaction decreased. Additionally, seniors who were satisfied with the kind and frequency of contact with family members were, all else being equal, more likely than other seniors to have received informal care, which is linked to more resources, and in turn better health outcomes (Gilmour, 2012; British Columbia Ministry of Health, 2004).

According to Gilmour (2012), "individual's perceptions of the availability of social support are thought to be more important than received support" (p. 1). Furthermore, it has been shown that a lack of anticipated or expected support can result in increased psychological distress, leading to declines in seniors' overall health (Seeman, 2000). This highlights the important role of PSPs, as they often help seniors feel important, valued, and provide a sense of social connectedness (Public Health Agency of Canada, 2006). To study the association between seniors' perceived and actual social patterns and health, Cornwell and Waite (2009) analyzed data from the NSHAP on community-dwelling seniors. Two hypotheses were constructed: (1) actual lack of support and perceived lack of support are independently associated with health and (2) perceived lack of support mediates the relationship between actual support and health. Using a sample of 2,910 American seniors, researchers found that actual and perceived social support had distinct effects on health. Actual lack of social support was associated with lower self-rated physical health, independent of whether seniors perceived the shortage. Seniors who received satisfactory levels of actual support but perceived the support as inadequate also reported lower self-rated physical health. This suggests that high levels of actual support only have positive effects on health if seniors perceive the support in a positive manner. In sum, both actual and

perceived support mattered to self-rated overall health (Cornwell & Waite, 2009).

To date, there are very few studies that investigate the effects of social support on the perceived health of seniors in Ontario, or even Canada, let alone seniors living in a RH. Seeing as health risks associated with a lack of social support have been compared in magnitude to the well-known dangers of smoking cigarettes and obesity, a complete understanding of seniors' social support is crucial to promote healthy aging (Cornwell & Waite, 2009; Holt-Lunstad et al., 2010). Fitzpatrick and colleagues (2005) examined social support factors and their relationships to mental and physical health in 187 community-dwelling seniors from southern Ontario, composed of predominantly white females (mean age of 72.5 years). Using a questionnaire, they asked seniors about self-perceived health and forms of social support received from informal caregivers and friendships. Results indicated that there was a significant linear relationship between social support received through caregiving and positive physical health, mental health, and happiness with personal life (Fitzpatrick, Gitelson, Andereck, & Mesbur, 2005). Essentially, those receiving support from informal caregivers (family) perceived their overall health and well-being to be better than those receiving support through friendships and support staff. These findings reiterate the relationship between seniors' health and social support, and the fact that as individuals age, family members often become primary sources of support.

While the aforementioned studies provide insight into seniors' perceptions of social support, there is a lack of literature on this support specifically in RHs. Bekhet and Zauszniewski (2012) investigated mental health of seniors by administering a questionnaire to 314 American RLSs. They found that 29% of the sample reported feeling lonely, which is concerning because loneliness is linked to depression, which are both risk factors for social isolation (Bekhet & Zauszniewski, 2012). Further, a review by Theurer et al. (2015) looked at 'psycho-social' care in

residential care, referring to LTC facilities and RHs. They argued that the underpinnings of the social environments fostered in some of these facilities are troublesome as social activities are "designed to entertain and distract, rather than foster meaningful connections or engagement" (p. 203). As such, exploring the perceptions of RLSs warrants further investigation as RHs provide a unique social environment, and in turn, potentially unique social experiences. Thus, when studying seniors' social relationships, it is important to consider not only the people involved, but also the living arrangement, which can help or hinder seniors' social well-being.

1.4 SENIOR HOUSING

1.4.1 Retirement Homes

Retirement and nursing homes are often thought of and talked about as one entity. While both of these facilities provide housing for seniors, they are fundamentally different in many respects. Retirement homes, sometimes also referred to as assisted or residential care facilities, are privately owned buildings that rent units of accommodation to seniors who want to remain living within the community with moderate to no assistance ("Retirement Homes Regulatory Authority General Information," 2017; "Residential Care | CIHI", 2018). Based on data from the 2016 census, 3% of seniors in Canada live in a retirement home residence (Statistics Canada, 2017). In Ontario, RHs are licensed and regulated by the Retirement Homes Regulatory Authority (RHRA), which ensures the safety, security, and protection of RH residents. RHs offer a unique social and physical environment tailored to seniors' lifestyles. While services and amenities vary between RHs, many facilities offer social and recreational activities, exercise programs, visiting or on-staff health care professionals, and assistance with housekeeping, personal care, and medication management. The cost of stay is paid out of pocket, ranging from $1,500 to $5,000 per month (Housing for Older Canadians: The Definitive Guide to the Over-55

Market, 2015) depending on location of the home, amenity options, and if medical or health services are provided. Alternatively, nursing homes, also known as long-term care (LTC) facilities, provide accommodation for seniors who do not need to be in a hospital, but can no longer be cared for at home. In Ontario, LTC facilities are regulated and partially funded by the Ministry of Health and Long Term Care. Admissions into these facilities are managed by Community Care Access Centres, and overseen by Local Health Integration Networks (LHIN). LTC offers 24 hour nursing and personal care, along with other services such as meals, housekeeping, laundry, medical services, and recreational programs. Unlike RHs, residents living in LTC often have debilitating conditions, leaving little room for independence ("Residential Facilities, Assisted Living, and Nursing Homes", 2017).

The literature on RHs is relatively scarce, especially within the Canadian context. RHs are not heavily researched likely due to the relatively small percentage of seniors that currently occupy them, inconsistent terminology used to identify them, and a lack of funding for research of non-publicly funded senior resources. From a theoretical standpoint, Canadian RHs provide an environment with the potential to promote healthy aging through initiatives recommended by the Canadian Medical Association. These include opportunities for regular physical activity, proper nutrition through meal service, installed safety features such as grab bars for injury prevention, and regular community and social opportunities to promote mental health and well-being (Canadian Medical Association, 2016). RHs also enable seniors to 'age in place', which refers to staying in the same community so that seniors remain close to familiar people, places, and services (Housing for Older Canadians: The Definitive Guide to the Over-55 Market, 2015). In addition to services and activities offered by each RH, many seniors living in RHs receive external government sourced services through their Local Health Integrated Network (LHIN),

formerly known as Community Care Access Center (CCAC). The LHIN's main objective is to provide home-care services to Ontarians, who without this support would have to stay in a hospital or move into LTC. In 2015, over 60% of CCAC's clients were seniors, receiving home-care services which included assistance with activities of daily living (ADL) and instrumental activities of daily living (IADLs) (Auditor General of Ontario, 2015). As such, LHINs play an integral role in keeping seniors in the community longer by ensuring they receive care in the community (Auditor General of Ontario, 2015). When talking about aging in place, some will argue that aging in place, or seniors staying in the community refer to remaining in one's adult home. However, the Government of Canada defines aging in place as "having the health and social supports and services you need to live safely and independently in your home or your community for as long as you wish and are able" (Government of Canada, 2012, p. 2). When seniors (n=121) in two New Zealand communities were asked about the meaning of 'aging in place', they expressed feeling stronger connections to the people and familiarity of an area rather than the particular home in which they lived (Wiles, Leibing, Guberman, Reeve, & Allen, 2012). This suggests that seniors may value the milieu of their living situation more than the physical aspects of the environment. If remaining in a community where one has ties to the people, places, and memories, is what seniors prioritize about their living arrangements, then living in a RH is a plausible option for seniors wanting to 'age in place', provided the RH is in the same vicinity as their friends, family, and community.

1.4.2 Social Relationships in Retirement Homes

Communal spaces, recreational programs, group dining, and hosting special events are a few ways that many RHs try to foster social interaction and friendship building among their residents (Ontario Retirement Communities Association, 2013). Whether these efforts result in

meaningful relationships, or simply help pass the time is up for debate. Much of the existing literature on RHs has looked at RLSs' quality of life and satisfaction with their living arrangements, and found that social relationships consistently play a key role in both outcomes. For example, to investigate the quality of life of RLSs, Mitchell and Kemp (2000) collected data from 201 RLSs, the majority of whom were female (74%), non-hispanic white (96%), and widowed (69%). Participants completed a survey that included questions regarding health status, social involvement, RH characteristics, and social climate of the RH. Regression analysis revealed facilities where staff members were supportive, and residents were involved with each other had the greatest positive influences on quality of life (QOL). Family contact and participation in social activities were the next strongest predictors of QOL (Mitchell & Kemp, 2000). Overall, this study demonstrated that social factors play a strong role in QOL of residents, and urged key stakeholders to consider the importance of social relationships when making future decisions about programming in RHs. Park (2009) also investigated the relationship between RLSs' life satisfaction and social engagement within their RH by administering a questionnaire to 82 RLSs from southern USA. Similar to Mitchell and Kemp (2000), this study found the perceived friendliness of residents and staff were most significantly associated with RLS's life satisfaction (Park, 2009). These findings suggested that although the literature on seniors' social support emphasizes the role of close family ties, people within the RH also strongly influence QOL, perhaps due to their more frequent contact.

While quantitative studies such as the ones above were able to identify the effects certain social relationships have on seniors' well-being, they failed to provide detail on why certain relationships were the most influential on QOL, and how RLSs perceived them. To supplement previous quantitative findings, Minney and Ranzjin (2016) used a qualitative approach to explore

what constituted a ‘good life’ in 13 RLSs and found that social relationships were important to QOL because they contributed to optimal functioning. After being asked about the importance of social relationships, one participant shared, “the most important things are company, having things to do, also trying to learn something no matter what it is, as long as you use your brain” (Minney & Ranzjin, 2016, p. 922). Thus, social relationships were not only good for ‘psycho-emotional’ support, but also for entertainment and continuous learning. Thomas and colleagues (2013) looked specifically at RLSs’ perceptions and experiences of social interactions while living in a RH. Despite having only interviewed six residents, researchers found themes supported by other literature including the importance of family, and fostering friendships with fellow residents. In this case, family relationships were valued most by residents, as they occurred on a regular basis, and provided the most opportunity for further social interaction as family members facilitated visits with friends and family beyond the RH (Thomas, O’Connell, & Gaskin, 2013). Based on the literature, RLSs’ relationships typically fall into 1 of 3 categories: relationships with residents, relationships with staff, and relationships with people living outside the RH, namely family members. That being said, these relationships should not be studied as isolated categories as they have been in the past, but instead as a whole unit. To gain a comprehensive understanding of RLSs’ social relationships, the ways in which each of these relationships shape one another and how different parties experience the same phenomenon will be investigated.

1.5 GAPS IN LITERATURE

Although there is extensive research available on successful aging and seniors’ health, there are gaps in the literature leading to an incomplete understanding of the link between seniors’ social relationships and overall well-being, particularly within retirement home settings.

Current research in the area of RLSs' social and family relationships is either outdated, fails to use Canadian samples, or only briefly mentions social health as part of a larger study. For example, some studies are based in LTC settings (Coyle & Dugan, 2012; Giuli et al., 2012; Hubbard, Tester, & Downs, 2003) and focus on the negative health outcomes (e.g., depression, social isolation, neglect) resulting from lack of social relationships. Further, many studies quantified seniors' social participation by collecting data on time, frequency, duration of social occurrences and compared it to their medical diagnoses (Fitzpatrick et al., 2005; Herzog, Ofstedal, & Wheeler, 2002; Isaac, Stewart, Artero, Ancelin, & Ritchie, 2009) but failed to capture participants' feelings of adequacy of support. Other studies investigated social experiences of RLSs in isolation, leaving out family and friends who are an integral part of seniors' lives (Hubbard et al., 2003; Mitchell & Kemp, 2000; Thomas et al., 2013). While all these studies provide valuable insight into RLSs' social relationships, they often isolate seniors' social experiences, and thus fail to capture the complexity of the phenomenon. To gain a complete understanding of the phenomenon, one must look at social relationships as a product of seniors' environment, both past and present. With the aging population, changing family structures, and shifting roles of seniors in society, current research on the dynamics of RLSs and their social needs is essential to enhance seniors' overall health and QOL through social experiences and relationships within RHs.

1.6 RESEARCH PURPOSE

> "Those concerned with health and social administration must, at every stage, treat old people as an inseparable part of a family group, which is more than just a residential unit. They are not simply individuals, let alone *cases* occupying beds or chairs. They are members of families and whether or not they are treated as such largely determines their security, their health and their happiness" (Harris & Tanner, 2008, p. 44)

As suggested by the previous quote, RLSs' social relationships are complex and closely intertwined with their built and social environment. Thus, the best way to understand these relationships is through exploring the nature in which they occur and what influences them. This study will not treat seniors as individual cases within a RH, but instead embrace the inseparable networks and ties they're embedded in both inside and outside of the RH, and examine these units as a whole. As such, the purpose of this research is to explore the lived experiences of seniors living within a retirement home by examining seniors' social relationships with their family, friends, staff and PSPs. Three guiding research questions will be used to gain a deeper understanding of this phenomenon:

1) What influences the social relationships of retirement-living seniors?

2) How do retirement-living seniors perceive their social relationships?

3) How does living within a retirement home affect relationships?

Although other people within the RH influence seniors' social well-being, this study will focus on interviewing seniors and their family members who are typically their strongest ties. Each RLS will be asked to talk about her social experiences with family members, RH residents, friends, and staff since moving into the RH. Each PSP will be asked to speak about his/her relationship with the senior as well as relationships outside of their mutual one, such as the seniors' relationships with staff, friends, volunteers, etc. The purpose of interviewing RLS-PSP dyads is to obtain a deeper understanding and more complete picture of the social dynamics of each senior and her social relationships.

CHAPTER 2: METHODOLOGY

2.1 PARTICIPANTS

Morse (2007) states, "it is necessary to locate excellent participants to obtain excellent data" (p. 231). For this study, "excellent participants" referred to senior women living within a retirement home, and their PSPs (Morse, 2007). Purposeful sampling, specifically criterion and snowball sampling, were employed to recruit eighteen participants who were able and willing to provide detailed insight into the day-to-day experiences of RLSs. Criterion sampling is a method that only includes participants in a study if they "meet some criteria" (Creswell, 2013, p. 158). Snowball sampling is based on word of mouth, where the researcher asks individuals if they know any seniors who fit the study criteria, or study participants can refer other seniors to the researcher as potential participants (Creswell, 2013).

Eleven RLS participants were recruited through researcher connections within a RH facility in Ontario where the researcher volunteered for 3 years prior to the start of the study. During this time period, the researcher had the opportunity to familiarize herself with the RH's staff, residents, and visitors. After doing one-on-one room visits, helping out with special events, and most recently teaching weekly chair yoga classes, the researcher became a part of the social network of the RH. The researcher's involvement with the RH helped her build rapport with both staff and residents, which aided with recruitment. Furthermore, this rapport helped residents feel more comfortable with the study, which increased the chance of recruiting a diverse range of seniors willing to disclose deeper, higher quality data (Bell, Fahmy, & Gordon, 2014). Evidently, the researcher played a key role in the recruitment process. With the help of the recreation director, potential RLS participants received a written invitation to participate in the study. Once seniors who were interested contacted the researcher, they became enrolled in the study provided they met the following criteria: (1) female seniors must be 65 years or older and living in the

current retirement home between 1- 3 years; (2) female seniors must be living alone in their unit/apartment/suite; (3) female seniors must be widowed, single, or divorced; (4) female seniors must have at least one child, grandchild, or close family member (e.g., sibling) that is alive; (5) female seniors must not be diagnosed with dementia or neurocognitive disorders as defined in the DSM-5 (ie. frontotemporal lobar degeneration/ Pick's disease, Lewy body disease, delirium or impairments due to traumatic brain injury (TBI), and prion disease), and (6) female seniors must not have any severe visual, hearing, or speech impairments that would limit their ability to communicate and socialize with others. These criteria were chosen to represent the average RLS profile in Canada, as 72% of seniors living in RHs are women, and 89% of these women live alone (Hudon & Milan, 2016). PSPs were selected by asking seniors to identify one to three people with whom they discuss “things that are important to you” on the face sheet, as in previous studies this question elicited names of strong, frequently accessed, long-term contacts (Cornwell et al., 2014). At the beginning of each interview, seniors were asked to specify which of these individuals they considered their primary support person. Upon completion of their interviews, seniors were asked if their PSPs would be willing to participate in the study. All seniors answered yes and were asked to pass along a letter to their main PSP inviting them to participate in the study. Each willing PSP then contacted the researcher via phone or email to begin the study. The inclusion criteria for PSPs were: (1) PSP must be someone living outside of the RH who seniors identified as family; (2) PSP must be 18 years or older; (3) PSP must have some degree of contact with seniors weekly (call, email, visit, letter, etc); and (4) PSP cannot have any cognitive impairments that limit their ability to provide support, as listed above. All seniors passed along the letters to their PSPs, and seven PSPs reached out and agreed to

participate in the study. For more detail regarding PSPs, including those who did not participate in the study, see section 3.1 below.

2.2 RESEARCH TOOLS AND PROCEDURE

2.2.1 The Qualitative Method

Qualitative research methods were used to develop an in-depth understanding of the lived experiences of RLSs. According to Patton (2015), using qualitative inquiry helps illuminate meanings, study how things work, capture seniors' perspectives, and understand experiences in the context in which they occur. For this study, both the purpose and research questions were qualitative in nature as they sought to gain a holistic understanding of a particular phenomenon or experience. Qualitative methodology is grounded in a constructivist paradigm (Creswell, 2013), which is the idea that the nature and reality of a phenomenon are always relative to one's environment and experiences. Furthermore, there is no single truth; instead many realities can be observed in the world, with each person's reality being equally as important and true as the next person's reality (Guba, 1981). Since the researcher's personal worldview aligns with the constructivist paradigm, qualitative methodology was deemed most appropriate, as these methods best illustrate the many realities, stories, and experiences of retirement living seniors in the voices of the RLSs.

More specifically, the theoretical orientation guiding this study was phenomenology. Examining RLSs' social relationships and their PSPs' perspectives of these relationships allowed for deeper insight into the meaning, structure, and essence of the phenomenon (Patton, 2015). Using a qualitative approach with both RLSs and their PSPs enabled the researcher to "thoroughly capture and describe how people experience some phenomenon- how they perceive it, describe it, feel about it, judge it, remember it, make sense of it, and talk about it with others"

(Patton, 2015, p. 115). Ultimately, qualitative inquiry allowed for an in-depth, first hand perspective and understanding of the social relationships of RLSs.

2.2.2 Ethics

Before beginning the study, approval of all tools and procedures were obtained from the Wilfrid Laurier University Research Ethics Board. Participants read and signed an informed consent statement prior to participating in the study and were encouraged to ask questions at any point if clarification was needed. To maintain confidentiality and anonymity, the transcribed interviews were stripped of all personal identifiers.

2.2.3 Background Questionnaire

Participants completed a background face sheet based on their designation of RLS or PSP (see Appendix A & B). Senior participants completed the face sheet with the researcher present to assist with explaining or clarifying any questions. The face sheet for seniors consisted of: (1) demographic information, such as date of birth, marital status, number of children/grandchildren, living accommodations (past and present), educational attainment and employment; (2) questions about their personal health and; (3) questions about their relationships with the PSPs and other people in the RH. The face sheet for each PSP consisted of: (1) demographic information, as listed above; (2) questions about his/her relationship with the senior and; (3) forms and duration of support provided to senior. The information gathered from these face sheets were used to provide the researcher with context prior to the interviews and develop rapport with participants.

2.2.4 Interviews

Each participant took part in a one-on-one semi structured interview with the researcher. Interviews were arranged directly with each participant, at a time and place that was most convenient for each participant. All interviews with seniors and PSPs were conducted in person,

with the exception of one phone interview with a PSP who lived out of province. Interview lengths varied based on breadth of participants' responses. For seniors, the interviews lasted for an average of 65 minutes, with the shortest and longest times being 26 and 107 minutes, respectively. PSP interviews lasted an average of 55 minutes, with 35 minutes being the shortest, and 62 minutes the longest.

Interviews with each senior included 21 open-ended questions about her background, relationships with RH staff, residents, her family and PSP, her previous home, and overall retirement living experiences (see Appendix C). Similarly, the interview with each PSP included 22 open-ended questions consisting of background information, perceptions of his/her relationship with the senior, the seniors' relationships with others in the RH, the senior living in the RH, as well as his/her experiences of being a PSP to a RLS (see Appendix D).

All interviews were audio recorded and transcribed verbatim so that data analysis could begin and the researcher could monitor saturation of data throughout the collection process. Data analysis involved the researcher carefully reading through transcripts and identifying reoccurring themes, topics, and areas of discussion. Data collection continued until the researcher felt saturation was reached, which is defined as the point where no new information is obtained and future interviews would not contribute to or enrich the data (Lincoln & Guba, 1985). The researcher determined saturation had been reached once she noticed herself being less intrigued while reviewing transcripts, due to the seemingly repetitive narratives. Saturation was further confirmed through weekly debriefs with her supervisor, where discussions about recently collected data started to sound like previous conversations about earlier transcripts. At this point the researcher felt saturation had been reached, recruitment of participants ceased, and further analysis of the data was carried out.

2.2.5 Field Notes

Handwritten field notes were taken by the researcher to further enhance data collection. The researcher took field notes prior, during, and immediately following each one-on-one interview, to help capture the essence of the phenomenon (Lincoln & Guba, 1985). Field notes recorded the date, location, physical setting, as well as participants' body language, emotional reactions, and responses to certain questions. Field notes were used while data collection was ongoing to foster self-reflection, highlight important information shared by participants, and reveal emergent themes worthy of further investigation in subsequent interviews. Field notes also later aided in data analysis by adding context, helping the researcher recall and make meaning of what she observed during each interview, and provided reason as to why certain decisions were made during the thesis process (Lincoln & Guba, 1985).

2.2.6 Member Checks

Throughout the data collection phase, the researcher transcribed each interview verbatim after it had taken place. Each participant was then given a copy of his or her interview transcript to review and confirm that the data was captured as intended. Participants were told to "correct, amend or extend" (Lincoln & Guba, 1985, p. 236) any information to ensure the data accurately depicted their experiences. Member checks served three key purposes in this qualitative research: (1) member checks lend credibility to the study by confirming that data is true and expressive for the population under study; (2) member checks strengthen the researcher-participant relationship by allowing participants to have more control over their responses and how they are used in the study (Patton, 2015) and; (3) member checks provide the researcher with an opportunity for follow up to clarify and obtain a better understanding of the data collected during the interview (Lincoln & Guba, 1985). Member checks were distributed to each participant in their chosen

format (either physical hard copy delivered to their door or an electronic copy sent via email). One RLS participant requested major edits to her transcript as she felt she disclosed too much personal information about her children's lives. These changes did not have anything to do with her experiences of RH living or her relationships. The requested changes were made immediately and she approved the revised transcript. As for the remainder of the participants, thirteen returned their transcripts with few (spelling and grammar) or no edits made, while 5 participants did not return their member checks. For those who did not return their member checks, the original interview transcripts were used for data analysis.

2.2.7 Triangulation

Triangulation is the notion that a phenomenon is best understood when investigated using a combination of data sources (Given, 2008). Using a multi-method approach allows the researcher to explore different dimensions of phenomena, facilitating a deeper understanding of participants' experiences, thereby enriching data interpretations and strengthening findings. For this study, two types of triangulation were employed: data triangulation and investigator triangulation. Data triangulation involved collecting multiple sources of data from each participant. As such, background face sheets, field notes, one-on-one semi-structured interviews, and member checks were collected from each study participant. Investigator triangulation involves using several researchers in the data analysis process (Patton, 2015). This study included the primary researcher and her supervisor interpreting the data and analyzing the findings. Further a group of qualitative professors and graduate (MKin/PhD) students periodically reviewed and discussed some of the transcripts, providing feedback on the research tools being used and interpretations of the findings. Debriefing with other researchers not

directly involved in the study also reduced researcher bias and ensured the findings are presented as the participants intended them to be shared (Given, 2008).

2.3 TRUSTWORTHINESS: CREDIBILITY, TRANSFERABILITY, AND CONFIRMABILITY

In qualitative research, trustworthiness is a strategy used to determine the value and rigor of a study's findings (Given, 2008). Lincoln and Guba (1985) suggest the following criteria for establishing trustworthiness: credibility, transferability, and confirmability. Each will be discussed in turn.

2.3.1 Credibility

Credibility refers to how accurately the researcher's descriptions and interpretations reflect the participant's views and experiences (Padgett, 2012). Patton (2015) recommends using the following factors to establish credibility: (1) appropriate methods and techniques to obtain high-quality data; (2) ensuring credibility of the inquirer; and (3) readers' and users' belief in qualitative research and its value.

As previously mentioned, triangulation (2.2.7: Triangulation) is a commonly used technique that increases credibility by validating data and information against at least one other source or method (Lincoln & Guba, 1985). Two forms of triangulation were used to establish credibility of the current study, which were: data and investigator (Lincoln & Guba, 1985; Patton, 2012). Data triangulation entails using different data sources to examine the same phenomenon, namely seniors, their support person, and field notes of the researcher (Lincoln & Guba, 1985). Each source has the potential to reveal unique aspects of a similar experience. Thus, the data represented many participants' experiences, which was beneficial when identifying patterns and forming themes throughout analysis. Investigator triangulation involves

having several researchers evaluate the data and review the findings (Patton, 2015). The primary researcher and her supervisor evaluated the data independently, then came together to discuss their respective ideas in order to minimize the chance of personal bias that can result from a single researcher's interpretation and perspective. Flick (2009) suggests another form of investigator triangulation known as peer debriefing, where other people who are not directly involved in the research contribute to the data interpretation process, reducing the chance of missing important information as a result of the researcher's 'own blind spot'. This technique lends further credibility to the study and was employed in qualitative group meetings where study research tools, findings, and analyses were discussed with a group of qualitative professors and graduate (MKin/PhD) students. Using two triangulation methods enhanced credibility of the study (Patton, 2015).

While not a type of triangulation, Patton (2015) also notes credibility of the inquirer (e.g., training and experience), along with philosophical belief and value of the qualitative research (eg. worldview) as two equally necessary components of establishing credibility. In qualitative research, the primary investigator is an integral tool in the process. In order to ensure the researcher as an integral tool in the process, the researcher completed a qualitative course and extensive literature search to familiarize herself with the area of research. The researcher also volunteered with the study population for 3 years, gaining first-hand experience and building rapport with seniors residing in the RH. Additionally, the researcher used field notes (see 2.2.5 Field Notes) to refrain from judgment when interpreting seniors' and their PSPs' experiences based on her own personal experiences and observations. Ultimately field notes helped the researcher try to remain neutral during the study through self-reflection and acknowledging personal bias and preconceptions. The researcher also kept an ongoing journal to reflect on how

her personal knowledge, experiences, and emotions helped co-construct the data being collected. This journal allowed the researcher to assess the data at face value to the best of her ability, without interference of prejudices, viewpoints, and assumptions about the phenomenon. Finally, the researcher holds a constructivist worldview (see 2.2.1: The Qualitative Methods) and firmly believes that a qualitative inquiry is the most appropriate approach to shed light on and gain insight into the phenomenon of social relationships within RHs.

2.3.2 Transferability

According to Lincoln and Guba (1985), transferability is used in qualitative research in order to demonstrate that research findings can be applied to other contexts. It is the researcher's job to provide a 'thick description' of the context, emotion, and participants in a study (Creswell, 2013). Providing sufficient detail enables other researchers to determine whether the study findings can be applied to their own work. To maintain transferability of the current study, information-rich cases were selected by adhering to the established inclusion criteria. In order to make the results meaningful, thick description was used throughout the study, providing other readers with the necessary details and context to make the results meaningful (Creswell, 2013).

2.3.3 Confirmability

Lincoln and Guba (1985) describe confirmability as, "a degree of neutrality or the extent to which the findings of a study are shaped by the respondents and not researcher bias, motivation, or interest" (p. 302). Techniques utilized to strengthen confirmability of this study were triangulation (see 2.2.7 Triangulation) and field notes (see 2.2.5 Field Notes). A combination of these techniques provided a description of what steps were taken throughout the study and the reasons guiding those decisions. Making the development of the research process

transparent lends confirmability to the study by enabling other researchers to trace the research steps, and how the study reflects the participants' lived experiences.

2.4 DATA TREATMENT

2.4.1 Qualitative Analysis: Phenomenology

The theoretical orientation that was used for this study was phenomenology. Patton (2002) describes phenomenology as:

> "how human beings make sense of experience and transform experience into consciousness, both individually and as a shared meaning. This requires methodologically, carefully, and thoroughly capturing and describing how people experience some phenomenon- how they perceive it, describe it, feel about it, judge it, remember it, make sense of it, and talk about it with others." (p. 115).

Van Manen (1990) stipulates that in order to capture and describe how a person experiences a phenomenon, it must first be brought to consciousness. Thus, the researcher explored the social relationships of RLSs by interviewing those who had lived through the phenomenon and could help elucidate the "meaning, structure and essence" (p.573) of the phenomenon from first-hand experience (Patton, 2012). Using a phenomenological orientation was believed to be the best way to investigate how RLSs and their PSPs experience social relationships in RHs as it involved careful description, investigation, and analyses of the phenomenon in question.

2.4.2 Qualitative Analysis: Thematic Analysis

According to Moustakis (1994), phenomenology is committed to presenting vivid, accurate, and complete descriptions of experiences, often illustrated through themes that "awaken further focus and meaning" (p. 59). Moustakis' (1994) steps were used as a guide for thematic analysis. The first step of the analytic process was époche, where the researcher reviewed journal and field notes, flagging anything that could be considered preconceived biases

towards the study participants or data. This step was necessary in order to "see the experiences as they appear, free of prejudgments and preconceptions" (p. 91). Beginning with RLSs' transcripts the researcher continued to become familiar with the data through reading and re-reading interview transcripts many times, noting and highlighting reoccurring phrases and key ideas in her journal. Start nodes were produced from the highlighted phrases, and then coded based on whether the experience was internalized or explicit, occurred specifically in the RH or in other settings, with RH or non-RH people, and whether each of the experiences were perceived and/or conveyed in a positive, negative, or neutral tone. The next step was phenomenological reduction, which involved treating each participant's transcript as its own entity, to see the RLSs' and PSPs' data in its simplest form. During this step, the researcher identified expressions that were necessary to understanding the phenomenon, determined the more appropriate node for quotes that were double coded, and eliminated overlapping or vague expressions. Next, horizonatalization was used to view the data as a whole and assign equal value to each meaningful expression. Here, data was further organized into corresponding subthemes using NVivo qualitative data analysis software. Quotes representing each subtheme were re-read to ensure quotes were not removed from the context in which they were originally discussed and to check each subtheme was distinct from the others. Following development of themes and subthemes for RLSs' data, PSPs' transcripts were analyzed using the same protocol. Data from PSPs' transcripts about how they interpreted the seniors' and their own experiences aligned with pre-existing themes and subthemes, with the addition of one emerging theme that did not come through in the RLSs' interviews. Comparison of perceptions between the two participant groups, as well as between each of the dyads was noted. Themes and subthemes were then arranged in a logical order to allow for flow of ideas. The next step included textural portrayal and structural

descriptions to provide a complete essence of the lived experiences of RLSs' and their social relationships (Moustakis, 1994). In this step, verbatim quotes were utilized to highlight how RLSs and their PSPs perceived RH living and it's effects on social relationships. The final step involved the primary researcher meeting with her advisor to discuss themes that emerged as a form of investigator triangulation.

CHAPTER 3: RESULTS

3.1 INTRODUCTION TO PARTICIPANTS

This study consisted of 11 retirement living seniors, and 7 primary support persons, for a total sample size of eighteen individuals. The seniors were all females who had been living in the current retirement home between one and three years. Seniors ranged in age from 73 to 93 (mean=85), and they all spoke fondly of their primary support persons. Most of the seniors' previous homes were within a 20 km radius from the current retirement home. The three participants whose adult homes were more than 20 kms away from the retirement home had all moved to the current RH because it was closer to their families. At the time of data collection, five seniors were living in assisted-living suites, while the remaining six were in independent suites. The assisted-living suites included medication administration, personal laundry service, all three meals, and assistance with personal care as needed. In contrast, independent suites seniors only had their linens laundered and were responsible for making their own breakfast. If an independent living senior temporarily wanted or needed any of the services that assisted living seniors received, they paid a fee-for-service charge. All suites were in the same building, serviced by the same staff, and both independent and assisted living seniors participating in this study had access to the same common areas/recreational activities within the retirement home. One participant was moved to a long-term care facility a few weeks after her interview was

completed, while another participant was admitted to the hospital for a fracture resulting from an accident a few weeks after her interview. Both of these participants remained in the study as they met the inclusion criteria at the time of their interviews (Table 1).

All seniors, with the exception of one, nominated up to three support people on the background questionnaire, with whom they had regular weekly contact (at least once per week). At the beginning of each one-on-one interview, each senior identified the person she felt most supported by, which was referred to as her PSP for the remainder of the study. One senior did not nominate any support people, as she believed she did not require physical support from anyone, and believed all her relationships were equally supportive and she could not select only one. Three nominated PSPs chose not to participate in the study due to time constraints. The PSPs who participated included four daughters, one daughter-in-law, one niece, and one son. The PSPs who did not participate were three daughters of independent living seniors. There was no reason to believe the seniors whose support people participated differed from the seniors whose support people did not. At the time of the study, one of these participants was receiving outpatient dialysis three times per week, while her support person provided her transportation to and from these appointments, which consumed all the PSPs' time. The second senior had fallen out of a moving vehicle and suffered a hip fracture, and thus her primary support person was pre-occupied with visiting her mom and coordinating care, and felt her time was limited to participate in the study. The third seniors' support person was on a temporary disability leave from work, and had her own health to consider at the time of the research project. Nevertheless, all three of these seniors did not have anything negative to say about their support people, or their mutual relationships. With the exception of the son who lived out of province, all primary support people lived within a 40-minute drive of the retirement home. Two of the support people

were retired, four were still working, and only one person still had children that were dependent on her (specifically, two university attending children who were living at home and requiring financial assistance). All seniors' support persons provided the seniors with some form of emotional and/or social support. Both seniors and their support people reported the same amount of average weekly contact with one another. For more detailed information regarding the primary support persons, refer to Table 2.

Table 1: Demographic Information for Retirement Living Seniors

Participant	Alice**	Bertha**	Elyse	Ester**	Gertrude**	Ingrid**	Karen	Lorna**	Lucy	Ruth	Sonya**
Age	84	84	73	87	88	92	76	93	82	86	87
Years living in RH	1.25	1	3	3	2	1.5	2	1.75	1.5	3	2
Self-perceived overall health	Fair	Fair	Good	Fair	Fair	Fair/ Good	Fair	Excellent	Fair/ Good	Fair	Fair
Health Conditions	Arthritis Incontinence Blind in one eye* Depression* Pace maker*	Blind* High blood pressure Neuropathy* Constipation	Arthritis High blood pressure Acid reflux	Arthritis Effects of stroke High blood pressure Poor balance*	Arthritis* Diabetes * High blood pressure Heart disease* Urinary incontinence No use of right arm	Arthritis Cancer Cataracts Heart disease	Arthritis * Bipolar* Cataracts* Chronic renal failure* High blood pressure	Arthritis High blood pressure	Arthritis* High blood pressure Stomach acidity* Autoimmune disease* Urinary incontinence	Arthritis* Diabetes* High blood pressure Heart disease Irritable bowel syndrome	Arthritis* Angina Diabetes Effects of stroke* Pre - diabetic
Number of children	5	2	2	6	2	2	1	0	9 (5 step)	5	2
Number of (great/) grandchildren	9	2	4	7	3	7	2	0	42	15	9
Relationship with PSP	Mother-Son	Mother-Daughter	N/A	Mother-Daughter	Mother-Daughter	Mother-Daughter In Law	Mother-Daughter In Law	Aunt-Niece/ 'like a daughter'	Friend/ 'like a second daughter'	Mother-Daughter	Mother-Daughter
Weekly contact with PSP	Daily	3 times per week	N/A	At least once per week	Daily	4 times per week	Once per week	3 times per week	Once per week	At least once per week	3 or 4 times per week
Modes of contact with PSP	Phone call	Visit Phone Call Outing	N/A	Visit Phone Call	Visit Phone Call	Visit Phone Call	Phone Call Email	Visit Phone Call	Visit Phone Call Outing	Visit Phone Call	Visit Phone Call Outing

* Interferes with daily life

** Primary support person interviewed

Table 2: Demographic information for primary support persons

Support Person	**Allison**	**Amber**	**Dee**	**Deb**	**Diana**	**Jack**	**Lisa**
Support Person to:	Ingrid	Ester	Gertrude	Lorna	Sonya	Alice	Bertha
Relationship to RLS	Daughter-in-law	Daughter	Daughter	Niece	Daughter	Son	Daughter
Current Age	63	58	63	57	60	58	50
Number of Years as Primary Support Person	1.5	At least 5 years	6	2	1	'Forever'	10
Current Employment Status	Admin/ Office Work	Admin/ Assistant	Retired	Sick Leave	Retired	Finance/ Business	School Principal
Frequency of Contact with Senior (per week)	4 times per week	3-4 times per week	Daily	Daily	1- 3 times per week	Daily	3-4 times per week
Types of Support Provided to Senior NOTE: based on face sheet & interview	1. Emotional 2. Medical Appointments 3. Social	1. Banking 2. Shopping 3. Medical Appointments 4.Transportation 5. Social 6. Emotional	1. Financial Management 2. Emotional 3. Physical Support 4. Social	1. Transportation 2. Medical Appointments 3. Financial Affairs 4. Social Activities	1.Transportation 2.Appointments 3.Personal Care (as needed) 4.Social- Going Out	1. Financial Management 2. Personal Care Arrangements 3. Transportation & Appointment Arrangements 4. Social 5. Emotional	1. Emotional 2. Errands 3. Social 4. Everything else as needed

3.2 THEMES

My seniors and some of their primary support people shared stories and insights about their social relationships and living in a retirement home facility. While it was not the focus of the study, discussing daily life and the state of relationships prior to retirement home living helped provide context for the seniors' current social patterns and experiences. Analysis of the data revealed four major themes regarding the lived experiences of retirement living seniors and their social relationships: (1) It's all in the attitude; (2) Barriers to friendship; (3) Life beyond the RH and; (4) The bigger picture. Quotes used to support the first three themes include both seniors' perceptions of their own experiences, as well as the PSPs' perceptions of these experiences. Theme 4 focuses specifically on PSPs' views, and thus only includes quotes from the support people. All themes and the respective subthemes are summarized in Table 3. Each will be discussed in turn.

Table 3: Themes and subthemes of the lived experiences of retirement living seniors and their primary family support persons.

Theme	**Subthemes**
1. It's all in the attitude	a) "It's me": Self-reflection b) "They say these are the golden years, but I don't know where the gold is": The situation
2. Barriers to friendship	a) "It's just that I'm not as able to do what I would like": Declining health b) "There's not a huge connection thing": Integration and interest
3. Life beyond the retirement home	a) Other involvements: "You have to keep your mind busy" b) "I don't know what I would do if I didn't have any family"
4. The bigger picture	a) "We tried so hard": PSPs' efforts b) "Warehoused": RH living and treatment of seniors

3.3 IT'S ALL IN THE ATTITUDE

During the interviews, all participants shared their ways of thinking or feeling about different aspects of retirement home living. In doing so, some discussed their experiences in a positive light, while others had a more negative outlook. Whether it was how they viewed themselves, perceptions of others, or opinions about their living situations, participants' attitudes towards RH living influenced their social interactions and relationships within the RH. Two subthemes emerged from this theme: (a) "It's me": Self-reflection; and (b) "They say these are the golden years, but I don't know where the gold is": The situation.

3.3.1 "It's me": Self-reflection

All seniors discussed how intrinsic factors influenced their social patterns and relationships within the RH. Many of the seniors described focusing on the activities/tasks they were still capable of completing, and learning to accept activities/tasks they could no longer do.

> *… you know what? You put it behind you most of the time and forget about it and think about how lucky I am that I'm still here and have what I do have. I still have my brain - I think (giggle)…You have to focus on the positives. Do what you can do, and what you can't, you leave behind. And say darn why can't I do it!* ~**Lucy** (senior)

> *… sometimes you feel like, oh if I could do this and that. But I can't get around anymore so what the heck! (laughs). I can't do it, so I, you know, you just have to focus on what you can do.* ~**Lorna** (Senior)

> *Oh no, I don't get emotional. I refuse to feel sorry for myself. So it's something that you have to accept and work with, to get better. If you can succeed, then you're lucky. If you cannot succeed, that's too bad.* **~Sonia** (senior)

PSPs acknowledged the seniors' determination to remain as independent as possible.

> *[I've known her] 40 years. She was very independent. Still is very independent. Doesn't like to admit that she's older. Um, I would have to say, if I were to sum her up, she's generally happy…. she's independent as the day is long…* ~**Allison** (daughter-in-law of Ingrid)

> *Even with the use of only one hand, was able to keep a cleaner house than [most] people. [Recently] I found all these dust cloths… she was still doing her own dusting!* ~**Dee** (daughter of Gertrude)

> *…. she went through the war and concentration camps and all that sort of stuff…. I understand her need to be a survivor, in control, independent, and that kind of thing. So I can cut her that slack, like that's who she is and that's just who she needs to be. So it's become OK with me.* ~**Diana** (daughter of Sonia)

> *But she was also very resilient in knowing she couldn't go to the hairdresser so she found one to come to her. She couldn't you know, do her feet, so she found someone to come to her, which she's continued.* ~**Amber** (daughter of Ester)

Ester tried to put the negatives aside and counted her blessings.

> *… I was losing my balance a lot and falling at home. And, it was my decision that I can now no longer stay at home… No fractures. (whispers) Fortunately! But I fell on my face and I had [a] big black eye, and one time I fell on the end of my cane and, hit my chin and it was black and blue, and uh, my face usually took the hit. But everything's OK. I'm you know, thankful for what I have. I'm grateful.* **~Ester** (senior)

Bertha also counted her blessings as she began to think about what she wanted for herself moving forward. Her daughter also noted this change in her mother's outlook.

> *Here at [RH] I am at a different place in my mental outlook for what to expect for myself coming up. And I, I know that I'm settling into something that's much more laid back and not thinking about what I can do and what I can't do. It's not so much about that anymore. I just want to have the relationships with the people I know and love, and I don't want those things to sort of change too much. I think I'm at a pretty good spot right now in my thinking.* **~Bertha** (senior)

> *Well my mom is pretty proud. Like I don't think she was too happy to come here. But I think she's kind of resigned herself to it, and she's kind of making the most of it, which is good.* ~**Lisa** (daughter of Bertha)

Additionally, Ruth and Elyse took pride in not letting their ages slow them down, as both of them made an effort to remain socially active with people in their networks.

> *On the whole, I get along good with everybody. Uh, we all have our differences but you gotta overlook a lot of that. When you're in a place like this, you can't start to fight over every little bit, you know? I talk to everybody, try to be friendly.* **~Ruth** (senior)

> *Yeah, I don't take part in everything, but I'm out and about…. I go with the flow. I help. I always want to assist. I think that's the nurse in me. If I ever see something I can help someone with I'll do it …. I've kept up with my friends, I've kept up with my church, and just added this to it.* **~Elyse** (senior)

In contrast, a few doubted their ability to overcome age-related challenges and become more social. They blamed themselves for only having a few loose social relationships within the RH. For Alice, this mind-set decreased her self-confidence.

> *I don't know. I always said, this is a good place, it's a good place to be, but it's ME that has problems, you know. But I say it's a good place, but it's me…. I'm complaining a lot. I'm a complainer and people don't like to hear that. I am a complainer, I know that*. ~**Alice** (senior)

Her son, Jack, concurred with his mom's perspective:

> *So I think from her perspective, it's really funny because she has quite a self-deprecating opinion of herself as a whole…. she talks a lot about the residents there and how they're smart and self-supporting, or they can do their own things, and she's not….I think where she struggles is that she doesn't have the ability, or feels she doesn't have the ability to make new ones. So she isolates herself… So I try to remind her all the time that actually in terms of accomplishments, she's not giving herself enough credit.* ~**Jack** (son of Alice)

Lorna's niece felt her aunt had a negatively skewed opinion of herself, which led her to spend most of her time alone in her room.

> *She said ' I don't mix well'. And that's how she defines herself, and it's kind of odd if you know her, because she mixes really well! She says it almost as apologetically, like ' I don't mix well'. So I don't think it upsets her, I think that's just how she sees it.* ~**Deb** (niece of Lorna)

Karen attributed her lack of social relationships within the RH to her accent. She also acknowledged other factors that played a role.

> *…I have the accent, which I believe more than majority of the seniors don't understand me. And at first I feel like you know they don't include me in their conversation or you know. But eventually I realized it's not them, it's me. What I say, they don't under*stand*… Sometimes its also the loss of hearing, so those two combined, it's, it's quite a bit. Makes it hard to communicate.* ~**Karen** (senior)

Ingrid wished her situation was different and held on to the past. This led to a sense of hopelessness, and she felt this was the way life was meant to be now.

> *I just long for my friends. Because if I had new ones here, I suppose I'd feel better. But I don't really bother. I try not to….The worst was about the first six months. Not easy. (pause) I'm not blaming anybody or anything, that's just life…* ~**Ingrid** (senior)

Finally, Dee commented on how a negative outlook on life affected her mother's relationships.

> *And when they get to that age, its, I hate to say it, I've noticed since she got sick in March, that it's now kind of all about [the senior], you know. And um, that she gets crabby when it's not about her (laughs)….the last little while, she has um, I think she's angry. Looking at the end of her life.* ~**Dee** (daughter of Gertrude)

Overall, seniors who viewed themselves positively tried making the most of the RH experience. They were often making efforts to be social with other seniors, and if they did not, it was typically due to personal preference. On the other hand, seniors who were less confident and less optimistic about their lives struggled with socializing in the RH; however their lack of socializing was not due to personal preference, but rather their insecurities, which hindered them from participating in RH life.

3.3.2 "They say these are the golden years, but I don't know where the gold is": The situation

The title of this subtheme, shared by Alice, references her views on aging and retirement living. Many seniors shared their thoughts on having the retirement home as their permanent 'home' now. For many, their overall experiences and attitudes about living within a RH boiled down to whether they wanted or needed to be there. Participants who did not have much choice in moving from their adult homes into a RH were less satisfied with their living situations. Alice and her son, Jack, felt strongly about the current situation.

> *And uh, so I feel, when I'm in here I feel like locked in. I feel all alone. I feel trapped.* ~**Alice** (senior)

> *What it leaves the situation as, is that now everyday she's depressed. She phones me up and tells me she wishes she could die. So tell me how THAT'S making sense.* ~**Jack** (son of Alice)

Karen's tone throughout the interview indicated she was neither satisfied nor dissatisfied, and had a laid back attitude to RH life.

> *I guess this is it. I don't think it will improve. I wish certain things will be better, but I, I doubt it.* ~**Karen** (senior)

Ingrid and her daughter-in-law, Allison, did not see eye to eye on the current situation.

> *I would love to be in my own home, like I was. I was doing OK, the family knows I was OK. But they were afraid of the winter, that I might fall, and then they couldn't get to me, and visit me like they would like to and all that stuff …. so for me, I'm quite comfortable here [but] I wish I could see trees, wish! I can't even see the sky from here! So I sometimes peek out. Whereas where I lived, windows all around me, looking at all the beauty of the country side, animals and birds. That's what I miss a lot. There's nothing here. City life! Really?!* ~**Ingrid** (senior)

> *… she knew she had to make a move. Because she knew she could see everything coming to an end where she was. And even though she loved it there, her friends were becoming ill. Some were dying. Um, and less were gonna be available to help her out. So she knew that was also happening….I would have to say that in a year and a half that has all changed. She has found her place now. And she knows everyone…. I know she knows the staff is excellent. And the people here are excellent.* ~**Allison** (daughter-in-law of Ingrid)

Support people discussed their RLSs did not like the idea of being surrounded by 'old people'. This frame of mind led to a 'me' versus 'them' perspective, and made it challenging for seniors to adjust to their living situation.

> *[Initially] she began to hibernate in her room a lot. She didn't want to kind of come out and participate….I would have to say that my mother-in-law never felt old, does not still feel elderly, doesn't want to be seen with old people…. you know, she'll refuse a bus trip. And I wonder, why would she refuse to go out to a restaurant or a drive? I mean, she goes to these restaurants with me, she's been doing that for years. She knows them. So why wouldn't she want to go out for lunch? And I honestly truly believe that she doesn't want to be classified as old. Like I'm with a busload of old people. I really do.* ~**Allison** (daughter-in-law of Ingrid)

> *Well in the first months it was really hard, because she was forced into doing this. It wasn't of her choosing….her attitude at the time was 'all these old people! I have to be with all these OLD people!' You know, and she needs a walker. Well she didn't want*

> *anyone to see her with a walker. And hearing aids- 'well I don't need them!' well you can't hear!!! (laughs) And like everybody here has a walker and hearing aids, everybody!! So it's not like you're different. You're just one of the group. So that was very difficult coming down here for her. She just found that very insulting to her image. In her mind she's not one of those old people with walkers and hearing aids. But in truth, she is!* ~**Diana** (daughter of Sonia)

Unlike Sonia and Ingrid, Lorna actually felt she was the 'old person' in some scenarios.

> *[My aunt] said something to me the other day, 'well this little girl'… and this little girl came along and said she wanted to know if she could change the channel, and [my aunt] said not right now dear. And the little girl was a resident you know (laughs). So she talks about the young ones, being 80, the little girls. But I think she's comfortable.* ~**Deb** (niece of Lorna)

A few seniors, who had initially moved in because they needed to, had opened up and were beginning to appreciate their circumstances. The following four quotes depict these sentiments.

> *… it's nice to have a place for old people like me and others. And to make a change and to be taken care of. It's good, because otherwise what would we do? That's it. And it doesn't matter whether you have a lot of money or not. When you're sick it doesn't matter anymore…. It depends on the person, whether they need care, like when they're sick, or they're retiring…. I wouldn't move into a place like this if I was healthy.* ~**Sonia** (senior)

> *… right now I'm doing quite well. I think I kind of calm myself and think I'm in a safe place. There is nothing bad that can happen here. Everything will be OK, but certainly the excitement of life has gone. You know, there is nothing that you can do to bring it to that joyous kind of feeling of excitement, but it's a good feeling.* ~**Bertha** (senior)

> *…I [am] quite happy here. I get good care. I wasn't able to look after myself and they did so, you know, you accept these things. There was no other choice.* ~**Gertrude** (senior)

> *…after all my friends died and everything, I had a breakdown. And I just couldn't stay alone anymore, and that's why I'm here. I needed to go somewhere where there was people around. [Here] there's more things going on than if I was in my condominium. I wouldn't make an effort to go out as much, you know. I know I'd be sitting alone more. But now I make an effort to go out and attend the things. There's opportunity here to socialize.* ~**Ruth** (senior)

Lastly, participants who moved to the RH on their own terms were extremely satisfied with their living arrangements.

> *... I love it here. I don't want to be anywhere else but here. I hope I don't have to move on from here. I like to be independent and that's what they let you do. And they're also caring. I mean all the staff is. And I'm sure they're just as caring to everybody else.* ~**Lucy** (senior)

> *...it's just that we're close in here, so, we got to know each other very well. It's been so nice. Close friends. And then the one friend that I play cards with knows a former neighbour of mine, from where I lived in [location]. She's a close friend of hers. And then this other lady that I play cards with, her last name was [last name stated] too, and I said one day, do you know so and so? "Oh yeah, that was my other husband's brother!". Small world it is…. It's not like an institution to me; it's more like a home.* ~**Ester** (senior)

> *... I live like a queen! (laughs). At least I feel like I do.* ~**Lorna** (senior)

Elyse was able to maintain a very active social life both in and outside the retirement home since the day she moved into the RH. She shared her secret to accepting and embracing retirement home living:

> *Don't wait until you are housebound! Like if people would move in here to a place like this when they can still drive and have a car [like I did], they wouldn't feel so confined and trapped. But they just don't want to give up their independence and their home. And so they hang on, and hang on, and hang on, and then they get to the point where they HAVE TO do something and that's when it really bothers them.* ~**Elyse** (senior)

One of the PSPs, Deb, shared similar advice on the importance of embracing RH living.

> *In the case of seniors, and I think of this with my mom, and now with my aunt …. it's not that they don't know what they want, it's just really hard for them to let go of what they had. Their independence in their home, and you know all their lives, I think there was a whole generation - I think that retirement home living is different now than it certainly was when my parents were my age. They think of it as a nursing home, and just really awful. You know, not necessarily very pleasant…. And I think that's part of it, helping them see things differently.* ~**Deb** (niece of Lorna)

Ultimately, the circumstances that led seniors to move into the RH had considerable influence on how satisfied they were with their current living arrangements. Pre-conceived notions of RHs and living with other strangers also affected RLSs' experiences and social patterns within the RH. Even though some seniors were settling into and enjoying their RH living more than others, all of them recognized they were in a good place and felt safe being there.

3.4 BARRIERS TO FRIENDSHIPS

Although participants were never explicitly asked about what factors influenced their social relationships within the RH, all of them brought up various barriers to making and maintaining friendships. Barriers identified included both personal factors and retirement home milieu. The two subthemes, (a) “It’s just that I’m not as able to do what I would like”: Declining health; and (b) “There’s not a huge connection thing”: Integration and interest, both describe the challenges of making and maintaining social relationships in a RH setting.

3.4.1 “It’s just that I’m not as able to do what I would like”: Declining health

Many seniors conveyed declines in their physical and mental health significantly influenced their socialization patterns, and in turn their relationships within the RH. Different health issues presented various barriers to making friends. For example, seniors, like Ester, who had mobility issues, stopped attending some of the activities previously enjoyed.

> *Well, when I first came here they used to have shuffleboard every Friday afternoon, and I used to go to that with the walker. But since I've been in a wheelchair, I, it's just too inconvenient so I don't go back there anymore. And when there's entertainment for welcoming new residents, or, birthdays, those days I try to go. And bingo maybe once a month. I usually go to that.* ~**Ester** (senior)

Similarly, Gertrude found as her mobility decreased, so did her participation in activities. This limited her relationships with friends, and she became more dependent on her daughter for socializing within the RH.

> *I was [involved] when I could walk up myself, but now I have to go and there's no one around to take me. So if my daughter is here, she'll sometimes take me up to some of the things.* ~**Gertrude** (senior)

Although Sonia could get herself to the activities, she was sometimes unable to participate due to the effects of her stroke including impaired dexterity and fine motor skills. She also felt the

effects of her stroke negatively influenced her relationships with friends and family, as demonstrated by the following two quotes:

> *Well I am happy but I wish that my health was better. You see, then you get involved very much more. And so, for instance, I used to do a lot of crocheting or hooking rugs and things like that. Well I can't do that anymore. So that puts strain on any relationships I may have had doing those activities.* ~**Sonia** (senior)

> *…it was different when you were healthy, we made like every family, all the holidays, birthdays, everything, picnics. We were together. But now of course it's changed, I cannot do all those things*. ~**Sonia** (senior)

Sonia's daughter, Diana, applauded her mother's perseverance to stay active despite some health setbacks.

> *She has tried to learn a couple of card games. She was doing shuffleboard upstairs, but after these last couple angina attacks, she's finding that she's more weak. But she's going to exercise regularly, like I think it 2 or 3 times a week, plus yoga, which is fantastic.* ~**Diana** (daughter of Sonia)

Bertha was unable to participate in some activities due to her visual impairments.

> *My biggest problem is that I am legally blind, and, um... not... well I'm dealing as well as I think I can deal with it. But it's quite a problem because I don't see anything anymore straight on, so I can't do any reading or writing. If I write anything I can't see it after it's written, and um that it's quite a problem*. ~**Bertha** (senior)

Lucy's aches and pains deterred her from going to activities such as exercise class.

> *I can get around and do what I want. But today I feel [sticks out tongue and thumbs down] But I am here [in the RH] most of the time, just some of the things I don't participate in…. Like for instance, I probably should be doing exercises, but I know I can't because my back is crappy.* ~**Lucy** (senior)

One senior opted out of activities due to a fear of becoming ill.

> *I don't go out and knit with the ladies too much because some of them had been sick and I don't wanna get sick (giggles)!* ~**Lorna** (senior)

Another health-related barrier to making friends was poor mental health. Alice's mental health issues often made her feel self-conscious about her ability to partake in, and communicate with, old friends as well as new peers in the RH:

> *I mean if I would be as healthy with my mind as I am with my body, I would be OK. Because I have no problem with my body eh?.... but my mind could be a little bit different. You know? Since I wasn't feeling good [got clinically depressed], I stopped communicating. It's my fault. I didn't want to because when I don't feel good, I don't want to. They were calling me, but I didn't call them. So, I had, I had a lot of friends and I, I just stopped.* ~**Alice** (senior)

Alice's son concurred stating:

> *...we tried putting her in group settings through the city - the city programs with seniors. And that goes back to her inability to feel comfortable in group settings with strange people. So that didn't work. So she's continually opted to say no, no, no, no to efforts to try and get her acclimatized and get her something to do, and get her interacting above what the home's doing.* ~**Jack** (son of Alice)

For Karen, the effects of her mental illness and chronic disease were twofold. Her treatments were scheduled at the same times as activities at the RH. Moreover, even when she was at the RH during scheduled activities, the side effects of her treatments and medications left her too exhausted to attend.

> *...they have a lot of activities. But me, because of my dialysis, I cannot go in the morning trip, or else, whenever it is in the afternoon I may already be too tired. So I personally don't really join. But I can see them, they like, are interested.* ~**Karen** (senior)

Similar to Karen, Gertrude's mental health, mobility and other comorbidities amplified the barriers to being social. One week, she was quarantined to her room, and even during weeks when she was not so ill, she still had to wait for her daughter to come take her to activities.

> *It's just boredom mostly with me. And depression. In my room. Here [this week] I've been in now three days, I can't go out.* ~**Gertrude** (senior)

Gertrude's daughter discussed a serious lung infection that sent her mother on a downward spiral.

> *But since this lung infection, it's really done a number on her. She's not nearly as talkative. She doesn't get interest out of a lot of things. And my cousin, who also, basically when [husband] and I went away to Europe for three weeks this summer, I counted on my cousin more than my brother to provide for my mother. And this cousin was just amazed, she said, you know, when she went in to talk to my mother, she said, 'I made sure I didn't come in until after 2 o'clock because I know you watch your story'.*

> *And my mother said, 'I don't watch it anymore.' And my mother had watched the same opera for a gazzilion years, and even got [cousins's] mother watching it. But my mother, after May just did not watch again…. Since this lung infection. You know, her personality has changed. She's not laughing.* ~**Dee** (daughter of Gertrude)

Hearing impairments were also a common barrier to socializing with others. Hearing issues hindered seniors' ease of, and willingness to, communicate and make new friends.

> *Well, I've always been one, like I like to converse quietly, not having a mass of people around, you know? Well because of the hearing I suppose.* ~**Ingrid** (senior)

> *...then when she moved [to RH], they're like a community and they want [her] to socialize and stuff, and um, I think she was afraid she couldn't hear them, because her hearing is not that great. So she was afraid she was missing things and then of course everything was wrong.* ~**Allison** (daughter-in-law of Ingrid)

> *...I think it's up to me, you know. And it's, it's, when we go for walks [there is a walking 'club'], my hearing isn't that good, and I walk, but I can't hear what they're saying. So I just say OK, you know, because they get tired of repeating themselves. So I think the hearing has a lot of problems with me. I can hear from person to person, but otherwise it's hard* ~**Alice** (senior)

> *I don't hear. I don't know what they're talking about. So, that's, that's probably why [I don't have friends]… I don't think I can change it. I don't know...* ~**Karen** (Senior)

> *I don't hear well, so I don't always go to the coffee breaks because of my hearing. I have to keep asking people to repeat themselves, you know?* ~**Lorna** (senior)

Undoubtedly, declining health had a direct negative effect on many seniors' social lives. Not only did it limit their ability to take part in some activities, it also made it difficult to take advantage of other social opportunities, such as conversing with other residents in the halls, meal times, and so on. This sub-theme revealed that health problems for some seniors prevented them from participating in activities and communicating with other residents, which in turn decreased their chances of building meaningful relationships with those around them and ultimately affected their quality of life.

3.4.2 "There's not a huge connection thing": Integration and interest

Within this subtheme, seniors shared mixed feelings about their peers from the RH. Many participants felt the RH milieu presented social barriers to building new friendships. Whereas the first theme conveyed how friendly all the residents were with each other, when delved deeper, this theme demonstrated that it is just surface level friendliness. Seniors noted that everyone, including staff, were very private. Living in an environment where people kept to themselves made it hard for RLSs to integrate and feel included in their social environment.

> *… amicable. I like everybody. I'm comfortable with everybody. What would the word be.... there isn't anybody that I don't trust, or wouldn't want to depend on…. But you know that you don' -, you can't cross that - can't get too much information about people (giggles). So you kind of keep them at an arms-length. But they are very good relationships, I don't have any trouble. …. the lady across the hall, she's so cute, but if anybody went to her door and knocked on it, she'd never ask them to come in. There's not a huge connection thing. And you go up and down the halls at night and the doors are all closed and you think it's just like a morgue.* ~**Bertha** (senior)

> *I don't have a lot of visiting back and forth because we do most of our visiting when we're together [at] activities and stuff you know.* ~**Ruth** (senior)

> *Yeah, there's not much going on, you know. And I, I would like to have something every hour on the hour, have something to go to, that would be nice. But I know that's not possible.* ~**Alice** (senior)

Ingrid found the types of people and fast pace of the RH made it difficult to make strong connections.

> *Well they're all very nice if you can get to them, if you know what I mean? Um, one day you can say speak to somebody just briefly, because it's all on the move all the time. Briefly, and the next day they look right through you …. and I, I don't want to infringe on anyone else's things they do, or they want to do so uh. You see, everybody's got their friends here, their family. Nearly every body, so they're not interested in an outsider, which I feel I am.* **~Ingrid** (senior)

On the other hand, a few seniors thought very fondly of their RH peers and enjoyed their company.

> *And, I've made friends in here. We get together and play cards a couple times a week. And, I just find everyone is sooo friendly and helpful in here. Like, it's just like, been wonderful. Especially since I'm in a wheelchair. "Can I help you?"…. some people are less able to push me …. (giggles). And I say "no, don't do that, I don't want you to hurt yourself"* **~Ester** (senior)

> *… I look forward to going to the table to have a meal. And the one lad at the table, [name], he's younger than me, we've been together at that table since I came about 2 years ago. And uh, he had told me he came in and his wife had died the next day or something. So we got communicating and we got close, like a brother and sister you know.* **~Lorna** (senior)

For some seniors, having positive interactions did not necessarily translate to building close and meaningful relationships similar to the relationships they had as adults outside of the RH.

> *I, I haven't got close to anyone. But everyone is so friendly and we always pass the time of day, uh, when we meet in the hall or going to the meals…I, uh, enjoy the people at the table that we have the meals with. And I speak to everyone, and I try to go to a few of the activities we have.* ~**Lorna** (senior)

> *Well I'm friends with [name], we come and go. I'm not really close friends with anybody…. Some of the residents I could get along without, but that would happen anywhere you went. And they probably think the same of me* (laughs). ~**Lucy** (senior)

All seniors contended their RH relationships were not as close due to a number of factors, such as time living in the RH and impending mortality of seniors.

> *I'm not as close to anybody as I used to be because I haven't known them for as long. But, oh well, when you're in a group like we've got here, some come and some go. And um, uhhh, some die, and it's hard to have really strong friendships. It is. And the older you get the harder it is to make new friends.* ~**Ruth** (senior)

> *Yeah, not good friends, because you don't have good friends with someone who you meet just recently. Friendship you have to be build up, build up over the time. But I have a few nice ladies [and] we like each other. And they have to put up with me (laughs)…. But on the whole, it's a good community life. Yeah. And there is some people that I really enjoy and love (giggles) Oh yeah. It's good.* ~**Sonia** (senior)

Additionally, participants felt there was not much to talk about within the RH, making it difficult to connect with some of their peers. Seemingly, most seniors acknowledged there was nothing to cultivate new friendships and no history like they had with friends outside the RH.

> *It is a hard thing to have a social network here because, well, people are different you know. You don't know sometimes what to talk about. It's this everyday little things that people pick up and talk. I don't get involved. But I have a few friends here that I can converse and discuss and loan the books, and we are getting along, a few of them, but not with too many. Yeah.* ~**Sonia** (senior)

> *Well, you've lived your life and not everybody wants to talk to you about your, the things you've done. And you don't want to listen to all of the others. People say things over and over and over, like you know, I mean your friends but it's a different kind of friendships.* ~**Ruth** (senior)

> *I don't have much to say. [People at table converse about] gossip things, or something about the church activities, or plans, or something like that. So here again, I'm not sure if it is them at fault, or I.* ~**Karen** (senior)

While there were a lot of activities and opportunities to socialize, seniors were not always interested in attending. Most seniors tried to go to a few activities, but none of them felt these programs were an integral part of their social lives, nor were they the primary means they socialized with others in the RH.

> *I haven't made any close friends here. I uh, enjoy the people at the table that we have the meals with. And I speak to everyone, and I try to go to a few of the activities we have. There's a lot that I don't go to because, not my cup of tea (giggles). But uh, I, I haven't got close to anyone here you know. I'm kind of a loner.* ~**Lorna** (senior)

> *I try to go to the resident forums and I try to go to the food council. But all the craft things and, and game things, um, I was going regularly on Wednesday nights for Wendy, but I'm getting lazy. I feel like sitting down and watching television instead of playing games…you know, if I feel like it I do it, and if I don't, I don't.* ~**Elyse** (senior)

> *But some of the things I just don't [do]- knit and chat I don't go to, no, I'm not into that anymore. I've done my share of [knitting], as you can see behind me. And shuffle board I don't bother with that. It just doesn't interest me.* ~**Lucy** (Senior)

Positive social experiences seniors noted often occurred outside scheduled recreation time, typically in small groups or one-on-one interactions. For example, while sitting in a common area, a group of seniors invited Ester to join in a game one evening.

> *Well, they were socializing one night, and playing cards or something, and I was watching this group playing this game, and I was just sitting watching them when, "oh, would you like to join us." And I thought it sounded interesting, so we became a foursome and we've been playing ever since!* ~**Ester** (senior)

Her daughter commented on Ester's social patterns.

> *…she's been pretty good. She's made, as you can see, a lot of new friends, and has just warmed up to people. I've also noticed that she's more outgoing! Like somebody new moved in, I don't know, four or six months ago, and she found out that this lady liked to play scrabble. She approached her, and said can we play scrabble some afternoon, so it was great.* ~**Amber** (daughter of Ester)

Other seniors felt welcomed through peers' and staff members' kind gestures when they had moved into the RH.

> *Company is also not ideal, but if I'm in real trouble. Like [name], she would follow me whenever I'm sick, or weak. Yeah, so, I guess company in the sense of there are people I can go to….When I came, she followed me, and she told me how to open the door, and you know, like little things like that. But I don't think anyone else would like to do that…*~**Karen** (senior)

> *The girl [PSW] came in and, at meal, at the first meal and told me to follow her because I had to use my walker. And that's when they set me at the table and from then on, things just mixed in and fell into place.* ~**Lorna** (senior)

Support persons also supported the notion of peers and staff trying to integrate newcomers in RH living:

> *She met some people right off the bat that she did like. I was very surprised when she first moved in there, she was set at a table with uh, a man who did not speak very much, but with a couple who was in there, and the woman who has since died. But they were uh, very chatty. Uh, but the husband kept trying to give my mother food off his plate.…I think he was just trying to be friendly.* ~**Dee** (daughter of Gertrude)

> *... they bring a young university student in. She plays scrabble with them, she converses with them, and she's very good at taking an interest in their life as university students, she sees them as her grandchildren. So the activities director, kudos to them, is to find out what makes somebody tick and make them respond, and they found the right trigger for mom.* ~**Allison** (daughter-in-law of Ingrid)

> *Honestly, I think what's good about it, like, she likes the activities coordinator, and so she'll often say '[coordinator] planned an event so I'm going to go because she worked so hard'. But I mean there's nooo like, [coordinator] doesn't make her feel like she has to*

> *go. If my aunt says I'm tired and I don't feel like going, and that's fine. So they don't put pressure, and I think that's a nice, I mean there are opportunities, and she's felt comfortable to take some of them, but if she doesn't want to, they don't pressure her into it. So that's a good balance.* ~**Deb** (niece of Lorna)

Based on these quotes it was evident all participants enjoyed being surrounded by others to an extent, even when the quality of relationships was not always present. Despite many of the participants stating they 'hadn't made any close friends', none of them expressed a desire to get closer, or change the state of their current relationships. Interestingly, of the experiences shared where seniors felt welcomed and integrated, most did not occur during organized RH activities. Instead, bonds between seniors happened in small groups or one-on-one scenarios. Evidently, having recreational activities a few times a day was not enough to foster friendships among residents. Perhaps inclusive environments promoting friendships and relationships with the RH may require more intimate social events and individualized programing, as opposed to large-scale activities.

3.5 LIFE BEYOND THE RETIREMENT HOME

In addition to the inner workings of each individual and her current environment, factors beyond the retirement home also influenced seniors' social relationships. Life beyond the retirement home included experiences seniors had prior to moving into the RH, as well as outside involvements and relationships they continued to have while living in the RH. To better understand how RH living influenced social relationships, it was important to consider how each seniors' experiences beyond the RH changed or remained the same after they moved into the current RH. The seniors' experiences led to the development of two subthemes: (a) Other involvements: "You have to keep your mind busy", and (b) "I don't know what I would do if I didn't have any family".

3.5.1 Other involvements: "You have to busy your mind"

The title of this subtheme, shared by Sonia, echoed the importance of remaining connected with the world outside the RH. Whether it was through watching the news, writing to friends, visiting with family, or volunteering, all seniors made an effort to keep their minds busy with matters beyond the four walls of the RH. While talking about their current relationships, many participants reminisced about their adult social lives. Often seniors' social preferences mirrored their adult social patterns. For example, Ester who was socially active in her last retirement community maintained past relationships and tried to remain involved in the RH.

> *It was a little community there [at my previous condo]. We used to get together [once] a week for coffee hour and socialize, play games one day a week, and then we'd have every once in a while, we'd have a gathering of something. I still have the same people that always keep in contact with me.* ~**Ester** (senior)

> *…they had moved into this condo, but he [dad] had another stroke shortly after that ultimately took his life. So she developed new friends there, and really got involved with the condo community, and started going for coffee hour and helping out, and um, doing more things at the church which was very important to her. Um, yeah, serving on the church council and lots of things like that…. [In terms of contact now] phone calls, yes. Visits, umm, are tapering off because they're aging as well.* ~**Amber** (daughter of Ester)

Elyse revealed she was always on the go as an adult, and remained just as busy in her senior years. Her nickname in the RH was the "energizer bunny" because she was always on the go. The following quotes reflect her activity prior to moving to the RH and after moving to the RH.

> *So, and then when [my daughter] came along it was like he was too busy to look after kids and back then you did not hire kids to come in and look after your kids. So I stayed home and I became the, the housewife, the mother, the roadrunner, the hired man, the gardener, the bookkeeper, the, just about everything.* ~**Elyse** (senior)

> *And it's just I have that group of friends, and I have another group of friends, and I have my nurses, you know, ever since probably the 45th reunion which was 7 years ago now I think, we have got together like, always something coming across on the internet from them. And we regularly get together a couple times a year. And you don't see them all the time but you still keep in touch with them* ~**Elyse** (senior)

Several seniors were socially active as adults, but became less social as they aged. They explained the social groups and connections they once had were no longer existent because many of the people involved in those groups and relationships had passed away. This decrease in social activity was not due to the RH, but instead the natural process of aging.

> *… we belonged to several churches. Where we lived, we belonged to [name of church] that was a very nice Parish, and high school for the kids. And yes I met some friends, the same group who came from Africa, the same girls, we kept in touch. Yeah, that was nice. Actually all the time until about now they started to die out, pass away. There are only two girls - I and [friend] that are alive. The rest are all gone. Here in [town], the same in [other town], the group, half of them are gone! It's sad in a way because you're left without friends. You have to make your new friends…* ~**Sonia** (senior)

> *My confidant. Oh yeah, she was wonderful with everybody (pause).... she and I played scrabble constantly. Almost every Sunday afternoon, except when she was having her family coming….Ohhhh I (stutters) miss her (pause). That was the last time. Walked out of their kitchen there (points to photo).* ~**Ingrid** (senior)

> *Well, we could go to anyone and have a nice conversation and we could laugh and we did things for each other. We didn't over extend our, our um, support, but we were always there for each other. [Now] my friends are all gone*. ~**Ruth** (senior)

Support persons relayed the same sentiments expressed by seniors:

> *There are still two people in her apartment building that keep in contact with her. Um, as her physically, as she got less and less mobile. She went less and less to church, umm, and since she didn't renew her license back in 2011, she relied on me to drive her there, and so yes, she belonged to a couple groups at the church, that fell by the way side because I was working and she didn't have a car anymore [so] some of those connections were lost…..more emotional support was expected [from me] because she didn't have the group of peers in her apartment building. They would mostly call her, but not visit.* ~**Dee** (daughter of Gertrude)

In contrast, a few of the seniors were more introverted and spent a lot of their adult life doing more independent activities. They did not feel the need to join community groups or spend time with friends because they were busy gardening, working, and caring for their families. Unfortunately, life circumstances no longer allowed these women to do the things that consumed their free time and brought them joy as adults.

> *Like I always miss the place that I lived by myself [house], where I could do gardening. I looove gardening. I [was] always outside. And then cooking, so, those are two things or maybe three things, sowing too. But sowing it's not very easy for me because I have a lot of tremors, and well... But baking, I like that. And my children, they really like the baking (giggle). So I can't do those, and that I think I miss.* ~**Karen** (senior)

> *I worked at Loblaws and A&P, at both stores. And um, other than that we didn't do too much because of my husband's health.* ~**Lorna** (senior)

Alice reflected on her experiences, noting not having strong social ties or interests outside of the farm and family.

> *Maybe I should've moved in the city and you know. I maybe was, I, I had no interest in anything. Just the farm. I mean, just- I didn't do the farming, just the place was big, I had to take care of around the house you know, and all that stuff. And I, I didn't really have many friends. I had, I had my relatives but I really didn't have no friends or I didn't do anything outside, so I think that was bad too. I was more alone.* ~**Alice** (senior)

She believed not have strong ties as an adult hindered her ability to make new relationships later in life. Unlike the participants whose adult social circles had diminished, seniors who were able to maintain close contact with old friends, and engage in RH living were very satisfied with their social well-being. For example, Bertha still kept in very close contact with her old friends and tried to have a positive outlook concerning her current living arrangements and social situations.

> *She did all kinds of stuff. She played bridge. They would get together. I would say the one friend and she got together like every other day. [name], the one with cancer, is probably her strongest support. But she has lots of other really good friends that did all kinds of things together. So they would go out for lunch, they'd get together for birthdays, they'd go to cottages, they'd just do all kinds of stuff.* ~**Lisa** (daughter of Bertha)

> *OK, I have probably 5 really good friends who have contributed a lot to my well-being over the years and they've remained pretty faithful. It's a lot harder now, um, for groups to get together, but they do remember me and come see me, and that makes life good. You have to have contacts and get sort of out once in a while. When I'm in the dining room I think to myself 'ohhh my gosh, this is like being in the hospital'. Then I shut that out because I wouldn't want to think that way, but it has a bit of that flavour to it, you know?* ~**Bertha** (senior)

Elyse was also able to maintain close contact with lifelong friends, still keeping in touch with all of them.

> *I like to keep busy…. Like for the last, oh, I don't know. Even before we left [our home], I liked to go out to lunch with my friends and connect. I have a very good friend in [hometown] that was my back door neighbour. And her and I had lunch together with another gal that we had gone to Florida back when the kids were just teen- well [daughter] turned 13 that year. And so, you know, I've had that relationship ever since she moved in next door to me, back when I was in [hometown], before I moved to the farm. So we were having lunch, well we should invite so and so. So the next time we invited another one that was having difficulty with her husband. He had Alzheimer's and she was by herself and he was in the nursing home, and that as four of us. It's gone to 14! And we have lunch every month! …. Friends are very, very important to you! And the more friends you can have, you know, the more friends you have, I think the better your life will be.* ~**Elyse** (senior)

Lucy explained she did not see her friends as much, but they are still very close and kept in touch. She was happy with the state of these relationships.

> *Oh I did lots of things. I joined a women's institute in St. George after [husband] passed away. And I went to bible study group, I started that too. It was every Monday and the women's institute was once a month. [I still do] the bible study group once in a while. I don't go to the study per say, but we see each other. Not often but I keep in touch with them.* ~**Lucy** (senior)

Sonia found her friends and family were very loyal and began to visit her more frequently in the RH once she was not well enough to get out to them. She was grateful and relied on these relationships to stay socially connected with the outside world.

> *I see them, I see them. They take turns, they must because (giggles) it works this way. They come, uhhh, three times a month, 2 times a month, it depends. Yeah. And that keeps me really positive and know what is happening in the outside world, because here, you don't hear anything except the television and I don't watch too much television because I, I like to have first-hand experience. Since I got sick, well everybody comes here.* ~**Sonia** (Senior)

The relationships and involvements seniors had established in adulthood appeared to be more important relationships than the relationships they had formed within the RH. Consequently, RLSs tried to maintain these connections in order to maintain their overall social well-being. While moving into the RH did not necessarily improve social relationships for seniors in general, it also did not appear to negatively effect seniors' social well-being. In fact, overall, seniors

tended to maintain or increase the amount of socializing they did after moving into the RH. The only difference, for some seniors, was the shift from predominantly socializing with friends when they were adults, to now socializing predominantly with family members rather than RH peers. In short, even if social patterns changed, moving into the RH was not the cause of the changes in their relationships beyond the walls of the RH.

3.5.2 "I don't know what I would do if I didn't have any family"

It was clear all RLSs considered family one of their strongest social ties. In addition to helping with care, families also acted as primary sources for socialization, chatting and visiting with the seniors on a regular basis. In many ways, families had an integral role in keeping seniors socially active. All seniors expressed how much they relied on their families.

> *I don't know what I would do if I didn't have any family. It'd be a sad life. So I'm glad in a way that we have these two daughters…. It's piece of mind, because you know when you need it, like I was at the end of November, I got a heart attack, and if I didn't have any support that would be really bad. But this way, [daughter] took over at night; [daughter #2] took over during the day. You know it's a family unit (giggles), it's a good, good relationship.* ~**Sonia** (senior)

> *She'll offer to do anything for me. Or, like my fan there, I just said guess I won't use the fan anymore, and the next Sunday she takes it. I didn't say anything to her- it was just gone to the car. Things like that, she's very thoughtful.* ~**Ingrid** (senior)
> *I know that if I were to call them, they would be here. There would be nothing that would stop them, you know. I know that now. They are very reliable. They would do anything for [me], and they're not always here to just sort of (pause), what would the word be... uh… spoil you I guess and that sort of thing, but I know they'd do anything that I ask them to do.* ~**Bertha** (senior)

Ester and Lucy found comfort in knowing their families were always there as supports who they could talk things over with, whether it be about how they were feeling or important decisions regarding their health.

> *Well, it means a lot to me because my memory sometimes isn't like what it should be, so when someone else is with me, especially with appointments and things. And that means a lot for me, for someone to be with me. Well [daughter], like she keeps pretty good tabs on me at all times. And helps me with my financials. And then [son] is there too, with his*

> *wife. Yeah... it's good to have somebody that I can communicate with and talk things over.* ~**Ester** (Senior)

> *Well my kids are very supportive…. My kids phone me all the time. One kid phoned me this morning. The other day three of them phoned, 3 out of the 4. The other one I talked to the day before. So I have no problems that way. They've been great ever since I came here.* ~**Lucy** (senior)

Alice appreciated her family, but wished they could visit more frequently.

> *You know, it's nice to phone, but it's not around. Being around you know, it's a different thing.* If *they can, they come and visit more at first, and then you can kind of get used to it. But not everybody can do that because a lot of those people are working, and they have to do their own thing.* ~**Alice** (senior)

Bertha also shared her view on the matter by stating:

> *…but I see a lot that just sort of yearn for their families, you know? I have a friend here, [Alice], and she has 5 children, and seems to me that there is more anxiety about whether they're going to come and see them, or they're not going to, or what they can provide in care. And I'm still at that point where I'm quite happy with a phone call if that's what I get that week (laughs), or two or three.* ~**Bertha** (senior)

Additionally, all participants talked about how busy their families were, but tried to be understanding and respect their family members' personal lives. Many seniors made remarks about feeling like they were a burden to their families at times. Seniors often tried to stay out of their family's way by avoiding asking for help unless absolutely necessary.

> *I've got nothing to grumble about them at all. They're wonderful. They really are. They go out of their way, and I don't want to ask. I don't want to ask them to do anything for me, as long as I can…. I won't ask sometimes because that'll affect that and that, so I work it out.* ~**Ingrid** (senior)

> *Like they're up to their ears at work, and ummm, you say 'could you come for whatever'. You know, like now I hardly don't ever ask them even because I think, I know they are pretty well busy all the time. So if I have something that's really special that I want them to come to, I would mention it. But I would never push them to come if they have stuff on their plate, and it often happens.* ~**Bertha** (senior)

Although some seniors wished they could spend more time with their families at times, they were thankful for the relationships they had and came to terms with the attention they were receiving.

> *I have, oh, uh, no family, my family is all gone. Uh, but I have wonderful nieces and nephews and they try to keep in touch with me as much as they can. Of course people are young and they have a life, so I understand that. They have a life. And they have children. So I don't interfere.* ~**Lorna** (senior)

> *..we get along good, you know. I know my daughter says different times we are so lucky. Well that we're all, that we get along good, you know, yeah. And also, um, with me, I'm not a demanding person you know. So they, they can live their life, [and] I don't interfere.* ~**Ruth** (senior)

Lucy was accepting yet disheartened by her family situation.

> *Well my kids are very supportive. They've really been good. At times they don't get along, but then all of a sudden they do. So you don't worry about it. I think every family has the same thing…. When they grow up and they got their own life, it changes. And it's just automatic with every family. And you can't help it, because they just, they've got jobs and stuff that they have to do. They don't have time for you and their fun you know. You just fade away into the background… Sometimes [it bothers me] but most of the time not. I realize that's how it is.* ~**Lucy** (senior)

Seniors who had more severe health conditions and required more care felt that relationships with their families were centered on caregiving, rather than socializing and enjoying each other's company. For example, only the family members who were involved in Gertrude's direct care kept in close contact with her.

> *I can't say they've [relationships with family] changed. They're more involved with me, with my care but as far as my relationship goes, it's still the same. Mostly the children. Yeah. Grandchildren? - they're all busy. Too busy to be bothered with me.* ~**Gertrude** (senior)

In Karen's situation, the family only had enough time to dedicate to physical health-related needs, leaving no room for leisure time together or to offer much social support.

> *…they [other residents] don't have that much love and attention from their family. Like me included. Now, because younger generations, they don't have time. Both husband and wife works, children goes to school, so its, its because of that lifestyle right…My*

> *grandchildren are very close to me, but, e-even my son, they become so involved with other things like sports or workout, uh, they don't have time for me.* ~**Karen** (senior)

All seniors experienced feeling left out or feeling like a burden to their families at one point or another. At the same time, participants were able to find the silver linings and be thankful for the support they did receive, recognizing how important it was to have family to lean on when needed.

3.6 THE BIGGER PICTURE

This theme specifically addressed support persons' experiences with, and opinions of, the retirement home structure as well as how seniors are treated in general. In reflecting on their responsibilities as support persons of RLSs, it became clear they did everything in their power to help seniors maintain their health, both socially and physically. However, many of the PSP felt that in addition to their own efforts and involvement, there was a need for further support from both RHs, and/or the health care professionals. The two subthemes, (a) "We tried so hard": PSPs' efforts"; and (b) "Warehoused": RH living and treatment of seniors, will be discussed in turn.

3.6.1 "We tried so hard": PSPs' efforts

As stated by a multitude of PSPs, "we tried so hard" referenced support people's constant efforts to ensure seniors were comfortable and happy in their environment. Throughout the interviews, support people reiterated the challenges associated with fulfilling RLSs' desires while also meeting their needs from a health perspective.

> *We [siblings] believed that we would like her to be as happy as she could be, doing whatever she wanted to do. And if it was living out [on the farm] then it was living out there….And it wasn't going to be a situation where we were going to force her to do anything, unless it was for her health or personal care. And so ultimately she was a danger to herself, so when she came out of [hospital] we all agreed it was time. Like it wasn't really an option to keep her at home anymore….I think she feels a lot more*

> *dependent on me [now]. Like I call her everyday. But that's because first of all she needs it, and there's not much I can do, but again, comfort, support, listen to the complaining, like that kind of thing….me looking after things changed, and became more frequent when she went into the [RH].* ~**Jack** (son of Alice)

Another senior could not go back home after experiencing a fall and having to be hospitalized. RH living was the best option as conveyed by her PSP.

> *And she loved it [the retirement community]. And then she fell. And she wanted to go back I think. But we were saying, like I said basically I can't have the situation happen again, so you can't be in charge of your meds. So then I was looking into how much it would cost to get someone to come and give her medications everyday, and it was just going to be, I mean on top of that place, which was expensive, it was going to be way too much….And she never really let me be a part of that decision making, because I would have told her that. Like I was trying to get her to go to a place, where if she got worse, she could just stay in the same place, you know what I mean? …. And I kind of wanted her to move to a home that was closer to my home, but ultimately I want her to be happy too, and this is where she wanted to go.* ~**Lisa** (daughter of Bertha)

As depicted in the following quotes, Amber tried to let her mom maintain as much control of her life as possible, and empower her to be involved in the decision making concerning her living arrangements or day to day tasks:

> *I wasn't working on Fridays at that time so we started visiting homes throughout [the area], and we'd have lunch at them. And she actually even stayed at another one for respite for a week, just to see if she liked it. And this was my preference, but I couldn't say 'you have to come here', so actually one of her church friends got involved and brought her here, and had lunch with her here, and that was sort of the clincher.* ~**Amber** (daughter of Ester)

> *… keep them as involved in the decision-making as possible. Like when my mom says she needs a new coat, I bring her in here (computer lounge) and we go online to The Bay or whatever, and we scroll through and let her pick out what kinds of things she likes, instead of me just going out and buying whatever I think for her. And even for things like banking, not that they're going to do it themselves but I go on the site with my mom and log her in, so I can show her that these are your accounts, and this is what you have and that sort of thing. So that would be the only thing. It's to keep them involved. And I think she really appreciates that.* ~**Amber** (daughter of Ester)

In some cases, the seniors were not in any position to select a RH, so PSPs did the groundwork and tried to make the best of the situation. Deb used baby steps to eventually transition her aunt into a place her own mother had enjoyed when she was still alive.

> *…as I started calling everyday…. I could hear like she's not functioning very well up there [in her home]….And she fell a couple times, like she would go out there on the grass. So fortunately she didn't hurt herself or break a hip or anything. So I said to my husband, she's not functioning well….So then it was a couple months later when we went and got her, and we talked her into coming and spending the rest of the winter with us…. So then we started talking about it and she agreed to a retirement home….And so I asked her where, and she said ' down there with you dear because you take care of everything'. So she made that easier….I suggested it [the RH]. I mean she knew of no other places down here. She just took my word. And I just said 'lets try [RH]'. Because when my mom had gone in, we had done some research and visited several. And so I think [the RH] proximity was great, and we liked the vibe there. So I said 'lets try it' and it worked out…. Like I think she feels like her room feels like her little home. And she feels very at ease there.* ~**Deb** (niece of Lorna)

Diana and her sister also had their mom's best interest at heart.

> *… she was virtually incapacitated. She had the stroke on the right side. She had no input. Really, because she couldn't…. My sister and I had to orchestrate everything. It was unfortunate we couldn't convert her home to make it work, [so] that she could still be there…. We went to three different places. And [this] was a beautiful place…. The little door to her back patio we knew she would looove. She could plant a little something…* ~**Diana** (daughter of Sonia)

The majority of PSPs felt they put in an equal or greater amount of time and effort into supporting their seniors currently, than they did prior to the RH or during the transitions into the RH. For example, the following quotes illustrated some of the ways in which PSPs supported the seniors outside of the RH, such as having them come over for dinner on a regular basis.

> *You know, she's here almost every Sunday for supper, just so she has a break from her little room. Um, so I suppose a lot of the [bond we have] is just from the frequent contact we have.* ~**Allison** (daughter-in-law of Ingrid)

> *…by the time I drive here, pick her up, drive home. Drive back. It's between 45 min [to] an hour. And you have to throw in there, although I'd be making dinner anyways, but I make a really good dinner [when she comes over].* ~**Lisa** (daughter of Bertha)

PSPs also spoke of socializing with their seniors within the walls of the RH.

> *I'm sure before I leave we'll have to go visit to deliver the flowers etc. Ummm, time permitting, we will come back here and play a game of scrabble. Or in the summer, get outside and play scrabble, or just visit. Reminisce…. the trust has been built up. Like I don't let her down. You know, and, unfortunately, or fortunately, I make her think.* ~**Amber** (daughter of Ester)

> *…we were, especially [involved] at the time when she fell, maybe even when she first moved in, [my sister] and her husband would go on certain days, and I would go on certain days, and practically 5 out of 7 days somebody would be visiting. Mom finally said, "You don't have to come everyday you know!" (laughs). In other words she was feeling better, and getting involved in things, so we didn't have to be there all the time bugging her.* ~**Diana** (daughter of Sonia)

Dee went one-step further and attended activities at the RH to facilitate her mom's participation in programs so she could socialize with her RH peers. In short, Dee felt she was better equipped to "get her going better" than other seniors or RH personnel.

> *Soooo, I've been in there three different times when I see a bingo game going on, with people who are probably more her level of cognition. And um, so I, after the dust settled a bit, I'd go down and take her to some things.* ~**Dee** (Daughter of Gertrude)

Although PSPs acknowledged supporting their seniors was beneficial, particularly for the seniors, PSPs also noted the emotional toll and sacrifices that came with being support persons.

> *Oh it's a stressful thing. I think it sets me off. When she's really depressed, it's hard to decompress from that. I accept it because I've seen it for so long, but it's not really something that you really enjoy going through, let me tell ya!* ~**Jack** (son of Alice)

> *I did talk to her everyday on the phone since she got this lung infection in the spring. She's, really become quite a different person. She's withdrawn, and has I think gotten a little angry, and I'm the support person, so I get the brunt of that... (sad whisper). So, um, a task that I did (voice quiver) willingly for many years, has now become I don't know. Kind of a [chore]. It's becoming difficult (tears in eyes).* ~**Dee** (daughter of Gertrude)

Supporting the seniors was also more arduous, when the support was not appreciated or the PSPs were not treated well by their seniors. Diana reiterated the following story where her mother was ungrateful for the work completed by her support people:

> *….So my sister, and I, and [niece] went through all the clothing. We filled 8 drawers and her closet. Well then everytime it's like " I can't find my pair of black pants, you girls must've gave them away!!"…. Um, "I had a blue carrying bag, you girls must have gave that away!!!" Well, that was hurtful to us. We tried so hard to think what she would want. We tried. We just tried soooo hard!.... and finally I said to her, 'you know what, when I hear how unhappy you are with our choices, I get really upset because I feel like we failed you. Like we did a bad job. We did it all wrong. Like we failed you. "Well you didn't! You did a good job." And I said, 'well then you need to stop telling us that we gave it all away! That we kept the wrong stuff, that we did it wrong. Because that hurts.'* ~**Diana** (daughter of Sonia)

Lisa also felt her mother did not acknowledge or appreciate the support she provided, support that never seemed good enough for her mom.

> *I was sleeping on her floor, on the couch cushions, and looking after her after she did fall and break her ribs because she was so out of it from the medication. She didn't want to stay in the hospital, and she was putting up a big stink with the doctor. And I said this is a problem. So anyways, it just went on and on and on….I think all I would've liked was just some kind of recognition…. I'm just always the- I feel like no matter what I do, it's never good enough. And I don't know. I feel like I just can't solve anything.* ~**Lisa** (daughter of Bertha)

Similarly Allison commented on how the busyness of her life made supporting her mother-in-law a chore at times.

> *… the only time it becomes a chore is if I'm really busy at work. Last year she had a lot of doctors appointments…. A lot of my vacation time is spent driving her to doctors and eye appointments and ear appointments, and she had a growth on her nose that had to be removed last year. She had a lot going on. So, it has clearly fallen mostly on my shoulders, because my sister-in-law can't do it, and the kids are all working, they all have jobs and families. I'm by myself, whereas they have other responsibilities. So yeah, it has been challenging you know.* ~**Allison** (daughter-in-law of Ingrid)

Despite the challenges, people stated they were willing to assume their supportive roles, whether there were positives attached to their roles or not.

> *Not a problem [being the PSP]. My sister pulls her weight in different ways. Like I do the financials, the doctors appointments, the shopping. I do all of that for the most part. But I know how it affects my sister negatively…. if I were to say that she needs to take it over, that would cause her grief, and there's no need to do that. I'm available, I'm capable, and I can do that.* ~**Diana** (daughter of Sonia)

> *She sees us as her primary caregivers, and that's a role that we've willingly taken on. I know she feels very grateful, and expresses that and her appreciation to us. But we don't mind, and its just that's our role right now and that's fine…. there's this pleasure of having this person you love closer and in your life. That's nice. There's a sense of um, fulfilment that you're helping someone who needs help at this time in their life. And you feel good about being able to do that. Because you think, how could she ever do this on her own. And you think about the people who have no support and think oh my goodness that must be so hard. So there's a sense of fulfilment.* ~**Deb** (niece of Lorna)

> *Its like how do I not answer the phone?! .... I fill the certain obligation and I'm willing to fulfil it.* ~**Jack** (son of Alice)

> *I am the one who is willing to take her to her appointments…. I'd rather kind of be the support and take her there, learn what's happening, how her body is changing or whatever. Because her hearing isn't that great, so the doctors are usually telling her things and I'm hoping I'm getting the whole story. A lot of that has changed because they've been helping her, so it isn't as frequent.* ~**Allison** (daughter-in-law of Ingrid)

All PSPs conveyed they tried their best to support seniors in all aspects of their lives. While supporting seniors' physical needs was often the top priority, all PSPs acknowledged the importance of social needs as well, if time permitted to fulfil both needs. Ultimately, each PSP had his or her own method of trying to facilitate the senior to be social. Whether it was through encouraging participation in the RH activities, helping maintain seniors' confidence and independence, or chatting with them weekly, all PSPs tried their best to ensure the social and physical health of their seniors. PSPs wished they had additional support in place to meet their seniors' social needs and acknowledged other shortcomings about RH living, as summarized in the subsequent subtheme.

3.6.2 "Warehoused": RH living and treatment of seniors

Within this subtheme, PSPs shared their points of view on how independent and assisted retirement living is currently operated in Ontario, as well as their impressions, likes, and dislikes of the RH where their family members currently resided. The title of this theme, "Warehoused", illustrated some of the concerns and skepticism surrounding RH living and treatment of seniors

in general. For example, although Lisa recognized her mother needed to live in a place that provided support, she questioned whether her mother was truly cared for or happy within the RH.

> *….It's like dropping your child off at school, and thinking are they going to be good to them?…. It just feels worse in a way too though, because when they get to this point, like is their quality of life good? I feel guilty that she's probably lonely or bored. Like I wouldn't want to live here...* ~**Lisa** (daughter of Bertha)

Jack bluntly stated his feelings about RH living with respect to his mother's situation. The title of this sub-theme reflected his views.

> *…if someone said well would you believe that in this country we should have the option of ending yourself if you wanted to. I'd say yeah. To die with dignity, I think personally for myself, is what this country [needs to] get to. Because living in a RH when you don't want to live is not a good solution. Where is the quality of life?.... So this comes back to the societal burden of what do we do with people who don't really want to be in those environments but are forced to be there…. I call it warehouse living. She's warehoused until she dies. Sorry, but that's what it is.* ~**Jack** (son of Alice)

Further, some PSPs felt RH living was not necessarily sustainable for all seniors in terms of cost and/or level of care provided.

> *… you know they [the government] try to keep them in their own homes as long as they can. The problem is if you look at the size of our properties, we're getting older and it's getting harder to take care of them. It's not that they don't want to do the work, it's that they aren't physically capable of doing it and they can't pay someone to do it for them [yet] owning their own property is very important. Paying $4000 month for care [cost of RH], that's a different story. If you only make, some of them $18000-$25000 a year, $4000 is not sustainable. It's ridiculous….. And I think her biggest fear about everything, and still is, is running out of money.* ~**Allison** (daughter-in-law of Ingrid)

> *I know before we got Paramed involved, and that she's got that support, it was difficult. Well, I mean she was still getting a shower twice a week. But they gave her 15 minutes. Well, you can't shower, in that [time], in 15 minutes. I can jump in (giggles), but her... [NO].* ~**Amber** (daughter of Ester)

In addition, Lisa and Diana expressed concern over the medications their mothers were being prescribed prior to moving into the RH.

> *What really irritated me when she was in rehab, and we were selling the house, so we had to ask questions about certain things, the next thing I know, they put her on antidepressants. And I said why is she on those?! Well, she was crying they said. She was upset. And I said, under the circumstances, having a stroke, being yanked from your house, going to a place you're not sure of - you don't think you would cry!? I'd be more concerned if she WASN'T crying?! Like seriously. It took me 10 months to get her off those antidepressants, working with her doctor. 10 months. If the woman wants to cry because she is grieving, let her cry! That's healthy. To bottle it all up, that's not good. That's where depression comes in. So she's off the antidepressants, and she looks brighter. Her eyes are alive. Much better. But it took me a long time.* ~**Diana** (daughter of Sonia)

> *He wasn't going to sign off that she needed to go to [rehab centre], and I went in and said you will sign this, because you have given her this medication, and she was taking too much of it. So anyways, he did sign it and she went. Then I found out when my dad was sick that she was back on the medication from the same doctor! I don't know how long she was actually off of it. Like I think he put her right back on it. And you know what he said to me? He said, ' Lisa, you should know what your mother is like. She will not say no.' She basically, like he was sort of saying that she was harassing him….And I said, I wonder what The College of Physicians would say about that.* ~**Lisa** (daughter of Bertha)

Allison and Dee talked about the differences between RH living and nursing homes, with RHs being the preferred living environment. For example, Allison felt RHs were able to give more attention to each individual's social well-being, while nursing homes had their hands full with tending to high physical care needs of the residents.

> *The people there are absolutely, in my opinion, they are really great. They work hard. They have considerable care for each person. They try to meet all their needs. It's not a nursing home, it's still a retirement home. It's assisted living. And there's a big difference because I know when my mother was in a nursing home, I think there was 1 nurse for every 6 patients, and then when my daughter was in nursing school, and she was working in a nursing home, it became 1 in every 8. Now I believe we're at 1 in every 10. Well it's impossible to get 10 people out of bed, dressed, and down for breakfast in less than an hour. And, um, the cutbacks of you know, are fierce, to the care that's being given. Definitely noticeable.* ~**Allison** (daughter-in-law of Ingrid)

Dee's mother had recently moved to a nursing home to get more support with her physical care needs. Dee reflected on the transition, noting the RH was better for her mom's social well-being.

> *I think as far as her physical need, that's going to be taken away from me and it'll allow me to focus more of my energy on you know, social support…..And I've been there for a couple meals with her. And um, so, despite the fact that she really wanted to get more assistance, and get more bathing than is offered at a retirement home, she misses, I think, some of the social aspects.* ~**Dee** (daughter of Gertrude)

The aforementioned issues were often beyond the control of the RH, and under the purview of government agencies. Nevertheless, concerns about the availability of resources specifically pertaining to the current RH were also mentioned. For example, PSPs felt the number of staff was sometimes an issue in the current RH, as seniors did not always receive the prompt physical assistance they required.

> *Um, I think they could give more individual attention to the residents, in terms of like, you know, her health, and then other things. Like even the other day I came in and looked at her door and said, 'oh my god mom, your door is like at the bottom, and the top is coming off. Honestly. I don't know. You're paying $4000 a month, could someone please notice the door?!'* ~**Lisa** (daughter of Bertha)

> *…a couple of times, I was left to clean up a mess when there wasn't someone available quick enough to help her to the toilet. Since spring….it had become an issue, so I know, I couldn't do it. And I didn't want to embarrass my mom so I'd be turning my head, but I would gag! It's, I had that gag reflex (laughs) like I knew I wasn't going to throw up, I was just like, really grossed out….there were a couple of people who had to do that distasteful job and didn't like it. And back in the spring my mother said to me, and it just kind of broke my heart, she said I don't think they want me here anymore.* ~**Dee** (daughter of Gertrude)

Amber and Dee noted challenges seniors faced navigating the RH environment.

> *And again, coming to that yoga class, although she didn't do too much, I think it was just good for her to get out of her room, you know?….. they do offer activities there. There are just people who are not mobile enough. It's like, they can get down for their meals and back, but then they need to sit down for a while. So I think the level of staffing would need to change….they would need another body there to make sure that people get out to what they want.* ~**Dee** (daughter of Gertrude)

> *…being a retirement home, it really isn't accessible. For example, she can't get out that door [onto communal balcony] without me, because there's lips on everything. The only flat door is the main entrance, in this building. Which, and there is so many beautiful places, if they could get out. Because even with a walker, to lift your walker over the lip is difficult. The doors are heavy for safety and security, and I get that, but also they put an extra door on there [points to balcony], so that's another obstacle. So even if I'm*

> *sitting out here with her and there is someone else coming out with their walker, I have to get up to help them. Which is fine, but it's just something to note.* ~**Amber** (daughter of Ester)

At times, Lisa and Jack felt the RH could have more communication and support for families of RLSs.

> *Like when we came here originally, I feel like there was a bit of a lack of clarity around whether they were going to accept her or not. And they were all into this thing about she was coming from a locked facility, which she was. But I felt like they weren't confirming that she was going to be admitted here, when we had already given our notice at the other place. I just don't necessarily see it as a warm caring place. Like there are definitely nurses that have been good to her…. you wonder about the people who work here, and are they treating her well, and I don't know!* ~**Lisa** (daughter of Bertha)

> *So you've got a senior like my mom who can't go into a nursing home because that's totally wrong for her yet, but has mental health issues, or has issues that need additional support…. all of the things I tried I had to do myself. I had to find it myself, I had to explore it myself, I had to try it myself. I had to line it up, and it failed. And [RH] had no part of that. And they're the specialists. And I'm the lay man. So if [community services] were at least connected to the facility, it'd be easier to get help.* ~**Jack** (son of Alice)

Despite some of the shortcomings of RHs or the infrastructure in place for seniors in the healthcare system, PSPs also noted positives of RH living. Throughout the interviews, benefits of RH living for both the PSPs and RLSs emerged. For example, having on site medical assistance provided PSPs with a sense of relief and ensured RLSs had the care they needed in the comfort of their own home when they were ill.

> *I feel greatly supported. I feel relieved. She has the care she needed, and it's hard to explain to her. Like even when she was ill and I had to take her back from the hospital to the RH. I said this is where your care is. I can't give you the care that you need. Here you have your doctors on your doorstep, the nurses can get you the medication you need daily, and the PSWs are helping you with showering and all of that. They brought all her meals to her, and I couldn't do that unless I took off work.* ~**Allison** (daughter-in-law of Ingrid)

> *Um, I feel that she is in a safe place. It is very comforting to know that when she has the flu, they check on her regularly. Like peace of mind that way.* ~**Amber** (daughter of Ester)

Jack and Lisa reiterated the piece of mind they had knowing there was someone looking after their parents. They also noted the seniors no longer posed a danger to themselves, as they did when they were living on their own.

> *… it's definitely less stressful for me, like the reality is from a personal care observation point of view, she's not cooking for herself. She doesn't like it because she's, in essentially, in a federal institution that is one room with some time out, right. From my perspective, given the circumstances without the choice of whatever she can do, she's in an environment where she's looked after, as far as I can tell….I believe she is looked after in a fashion that is better than her alternatives.* ~**Jack** (son of Alice)

> *So, I feel really good that I know that if she fell, someone would be here and find her. And I feel good about the fact that someone is overseeing her medication. And I feel good that I don't have to worry about her starting a fire in her house, or falling down the stairs necessarily. So there are a lot of positive things about it.* ~**Lisa** (daughter of Bertha)

In addition to their own piece of mind, PSPs felt the RH contributed to the overall well-being of seniors. Diana shared the following about how the RH contributed to her mother's health from a cognitive perspective:

> *It keeps her mind active. She is with a group of people who are similar to her in some way. Age-wise. Disability-wise. And she's starting to be much more comfortable with that. She doesn't care about being seen with her walker. It's, I think it's much more stimulating, so that's a good thing. Plus we also pay for the distribution of medication, because we know that she would stop taking something if she didn't feel it was doing any good. So that's huge. We know she's getting her meds as prescribed.* ~**Diana** (daughter of Sonia)

The PSPs praised the efforts of the activity coordinator to engage the seniors when she could, by facilitating different activities outside of those typically provided. For example, Allison expressed the following about the activity director and her ability to provide for her mother-in-law who was not pleased with the typical activities provided.

> *I don't think she sees herself as elderly, and I think that's why the nurses, not the nurses, the activity director, came up with the right solution: they bring a young university in, she plays scrabble with them, she converses with them, and she's very good at taking an interest in their life as university students, she sees them as her grandchildren. But, she likes being around young people…. so the activities director, kudos to them, is to find*

> *out what makes somebody tick and make them respond, and they found the right trigger for mom.* ~**Allison** (daughter-in-law of Ingrid)

Deb further applauded the activity coordinator on creating opportunities to be social within the RH. She felt there was a good balance between the staff encouraging seniors to attend and respecting their decision to pass on certain activities.

> *Honestly, I think what's good about it, like, she likes [name] who's the activities coordinator, and so she'll often say '[activity coordinator] planned an event so I'm going to go because she worked so hard'. But I mean there's nooo like, [activity coordinator] doesn't make her feel like she has to go. If my aunt says I'm tired and I don't feel like going, and that's fine. So they don't put pressure, and I think that's nice. I mean there are opportunities, and she's felt comfortable to take some of them, but if she doesn't want to, they don't pressure her into it. So that's a good balance….its a different experience than when we were growing up, like when people used to worry 'please don't put me in a home when I get older'. It's a very different reality. Like they really try to do what would seniors enjoy. There's puzzles, game rooms, big screens, you know they've tried to make it their home.* ~**Deb** (niece of Lorna)

Many barriers hindering seniors' social well-being were systemic in nature. This was conveyed through the PSPs' repeated suggestions for increased staff and better-regulated RH functioning. Although there were a number of critiques against RHs, there was also positive feedback, showcasing that although RH living is not perfect, there was often no better option, and being there ultimately had some benefits for both the seniors and their families.

3.7 SUMMARY

The purpose of this study was to explore the lived experiences of seniors living within a retirement home through examining seniors' social relationships with their family, friends, staff, and PSPs. Eighteen individuals (eleven seniors and seven PSP) participated in semi-structured one-on-one interviews. Four key themes emerged from the interviews: (1) It's all in the attitude; (2) Barriers to friendship; (3) Life beyond the retirement home; and (4) The bigger picture.

Although perceptions of RH living varied both within and between groups, themes emerged that were consistent across all participants' experiences. For RLSs, the way they thought about their abilities and different aspects of RH living shaped how they interacted with others. In addition to internalized reasons, seniors and PSPs felt the main barriers to being social were often due to factors beyond the RLSs' control, namely health declines and the social milieu of the RH. With regards to social relationships, all RLSs and PSPs acknowledged that friendships and connections outside of the RH influenced seniors' overall social patterns and well-being. Support persons, although not affected by RH living directly, shared some of psychological effects they experienced from their roles as PSPs. Nevertheless, most PSPs were generally satisfied with the current RH, but felt that some of the shortcomings of RH facilities were due to broader systemic issues.

CHAPTER 4: DISCUSSION

4.1 COMPARISON TO PREVIOUS LITERATURE

These research findings, based on the narratives of RLSs and their PSPs, demonstrated the realities of developing and maintaining social relationships while living in a retirement home. When describing the RH experience, regardless of their level of satisfaction with the home, most seniors were critical of themselves, often taking onus for any discontentment with their relationships or current social situations. In contrast, PSPs spoke more optimistically about the seniors' experiences, recognizing the shortcomings of RH living could be attributed not only to the seniors' internal factors but also factors beyond their control (e.g., hearing loss, mobility issues, etc). In general seniors' and their primary support persons' views about the RH aligned; however, support people expressed stronger views about issues related to how seniors are treated by society, while RLSs provided more detail about RH living experience itself. Comparing and

contrasting seniors' and their PSPs' views with respect to social well-being and relationships is seemingly novel, as past literature tends to focus on only one of these perspectives (see, for example, (Fitzpatrick, 2005; Kemp, Ball, Hollingsworth, & Perkins, 2012).

4.1.1 Social Theories of Aging

Previous literature examining social behaviors throughout the lifespan has generated several social theories of aging. These theories were developed on the basis that as individuals age, changes in roles, relationships, and life circumstances occur, subsequently affecting how seniors perceive and behave in their environments (Lange & Grossman, 2009). Throughout the current study's interviews, seniors discussed attitudes towards themselves, the aging process, and different aspects of RH living, all of which shaped how they interacted with others, and ultimately their social well-being. Based on the results of the present research, the theory of disengagement emerged as the most salient social theory of aging to support findings from this study. The theory of disengagement contends that as individuals age, they gradually withdraw and/or disengage from the social roles and relationships that were central to their identity in adulthood (Achenbaum, 2009; Cumming & Henry, 1961). While this theory has been widely criticized, contemporary versions of the theory (e.g., socio-emotional selectivity theory), which focus on decreased social contacts and introversion as one ages, continue to be used in current theory and practice (Adams, Roberts & Cole, 2010; Fredrickson & Carstensen, 1990; Fox, Morrow-Howell, Herbers, Battista & Baum, 2017). Although a few of the RLSs' narratives conveyed more behaviors that align with the theory of disengagement than others, all seniors' narratives revealed acts of the disengagement theory to some extent. For example, RLSs who were insecure about their abilities, often due to fear of not performing a task as well as they could have in the past, had a harder time stepping out of their comfort zones and engaging with

RH peers. Further, RLSs who were optimistic and tried to focus on their strengths and abilities still seemed to disengage from activities they were no longer able to do on their own, such as volunteering with the church or engaging in activities centering around previous hobbies (e.g., crafts, baking, etc.). PSPs also concurred, stating that seniors who had changed their outlooks and were beginning to see their worlds getting smaller as friends and family passed away were not as involved, and began to withdraw from their social networks. Adams, Roberts and Cole (2010) investigated self-perceived changes in social activities of seniors living in continuing care retirement facilities and found that with age, participants reported disengagement from active social activities such as keeping up with hobbies, and meeting/getting to know new people, and reported focusing their time and energy on passive social activities including family time, religion, and taking pleasure in small things. Similarly, central tenets of disengagement-related theories of aging were also evidenced in the present study (Cumming, 1964; Fox, Morrow-Howell, Herbers, Battista, & Baum, 2017)

Considering the critiques of the theory of disengagement, it could be argued that RLSs' experiences in this study also represented an opposite, yet equally cited theory of aging - the continuity theory. According to the continuity theory of aging, older adults make choices that allow them to maintain their activities, roles, behaviors, and relationships they had throughout adulthood (Atchley, 1989). In the current study, participants who continued to make an effort to attend activities and be friendly with people around them self-reported higher overall life satisfaction and self-perceived social well-being. These findings are consistent with Reichstadt, Sengupta, Depp, Palinkas and Jeste (2010), who investigated seniors' perspectives of what constitutes successful aging and found seniors emphasized the importance of good attitude and positive outlook as well as creating and/or maintaining social relationships, as it helped them

adapt to life's challenges and led to greater life satisfaction. Also contrary to the disengagement theory, some of the seniors and their support people in the current study actually noted an increase in social involvement compared to their social involvement prior to moving into the RH. This increase was attributed to the recreational programs and constantly having people around to mingle. The continuity theory (Atchley, 1989) is further illustrated in the current study by the involvements RLSs continued to have outside the RH that will be explained further in a later section regarding life beyond the RH.

When discussing the aforementioned theories of aging, it imperative to note their shortcomings. One of the criticisms of the continuity theory is that it neglects the role of chronic illness in the aging process (Little & McGiven, 2012). With this in mind, it seems seniors whose behaviors might have initially been partially explained by the disengagement theory of aging, were actually just chronically ill seniors doing their best to maintain as much of their adult roles and patterns as possible. As demonstrated by the current study, health declines posed challenges that made it seem like disengagement prevailed, when really continuity was what seniors were aiming for in some cases. Complex examples such as this one highlight the advantage of using a qualitative approach to examine social behaviors in RLSs and help bridge the gap between theory and practice, as neither theory fully explains seniors' social relationships. Although the theories partially explain social behaviors of seniors and the decreasing size of social networks in later life, they fail to capture the complexity and value of the relationships that remain. Seniors' and their support persons' perceptions of social life in later life, barriers to friendships, existing relationships outside the RH, and family roles in RHs will be discussed in turn.

4.1.2 RH Living

RLSs also expressed their opinions on having the RH as their 'home'. Seniors who wanted to move into a RH, or had at least come to terms with the effects of aging that led them to live in a RH, were more upbeat and took advantage of social opportunities. This is somewhat similar to a study by Haney, Fletcher and Robertson-Wilson (2018), which found that attitude and being open to change had a positive influence on participation in PA activities and social patterns among RLSs. In contrast, participants in the current study who did not have much choice in moving into the RH were less satisfied with not only their relationships, but also their situations as a whole. These patterns are consistent with the literature regarding transitions into RHs, where seniors who are more open minded and accepting of change have better health outcomes and life satisfaction than those who are resistant (Bekhet, Zauszniewski & Nakhla, 2009; Walker & McNamara, 2013). When asked, all RLSs and PSPs had agreed that senior participants had adjusted to the RH at the time the study was conducted, albeit to varying degrees. Thus, this study adds to the literature by studying experiences post-transition, showing that with time all RLSs began to come to terms with, sometimes even embracing their situation, and expressed gratitude towards having a safe and comfortable living environment. Some words of advice were also shared regarding how to make the most out of a new situation (in this case, an unwanted move to a RH). One RLS highlighted how important it is not to wait until a RH is needed, and strongly encouraged seniors to move on their own terms. As well, a PSP found that after explaining to the senior that RHs are not what they used to be, and emphasizing the difference between a RH and LTC, the senior felt more comfortable moving into the home, and adjusted well once she arrived. Finally, as cited in past works, PSPs noted the importance of seniors exercising control throughout the process, such as having the opportunity to explore

different RHs prior to the move, helped with successful transitions into RH living (Walker & McNamara, 2013). Future research should consider seniors' preconceived notions about RHs or 'aged care' dwellings and how these views change after transitioning into their new 'homes'.

A disconcerting finding with regards to attitudes concerning RH living was the concept of ageism/aging stereotypes among the residents. Whereas much of the literature and media focus on societal ageism (Angus & Reeve, 2006; Dionigi, 2015; Sims, 2016) the findings of this study shed light on one of the consequences of societal ageism: self-directed ageism, or in other words, prejudice against our feared future selves. Previous literature shows that aging stereotypes can have a significant negative influence on seniors' well-being, as seniors unknowingly incorporate these views into their identity and self-perceptions, especially when these stereotypes are self-relevant (Bennett & Gaines, 2010). While none of the RLSs explicitly talked about being old, or their feelings regarding being around older people, many of their support people did. PSPs conveyed the struggle seniors had facing their age, and becoming 'one of those old people'. Similar results were discussed by Dobbs et al. (2008), who found older adults in assisted living facilities tended to have negative views towards residents who were older or more disabled than themselves. In both studies, this apprehension to belong to a group of 'elderly individuals' posed a barrier to adjusting to and socializing within the RH, particularly since some of the seniors could not identify with the group. Bodner et al. (2015), who investigated attitudes toward seniors' own aging, found less positive attitudes towards aging were associated with accelerated increases in subjective age relative to seniors' chronological age. Feeling that one's subjective age is higher than her/his chronological age has a negative effect on individuals' perceptions of life satisfaction and well-being (Kotter-Gruhn & Hess, 2016; Steverink, Westerhof, Bode, & Dittmann-Kohli, 2001), which supports the negative influence of self-directed ageism on social

life displayed in the present study. Furthermore, Levy (2003) found that those with positive aging attitudes lived on average 7.5 years longer than those with negative attitudes, which further reiterates how stereotypes can influence one's identity, and ultimately longevity. Nevertheless, despite the initial self-directed ageism experienced by many seniors upon moving into the RH, PSPs found that with time, as RLSs overcame this idea of 'me' vs. 'them old people', they were better able to interact and benefit from programs and people within the RH. As such, education on eliminating ageism, particularly for senior populations is encouraged (Lawrie & Nykorowytsch-Macnab, 2014; Levy, 2016)

Throughout the interview process, seniors discussed the barriers to making friends within the RH much more frequently than facilitators. Both RLSs and their PSPs conveyed that deteriorating health was a key barrier to overall quality of life. As cited in previous literature, health complications presented challenges to participation in activities and building new relationships in RH-like settings (Ayalon, 2014, Mclaughlin, Adams, Vagenas, & Dobson, 2011; Walker & McNamara, 2013). For example, a qualitative study by Thomas, O'Connell, and Gaskin (2012) also reported that a change in health status was one of the strongest predictors of reduced participation and engagement among seniors living in an Australian aged care facility. Similar to previous work (Capella McDonnall, 2009; Fletcher & Guthrie, 2013), the currentstudy showed poor hearing and loss of vision were two common barriers to being social with others, especially when both parties had deficits. In the present study, participants who had these deficits were less inclined to take part in social opportunities, as being unable to engage fully made the activities less enjoyable and made them feel inferior to their 'healthy' peers. Additionally, difficulties with mobility often prevented seniors from leaving their rooms to socialize altogether due to the time and energy it took to get around or the lack of assistance to get them to desired

activities. Also, the two RLSs who had diagnosed mental health conditions felt that at times, their conditions were a burden on their social relationships and prevented them from being socially active within the RH.

RLSs also conveyed that the social milieu of the RH sometimes deterred them from socializing and further posed challenges to making new friends. Throughout the interviews, none of the seniors talked about RH friendships in much detail unless probed to do so. Once on the topic, RLSs spoke fondly of their RH peers and staff, mentioning that everyone was friendly and they felt a sense of comfort having them around. Still, positive interactions with others did not necessarily lead to the development of close bonds. Seniors expressed a lot of hesitation and uncertainty about how to become close with other seniors within the RH. Seniors conveyed that while they enjoyed each others company during meal times (when everyone was expected to be in the dining area together) and other RH programs/activities, they felt there was not much meaning to these interactions. Kemp (2012) and colleagues examined co-resident relationships in three assisted living facilities and found similar perceptions of relationships within the RHs, with residents often describing relationships as: ‘acquaintances’, ‘by circumstance’, and ‘friends, but not like when you’re younger, not the ‘I have something I want to tell you relationship’ (p. 494). Thereby, based on the current study and past works, it is evident RLSs feel less connected to their relationships within the RH, compared to previously established relationships beyond the RH.

When discussing social activity within the RH, many seniors reported a variety of recreational programs, but only attended a few per week that interested them. Seniors talked about enjoying the activities they went to, but did not feel the activities made a fundamental contribution to their social well-being. Theurer et al. (2015) critiqued ‘psychosocial care’ in LTC

and RHs, arguing that social programs were often ineffective in fostering engagement and peer support because they were often structured to entertainment and distract. Further, Fox (2016) and colleagues found that despite a variety of social programming being offered and living in close proximity to many other seniors, the top two reported barriers to social engagement (both structured and unstructured) within a senior home were ‘no opportunity’ and ‘no one to do it with’. Fox et al. (2016) contended inability to recognize these opportunities and not feeling comfortable with other people in the building as activity companions were thought to be the root causes of these barriers. Findings from the present study also supported this idea that simply offering activities is not sufficient, nor are the activities always effective in facilitating the development of friends for those who participate. Instead, both seniors and their PSPs noted meal times and unstructured leisure time throughout the day as periods of more frequent social interaction and bonding. Many of the RLSs enjoyed conversing at meals, but again, this was not enough to form strong connections that typically continued outside of meal times. Further, effective ways of getting involved varied among RLSs. Some participants were extroverts and approached social opportunities on their own; these seniors tended to be more satisfied with their social lives. Others relied on their families or staff to facilitate social opportunities in the RH. Although effective, families and staff were not always around to facilitate these social interactions with other residents, so RLSs who relied on these interactions to stay socially active were at a disadvantage.

A seemingly novel finding was RLSs’ and PSPs’ similar, yet meaningfully different, perspectives on social relationships and RH living. PSPs tended to state RLSs were seeing more people now and having more frequent interactions; however there were no comments on quality of these interactions. Conversely, seniors did not quantify their acquaintances or the number of

times they spoke to someone, but instead made it clear that most of the interactions they were having were not significant to them. RLSs focus on the quality of relationships rather than the decreasing size of their social networks has also been cited in previous studies that examined both community-based and institutional-living seniors (see, for example, Cornwell, Laumann & Schumm, 2008; Gilmour, 2012). The point that is noteworthy in the currentstudy is that PSPs did not acknowledge or were unaware of the lack of meaningful relationships seniors had in the RH. In short, all seniors expressed the importance and comfort of having people around all the time; however, all seniors did not feel their relationships with RH peers had much depth or meaning, or contributed to their social well-being.

Many seniors reminisced about their social involvements, past and present, outside of the RH. Participants felt having connections and regular contact with people outside the RH helped keep them interested with the world around them. The seniors who were able to keep strong connections with old friends had more positive attitudes towards their situation and expressed higher life satisfaction than participants who were not able to remain as close with old friends due to relocation, illness, or death. It is important to note that the move into a RH alone did not negatively affect existing relationships, as all seniors either maintained or acquired new social ties since moving into the RH. That being said, reduction or loss of social contact with individuals outside the RH did occur, but was often the result of illness or death. This natural process of aging and the toll it has on relationships reiterates the need for opportunities (both within and beyond the RH) to fill these voids in order to keep seniors socially active.

All participants in this study believed having outside relationships, especially strong familial relationships, had a positive influence on seniors' overall well-being. RLSs discussed how their families provided a means of socialization, as well as helped seniors maintain other

friendships through assisting with purchasing greeting cards to send, transportation to events, or sharing updates about mutual friends. Although seniors expressed appreciation towards their families, at times, they also felt left out and on the sidelines. Many RLSs stated their families were too busy to visit or contact them as much as they would like, but they had come to terms with it. Again, RLSs did not mention their desires about receiving more attention from their families; similar to the notion they had not discussed the lack of meaningful relationships they had within the RH. These feelings of acceptance towards adversity were likely due to seniors' tendency to present positive familial image even when they may feel otherwise (Williams & Guendouzi, 2004). This perceived lack of inclusion by family may also affect RLSs' social patterns within and outside the RH. Nevertheless, all seniors expressed gratitude towards their families, reiterating how important familial relationships were to them, regardless of the time spent with family.

4.1.3 PSPs' Perspectives

Every support person stated the seniors' move into the RH had affected both of their personal lives, as well as their mutual relationships. PSPs felt having the seniors in a RH brought them closer in a way and that the relationships evolved from strictly kin into more of a friendship. In contrast, previous informal caregiving literature has found that caregiving for a senior parent often puts strain on the mutual relationship rather than improving or strengthening the relationship (Bastawrous, 2013; Spruytte, Van Audenhove, Lammertyb, & Storms, 2002). It is important to note that although some literature has also explored the silver linings of caregiving (Davies & Nolan, 2006; MacFarlane, 2017), it is often within the context of nursing homes or dealing with seniors affected by dementia, where the caregiver-care recipient relationship differs from that of a relationship between PSP-RLS. Interestingly, seniors in the

current study did not perceive, or at least did not express, that the relationships with their PSPs had changed minimally, however this was maybe due to the seniors not wanting to discuss their growing dependency on their PSPs. These slightly differing perceptions of mutual relationships between RLSs and their families have not been noted in the literature, as no studies have considered both seniors' and support peoples' views on the same phenomena.

When discussing their roles as PSPs, participants conveyed they always tried to do what was in the best interest of the respective seniors. All PSPs found that while the seniors move into the RH alleviated some of the physical demands of being a support person, the time per week they spent supporting the seniors following the move into a RH either remained the same or slightly increased. Similar to Davies & Nolan (2006), who investigated roles of family caregivers of older adults living in a care home, PSPs in the current study shared that as the RH environment enabled seniors to handle some of their daily physical needs, the type of support expected of them shifted to more social and emotional support, except in times of health crises. Further, this study reveals that being a PSP to a RLS required more strategic forms of social support, such as planning visits outside of times when meal times or recreational activities were taking place and being more cognizant of their new environment and how to help 'get them going'. These types of supports differed slightly from the types of support that caregivers in Davies & Nolan (2006) reported, which included monitoring care received, regularly taking part in social activities to facilitate a sense of community, and providing feedback to staff and filling any care gaps. Overall, findings from the current study and previous literature reiterates that the role of informal-caregivers changes based on the senior care facility, and highlight the importance of family caregivers being made aware of what support will be available to the senior in the care facility versus the support they will need to provide from outside sources.

As well, support people in the current study discussed that being a PSP to a RLS sometimes required more time compared to when they were living in their own homes - often a result of health decline and gradual loss of independence of the seniors. Support people did not seem to mind the additional time they were spending to support the RLSs because they recognized that this added time commitment was a trade off for the piece of mind they now had, knowing the senior was under the watchful eye of the RH staff most of the day. While the PSPs in this study did not necessarily perceive the time commitment as a barrier, this is not always the case for all caregivers. Literature focusing on sandwich caregivers consistently notes time as one of the main barriers to caregiving for a senior family member (Suh, 2016; Steiner & Fletcher, 2017). In addition to the amount of time PSPs dedicated, support persons also discussed other adversities they experienced while performing PSP duties. Similar to previous caregiving literature (Steiner & Fletcher, 2017; Schulz & Sherwood, 2008), participants noted that providing support to seniors, regardless of where they live, comes with emotional tolls and sacrifices. In the case of support people of RLSs, the greatest stress was brought on in two key ways - either seniors were struggling and there was nothing the PSP could do to help, or seniors were being unappreciative and dismissive of the support they were receiving from their family. Nevertheless, though it was not always easy, all PSPs and RLSs expressed contentment with their mutual relationships for the most part.

While reflecting on the RH experience, many PSPs had critiques towards the system as a whole. They felt society was lacking in the way that seniors were treated and supported in our communities. As well, many support people were unclear on the mandates of RHs and sometimes wondered whether their seniors were looked after in a way that made them truly happy and met their needs. Addersson, Pettersson, and Sidenvall (2007) explored daily life after

moving into a care home from the relatives and contact persons perspectives and reported that while most relatives were satisfied with the security and privacy offered by the facility, they were concerned about their loved ones being bored and having difficulties adjusting to their new living environment. Further, PSPs also questioned whether publically administered care outside the RH was sufficient. Other PSPs questioned the way doctors handled seniors in terms of medication prescription. Essentially, many of the matters that influenced seniors' social and overall well-being were not within the PSPs scope, nor were they a function of the RH, but instead part of bigger systemic issues (i.e. standards regarding how to care for seniors, availability of additional support/resources, navigating the system and gaining access to required support/care for RLSs and their PSPs).

Finally, although there were a number of critiques against RHs, there was also positive feedback. PSPs acknowledged that although RH living is not perfect, sometimes there was no better option for seniors. PSPs noted RHs had come a long way, and appreciated the staffs' efforts to make it feel like home. Further, some suggestions were made on how to improve the care that seniors living in RHs and similar facilities received. The consensus between all PSPs was the need for more resources, in the form of staff and funding. They felt that these resources should stem from federal or provincial action. In order to keep seniors community-based for as long as possible and maintain their independence, an increase in staff is needed to give more attention and appropriate support to the seniors. Also better informing the families, and providing them support in supporting their seniors was strongly encouraged (Paladugu, 2018).

4.3 Limitations

This study is not without limitations. For example, this study examined seniors' social relationships while living in a RH setting, focusing on female residents and their PSPs'

experiences. Gender has been found to influence how social aspects of aging are perceived (Caetano, Silva, & Vettore, 2013), so perhaps including men in the study would have led to more variability in the findings, providing a more thorough understanding of all residents' social relationships. In a similar fashion, including RLSs, either women or men, who did not have any primary support people, may have led to further variability in the data. However, it must be noted the main goal of the qualitative inquiry was to offer depth rather than breadth, which required a homogenous sample.

Additionally, the information presented in the current study only reflects the point of view of one support person from each senior's social network, all of which were family members. Information gathered from additional support people including other relatives, friends, staff, and RH peers would have allowed for a deeper understanding of the different types of social relationships and the influence the RH had on each of these bonds.

4.4 Implications

This study provides significant contributions to the literature surrounding retirement homes, especially regarding RLSs' social well-being and relationships. As Canada's aging population continues to grow, so will the demand for community-based housing such as retirement homes (Seniors' Housing Report Ontario, 2016). The results of the current study provide implications for all levels of society, namely, policy makers, health care providers and RH staff, as well as RLSs and their families. Taking into account the long wait lists for LTC facilities and limited publicly funded home care services, seniors and their families will continue to opt for accommodation where extra support is available for seniors as needed ("Long-term Care Home Wait Time Information", 2018). Retirement homes are one such viable option, as they offer various services including on-site healthcare professionals and allow seniors to remain

within the community with support, if needed. In addition to meeting seniors' physical needs, retirement homes also need to consider social aspects of aging in order to influence residents' overall well-being. Information on seniors' social patterns, preferences, and experiences will be imperative in the development of strategies to ensure social needs of residents are met. External healthcare and service providers working with RH populations should also be educated about the factors that influence RLSs' social behaviors, the effects they have on overall well-being, and how to best facilitate the development and maintenance of social well-being.

The research presented is also of importance to government and policy makers, as keeping seniors healthy and community-based, rather than in hospitals and long-term care beds would be cost and resource efficient (The Ontario Association of Community Care Access Centres, The Ontario Federation of Community Mental Health and Addiction Programs, & The Ontario Hospital Association, 2010). In order for RHs to continue to be a viable community-based living option, measures need to be taken to ensure they meet the needs of the individuals living within these dwellings. As such, the Retirement Home Regulatory Authority (RHRA) can use research such as this to lobby the government to ensure appropriate resources and supports are put in place for RH management, families, and residents. Further, the RHRA can inform RHs about the importance of resident-family interactions and remaining connected to life beyond the RH.

Finally, as the number of families dealing with RHs continues to grow, arming families with the knowledge that RH living affects family members providing support to RLSs would be essential. Thus, individuals currently involved with RH living can be better informed about the benefits and challenges of RH living, and take comfort in knowing there are others experiencing the same phenomena. Using results such as these, all parties can work together in developing

strategies that facilitate the development of meaningful social interactions within RHs to improve overall quality of life. Further, creating more inclusive environments, modifying programs to accommodate health declines, promoting frequent contact with others, and supporting PSPs of those living within RHs would better facilitate the RH experience from a social perspective.

4.5 Future Research

As the landscape of senior housing continues to evolve, with policy makers and government advocating for seniors to remain community-based to contain healthcare costs, it is imperative to understand seniors' experiences and outcomes of RH living (Commission on the Future of Health Care in Canada., & Romanow, R., 2002; Seniors' Housing Report Ontario., 2016). Future research should explore experiences of seniors across different retirement homes, including privately owned vs. corporate homes, as varying programming, amenities, locations, and services may influence seniors' social patterns. Additionally, more research exploring the social experiences of understudied senior populations including men, low SES, and minority groups such as Indigenous and LGBTQ is warranted. It should also be noted that research pertaining to RHs in Ontario prior to 2010 should be interpreted with caution as retirement homes were not licensed or regulated at the time.

From a methodological standpoint, a longitudinal study on retirement home living would be fundamental in adding to the RH literature. Existing literature regarding transitions into RHs fail to prospectively capture seniors' experiences transitioning into RH living, up until the time they have adjusted to their environment. Tracking seniors' actual and perceived health and social patterns overtime, through transitions into as well as within the RH (independent to assisted, or specialized units such as memory care), would be beneficial. Further, future work should study seniors who have lived in RHs for a number of years, as these data would likely provide a more

stable and real representation of the day-to-day social life of RLSs. Additionally, continued use of qualitative inquiry to study health phenomena, such as the social well-being of RLSs is encouraged (Holm & Severinsson, 2013).

Finally, identifying the problem is only as useful as the solution developed thereafter. Thus, it is imperative future research contributes to the literature by suggesting means of improving the social health of seniors, for example, sharing and evaluating techniques that have worked for others in similar retirement home environments.

4.6 Conclusion

This study builds on previous literature regarding social aspects of aging and relationships in later life by providing insight into the factors affecting seniors' social patterns after moving into a retirement home. All seniors conveyed that living in a RH changed how, when, and/or with whom they socialize on a regular basis. Positive changes in social life were often linked to opportunities provided by RH, while decreases in social involvement were due to poor health and personal preference rather than the RH environment itself. Moreover, regular contact with PSPs and involvement outside the RH played a vital role in maintaining RLSs' overall perceived quality of life. Additionally, amidst their critiques, support persons reaffirmed the physical and social benefits of RH living for seniors as well as the piece of mind it provided seniors' families.

In conclusion, this study reveals that living in an environment designed to promote social participation does not always translate into meaningful interactions and developing new relationships. Individual factors including personality, physical and mental health, interests, and existing relationships, as well as the role of families and society's treatment of seniors must all be considered. Social relationships are complex, as is the collaboration required between

retirement homes, families, healthcare professionals, and governing bodies to ensure the health and well-being of senior populations is a priority. As such, it is anticipated that in addition to providing seniors and their PSPs a better understanding of what to expect when moving into a RH, the findings from this study will help inform health service providers, policy makers, and governments about the need for resources that can be tailored to support the unique social needs of seniors living in RHs and other aged care facilities.

REFERENCES

References

Achenbaum, A. (2009). Metahistorical perspective on the theories of aging. In V. L. Bengst.

Adams, K. B., Leibbrandt, S., & Moon, H. (2011). A critical review of the literature on social and leisure activity and wellbeing in later life. *Ageing and Society*, *31*(4). https://doi.org/10.1017/S0144686X10001091

Adams, K., Roberts, A., & Cole, M. (2010). Changes in activity and interest in the third and fourth age: Associations with health, functioning and depressive symptoms. *Occupational Therapy International*, *18*(1), 4-17. doi: 10.1002/oti.304

Aging wih Confidence: Ontario's Action Plan for Seniors. (2017). Retrieved from https://files.ontario.ca/ontarios_seniors_strategy_2017.pdf

Andersson, I., Pettersson, E., & Sidenvall, B. (2007). Daily life after moving into a care home ? experiences from older people, relatives and contact persons. *Journal Of Clinical Nursing*, *16*(9), 1712-1718. doi: 10.1111/j.1365-2702.2007.01703.x

Angus, J., & Reeve, P. (2006). Ageism: A Threat to "Aging Well" in the 21st Century. *Journal Of Applied Gerontology*, *25*(2), 137-152. doi: 10.1177/0733464805285745

Ashida, S. (2008). Differential Associations of Social Support and Social Connectedness With Structural Features of Social Networks and the Health Status of Older Adults. *Journal of Aging and Health*, *20*(7). Retrieved from http://resolver.scholarsportal.info/resolve/08982643/v20i0007/872_daossathsooa.xml

Atchley, R. (1989). A Continuity Theory of Normal Aging. *The Gerontologist*, *29*(2), 183-190. doi: 10.1093/geront/29.2.183

Auditor General of Ontario.(2015). Annual Report 2015. Queen's Printer for Ontario. Retrieved from http://www.auditor.on.ca/en/content/annualreports/arreports/en15/2015AR_en_final.pdf

August, K. J., & Rook, K. S. (2013). Social Relationships. In M. D. Gellman & J. R. Turner (Eds.), *Encyclopedia of Behavioral Medicine* (pp. 1838–1842). New York, NY: Springer New York. https://doi.org/10.1007/978-1-4419-1005-9_59

Ayalon, L. (2014). Perceptions of old age and aging in the continuing care retirement community. *International Psychogeriatrics*, *27*(04), 611-620. doi: 10.1017/s1041610214002415

Barnes, L. L., Mendes de Leon, C. F., Wilson, R. S., Bienias, J. L., & Evans, D. A. (2004). Social resources and cognitive decline in a population of older African Americans and whites. *Neurology*, *63*(12), 2322–6.

Bastawrous, M. (2013). Caregiver burden:A critical discussion. *International Journal Of Nursing Studies*, *50*(3), 431-441. doi: 10.1016/j.ijnurstu.2012.10.005

Bekhet, A. K., & Zauszniewski, J. A. (2012). Mental health of elders in retirement communities: is loneliness a key factor? *Archives of Psychiatric Nursing*, *26*(3), 214–24. https://doi.org/10.1016/j.apnu.2011.09.007

Bekhet, A., Zauszniewski, J., & Nakhla, W. (2009). Reasons for Relocation to Retirement Communities. *Western Journal Of Nursing Research*, *31*(4), 462-479. doi: 10.1177/0193945909332009

Bell, K., Fahmy, E., & Gordon, D. (2014). Quantitative conversations: the importance of developing rapport in standardised interviewing. *Quality & Quantity*, *50*(1), 193-212. doi: 10.1007/s11135-014-0144-2

Bennett, T., & Gaines, J. (2010). Believing what you hear: The impact of aging stereotypes upon the old. *Educational Gerontology*, 36(5), 435-445

Berkman, L. (1983). The Assessment of Social Networks and Social Support in the Elderly. *Journal Of The American Geriatrics Society*, *31*(12), 743-749. doi: 10.1111/j.1532-5415.1983.tb03393.x

Berkman, L. F., Glass, T., Brissette, I., & Seeman, T. E. (2000). From social integration to health: Durkheim in the new millennium. *Social Science & Medicine*, *51*(6), 843–857. https://doi.org/10.1016/S0277-9536(00)00065-4

Berkman, L., & Syme, S. (1979). Social networks, host resistance, and mortality: a nine-year follow-up study of Alameda County residents. *Psychosocial Processes And Health*, 43-67. doi: 10.1017/cbo9780511759048.005

Bodner, E., Ayalon, L., Avidor, S., & Palgi, Y. (2016). Accelerated increase and relative decrease in subjective age and changes in attitudes toward own aging over a 4-year period: results from the Health and Retirement Study. *European Journal Of Ageing*, *14*(1), 17-27. doi: 10.1007/s10433-016-0383-2

Cacioppo, J. T., & Hawkley, L. C. (2003). Social isolation and health, with an emphasis on underlying mechanisms. *Perspectives in Biology and Medicine*, *46*(3), S39–S39. Retrieved from http://go.galegroup.com.libproxy.wlu.ca/ps/retrieve.do?tabID=T002&resultListType=RESULT_LIST&searchResultsType=SingleTab&searchType=AdvancedSearchForm&currentPosition=1&docId=GALE%7CA106473987&docType=Article&sort=RELEVANCE&contentSegment=&prodId=AONE&con

Caetano, S. C., Silva, C. M., & Vettore, M. V. (2013). Gender differences in the association of perceived social support and social network with self-rated health status among older adults: a population-based study in Brazil. *BMC Geriatrics*, *13*, 122. http://doi.org/10.1186/1471-2318-13-122

Capella McDonnall, M. (2009). The Effects of Developing a Dual Sensory Loss on Depression in Older Adults: A Longitudinal Study. *Journal Of Aging And Health*, *21*(8), 1179-1199. doi: 10.1177/0898264309350077

Carver, L. F., & Buchanan, D. (2016). Successful aging: considering non-biomedical constructs. *Clinical Interventions in Aging*, *11*, 1623–1630. https://doi.org/10.2147/CIA.S117202

Center for Chronic Disease Control and Prevention. (2010). Measuring health days- a population assesment of health-related quality of life. Retrieved from https://www.cdc.gov/hrqol/pdfs/mhd.pdf

Charles, S., & Carstensen, L. (2008). Unpleasant situations elicit different emotional responses in younger and older adults. *Psychology and Aging*, *23*(3), 495–504. https://doi.org/10.1037/a0013284

Charles, S., & Carstensen, L. (2010). Social and Emotional Aging. *Annual Review Of Psychology*, *61*(1), 383-409. doi: 10.1146/annurev.psych.093008.100448

Cheng, S.T., Lee, C. K. L., Chan, A. C. M., Leung, E. M. F., & Lee, J.J. (2009). Social Network Types and Subjective Well-being in Chinese Older Adults. *Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, *64B*(6). https://doi.org/10.1093/geronb/gbp075

Cobb, S. (1976). Social Support as a Moderator of Life Stress. *Psychosomatic Medicine*, *38*(5). https://doi.org/http://dx.doi.org/10.1097/00006842-197609000-00003

Commission on the Future of Health Care in Canada., & Romanow, R. J. (2002). *Building on values: The future of health care in Canada*. Saskatoon, Sask.: Commission on the Future of Health Care in Canada.

Cornwell, B., Laumann, E., & Schumm, L. (2008). The Social Connectedness of Older Adults: A National Profile. *American Sociological Review*, *73*(2), 185-203. doi: 10.1177/000312240807300201

Cornwell, B., Schumm, P., Laumann, E., Kim, J., & Kim, Y.J. (2014). Assessment of Social Network Change in a National Longitudinal Survey. *Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, *69*(Suppl_2). https://doi.org/10.1093/geronb/gbu037

Cornwell, E. Y., & Waite, L. J. (2009). Social Disconnectedness, Perceived Isolation, and Health among Older Adults. *Source: Journal of Health and Social Behavior Journal of Health and Social Journal of Health and Social Behavior*, *50*(50), 31–48. https://doi.org/10.1177/002214650905000103

Coyle, C., & Dugan, E. (2012). Social Isolation, Loneliness and Health Among Older Adults. *Journal of Aging and Health*, *24*(8). Retrieved from http://resolver.scholarsportal.info/resolve/08982643/v24i0008/1346_silahaoa.xml

Cranswick, K., & Thomas, D. (2005). *Elder care and the complexities of social networks*. Retrieved from http://www.statcan.gc.ca/pub/11-008-x/2005001/article/7941-eng.pdf

Creswell, J. W. (2013). *Research design : qualitative, quantitative, and mixed methods approaches*. SAGE Publications.

Cumming, E., & Henry, W. (1961). *Growing old, the process of disengagement*. New York: Basic Books.

Davies, S., & Nolan, M. (2006). 'Making it better': Self-perceived roles of family caregivers of older people living in care homes: A qualitative study. *International Journal Of Nursing Studies*, *43*(3), 281-291. doi: 10.1016/j.ijnurstu.2005.04.009

Dionigi, R. (2015). Stereotypes of Aging: Their Effects on the Health of Older Adults. *Journal Of Geriatrics*, *2015*, 1-9. doi: 10.1155/2015/954027

Dobbs, D., Eckert, J., Rubinstein, B., Keimig, L., Clark, L., Frankowski, A., & Zimmerman, S. (2008). An Ethnographic Study of Stigma and Ageism in Residential Care or Assisted Living. *The Gerontologist*, *48*(4), 517-526. doi: 10.1093/geront/48.4.517

Fiori, K. L., Antonucci, T. C., & Cortina, K. S. (2006). Social Network Typologies and Mental Health Among Older Adults. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, *61*(1), P25–P32. https://doi.org/10.1093/geronb/61.1.P25

Fitzpatrick, T., Gitelson, R., Andereck, K., & Mesbur, E. (2005). Social Support Factors and Health Among a Senior Center Population in Southern, Canada. *Social Work in Health Care*, *40*(3). https://doi.org/10.1300/J010v40n03_02

Fletcher PC, Guthrie DM. The lived experiences of individuals with acquired deafblindness: Challenges and the future. *International Journal of Disability, Community and Rehabilitation* 2013; 12(1).

Flick, U. (2009). *An introduction to qualitative research*. Los Angeles: Sage Publications.

Fox, K., Morrow-Howell, N., Herbers, S., Battista, P., & Baum, C. (2017). Activity Disengagement: Understanding Challenges and Opportunities for Reengagement. *Occupational Therapy International*, 2017, 1-7. doi: 10.1155/2017/1983414

Fredrickson, B., Carstensen, L. (1990). Choosing Social Partners: How Old Age and Anticipated Endings Make People More Selective. *Psychol Aging*, 5(3): 335–347.

Gilmour, H. (2012). Social participation and the health and well-being of Canadian seniors. *Statistics Canada*, *23*(4).

Given, L. M. (2008). *The SAGE encyclopedia of qualitative research methods* Thousand Oaks, CA: SAGE Publications Ltd doi: 10.4135/9781412963909

Giuli, C., Spazzafumo, L., Sirolla, C., Abbatecola, A. M., Lattanzio, F., & Postacchini, D. (2012). Social isolation risk factors in older hospitalized individuals. *Archives of Gerontology and Geriatrics*, *55*(3). Retrieved from http://resolver.scholarsportal.info/resolve/01674943/v55i0003/580_sirfiohi.xml

Kotter-Grühn, D., & Hess, T. (2012). The Impact of Age Stereotypes on Self-perceptions of Aging Across the Adult Lifespan. *The Journals Of Gerontology: Series B*, *67*(5), 563-571. doi: 10.1093/geronb/gbr153

Lange, J., & Grossman, S. (2009). Theories of aging. In KL Mauk (Ed.), Gerontological nursing: Competencies for care (2nd ed.) (pp. 51–73). London: Jones and Bartlett.

Guba, E. G. (1981). Criteria for assessing the trustworthiness of naturalistic inquiries. Educational Communication and Technology Journal, 29(2), 75-91. doi: 10.1007/bf02766777

Haney, D., Fletcher, P., & Robertson-Wilson, J. (2018). A Qualitative Investigation of the Self-Perceived Health Behavior Changes in Seniors After Their Transitions Into a Retirement Home. *Clinical Nurse Specialist*, *32*(3), 129-138. doi: 10.1097/nur.0000000000000372

Harris, J., & Tanner, D. (2008). *Working with Older People*. Oxfordshire: Routlegde. Retrieved from https://books.google.ca/books?id=OsJ-AgAAQBAJ&dq="Those+concerned+with+health+and+social+administration+must,+at+every+stage,+treat+old+people+as+an+inseparable+part+of+a+family+group,+which+is+more+than+just+a+residential+unit.+They+are+not+simpl

Heikkinen, R.L., & Kauppinen, M. (2004). Depressive symptoms in late life: a 10-year follow-up. *Archives of Gerontology and Geriatrics*, *38*(3), 239–250. https://doi.org/10.1016/j.archger.2003.10.004

Herzog, A. R., Ofstedal, M. B., & Wheeler, L. M. (2002). Social engagement and its relationship to health. *Clinics in Geriatric Medicine, 18*(3), 593–609, ix. https://doi.org/10.1016/S0749-0690(02)00025-3

Holm, A., & Severinsson, E. (2013). A Qualitative Systematic Review of Older Persons' Perceptions of Health, Ill Health, and Their Community Health Care Needs. *Nursing Research And Practice, 2013*, 1-12. doi: 10.1155/2013/672702

Holt-Lunstad, J., Smith, T., & Layton, J. (2010). Social Relationships and Mortality Risk: A Meta-analytic Review. Plos Medicine, 7(7), e1000316. http://dx.doi.org/10.1371/journal.pmed.1000316

Housing for Older Canadians: The Definitive Guide to the Over-55 Market Volume 1 — Understanding the Market. (2012). Canada Mortgage and Housing Corporation. Retrieved from https://www03.cmhc-schl.gc.ca/catalog/productDetail.cfm?cat=178&itm=181&lang=en&sid=YprCVAH3m3p7LemwIHEcBy9smCjh0jV5lYnCelzedQ5BnFAcgATA1XCa5g5LPcJR&fr=1526045070029

Hubbard, G., Tester, S., & Downs, M. G. (2003). Meaningful social interactions between older people in institutional care settings. *Ageing and Society*, *23*(1). https://doi.org/10.1017/S0144686X02008991

Hudon, T., & Milan, A. (2016). *Women in Canada- a gender based statistical report- senior women.* Retrieved from http://www.statcan.gc.ca/pub/89-503-x/2015001/article/14316-eng.pdf

Isaac, V., Stewart, R., Artero, S., Ancelin, M.-L., & Ritchie, K. (2009). Social Activity and Improvement in Depressive Symptoms in Older People: A Prospective Community Cohort Study. *The American Journal of Geriatric Psychiatry*, *17*(8), 688–696. https://doi.org/10.1097/JGP.0b013e3181a88441

Keefe, J. (2011). *Supporting Caregivers and Caregiving in an Aging Canada*. Montreal. Retrieved from https://search-proquest-com.libproxy.wlu.ca/docview/1095558275/fulltextPDF/9A9B8C70C9E54B3EPQ/1?accountid=15090

Kemp, C., Ball, M., Hollingsworth, C., & Perkins, M. (2012). Strangers and Friends: Residents' Social Careers in Assisted Living. *The Journals Of Gerontology Series B: Psychological Sciences And Social Sciences*, *67*(4), 491-502. doi: 10.1093/geronb/gbs043

Knickman, J. R., & Snell, E. K. (2002). The 2030 Problem: Caring for Aging Baby Boomers. *Health Services Research*, *37*(4), 849–884. http://doi.org/10.1034/j.1600-0560.2002.56.x

Lawrie, L., & Nykorowytsch-Macnab, E. (2014). Shifting the Paradigm on Ageism: Strategies f or Positive Active Aging. Ontario Society (Coalition) of Senior Citizens' Organizations. Retrieved from http://www.ocsco.ca/uploads/Image/ShiftingTheParadigmOnAgeism-StrategiesForPositiveActiveAging.pdf

Leone, T., & Hessel, P. (2016). The effect of social participation on the subjective and objective health status of the over-fifties: evidence from SHARE, *36*(5). https://doi.org/10.1017/S0144686X15000148

Levy, S. (2016). Toward Reducing Ageism: PEACE (Positive Education about Aging and Contact Experiences) Model. *The Gerontologist*, gnw116. doi: 10.1093/geront/gnw116

Lincoln, Y., and Guba, E.G. (1985). Naturalistic Inquiry. Newbury Park, CA: Sage.

Little, W., & McGivern, R. (2012). *Introduction to Sociology – 1st Canadian Edition*[Ebook] (1st ed., pp. 420-424). Creative Commons Attribution. Retrieved from https://opentextbc.ca/introductiontosociology/front-matter/preface/

Long-term Care Home Wait Time Information - wwhealthline.ca. (2018). Retrieved from http://www.wwhealthline.ca/libraryContent.aspx?id=20564

MacFarlane, Sarah, "Exploring the Lived Experiences of Daughters/ Daughters-in-Law Providing Primary Informal Care to Their Mothers/ Mothers-in-Law with Dementia" (2016). *Theses and Dissertations (Comprehensive)*. 1974. http://scholars.wlu.ca/etd/1974

McLauglin, D., Adams, J., Vagenas, D., & Dobson, A. (2010). Factors which enhance or inhibit social support: a mixed-methods analysis of social networks in older women. *Ageing And Society*, *31*(01), 18-33. doi: 10.1017/s0144686x10000668

McPherson, M., Smith-Lovin, L., & Brashears, M. E. (2006). Social Isolation in America: Changes in Core Discussion Networks over Two Decades. *American Sociological Review*, *71*(3), 353–375. https://doi.org/10.1177/000312240607100301

Milan, A., & Vézina, M. (2011). *Senior Women*. Retrieved from http://www.statcan.gc.ca/pub/89-503-x/2010001/article/11441-eng.pdf

Minney, M. J., & Ranzjin, R. (2016). "We Had a Beautiful Home . . . But I Think I'm Happier Here": A Good or Better Life in Residential Aged Care. *The Gerontologist*, *56*(5). https://doi.org/10.1093/geront/gnu169

Mitchell, J. M., & Kemp, B. J. (2000). Quality of Life in Assisted Living Homes: A Multidimensional Analysis. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, *55*(2), P117–P127. https://doi.org/10.1093/geronb/55.2.P117

Morse, J.M. (2007). Sampling in grounded theory. In A. Bryant, & K. Charmaz (Eds), The Sage handbook of grounded theory. London: Sage.

Moustakas, C. (1994). Phenomenological research methods. Thousand Oaks, CA: Sage Publications.

Ontario Retirement Communities Association. (2013). Retirement Living FAQs. Retrieved June 7, 2017, from http://www.orcaretirement.com/retirement-living/faqs/

Paladugu, Sravana, "Aging Well: Informing Seniors About Local Resources Throughout The Aging Process" (2017).Family Medicin e Block Clerkship, Student Projects . 273. https://scholarworks.uvm.edu/fmclerk/273

Park, N. S. (2009). of Older Adults in Assisted Living Facilities The Relationship of Social Engagement to Psychological Well-Being. https://doi.org/10.1177/0733464808328606

Patton, M. Q. (2002). Qualitative research & evaluation methods. 3rd ed. Thousand Oaks, CA: Sage.

Patton, M.Q. (2015). Qualitative research & evaluation methods. 4th ed. California: Sage Publications.

Public Health Agency of Canada. (2011). The Senior Audience - Age-Friendly Communication. Retrieved June 13, 2017, from http://www.phac-aspc.gc.ca/seniors-aines/publications/public/various-varies/afcomm-commavecaines/3-eng.php

Public Health Agency of Canada (2014). *Report on the State of Public Health in Canada*. Retrieved from http://www.phac-aspc.gc.ca/cphorsphc-respcacsp/2014/assets/pdf/2014-eng.pdf

Reichstadt, J., Sengupta, G., Depp, C., Palinkas, L., & Jeste, D. (2010). Older Adults' Perspectives on Successful Aging: Qualitative Interviews. *The American Journal Of Geriatric Psychiatry*, *18*(7), 567-575. doi: 10.1097/jgp.0b013e3181e040bb

Residential Care | CIHI. (2018). *Cihi.ca*. Retrieved 25 April 2018, from https://www.cihi.ca/en/residential-care

Residential Facilities, Assisted Living, and Nursing Homes. (2017). National Institute on Aging. Retrieved from https://www.nia.nih.gov/health/residential-facilities-a ssisted-living-and-nursing-homes

Retirement Homes Act, 2010, (2010, C-11). Retrieved from the Government of Ontario website: https://www.ontario.ca/laws/statute/10r11

Retirement Homes Regulatory Authority General Information. (2017). Retrieved June 12, 2017, from http://www.rhra.ca/en/licensing/general/

Routasalo, P. E., Savikko, N., Tilvis, R. S., Strandberg, T. E., & Pitkala, K. H. (2006). Social Contacts and Their Relationship to Loneliness among Aged People ? A Population-Based Study. *Gerontology*, *52*(3), 181–187. https://doi.org/10.1159/000091828

Schulz, R., & Sherwood, P. R. (2008). Physical and Mental Health Effects of Family Caregiving. *The American Journal of Nursing*, *108*(9 Suppl), 23–27. http://doi.org/10.1097/01.NAJ.0000336406.45248.4c

Seeman, T., & Berkman, L. (1988). Structural characteristics of social networks and their relationship with social support in the elderly: Who provides support. *Social Science & Medicine*, *26*(7), 737-749. doi: 10.1016/0277-9536(88)90065-2

Seeman, T. E. (2000). Health Promoting Effects of Friends and Family on Health Outcomes in Older Adults. *American Journal of Health Promotion*, *14*(6), 362–370. https://doi.org/10.4278/0890-1171-14.6.362

Seniors' Housing Report Ontario. (2016). Canadian Mortgage and Housing Corporation. Retrieved from https://www.cmhc-schl.gc.ca/odpub/esub/65981/65981_2016_A01.pdf

Senior Living Options. (2013). Retrieved June 1, 2017, from http://www.orcaretirement.com/retirement-living/seniors-living-options/

Shields, M., & Laurent, M. (2006). *Healthy living among seniors*. *Laurent Health Reports* (Vol. 16). Retrieved from https://search-proquest-com.libproxy.wlu.ca/docview/207470989/fulltextPDF/70274A65C8A040C6PQ/1?accountid=15090

Silverstein, M., & Giarrusso, R. (2010). Aging and Family Life: A Decade Review. *Journal of Marriage and the Family, 72*(5), 1039–1058. https://doi.org/10.1111/j.1741-3737.2010.00749.x

Sims, J. (2016). Ageism: The next big '-ism' to address?. *Australasian Journal On Ageing, 35*(1), 8-8. doi: 10.1111/ajag.12315

Sinha, M. (2013). *Portrait of caregivers, 2012*. Retrieved from http://www.statcan.gc.ca/pub/89-652-x/89-652-x2013001-eng.pdf

Social Isolation Among Seniors: An Emerging Issue. (2004). Government of British Columbia. Retrieved from http://www.health.gov.bc.ca/library/publications/year/2004/Social_Isolation_Among_Seniors.pdf

Spruytte, N., Van Audenhove, C., Lammertyn, F., & Storms, G. (2002). The quality of the caregiving relationship in informal care for older adults with dementia and chronic psychiatric patients. Psychology and Psychotherapy: Theory, Research and Practice, 75, 295–311.

Statistics Canada. 2017. "Age and sex, and type of dwelling data: Key results from the 2016 Census" (figure). The Daily, Wednesday, May 3, 2017. Statistics Canada Catalogue no. no. 11-001-X. Ottawa, Ontario. http://www.statcan.gc.ca/daily-quotidien/170503/dq170503a-eng.pdf (accessed January 13, 2018).

Steiner, Allison & Fletcher, Paula. (2017). Sandwich Generation Caregiving: A Complex and Dynamic Role. Journal of Adult Development. 24. 10.1007/s10804-016-9252-7.

Steverink, N., Westerhof, G., Bode, C., & Dittmann-Kohli, F. (2001). The Personal Experience of Aging, Individual Resources, and Subjective Well-Being. *The Journals Of Gerontology Series B: Psychological Sciences And Social Sciences, 56*(6), P364-P373. doi: 10.1093/geronb/56.6.p364

Stoller, E. P., & Wisniewski, A. A. (2003). The Structure of Lay Consultation Networks: Managing Illness in Community Settings. *Journal of Aging and Health, 15*. https://doi.org/10.1177/0898264303253504

Suh, J. (2016). Measuring the "Sandwich": Care for Children and Adults in the American Time Use Survey 2003–2012. *Journal of Family and Economic Issues, 37*, 197–211. http://doi.org/10.1007/s10834-016-9483-6

The National Seniors Council. (2014). *Scoping Review of the Literature Social Isolation of Seniors*. Retrieved from https://www.canada.ca/content/dam/nsc-cna/documents/pdf/policy-and-program-development/publications-reports/2014/Scoping-Review-of-the-Literature-Social-Isolation-of-Seniors-2013-2014.pdf

The Ontario Association of Community Care Access Centres, The Ontario Federation of Community Mental Health and Addiction Programs and The Ontario Hospital Association. (2010). Ideas and opportunities for bending the heath care cost curve. p. 29. Retrieved from http://www.oha.com/News/MediaCentre/Documents/Bending%20the%20Health%20Care%20Cost%20Curve%20(Final %20Report%20-%20April%2013%202010).pdf

The Ontario Seniors' Secretariat. (2013). *Independence, Activity and Good Health: Ontario's Action Plan for Seniors*. Retrieved from http://www.oacao.org/images/ontarioseniorsactionplan-en.pdf

The State of Seniors Health Care in Canada. (2016). Canadian Medical Association. Retrieved from https://www.cma.ca/En/Lists/Medias/the-state-of-seniors-health-care-in-canada-september-2016.pdf

Thinking About Aging in Place. (2012). Government of Canada. Retrieved from https://www.canada.ca/content/dam/esdc-edsc/documents/corporate/seniors/forum/place.pdf

Theurer, K., Mortenson, B., Stone, R., Suto, M., Timonen, V., & Rozanova, J. (2015). The need for a social revolution in residential care. *Journal of Aging Studies, 35*, 201–210. https://doi.org/10.1016/j.jaging.2015.08.01

Thoits, P. A. (2011). Mechanisms Linking Social Ties and Support to Physical and Mental Health. *Journal of Health and Social Behavior, 52*(2), 145–161. https://doi.org/10.1177/0022146510395592

Thomas, J., O'Connell, B., & Gaskin, C. (2013). Social interaction and participation in leisure activities in residential aged care. *Contemporary Nursing, 45*(2). https://doi.org/10.5172/conu.2013.45.2.244

Umberson, D., & Montez, J. (2010). Social Relationships and Health: A Flashpoint for Health Policy Social Relationships and Health: A Flashpoint for Health Policy. *Journal of Health and Social Behavior, 51* (What Do We Know? Key Findings from 50 Years of Medical Sociology), 14. https://doi.org/10.1177/002214610383501

Waite, L., & Das, A. (2010). Families, social life, and well-being at older ages. *Demography*, *47*, S87-109. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/21302422

Walen, H., & Lachman, M. (2000). Social Support and Strain from Partner, Family, and Friends: Costs and Benefits for Men and Women in Adulthood. *Journal of Social and Personal Relationships*, *17*(1). https://doi.org/10.1177/0265407500171001

Walker, E., & McNamara, B. (2013). Relocating to retirement living: An occupational perspective on successful transitions. *Australian Occupational Therapy Journal*, *60*(6), 445-453. doi: 10.1111/1440-1630.12038

Wiles, J. L., Leibing, A., Guberman, N., Reeve, J., & Allen, R. (2012). The Meaning of "Aging in Place" to Older People. *The Gerontologist*, *52*(3). https://doi.org/10.1093/geront/gnr098

Williams, A., & Guendouzi, J. (2000). Adjusting to "The Home": Dialectical Dilemmas and Personal Relationships in a Retirement Community. *Journal Of Communication*, *50*(3), 65-82. doi: 10.1111/j.1460-2466.2000.tb02853.x

Williams, P., Barclay, W., Schmeid, V. (2004). Defining Social Support in Context: A Necessary Step in Improving Research, Intervention, and Practice. *Qualitative Health Research*, *14*(7), 942-960. http://dx.doi.org/10.1177/1049732304266997

Williams, P., Peckham, A., Kuluski, K., Montgomery, R., Morton, F., Watkins, J., (2010). Formal and Informal Care for Older Persons: Assessing the Balance in Ontario. *Department of Health Policy, Management and Evaluation,Univeristy of TorontoI.* Retrieved from https://www.ryerson.ca/content/dam/crncc/knowledge/relatedreports/balancecare/HMRU_caregiver_report_2010.pdf

Wilson, R. S., Krueger, K. R., Arnold, S. E., Schneider, J. A., Kelly, J. F., Barnes, L. L., (2007). Loneliness and Risk of Alzheimer Disease. *Archives of General Psychiatry*, *64*(2), 234. https://doi.org/10.1001/archpsyc.64.2.234

Wister, A., & McPherson, B. D. (2014). *Aging as a social process : Canadian perspectives* (6th ed.). Don Mills: Don Mills, ON:Oxford University Press.

World Health Organization. (2015), *World Report on Ageing And Health*. Geneva. Retrieved from http://apps.who.int/iris/bitstream/10665/186463/1/9789240694811_eng.pdf

Van Manen, M. (1990). Researching Lived Experience: Human Science for an Action Sensitive Pedagogy. London, Ontario, Canada: The Althouse Press.

APPENDIX A
Background Questionnaire – Retirement Living Seniors

Please answer the following questions. You may choose not to answer any questions if you feel uncomfortable doing so.

1. Date of birth: _____ (MM/YYYY)

2. What is your current marital status?
- ☐ Widowed
- ☐ Married/Common Law
- ☐ Divorced
- ☐ Single
- ☐ Separated
- ☐ Other: _____

3. What is the highest level of education you have attained?
- ☐ Elementary School
- ☐ High School
- ☐ College
- ☐ Undergraduate Degree
- ☐ Masters or Doctoral Degree
- ☐ Other: _____

4. Please list any previous employment you had as an adult.

_____

5. Do you have any children? If yes, please indicate how many.
- ☐ No
- ☐ Yes, _____

6. Do you have any grandchildren or great-grandchildren? If yes, please indicate how many.
- ☐ No
- ☐ Yes, Grandchildren =_____ Great Grandchildren =_____

7a.What type of dwelling did you live in prior to moving into [RH name]?
- ☐ House
- ☐ Condo/ Apartment
- ☐ Other: _____

7b. Who did you live with in your last home? Please check all that apply.
- ☐ Alone
- ☐ Child(ren)
- ☐ Grandchild(ren)
- ☐ Spouse
- ☐ Other: _____

8. When you lived in your previous residence, were you part of a group (ie., church group, knitting club, etc) or take part in social activities (ie., tea with friends, fitness group class, community classes, etc.)? If yes, please list activities and/or groups.
- ☐ No
- ☐ Yes: _____

9. How do you perceive your health?
☐ Poor ☐ Fair ☐ Good ☐ Excellent

10. Do you currently receive and/or provide any form of care or support.
☐ I provide care ☐ I receive care ☐ Neither

11. Please indicate any health conditions or impairments you have been diagnosed by a health professional and whether they interfere with your daily life.

Condition	**I have the condition** (Circle)		**It interferes with my daily life** (Circle)	
Arthritis/ rheumatism	Yes	No	Yes	No
Asthma	Yes	No	Yes	No
Cancer	Yes	No	Yes	No
Cataracts/ Glaucoma	Yes	No	Yes	No
Diabetes	Yes	No	Yes	No
Effects of stroke	Yes	No	Yes	No
Epilepsy	Yes	No	Yes	No
High blood pressure	Yes	No	Yes	No
Heart disease	Yes	No	Yes	No
Stomach/ Intestinal ulcers	Yes	No	Yes	No
Urinary incontinence	Yes	No	Yes	No
Other: _____	Yes	No	Yes	No
Other: _____	Yes	No	Yes	No
Other: _____	Yes	No	Yes	No

12. Please provide the names of one to three primary support persons with whom you discuss things that are important to you, and what your relationship is (ie., daughter, neighbor, etc.).
1) Name: _____ Relationship:_____
2) Name: _____ Relationship:_____
3) Name: _____ Relationship:_____

13. Last week, on average, how often did you have contact (ex: phone, visit, email, etc) with each of your primary support persons?
1) Name: _____ # of times:_____
2) Name: _____ # of times:_____
3) Name: _____ # of times:_____

14. What are the usual modes of contact between you and your primary support persons? Check all that apply (eg., visit, phone call, email, event/outing, etc)

Thank you for completing this questionnaire.

APPENDIX B
Background Questionnaire – Primary Support Person

Please answer the following questions. You may choose not to answer any questions

1. Date of birth: _____ (MM/YYYY)

2. What is your current marital status?
   - ☐ Widowed
   - ☐ Married/ Common Law
   - ☐ Divorced
   - ☐ Separated
   - ☐ Single
   - ☐ Other: _____

3. If you have any children or grandchildren please complete the following table. Please fill out a row for each child and/or grandchild.

Child/ Grandchild (Circle)	Gender	Age (Years)	Dependent on You (Yes/ No)
Child Grandchild			
Child Grandchild			
Child Grandchild			
Child Grandchild			
Child Grandchild			
Child Grandchild			
Child Grandchild			

4. What is the highest level of education you have attained?
   - ☐ Elementary School
   - ☐ High School
   - ☐ College
   - ☐ Undergraduate Degree
   - ☐ Masters or Doctoral Degree
   - ☐ Other: _____

5. Do you currently work? If yes, please specify your occupation.
   - ☐ No
   - ☐ Yes _____

6. Please complete the following sentence regarding your relationship to the senior? The senior is my…
   - ☐ Mom
   - ☐ Grandma
   - ☐ Sister
   - ☐ Mother-in-law
   - ☐ Friend
   - ☐ Other: _____

7. Were you involved in the decision process that led to the senior moving into [RH name]?
   ☐ Yes ☐ No

8. On average, how often do you have contact with the senior in a given week? Please specify:
   _____ days per week

9. What is your most common form of contact?
   ☐ Phone calls
   ☐ Skype/Facetime
   ☐ E-mails
   ☐ Letters/Mail
   ☐ Visits at [RH name]
   ☐ Other: _____

10. Please indicate all forms of support (ex: financial, personal care, social, etc) you provide to the senior and the duration of support.

Type of Support (Please specify)	**Duration of Support**	
	Prior to [RH]	**Currently**
EXAMPLE: transportation/ appointments	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

11. How long do you feel you have been the senior's primary support person? (e.g. months or years)

_____

12. Does the senior provide any support to you? (e.g. financial, social, emotional, etc)
   ☐ Yes ☐ No

Thank your for completing this questionnaire

APPENDIX C

Interview Guide- Retirement Living Senior (RLS)

My name is Kathy and I will be interviewing you for my study that examines social relationships within retirement homes. I am currently a first year Masters student at Wilfrid Laurier University, studying health and aging. Before we begin, I want to thank you for volunteering to participate in the study and taking the time to share your experiences. If you need a question clarified or a break during the interview, just ask. Do you have any questions for me before we begin? Let's get started…

1. Before we talk about your experiences living in a retirement home, I want to hear about your life. Can you tell me about yourself?

2. How would you describe your current health?
   - → Physical, social, mental
   - → ADL? IADL?
   - → Health conditions? Limitations? Adjustment to these conditions?
   - → Quality of life? Do you feel satisfied with your current state of health?

3. Can you describe your social network- the groups of people who surround you?
   - → Size? Composition?
   - → Tight knit?
   - → Constant? Changing?

4. Can you tell me about your family?
   - → Children/ grandchildren
   - → Extended family
   - → Where are they now?
   - → Culture?
   - → Can you describe your relationship with your family?

5. What does a supportive relationship mean to you? How would you define it?
   - → Do you feel your familial relationships fit this?
   - → How about your friendships?
   - → What kinds of relationships do you find most supportive? Family? Friends?

6. Can you tell me about your primary support person?
   - → Why do you consider her/him your PSP?
   - → Describe your relationship with this person? (ex: a typical week)
   - → How much contact do you have with them?
   - → How does person provide support to you?

6b. What factors contribute to your relationship with your PSP?
   - → Proximity?
   - → Cultural background/ ethnicity?
   - → Similar personalities/ interests?
   - → Family connection?

7. Do you think your relationship with (primary support person) has changed since you moved to [RH name]? In what way?
   - → Frequency of contact
   - → Mode & nature of contact
   - → Prior to [RH name] vs now

8. What is one word or phrase that you would use to describe your current relationship with your (primary support person)? How about your relationships with people at [RH name]?

Next I'm going to ask you a few questions about your last "home"… thinking back to your last home:

9. Can you tell me about your living arrangements as an adult? What was it like living there?
   - → Who lived there?
   - → Location; close to PSP? Family? Friends?
   - → Likes/dislikes or challenges
   - → Did you receive or provide any form of care or support?

10. Can you talk about your decision to move away from home and into a retirement home?
   - → Factors that influenced the decision
   - → Did anyone help you make the decision?
   - → Why[RH name]? Factors involved in selecting this place?

Now I'm going to ask you about your experiences since moving into [RH name]…

11. Can you describe a typical day at [RH name]?
   - → Staff, resident and visitor interactions/ relationships
   - → Activities/ programs?
   - → Meals?
   - → Are you involved? Please describe
   - → Within and outside of [RH name]?

12. Do you feel that moving to [RH name] has influenced your social life/ patterns overall? Please explain.
   - → Activities
   - → Community involvement
   - → Contact with people

13. Can you describe your relationship with people who work or live at [RH name]? (Staff, residents, volunteers)
   - → Type of relationship (acquaintance, friend, professional)
   - → Mutually exclusive or integrated relationships?
   - → Perceptions/ value of these relationships

14. In what way, if any, has moving to [RH name] changed your relationships with family members? Old friends?
    - → Frequency of contact
    - → Mode & nature of contact

These last few questions will ask you to reflect on your entire experience of living in a retirement home.

15. Can you describe the social environment/atmosphere/vibe at[RH name]?
    - → Resident-resident interactions/ relationships
    - → Resident- staff interactions/ relationships
    - → Staff-staff interaction/ relationships

16. What are some of the pros and cons of living in a retirement home vs. your previous home?
    - → Regrets?
    - → Advantages?
    - → Expected vs unexpected changes/ differences?

17. If you could go back in time and give yourself one piece of advice about moving into a retirement home what would it be?
    - → Choosing a home
    - → Timing

18. What would make [RH name] a better place to live?
    - → Physical environment?
    - → Services offered?
    - → Smoother transition/ adjustment?

19. What advice would you give someone whose family member is moving into a retirement home in the near future?

20. Is there anything you would like to add or ask me?

Thank you for taking the time to participate in this study.

APPENDIX D

Interview Guide- Primary Support Person (PSP)

My name is Kathy and I will be interviewing you for my study that examines social relationships within retirement homes. I am currently a first year Masters student at Wilfrid Laurier University, studying health and aging. Before we begin, I want to thank you for the time to take part in the study. If you need a question clarified or a break during the interview, do not hesitate to ask. Do you have any questions for me before we begin? Let's get started…

1. Before we talk about your experience of being the primary support person of *a retirement living senior*, I want to hear a little about you. Can you tell me about yourself?

2. Can you tell me about your family?
   - → Immediate family
   - → Intergenerational interactions
   - → Culture

3. What does a supportive relationship mean to you? How would you define it?
   - → Do you feel your familial relationships/ friendships fit this?
   - → What factors contribute to a strong supportive relationship?
   - → How many people do you feel rely primarily on your social support?

Next, I'm going to ask you a few questions about *the senior*:

4. Can you tell me about *the senior*? What was she like as an adult?
   - → Personality
   - → Health/ Abilities
   - → Roles/ Activities/ Hobbies

5. Can you tell me about your relationship with *the senior*? How involved are you?
   - → How you two are related/ know each other
   - → What you do together/ talk about
   - → How the relationship has evolved throughout the years

6. What does the senior talk to you about?
   - → Confidential? Gossip? Issues?
   - → Other seniors/ relationships?
   - → Activities?

7. Why do you think she identified you as her primary support person?
   - → Did her choice surprise you? Is this a new role for you?
   - → Other types of support provided?
   - → Reciprocal support?

8. What factors contribute to your social relationship with the *senior*?
   - → Proximity?
   - → Cultural background/ ethnicity?
   - → Similar personalities/ interests?
   - → Relationship status (eg. Daughter-mom)

9. Can you tell me about *the seniors* living arrangements prior to moving into[RH name]?
   - → Where? With who?
   - → Why did she move from this dwelling?
   - → Did you provide the support mentioned above during this time?

These next few questions will focus on t*he senior* since she moved into [RH name]…

10. Can you talk about the senior's decision to move into [RH name]?
    - → Factors/anyone that influenced her decision (you?)
    - → Why [RH name]? Factors involved in selecting this place?
    - → How is accommodation cost covered?

11. What, if any, effect did moving to [RH name] have on *the senior*?
    - → Lifestyle
    - → Community involvement/ activities
    - → Contact with people
    - → Health (emotional, physical, social)

12. Can you talk about the senior's relationships within the RH? (ie. other seniors, staff, volunteers)
    - → Steady or always fluctuating
    - → Relationship by choice or default
    - → Type of relationship

13. In what way, if any, has moving to [RH name] changed the senior's relationship with her family?
    - → Frequency of contact
    - → Mode & nature of contact
    - → Which family members

Now I will ask you to reflect on the entire experience of being the primary support person for *the senior* since her move to [RH name]…

14. Do you feel that the move to [RH name] has changed your relationship with *the senior?*
    - → Frequency of contact?
    - → Reasons for interactions/ topics of conversation
    - → Grew closer/ apart

15. What are some of the pros and cons of providing social support to *the senior* while she is living at [RH name] (vs when she lived in her own home)?

16. Has being the primary support person for *the senior* at [RH name] had any effects on your personal life?
    - → Your relationships with other family/ friends
    - → Your health
    - → Financial

17. Can you describe the social environment/atmosphere/vibe at [RH name]?
    - → Resident-resident interactions/ relationships
    - → Resident- staff interactions/ relationships
    - → Staff-staff interaction/ relationships

18. What could [RH name] do to better *the senior's* experience of living within a retirement home?
    - → Activities
    - → Support (type, frequency, from who? For whom?)

19. What are some pros and cons of having the senior live in a RH?

20. What advice would you give someone whose family member is moving into a retirement home in the near future?

21. What is one word or phrase that you would use to describe the persons experience of living at [RH name]?

22. Is there anything you would like to add or ask me?

Thank you for taking the time to participate in this study.