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Forum

A Buberian Approach to the Co-construction of Relationships Between Professional Caregivers and Residents in Nursing Homes

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This article demonstrates the value of a Buberian approach to relationships between professional caregivers and residents in nursing homes. Extant research on relationships between professional caregivers and residents typically distinguishes between task-centered and person-centered communication yet tends to privilege either the perspective of professionals or residents. To address this issue, we develop an approach that addresses the co-construction of I-It and I-Thou relationships, based on Martin Buber's social existentialist philosophy. In turn, we show the merit of this approach by using it to analyze interactional data from an observational study on morning care in Dutch nursing homes. As these examples illustrate, our analytical perspective is useful because it highlights how different caregiver–resident relationships are co-created and unfold over time. Thus, by revealing how these relationships are worked out in everyday interactions through subtle shifts between task-centered and person-centered communicative practices, this article offers important insights for improving the quality of care in nursing homes.

Key Words: Nursing homes, Caregiving, Relationships, Task-centered care, Person-centered care, Martin Buber

There is increasing attention for quality of life in nursing homes. Although many factors affect this quality, such as national policies regarding long-term care, the architectural design of nursing homes, and their management, the relationship between caregiving professionals and residents is of paramount importance for the accomplishment of quality care in these settings. Hence, establishing and maintaining good relationships with residents is key to the quality of caregivers' work (Bowers, Esmond, & Jacobson, 2000; Scott-Cawiezell et al., 2004). Professionals' positive perceptions of care relationships are associated, for example,

with higher job satisfaction (Karsh, Booske, & Sainfort, 2005; Kostiwa & Meeks, 2009) and lower turnover (Castle, Engberg, & Men, 2007; Mittal, Rosen, & Leana, 2009). Likewise, several studies have indicated that the quality of these relationships is also important for residents by showing positive associations with their mental health and well-being (Custers, Kuin, Riksen-Walraven, & Westerhof, 2011; Custers, Westerhof, Kuin, & Riksen-Walraven, 2010). Given the centrality of relationships to both professionals and residents, enhancing their relationships by empowering both parties thus provides an important means for improving the quality of life in nursing homes (Rahman & Schnelle, 2008).

More research is needed, however, to understand the complexities of these relationships to promote the quality of life in these institutional contexts, as studies typically privilege the perspective of the professional caregiver or resident. Recently, scholars have begun to emphasize the need for a more relational approach, one that pays attention to the actual interactions in which caregivers and residents engage (see Holstein, Parks, & Waymach, 2011; Perkins, Ball, Whittington, & Hollingsworth, 2012). The current article offers a much-needed theoretical contribution to this emerging research by proposing an approach to relationships, grounded in Martin Buber's (1958/2000) social existentialist philosophy. To start, we will review the literature on caregiver–resident relationships in the next section, *Studies on Caregiver-Resident Relationships*. Subsequently, we will discuss Buber's philosophy and extend it for the purpose of studying the construction of these relationships. To demonstrate the merit of our approach, we will then use it to examine interactional data from an observational study on morning care in several Dutch nursing homes. And, finally, we will reflect on the implications of our work for gerontological praxis and research.

Studies on Caregiver–Resident Relationships

Caregiving relationships in nursing homes demand that professionals continuously switch between tasks that are characterized by professional distance and more person-centered tasks, characterized by proximity (Boeije, 1994). Accordingly, caregivers typically alternate between two behavioral styles: instrumental or task-related behaviors, focusing on assessing and solving medical or care problems, and affective or

socio-emotional behaviors, focusing on establishing trustful, respectful, and comforting relationships with residents (Caris-Verhallen, Kerkstra, & Bensing, 1997).

In the 1990s, research suggested that caregiving relationships were rather problematic. Some studies indicated that professionals in nursing homes tend to orient themselves more toward a successful completion of their tasks than the psychological needs of individual residents. Observational studies on interactions in nursing homes also demonstrated that staff tends to pay more attention to the resident's body than on the resident as a person (Gubrium & Holstein, 1999). In addition, research showed that high amounts of patronizing behaviors are associated with a communicative style that centers on the care needs of older persons rather than their social and emotional needs (Williams & Nussbaum, 2001). Furthermore, Margaret Baltes (1996) found that staff reinforces behaviors of residents who show a need for personal assistance, whereas they largely ignore behaviors that display independence and social activity. Grainger (1993) even noted that caring professionals use a number of so-called "deflecting discursive strategies" in dealing with residents' emotional needs, such as ignoring them or referring the older person to someone else who is in charge.

Recent research shows, though, that task-related and socio-emotional behaviors can often coexist. For example, Brown-Wilson, Davies, and Nolan (2009) distinguished between three types of staff–resident relationships. In *pragmatic* relationships, task-related talk is central, whereas *responsive* relationships focus on the person "behind" the resident, and *reciprocal* relationships include negotiation and compromise between the needs of residents and staff. Ryvicker (2009) concluded that although objectification of residents is one aspect of nursing care, staff often tries to diminish this by talking with residents about their personal interests and histories. Moreover, Custers and colleagues (2011) found that while there is quite some variation, professional caregivers in nursing homes do support psychological needs like autonomy, relatedness, and competence. Thus, whereas researchers were rather critical of professionals' task orientation in the past, scholars now seem to be adopting a more appreciative view by highlighting the fact that professionals in nursing homes also behave in person-centered ways.

Fewer studies have looked at the ways in which residents experience and appreciate the behaviors

of nursing professionals, yet they reveal similar differences with regard to task-centered and person-centered behaviors. For instance, Bowers, Fibich, and Jacobson (2001) distinguished between a *care-as-service* group of residents for whom the instrumental aspects of care were important, a *care-as-comfort* group who focused on maintaining their physical comfort, and a *care-as-relating* group who emphasized the affective aspects of care. Bergland and Kirkevold (2005) discovered similar differences between residents. In their study, one group preferred distant relationships, focusing on competent practical help rather than the person who provides it; a second group preferred nonpersonal relationships, wanting a nice, friendly, caring attitude; and a third group preferred close and personal relationships. Another study showed that residents described a good relationship as including a mix of instrumental and emotional support, that is, "having a confidant," "the staff having my best interests at heart," "taking initiatives" (i.e., doing extra things for the residents without being asked to do so), and "being dependable" (McGilton & Boscart, 2007). To conclude, a more recent study suggested that residents vary in the degree to which they deem it important that staff fulfills basic psychological needs like autonomy and relatedness (Custers, Westerhof, Kuin, Gerritsen, & Riksen-Walraven, 2012).

Thus, extant research on the perspective of residents converges with research on the perspective of caregiving professionals in their distinction between task-centered and person-centered communication, yet few look at both perspectives. Consequently, professionals or residents are characterized as preferring a task-centered or a person-centered communicative style, which unduly reduces the complexity of their everyday interactions and makes it difficult to understand the communicative dynamics of caregiving relationships that can help promote quality of life in nursing homes contexts. What is needed to improve quality of care and quality of life in nursing homes, therefore, is a theoretical approach that can be used to examine how care relationships are conjointly produced and reproduced in ongoing interactions between caregivers and residents; that is, an approach that allows us to examine how the quality of these relationships is co-constructed by professionals and residents, as both play an active role in the accomplishment of daily interactions. In the next section *Buber's View of Relationships*, we will propose such an approach.

Buber's View of Relationships

In light of our review of the literature, it is clear that our approach needs to account for the task-centered and person-centered aspects of interactions, as well as the co-constructed quality of relationships. Buber's view of relationships provides a sound basis for the development of this approach.

Buber (1878–1965) was a philosopher of Jewish-Austrian descent, known for his social existentialist philosophy. Buber contended that there is no such thing as a singular person or "I," but that human beings are always in relation to the world around them. Hence, "I" only becomes meaningful in relation to the world. In his well-known book, *I and Thou*, Buber (1958/2000) distinguished between *I-Thou* and *I-It* relationships. An I-Thou relationship is characterized by true interest in the uniqueness of the other person to whom one is relating. It consists of a mutual, free, immediate, and nonobjectifying way of making each other present. By contrast, an I-It relationship implies objectification: As with objects in the natural world that have a specific location in space and time, the relationship with the other person is more unidirectional and treats the other as if he or she were a "thing." In other words, the other is seen as a means to an end, which sharply contrasts with the "immediacy" of the other in an I-Thou relationship.

Although Buber asserted that every individual yearns for I-Thou relationships and that an overemphasis on I-It relationships can be dehumanizing, I-It relationships are important. Buber considered I-It relationships to be essential because they provide order and consistency in life. He also contended that I-Thou relationships can only be established "in the moment," which means that they cannot last forever. Relationships are therefore best characterized as a continuous alteration between I-Thou and I-It. Furthermore, the nature of relationships is recursive: An I who treats another person as an object (It) becomes an It, just like treating another as a Thou transforms oneself into a Thou. So, interlocutors constitute the nature of a relationship in their ongoing interactions.

Buber used his philosophy to describe client–therapist and teacher–student relationships. Others have built on these insights to develop approaches to psychotherapy (Friedman, 1998, 2008), contextual psychotherapy (Boszormenyi-Nagy, 1987), medicine (Cohn, 2001; Scott, Scott, Miller, Stange, & Crabtree, 2009), and mental health care nursing (Hanson & Taylor, 2000).

While different, these professional relationships consist of an intricate mix between I-It—focusing on a more methodical delivery of therapy, care, or knowledge to a client, patient, or student—and I-Thou—focusing on the other as an individual person with his or her own specific wants and needs. In addition, across these fields, establishing more or less temporary I-Thou relationships is believed to be important because it prevents technocratic or bureaucratic professionalism.

To our knowledge, Buber's view has not been extended to examine how the quality of caregiver–resident relationships is co-constructed during the course of day-to-day interactions in nursing homes. Buber's differentiation between two modes of relational being resembles the distinction between task-centered (I-It) and person-centered behaviors (I-Thou), yet adds a new dimension that allows us to understand how the nature of relationships between professionals and residents are "worked out" in actual encounters. Thus, Buber's perspective does not privilege the caregiver or the resident, but zooms in on the ways in which they *are together*, revealing how the quality of their togetherness is "coproduced" through subtle shifts between I-It (task-centered) and I-Thou (person-centered) communicative practices. In the next section, *Extending Buber's View*, we will demonstrate the usefulness of this approach for gerontological praxis and research by using it to analyze observational data of morning care interactions, which were collected through video recording for a previous study (see Custers et al., 2011).

Extending Buber's View to Study the Co-construction of Relationships in Nursing Homes: An Empirical Illustration

In The Netherlands, different groups of residents (e.g., somatic, psychogeriatric, Korsakov) generally live in separate units within the same nursing home. The data for this study were collected through nonparticipant observation in somatic wards with residents whose problems were primarily physical and whose cognition was relatively intact. All participants were 50 years or older, spoke Dutch, did not have any communication problems due to severe aphasia or hearing loss, and did not suffer from severe cognitive impairment (Mini-Mental State Examination Score >15). Professional caregivers were mainly female part-time nurse aids who had much experience with working in nursing homes. Approval for this research was obtained from the Ethics Committee for Behavioral Scientific Research of the Radboud University Nijmegen, in accordance with the Dutch law.

Observations from this study were selected for this article because they show basic interactional patterns that illustrate important variations in the co-construction of the quality of caregiver–resident relationships. We do not exclude the possibility of alternative interpretations, however, or claim that these examples cover the gamut of possible interactional patterns in nursing homes.

In what follows, we will show the start of three interactions, where a nurse aid enters the room of the resident to provide morning care. Within the institutional context of nursing homes and the routine of morning care, it is often the professional who initiates the interaction. Obviously, this does not mean that residents do not play a central role in the interactions, nor, as we will see, that all interactions are purely task-centered. In the following excerpts, the nurses take the initiative in each of these interactions by entering the room and starting a conversation, but how this is done and how each resident reacts reveal important differences in the situational co-creation of the quality of their relationships.

Interaction 1
[The nurse aid enters the room.]
N: Hello, I'm coming to help you.
R: Yes, that's fine.
N: Is it? That's nice. Let's start then.
[The nurse leaves to get water while the resident waits in bed to get washed.]

Interaction 2
[The nurse aid enters the room.]
N: Did you sleep well?
R: No, not quite.
N: How come?
R: Worries [starts crying]
[The nurse aid sits down on the bed]
N: Is it about Gerard?
[The resident starts to talk about her son.]

Interaction 3
[The nurse aid enters the room.]
N: Good morning, how are you doing?
R: Are you here to prick me?
N: Yes, for your blood sugar, huh. You have a four-point day curve today, do you know what that means?
R: Yes.
N: So, I'll start pricking in a moment and then another three times today, ok?
R: That's fine.
N: I will first move your bed a little higher.

In each of the interactions, we see that the nurse starts with an *invitation* to co-construct the nature of the relationship, but the kind of invitation that is offered differs. From a Buberian perspective, the invitation in the first interaction ("Hello, I'm coming to help you") could be seen as an invitation to create an I-It relationship: The nurse aid initiates the conversation in such a way that it seems like she perceives it as a task-centered relationship in which she comes to help the resident. The invitation in the second interaction is more ambivalent: The nurse's question ("Did you sleep well?") could be taken as the start of an I-It relationship, as it focuses on the quality of sleep, which could lead to more talk about professional care. It could also be interpreted as an expression of concern about the other, however, and thus be taken as the onset of an I-Thou relationship. In the third interaction, the invitation ("Good morning, how are you doing?") suggests a clearer, less ambiguous move toward the co-construction of an I-Thou relationship— although it could also indicate a mere expression of politeness. Hence, across these three situations, we can see that the nurse aids set the stage, in more or less ambivalent ways, for the co-construction of a particular kind of relationship, suggesting that the coproduction of the quality of their being together is more or less open to interpretation and always under construction. Moreover, these brief passages illustrate that the nature of the caregiver–resident relationships is not black or white, either I-It or I-Thou, but a subtle combination of these two orientations to being in the world.

In line with these insights, the three excerpts also reveal that the nature of these relationships really is co-constructed with the residents. That is, the resident may or may not *welcome* the invitation to establish a particular kind of relationship. For example, in the first interaction, the resident seems to acknowledge (or even welcome) the move toward a more I-It or task-centered relationship by expressing that she is fine with being helped ("Yes, that's fine"). In the second interaction, the resident accepts the invitation to talk about her sleep ("No, not quite"), although the relationship might still be created together in one way or the other. The resident then responds to the nurse's question ("How come?") with a verbal reply ("worries"), followed by a nonverbal expression of emotions (crying). This suggests that the resident welcomes the invitation of the caregiver toward an I-Thou relationship. In the third interaction, the resident does not welcome the invitation of the nursing professional to engage in personal talk. Rather, he responds to the question with a counterquestion ("Are you here to prick me?") that opens the floor for the construction of a more I-It, task-oriented relationship.

Though the reaction of the resident is important in each of the interactions, the relationship only appears to take a more definitive (albeit still temporary, situational) form in the next turn of talk, that is, when the professional *recognizes* how the resident interprets her invitation. This can be seen in each of the interactions: The recognition is verbally expressed by acknowledging the resident's welcome (interactions 1 and 3) or by posing a question that further helps to establish the nature of the relationship (interaction 2: "Is it about Gerard?"). Recognizing the resident's welcome is also expressed through the actions in which the nurses engage. In interactions 1 and 3, the I-It nature of the relationship is reinforced by activities that focus on taking care of the resident's physical needs (getting water for washing or moving the bed up to start pricking for blood). In interaction 2, the quality of the relationship is further established by the nurse's sitting down on the bed.

Thus, it takes three turns (inviting, welcoming/ accepting or rejecting the invitation, and recognizing) before the nature of the relationship is more or less established. In each of these three turns, nursing professionals and residents are active agents who both shape the quality of their being together. What is important to point out, however, is that this quality can be rather volatile, as both parties may shift their orientations during the same interaction. The fourth interaction provides a short illustration of this shifting. The excerpt starts when the nurse aid is helping the resident get dressed:

Interaction 4
[The nurse aid enters the room.]
N: Good morning. Shall we start getting dressed?
R: Yes.
N: Then I'll take away the blanket.
[Silence, the nurse aid is dressing the resident]
N: Did you sleep well?
R: No, my neighbor was making lots of noise last night.
N: Oh, yes? Did she wake you up?
R: Yes, it was terrible.
N: Come, let me take off your pajamas, can you come up for a moment?
R: Yes.
N: That's quite annoying, yes. Do you want to get out of bed already then?
R: Yes, I would like to get up.

In this interaction, the nurse aid enters the room and asks the resident if she wants to start getting dressed, thereby inviting an I-It relationship that focuses on instrumental care. The resident welcomes the invitation, and the nurse aid recognizes this welcome by announcing the first task-centered act (taking the blanket away). It seems that an I-It relationship is being established, but the nurse aid asks a new question after a moment of silently dressing the resident ("Did you sleep well?"). As example 2 illustrated, this might be a somewhat ambiguous invitation to continue the I-It relationship or to co-construct an I-Thou relationship. The resident welcomes this invitation toward a more person-centered relationship by explaining why she did not sleep well ("No, my neighbor was making lots of noise last night"). In turn, the resident's welcome is recognized by the nurse who reacts with a follow-up question that focuses on what happened to the resident as a person ("Oh, yes? Did she wake you up?"). The resident appears to welcome this as a renewed invitation to a more person-focused relationship by disclosing her feelings ("Yes, it was terrible"). At this point, the relationship seems to have been transformed from a purely task-centered to a more person-centered relationship. However, the nurse aid still needs to recognize this. Interestingly, she interrupts the flow of the conversation with a new task-centered invitation ("Can you come up for a moment?"), which is acknowledged by the resident ("Yes"). Only after this short interruption does the nurse finally recognize the resident's earlier welcome of the more person-centered relationship ("That's quite annoying, yes"). In the same turn, she poses a question that recognizes the resident's bad sleep, in particular by adding the word "then." This may be interpreted as a further recognition of the woman's need for talk and understanding. By simultaneously focusing on the task at hand in this turn, though, the nurse also reinforces the I-It relationship that was already "under construction." The resident welcomes this task-centered turn by responding that she would like to get up. Thus, this fourth interaction shows that the nature of a relationship is never predefined or established once and for all: As the interaction unfolds, we see how the nature of the relationship shifts between I-It and I-Thou orientations. Through their communicative moves, both parties partake in the creation of their momentary being together and, as agents, both make a difference in its co-construction.

The examples we have provided displayed situations where the nursing professional initiates this co-construction, but residents may take the initiative as well. For example, they may call caregivers for help with going to the bathroom and thus invite the professional in the construction of an I-It relationship. Alternatively, they may invite caregivers to create a relationship that is more person-centered by calling them and starting a conversation in which they disclose personal information, or by directly inviting professionals to disclose personal information to them.

Through these brief examples, we have illustrated how the co-construction of the quality of caregiver–resident relationships is an ongoing process during which interlocutors shift between the I-It and I-Thou orientations of their being together. As we have indicated, this coproduction involves subtle communicative moves that signal the invitation to a particular kind of relationship, welcoming or rejecting this invitation, and then acknowledging the acceptance or rejection—of course, *not* acknowledging is also an option. Even within the relatively short period in which morning care is provided, then, the perceived quality of the relationship is never fixed or given, and always depends on the ways in which the interaction unravels. Together, professionals and residents work out this quality, providing them with a temporary sense of "negotiated order" (Strauss, 1978)—one that will have to be renegotiated again during their next encounter.

Discussion

Extant research has mainly focused on the perspective of the professional caregiver or resident rather than their relationship. We have demonstrated the value of extending Buber's view of relationships for gaining in-depth insight into the co-constructed nature of caregiver–resident relationships in nursing homes. Using examples of daily interactions, we have shown the usefulness of this approach and illustrated that these relationships do not only depend on professionals' cognitive scripts or residents' wants but also, and especially, on their joint sensemaking across time. Thus, the quality of these relationships is dynamically coproduced through subtle shifts in task- or person-centeredness, resulting in a negotiated sense of relatedness. What role may this approach play in advancing gerontological praxis and research, particularly with the aim of improving the quality of care in nursing homes?

Previous studies have often noted a lack of person-centered communication. From the perspective

we have developed here, it is not the amount of person-centered communication per se that is important in determining the quality of care, but rather the co-creation between professionals and residents of both task-centered and person-centered relationships. As mentioned, Buber's perspective has been applied to various types of relationships, such as between therapists and clients, teachers and students, or doctors and patients. Our illustrations show that interactional patterns may be dominated by I-It-centered practices, as these practices are an integral part of caregiving routines in nursing homes. In other words, an I-It orientation may often be the starting point for interactions between professionals and residents and it would even be difficult to imagine these kinds of relationships without this orientation. Some residents seem to recognize this well and even want the caregiver to be task-centered. Relationships that are dominated by this I-It orientation and provide little room for an I-Thou orientation are nevertheless destined to be experienced as cold and distanced. Then again, the construction of I-Thou relationships in professional contexts still requires continuous attention to the task at hand. Caregivers and residents are continuously engaged, therefore, in a delicate balancing act. For example, showing interest in another person or focusing on his or her emotions does not necessarily result in the construction of a genuine I-Thou relationship in Buber's original understanding of the term, if the caregiver is simply expressing this interest to facilitate the performance of a given task. In this case, the professional's orientation toward the resident as a person is rather instrumental, which gives the feel of an I-It relationship. This suggests that an authentic I-Thou relationship demands both parties to rise above the task at hand and open themselves up to the immediacy of their connectedness (see also Pembroke, 2010). In turn, our perspective on relationships demonstrates that more is needed to enhance the quality of care than caregivers behaving in a more person-centered way.

An important question that follows from these findings is how the quality of care in nursing homes can be improved by adopting the approach we have developed. This approach is congruent with existing initiatives to promote more person-oriented care (Brooker, 2005; Coleman & Medvene, 2012; Edvardsson & Innes, 2010), yet is more squarely focused on the subtleties of everyday communication and, thus, on quality care as a *mutual* accomplishment. A first step toward implementing our approach in the setting of an actual nursing home could involve making professionals more aware of the co-constructed nature of their relationships with residents. This could be achieved by training caregivers in recognizing how the quality of these relationships is shaped through shifts in task-centered and person-centered communicative practices. A second step could involve training professionals in these practices in supervised simulated encounters, which could be video recorded and then played back and discussed individually or in groups. Finally, caregivers could be asked to start putting these newly acquired communicative skills into practice in their daily interactions. Hence, our approach could help caregivers in crafting (or recrafting) their jobs—job crafting being understood as the process through which professionals redefine and reimagine their job in personally meaningful ways (see Berg, Wrzesniewski, & Dutton, 2010). In other words, because being person centered is consistently associated with increased quality of work in nursing professions (Bowers et al., 2000; Scott-Cawiezell et al., 2004), becoming more aware of the nature of relationships could help professionals in finding more (or renewed) meaning in their work within the constraints of their institutions.

Our Buberian perspective not only has important implications for professionals but could also be useful to researchers. Although we only provided short interactional sequences for illustrative purposes, larger samples of interactions could be systematically analyzed to gain deeper insight into the communicative intricacies of caregiver–resident relationships. For example, researchers could study how an I-It orientation is typically enacted through a focus on task accomplishment and instrumental touch, whereas an I-Thou orientation involves physical closeness (leaning forward, spontaneous, affective touch that is not necessary for the completion of a task), empathy, and the absence of obvious power or control differences. For analytical purposes, researchers could pay special attention, in this regard, to the ways in which the nature of a relationship is redefined through particular verbal and nonverbal moves. Yet, it would also be important to study instances in which this redefinition fails and possibly leads to an increasingly tense, strained, or even conflictual relationship. For this kind of research, existing coding schemes could be adapted (Baltes, 1996; Caris-Verhallen, Kerkstra, van der Heijden, & Bensing, 1998; Wen, Hudak, & Hwang, 2007). Our

approach centers on uncovering the complexities of interlocutors' conversational turn-taking practices, however, rather than their individual actions and reactions (see also Bavelas, 2005). Hence, it would be useful to develop new coding procedures to corroborate our exploratory findings.

Future research could also focus on contextualizing the co-construction of caregiver–resident relationships in greater detail. Previous studies suggest that many factors (e.g., a professional's level of education or job satisfaction; a resident's level of cognitive functioning; or nursing home policies and practices) play a central role in task-centered and person-centered communication (Caris-Verhallen et al., 1997; Caspar, Cooke, O'Rourke, & MacDonald, 2013). Therefore, studies could focus on examining how factors like these play into the constitution of relationships. From a Buberian perspective, these factors may affect the nature of relationships, but they do not determine them. Although task-centered care may be dominant in nursing homes, many situations provide room for personalized encounters and the establishment of I-Thou relationships, however temporary. As we have demonstrated, the quality of care in nursing is a joint accomplishment of both professionals and residents. The quality of their relationship depends, for an important part, on their "co-orientation," that is, their mutual recognition of the need for genuine contact and connection during the performance of routine tasks. Thus, what would be useful is to investigate how this co-orientation relates to other aspects of quality of care and quality of life in nursing homes.

In this article, we have highlighted the importance of paying close attention to the quality of caregiver–resident relationships for the improvement of the quality of life in nursing homes. We have illustrated that the nature of these relationships is never set in stone, which means that professionals and residents have the power to redefine the ways in which they relate to each other. In turn, their interactions become the sites for negotiating who they are to each other and how they are together. Understanding how this negotiation is accomplished through the delicate balancing of I-It and I-Thou of course requires insight into professionals' and residents' individual cognitive dispositions, needs, wants, and so on, but it also requires insight into the discursive and material ties that are (re)created between them through their daily communication. The latter implies a substantial shift in our way of looking at ourselves in relation to the world. A change in focusing on what is happening "between our ears" to what goes on "between our noses," so to speak, which can be achieved by taking heed of Buber's view of social life.

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