EXPLORING THE APPLICABILITY OF SELECTION, OPTIMIZATION, AND COMPENSATION MODEL TO THE PERSONAL GOALS OF NURSING HOME RESIDENTS

A Dissertation by

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EXPLORING THE APPLICABILITY OF SELECTION, OPTIMIZATION, AND COMPENSATION MODEL TO THE PERSONAL GOALS OF NURSING HOME RESIDENTS

The following faculty members have examined the final copy of this dissertation for form and content, and recommend that it be accepted in partial fulfillment of the requirement for the degree of Doctor of Philosophy with a major in Psychology.

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DEDICATION

To my grandmother, my inspiration,
and to my mother, who taught me love

In memory of my Aunt Kathy
This is because of you
There is only one solution if old age is not to be an absurd parody of our former life, and that is to go on pursuing ends that give our existence a meaning.

Simone de Beauvoir
ACKNOWLEDGMENTS

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ABSTRACT

Selection, optimization, and compensation theory (SOC) is a major theoretical framework through which human development has been studied. It is a process-oriented model that provides accounts for how gains are maximized and losses minimized throughout the lifespan, and particularly in later life. This theory has been previously used to inform caregiving approaches, although the extent that the care recipient themselves use this SOC process has not been examined. The purpose of this dissertation was to learn more about the goals of nursing home residents and strategies for goal pursuit within the context of the nursing home.

Eight cognitively-intact nursing home residents (mean age = 88.3 years; SD = 4.9) were interviewed for this mixed-methods study. Semi-structured interviews were conducted and three brief questionnaires were administered. Data were coded for goal identification and content, and also analyzed qualitatively in response to the large percentage of interview data unrelated to goals.

Results of the study suggest that these nursing home residents were not primarily oriented towards explicit goal selection or pursuit; 63% denied having goals outright. Goal coding analysis revealed only a small portion of interview responses related to goal identification or pursuit. Qualitative analyses, however, revealed 11 emergent themes across the interviews. Taken together these results may suggest that residents are able to describe domains of meaning, such as how they spend their time and what was important to them, but are less focused on intentionally-defined, behaviorally-driven goals. Implications relating to SOC theory and person-centered care are discussed.
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CHAPTER I
INTRODUCTION

If Margret Baltes were alive today, I would like to talk with her about expanding her research on caregiving to include the perspective and role of the care recipients. Her innovative research, inspired by learning theories, detailed the appearance, maintenance, and modification of dependent behavior of older adults (see Baltes, 1996 for a review). The patterns of dependency she identified supported the idea that aging is not determined solely by regress of biological capabilities, but that environmental and social conditions are also significant influencing factors, thus indicating that the process of aging can be actively shaped. Encouraged by the evidence, plasticity of behavior in old age was incorporated into training programs for caregivers, teaching them how to promote and sustain the autonomy of older adults (Baltes, Kindermann, Reisenzein, & Schmid, 1987; Baltes, Neumann, & Zank, 1994; Baltes & Reisenzein, 1986). What remains unexplored is how care recipients themselves—residents of nursing homes in this case—can promote and sustain their own autonomy using the underlying principles of selection, optimization, and compensation (SOC) model on which Margret Baltes based her work.

As a clinician, I see the framework of SOC as a promising and viable basis for working with clients to maximize gains and minimize losses during older adulthood. As SOC interventions to date have been aimed at caregivers and social partners of older adults, not enough is known about how the individuals themselves may incorporate these principles into their behavioral repertoire. This exploratory dissertation, then, represents a preliminary step of what may eventually be a behavioral intervention for older adults living in a nursing home. In it, I seek to learn more about the goals of nursing home residents, including how their goals or their
means of pursuing their goals may have been impacted by the setting of a nursing home and what kinds of goals, if any, residents set for themselves after entering the nursing home. Additionally, I want to learn more about how residents view their interactions with certified nurse aides (CNAs). CNAs provide approximately 80% of residents’ direct care (Heliker & Nguyen, 2010), meaning these are the staff members with whom residents have the most frequent and most intimate (e.g., dressing, bathing, toileting) contact. The interactions with the CNAs are of interest because I suspect that, given the proper means and context, residents may be able to capitalize on these interactions to help them move towards or maintain their personal goals. Finally, I want to know a bit about the characteristics of the residents, such as their levels of depression, perceived quality of life, and their tendency for experiential avoidance (i.e., desire to control or inhibit negatively valenced thoughts or emotions), that may impact whether residents have goals or utilize SOC strategies. These factors are plausibly related to one’s ability to set and pursue goals as well as to adapt to changing contexts.

Setting and pursuing goals plays an important role in this respect; intentionality and meaning-making are hallmarks of being a person (Sabat & Harré, 1994). For the purposes of this dissertation, goals are “desired states that people seek to obtain, maintain, or avoid” (Emmons, 1996, p. 314). Through them, people actively give direction to their development and through effective goal-directed actions, they shape their life course in aspired directions (Freund & Baltes, 2000). Considering the increasing interest in the active role that older adults play in shaping their development, it is surprising how little we know about their goals or how these goals change over time. This lack of knowledge may be due to the overwhelming amount of empirical evidence documenting the developmental losses in later adulthood and old age in particular, combined with the comparatively scarce evidence of studies on developmental gain.
throughout adulthood (Cheng & Heller, 2009). As a result psychologists fall prey to cultural ageist stereotypes that undervalue the abilities and agency of older adults. However, there is evidence that suggests not only that the content of goals shift to reflect relevant developmental tasks (e.g., Nurmi, 1992), but also that personal goals may be among the phenomena that show positive development throughout adulthood (e.g., Sheldon & Kasser, 2001). Given that residents of nursing homes have experienced certain physical and social losses leading to their placement in the nursing home, they may need to select, manage, and pursue goals in an increasingly resource-efficient manner. Of interest are the goals that nursing home residents report and the strategies that they use to facilitate goal achievement.

In addition to increased efforts to cultivate person-centered care that promote residents’ sense of agency, recent research has demonstrated there is a significant degree of behavioral reciprocity between nursing home residents and the CNAs who care for them (Runyan, 2012). That is, behavioral coding of resident/CNA caregiving interactions showed that residents’ prosocial communication behaviors were highly correlated with CNAs’ prosocial communication behaviors. This finding is important because it provides evidence of the two-way nature of social interactions within nursing homes and documents that residents have a role in creating or co-creating relationships with their caregivers. The present dissertation was inspired by this finding because it suggests a new way of viewing residents—as active and intentional agents who structure their social interactions with CNAs in order to meet their long-term goals. Residents’ goals may lead them to interact with CNAs in instrumental ways in order to get assistance in accomplishing their activities of daily living so as to free up resources for goal pursuit. Residents’ goals may also lead them to interact with CNAs with the idea of creating interpersonal relationships and positive experiences as ends in themselves.
This dissertation is intended to develop and explore the implications of this new way of viewing nursing home residents within the same framework used by Baltes in her work within nursing homes (Baltes et al., 1987, 1994; Baltes & Reisenzein, 1986). The proposed study will apply Selection, optimization, and compensation theory (Baltes & Baltes, 1990) from the perspective of nursing home residents with the intention of determining if nursing home residents use selection, optimization, and compensation strategies to accomplish the valued goals they have. Additionally, the study seeks to describe nursing home residents’ perspectives on their interactions with CNAs in order to determine if they view these interactions in ways that help them to accomplish their goals. In other words, to what extent do residents view their interactions with CNAs in instrumental terms and/or view relationships with CNAs and positive social interactions as ends in themselves?
CHAPTER II
LITERATURE REVIEW

Theoretical Framework

The theoretical framework guiding this investigation is Baltes and Baltes’ (1990) Selection, optimization, and compensation (SOC) model of successful aging. Applied as an action-theoretical model, SOC describes the relationship between mechanisms of goal attainment and developmental outcomes. SOC stems from developmental systems models (e.g., Lerner, 2002) and draws heavily from the organismic and contextual approaches discussed by Pepper (1942; see also Lerner, 2002). SOC’s major assumptions reflect these philosophical foundations and clarify its relationship with development as a lifespan phenomenon. Founded on the idea that development is lifelong, SOC rejects the notion that older adulthood is primarily associated with loss and decline. All phases of individual human development are characterized by losses and gains. Contrary to cultural stereotypes, this developmental perspective indicates that many gains are associated with the third age; i.e., approximately the period between 65 and 80 years of age. These gains often include increased social and emotional competence, greater historical and life experience, and better resource management (for a review of these findings, see Baltes & Baltes, 1990). Adopting SOC as a theoretical framework for the proposed study simultaneously establishes the perspective of older adults as continually developing individuals with particular developmental needs, goals, and skills.

Developmental foundation of SOC theory. SOC assumes that multiple interacting levels of the environment continuously influence ontogenetic development and that the developing individual likewise influences his/her environment, consciously and not (Baltes, 1997). Accordingly, SOC views development as the result of dynamic interactions between an
individual and all levels of his/her environment. Such person/environment interactions regulate an individual’s developmental trajectory. SOC also assumes resources are limited across the lifespan. Resources can be internal or external, and represent means that facilitate goal attainment (e.g., Freund, 2008), and ends to be obtained (e.g., Hawley, 1999). Internal resources include psychological capabilities (such as the number of tasks an individual can attend to simultaneously), while external resources include physical resources and the availability of helpful others (i.e., social resources). Goal attainment is often contingent on resource availability, and the SOC model describes how individuals manage resources in a goal-directed manner.

With an emphasis on the importance of maintaining a sense of meaning in life as a criterion of success, SOC has been influential in explaining how older adults can experience aging in a positive manner, even in the face of loss. For example, as people grow older, aging losses may result in complete immobility, need of care, and dependency. Even in this situation, individuals continue to reach goals and experience success in life, although success may relate to a mental activity of maintaining meaning in life, even if there is no hope for recovering physically or resuming certain abilities.

The adaptive task of the aging individual, then, is to select and concentrate on those domains that are of high priority and that involve a convergence of environmental demands, individual preferences, and biological capacity; i.e., use a selection strategy. Concurrently, there must also be a neglect of other weaker or less important domains, possibly to the extent of being dependent on others in those areas. By relinquishing resources that were directed towards these areas, the individual is able to focus more heavily on those areas that are most meaningful or most in line with life goals (Baltes & Baltes, 1990).
Goals in older adulthood. Setting and pursing personal goals plays an important role in maintaining a sense of meaning in life because it is through the identification and committed action towards them that people give direction to their development and shape their life course (e.g., Brandstädter & Lerner, 1999; Freund & Baltes, 2000). It is through accomplishing personal goals that an individual behaves in accordance with the values that are important to them. Goals, then, are important at every stage of life, but given the restricted time frame of older adults, they seem to take on a certain urgency or intensity. The limited literature on older adults’ motivation and volition has demonstrated not only that older adults have personal goals, but also that they tend to have more intergoal facilitation (i.e., when the pursuit of one goal simultaneously increases the likelihood of success in reaching another goal), and pursue their goals more intensely than their younger counterparts (Riediger, Freund, & Baltes, 2005).

Other empirical findings regarding the goals in older adulthood have shown differences in the themes or content of older adults (not nursing home residents specifically), as compared with their younger counterparts. Older adults tend to (a) select goals with greater sense of choice and self-expression rather than social pressure; (b) aim for goals that are more intrinsic and less extrinsic (e.g., community involvement vs. accumulating wealth); and (c) be more concerned with “mature” issues vis-à-vis Ericksonian generativity and ego integrity as opposed to identity formation (Sheldon & Kasser, 2001). Similarly, older adults are more likely than younger adults to express personal growth aspirations (Bauer & McAdams, 2004). To the extent that a resident’s stated goal (e.g., regain my ability to walk) may reflect a number of different functions (e.g., remaining autonomous, or improving physical health, or allowing for greater social interaction), an effort will be made to understand the underlying value(s) important to the resident.
Not only do the content or themes of older adults differ from younger adults, but they have been shown to have more intergoal facilitation, less intergoal interference, and greater goal-pursuit intensity (Reidiger et al., 2005). These findings suggest that older adults are more strategic in their goal selection and more engaged in their pursuit. Given that residents of nursing homes have experienced certain physical and social losses leading to their placement in the nursing home, they may need to select, manage, and pursue goals in an increasingly resource-efficient manner. Of interest are the goals that nursing home residents report, the strategies that they use to facilitate goal achievement, and how the components of SOC may apply to their goal setting and pursuit.

**Components of SOC.** As its name implies, the SOC model recognizes three fundamental strategies for life management: (a) selection, (b) optimization, and (c) compensation. Adopting these strategies can help individuals maximize gains and minimize losses by making the best of certain resources and finding ways to compensate for the loss of others (Freund, 2008; Hansson, Robson, & Limas, 2001). To introduce the SOC model, key features of each component are summarized below. Typical instances of each of the processes are listed in Figure 1 (adapted from Freund & Baltes, 2002):
Selection, Optimization, and Compensation Embedded in an Action-Theoretical Framework

<table>
<thead>
<tr>
<th>Selection (goals/preferences)</th>
<th>Optimization (goal-relevant means)</th>
<th>Compensation (means for counteracting loss in/blockage of goal-relevant means)</th>
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<td>Seizing the right moment</td>
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<td>Resource allocation</td>
<td>Changes in resource allocation</td>
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<td>Focusing on most important goals</td>
<td>(effort, time)</td>
<td>(effort, time)</td>
</tr>
<tr>
<td>Reconstruction of goal hierarchy</td>
<td>Modeling successful others</td>
<td>Modeling successful others who compensate</td>
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<tr>
<td>Adaptation of standards</td>
<td></td>
<td>Neglect of optimizing other means</td>
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<tr>
<td>Search for new goals</td>
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Figure 1

Selection strategies encompass choosing and prioritizing particular goals, tasks, and life domains and then concentrating effort in order to experience subjective satisfaction and achieve a sense of control in these areas. For instance, an aging adult may give up certain leisure activities that have become more difficult and are less fulfilling (e.g., gardening) and focus more on other activities (i.e., participating in a book club) that offer more potential for a rewarding experience. Once a goal is selected, the process of optimization refers to how that goal is to be effectively achieved. Optimization strategies aim to strengthen skills and capabilities and to coordinate use of resources to achieve the desired outcomes—i.e., to optimize performance in priority areas. Such strategies include investing time and effort, as well as being optimistic, persistent, tenacious, and committed. Continuing the example above, the older adult in this case would be able to invest more time and energy into book club activities if s/he gives up gardening. Applying more time and attention to book club-related activities can be seen as an optimization of the activity.

The last process, compensation, involves adapting to limitations and changes that may interfere with goal achievement in order to create an environment for successful development.
Compensation strategies include using external or technical aids to maintain a desirable level of performance, as well as asking for help. Compensation, Baltes (1997) notes, can be either automatic or planned, and is not limited to existing behaviors or resources. An individual who loves to read but has lost their sight may learn to read Braille or switch to listening to audiobooks. Someone who is scheduled for surgery may plan to have a maid to handle household duties that would require a great deal of effort for the individual to accomplish. This frees up the individual to focus not only recovery, but also on meaningful goals, such as maintaining social contact with members of his/her social network. The end result is an optimization of the selected activities through forfeiture of less important ones, which allows for maintenance of functioning in areas of highest importance to the individual. Of interest in the present study is if residents view CNAs as a compensatory means of achieving their personal goals.

**SOC applications.** There is substantive and compelling empirical evidence on the three principles of SOC with respect to positive or success-related outcomes across the lifespan. Since its formulation, SOC has been used extensively, including as a means of understanding strategies older adults use to age successfully at work (Abraham & Hansson, 1995; Unson & Richardson, 2013), cope with stress (Hansson et al., 2001), to understand the social motivations of older adults (Carstensen, Fung, & Charles, 2003), and as an intervention for patients with dementia (Volicer & Simard, 2006). Although SOC has been most commonly applied to community settings, the most relevant application to the present study was led by Margret Baltes, who examined its application within the setting of nursing homes. As such, it seemed a particularly pertinent framework with which to identify and map the strategies residents adopt in relation to pursuing their personal goals in the setting of the nursing home.
While SOC has been used to understand and explain the contextual fostering of dependency in nursing homes and as a framework for creating interventions for nursing home staff and also as a way of understanding goal selection and attainment, the study proposed in this dissertation may be one of the first times it has been used to understand the personal goals of nursing home residents and goal pursuit strategies. Using Baltes’ work as a starting point, the question of interest here is whether residents’ behavior is consistent with SOC principles. And, if they have selected goals, in what ways, if any, do their interactions with CNAs function to help them accomplish their goals? For example, does establishing and maintaining a friendly relationship with a CNA serve a function other than that of meeting social needs? Does it also have other instrumental functions such as decreasing awkwardness during caregiving tasks, increasing the quality of care that is received, passing time (Roberts & Bowers, 2015), or maintaining the resident’s self-image? A major objective of this dissertation is to explore whether residents use SOC strategies and whether their interactions with CNAs play a role in helping them to accomplish their goals.

The next section of this dissertation introduces the person-centered approach to caregiving. I am introducing this topic because it is consistent with the SOC theoretical framework being used here, and because a primary tenet of person-centered care involves preserving the personhood of residents, rather than allowing their disabilities or illnesses define them. Focusing on the personal goals that nursing home residents set and pursue, this dissertation is an aspect of person-centered care (PCC) that has been relatively unexplored.

**Person-Centered Care**

Person-centered caregiving is a construct that was originally conceptualized by Kitwood (1997) out of his work with dementia patients. He defined personhood as “a standing or status
that is bestowed upon one human being, by others, in the context of relationship and social
being. It implies recognition, respect, and trust” (p. 8). Kitwood urged people to stop assuming
that because people were older and may have cognitive impairment they were unable to be in
meaningful and fulfilling relationships with others. He believed that the best kind of care was to
continue to treat them as a person and to continue to help them define themselves through their
relationships with others. He defined this type of care as person-centered care.

Since Kitwood’s introduction of PCC, it has become a multi-dimensional concept. In a
major contribution to the research literature on person-centered caregiving, White, Newton-
Curtis, and Lyons (2008) developed a 64-item measure of “person-directed care” that identified 6
distinct factors based on a factor analysis. These included: (a) Personhood, (b) Knowing the
Person, (c) Autonomy, (d) Nurturing Relationships, (e) Comfort Care, and (f) Supportive
Environment. Personhood was the most important dimension and it was defined as emphasizing
that each person is unique, has inherent value, and is worthy of respect. This dimension
emphasizes knowing the person’s preferences and understanding their perspective. Knowing the
Person referred to knowledge of the resident’s history, cultural experience, personality, and
activities of daily living (ADLs). Autonomy was defined as care that emphasizes agency and
independence. Nurturing Relationships involved understanding that the person exists in a web of
social relationships and that these relationships should accentuate trust, communication,
consistency, attachment, friendship, and time together. Comfort Care was defined as care that is
not only competent, but that is well-rounded, including both physical and emotional care. The
last dimension, Supportive Environment, refers to architectural features that allow for and
encourage the provision of individualized and relationally-focused care. The most exciting
aspect of White’s research is a new understanding that person-centered care is diverse in its
meaning and that for some people person-centered care is about creating more personalized caregiving relationships and for others it is about promoting the autonomy of residents.

This dissertation closely fits in with the Personhood, Knowing the Person, and the Nurturing Relationships dimensions. The intention of the dissertation is to delve into a relatively unexplored aspect of agency—residents’ goals in living whilst residing in a nursing home. To date, PCC has striven to underscore residents’ agency through greater freedom in their food choices and dining times, social activities, and scheduling. However, there has been little emphasis on identifying and understanding the goals and means of goal attainment of nursing home residents.

Research by Coleman and Medvene (2013) and Grosch, Medvene, and Wolcott (2008) more specifically defined person-centered care as care that is driven by personalized or individualized care rather than task-driven. PCC has been defined both on an organizational level and on an interpersonal level. At the organizational level, person-centered care refers to an overarching culture of care that is reflected in the administration and architecture. It involves creating flexible policies that meet the needs of the residents and the caregivers, including giving residents choices in their caregiver, as well as in their eating, sleeping, and bathing routines. It also includes treating members of the caregiving team with respect, and allowing time for CNAs and residents to socialize and maintain relationships (Grosch et al., 2008). This dissertation is also closely related to caregiving that is focused on the person rather than physical tasks.

On an interpersonal level, person-centered care has been operationalized as focusing on the person instead of the task during caregiving and requires a range of communication and relationship-building behaviors and skills (Coleman & Medvene, 2013). On an interpersonal level, person-centered care also includes knowing the residents as persons, their preferences, and
how close or how distant a relationship residents want with the CNA (Coleman & Medvene, 2013). Interpersonal person-centered care also involves knowing how to incorporate these concepts during care by using a range of communication and relationship skills, such as showing interest and concern for the resident, orienting the resident to the task, offering choices, providing positive feedback, and showing reciprocity.

This interpersonal dimension of person-centered care is relevant to the present study because the aide ought to be familiar with the residents’ goals and values and ought to be able to assist the resident in achieving them. At a minimum, it would be expected that the aides acknowledge that residents have personal goals and know how to find out more from the residents about how they might be helpful to them in achieving their goals. However, from the perspective of this study, what is of interest is the extent to which residents use their interactions with aides in ways that help them move towards their goals as well as what information/resources from aides residents could use to facilitate goal achievement. More knowledge about the general types of goals that residents have and the adaptations they make in terms of pursuing them could then have implications for the future training of CNAs.

**Social lives of nursing home residents.** Despite the aspirations of PCC, research indicates that the overarching norm is a general sense of being isolated. For example, Bitzan and Kruzich (1990) found that over 42% of residents indicated they lacked close relationships with any individuals (staff or residents) within the setting. Similarly, Cheng (2009) found residents in Hong Kong nursing homes were socially isolated, reporting very few friends, and with only 20% of the residents indicating someone from within the nursing home as belonging to their social network. Although CNAs provide approximately 80% or more of the direct care to residents in the United States (Heliker & Nguyen, 2010), a study by Heliker and Scholler-Jaquish (2006)
found that even after 3 months at the facility, most residents still did not know the names of the CNAs who provided their care. This study (Heliker & Scholler-Jaquish, 2006) and a similar one by Saunders and Heliker (2008) found that following an initial period of grieving the loss of home and independence, many residents expressed positive feelings about gaining a new support system and making the best of the new situation. However, residents who did not develop relationships with other residents or staff dwelled on the loneliness and loss of their familiar social support. Residents view interactions with staff as helping to “pass time”.

**Types of relationships.** Several studies have identified that a variety of relationships exist in nursing homes settings and, furthermore, that different residents desire different types of relationships with their caregivers. Specifically, Bowers, Fibich, and Jacobson (2001) interviewed 26 nursing home residents and found that residents described how they perceived “quality of care” in three different ways: (a) care-as-service, (b) care-as-comfort, and (c) care-as-relating. Sixteen of the residents focused on the affect of their caregivers, the caregiver’s perceived motivations, and evidence of real friendship they found in their relationships. These residents did not mention technical care, instead centering their discussion around individual attention, affection, and friendship in relation to the CNA. Sharing information about personal lives (including invisible or past personal identities), being a good listener, and reciprocity in relationships were mentioned as specific indicators, and a “good” CNA was described as attending to these identities as they provided care. In this case, it could be speculated that these residents had developing friendships with others at the nursing home as a valued goal and saw the CNA as a way meeting this goal. The other residents did not define quality of care in terms of relationships, but instead as individualized care. This supports the idea that residents may use interpersonal relationships with caregivers to achieve different ends.
In another study, Brown-Wilson, Davies, and Nolan (2009) identified three different types of nonmutually exclusive relationships between residents and staff in nursing homes: (a) pragmatic relationships, which were characterized by a focus on the task and developed primarily through communications directly concerned with the practical nature of caregiving; (b) a personal and responsive relationship focused on understanding the resident as a person, developed through communications that involved social conversations with both residents and their family members; and (c) reciprocal relationships that had relationships as their focal point, featuring negotiation and compromise that took into account the needs of staff, residents and family members in the context of a trusting relationship. Consistent with the literature on socioemotional control (Carstensen et al., 2003), residents were able to become involved in and influence these relationships irrespective of their physical and cognitive abilities. Furthermore, it was during care routines that residents actively contributed towards developing relationships with staff, and it was the nature of these interactions that largely determined the type of relationship that emerged (Brown-Wilson et al., 2009). Not only do different residents have different types of relationships with staff, but these relationships tend to be related to the purposes of the interaction. Of interest is how different relationships with CNAs may be related to residents’ larger goals.

In a recent study, Roberts and Bowers (2015) found that residents’ relationships ranged from adversarial to utilitarian to friendly. Adversarial relationships were characterized by conflict and strife and typically developed when a resident lacked the ability to change, improve, or exist comfortably in a situation. In cases where residents described having an adversarial relationship with staff, they reported delays in care or lack of adequate care. Utilitarian relationships were generally neutral, occurring when residents needed to meet some need.
However, Roberts and Bowers noted that these types of relationships were usually accompanied by personal connections with staff. A few truly utilitarian relationships involved residents asking for something and receiving it with little interaction otherwise. Residents suggested that close relationships were not required in order to fulfill basic care needs. Finally, friendly relationships included acquaintanceships, casual friends, and close friends. These relationships vary by the levels of reciprocity, type and amount of interaction, and environmental factors. Reciprocity in self-disclosure was a particularly salient feature of friendly relationships. Close friendships between residents and staff were rare, but were described as being very meaningful and sources of great emotional support.

In her studies of the quality of staff/resident interactions, Foner (1994) found that CNA interactions with residents were neither consistently warm and supportive, nor harsh and cold. In light of this, recent research has been directed at this relationship between CNAs and residents, seeking to identify, measure, and increase CNAs’ person-centered abilities (Coleman & Medvene, 2013; Grosch et al., 2008; Lann-Wolcott, Medvene, & Williams, 2011; White et al., 2008). However, little is known about how the residents perceive their interactions with CNAs, their motivations for creating relationships, and strategies for managing their interactions. Relationships, even in the setting of a nursing home, are still mutually-influenced entities. Moreover, SOC theory assumes that individuals are both influenced by and sources of influence on their environments, including their social environments. Thus, the proposed study seeks to redress the lack of information known about how residents perceive relationships and interactions with CNAs and how these interactions may relate to attaining their personal goals.

Research on relationships broader than those that are formed within a nursing home facility have indicated the qualities of relationships change and become more multifaceted as we
age (Carstensen, Issacowitz, & Charles, 1999; Fingerman, Miller, & Charles, 2008). According to this body of research, relationships get better. Carstensen et al.’s (1999) theory of socioemotional selectivity is an application of SOC to individual’s social behaviors. The theory suggests that individuals of any age alter their behaviors as a function of their perceived temporal horizons; when the future appears limited, they pursue emotionally meaningful goals and engage in behaviors that maximize positive emotional rewards. Emotional motives refer most essentially to the regulation of emotional states, such as avoiding negative and seeking positive states, but also encompass desires such as finding meaning in life, gaining emotional intimacy, and establishing feelings of social belonging (Carstensen et al., 1999).

A greater value placed on emotionally meaningful goals was found to be accompanied by increased resource allocation to these goals, but how does this play out in nursing homes? Applying the theory to the present study, nursing home residents who perceive their time as limited “will pay more attention to the emotional quality of social exchanges and engage in strategic attempts to optimize emotional aspects of important social relationships” (Carstensen et al., 1999, p. 171). Of interest is whether the present study will find evidence consistent with Carstensen’s theory of emotion regulation and using close, positive relationships as a strategy to maintain positive affect.

**Helping residents attain their goals.** Most importantly, the kinds of resources or information residents may find useful in helping them to realize their goals is also of interest. If, for instance, residents were provided with more information about their CNAs’ backgrounds and preferences, might they be able to engage with the CNAs in new and more effective ways? What other tools or mechanisms would the residents find to be useful and effective in terms of meeting
their goals and behaving in ways consistent with realizing their goals? This dissertation is concerned with answering these questions as well.

**Personal Characteristics of Residents**

Also of interest are the contextual characteristics that may influence residents’ goal setting or pursuit behavior, as well as their interactions with CNAs. That is, I want to learn more about the conditions under which residents use SOC principles and proactively attempt to create specific types of relationships with CNAs. To this end, I plan to measure some characteristics that are known to influence goals and social interactions. Because depression prevalence is high among residents in nursing homes (Kramer, Allgaier, Fejtkova, Mergl & Hegerl, 2009) and because depression demonstrably affects goal setting and pursuit (see Street, 2002 for a review), this seems a relevant contextual variable to measure. If a resident denies having any goals or caring about goals after having moved into the nursing home, it would be useful to know if this apathy could be more due to relatively prominent depressive symptomatology rather than a lack of applicability of SOC. Measuring quality of life will provide a context for how satisfied the resident is with his/her life at the present, which may allow for some inferences regarding the usefulness of the resident’s goal attainment strategies.

Additionally, psychological flexibility may underlie the process of selection, optimization, and compensation insofar as having psychological flexibility would allow the resident to balance competing demands and adapt to changes or losses while maintaining goals and values (Alonso, Lopez, Losada, & Gonzalez, 2013). Thus, one facet of psychological flexibility—experiential avoidance—would be important to understanding the resident’s perspectives and behaviors as they adjust to life within a nursing home setting. Experiential avoidance describes the inability to accept aversive internal experiences and pursue important
values in the presence of these experiences (Hayes, Strosahl, & Wilson, 2012). This variable could be potentially relevant in a number of ways in the present study, such as in the case of a resident who forgoes creating art despite always having loved to paint because her parkinsonian tremor now decreases the quality of the product. In this case, she abandons something important to her because seeing the effects of the Parkinson’s is distressing and she is not willing to tolerate such distress.

Another possible source of influence that deserves noting is the organization and culture of the particular nursing home setting. The present study interviewed residents from a local nursing home that is part of a small chain (18 total facilities) of nonprofit senior-care communities. The culture and mission statement of the nursing home includes a commitment to person-centered care. Their stated goal is to replace institution-style care with warm, home-like environments centered on the resident’s personal choices and preferences. For instance, the particular location wherein this study takes place has an existing program that pairs staff volunteers with residents for social purposes. This may influence resident perceptions and behavior, as well as the types of relationships that exist between residents and staff and the social goals residents have. Knowledge of this overall culture/approach to care may limit the generalizability of the study’s findings.
Goals of the Study

In summary, this dissertation is intended to achieve the following goals:

1. Learn about the personal goals of residents and how they pursue these goals in the nursing home;
2. Explore the applicability of SOC principles to residents’ goal selection and pursuit;
3. Gather information on potentially relevant contextual conditions that may influence residents’ goal setting and pursuit. Variables that will be measured include: (a) depression, (b) quality of life, and (c) experiential avoidance;
4. Explore residents’ experiences with CNAs who have been helpful to them in pursuing their personal goals;
5. Learn about residents’ perspectives on what resources have been helpful to them in engaging CNAs to create relationships in which the CNAs have helped them to pursue their personal goals; e.g., biographical information about the CNAs, skills for communicating, more opportunities to share information, etc.
CHAPTER III
METHODOLOGY

The present study involved semi-structured interviews with residents of a skilled nursing facility in the Midwest. The interviews were meant to elicit information from residents regarding whether they have personal goals, and, if so, the content of their goals, the methods they employ to achieve their goals, and whether CNAs have been helpful to them in achieving their goals. The qualitative data information gathered from these interviews were analyzed using qualitative and other methods.

Setting

The setting of the study was a nursing home that is part of a small, regional chain of nonprofit senior communities. The culture of both the chain and the individual location involves a dedication to providing care that is person-centered and of high quality. The Vice President of Clinical Services for the chain was supportive of this study and referred me to a social worker at the facility. The social worker was also supportive of the study and saw it as fitting with the person-centered culture promoted by the facility. She also agreed to act as liaison between the researcher, residents, and other staff.

Participants

A small, purposive sample of residents participated in the study. All participants were current residents of the selected nursing home facility in the Midwest. At the time of participant selection, total census of the skilled nursing area of the facility was 34 residents. With help of the director of nursing and social worker, 13 of these residents were identified as possible participants based on meeting inclusion criteria.
**Inclusion criteria.** To be eligible to participate, participants were required to have had resided full-time in the skilled nursing part of the facility, as opposed to the assisted and independent living areas that are also part of the campus. Preference was for residents who had been in the nursing home for at least 3 months. No preferences for functional ability, age, race, sex, educational level, or marital status were specified.

Due to the nature of the questions and the topics, it was decided that a minimal level of cognitive functioning was necessary to ensure the data gathered were meaningful. As part of government required Minimum Data Set (MDS), each resident is administered the Brief Interview for Mental Status (BIMS; Saliba et al., 2012) at admission and every 6 months subsequently, along with other assessments to determine the nature and extent of services needed. Scores on the BIMS range from 0-15, with lower scores indicating cognitive impairment and higher scores suggesting lacking/minimal cognitive deficits. For the purposes of the study, inclusion criteria were set to select only those residents with a BIMS score of 12 or greater, as this cut-off point yields sensitivity of 83% for any cognitive impairment with a specificity of 91% (Saliba et al., 2012). Thirteen of the 34 total residents met the criteria of having a BIMS score of 12 or higher, based on administration by nursing staff within at least the last 6 months. All these residents had also resided at the nursing home for greater than 3 months.

Of the 13 participants who met criteria for participation, one was unable to be approached due to being either in the hospital or very ill for the duration of the data-gathering time period. Another eligible resident was not able to participate due to having had a recent stroke that hindered expressive communication. One eligible resident was approached about the study and initially agreed, but then later informed the social worker that she did not want to participate due to her own concerns regarding her cognitive ability. Ten residents completed the consent and
interview process; however, only 8 interviews were able to be used for the study. The data from two male participants were not able to be used. The first was later deemed ineligible because he was only living in the health care area of the nursing home so that he could share a room with his wife; otherwise, he would have been living independently or in the community. This represented a significant difference, as he did not receive any assistance with care and left the facility daily in his own vehicle. The second participant met criteria, but had a speech impediment that made the interview extremely difficult and the transcription impossible. I even made an attempt to interview him in multiple sessions and offered to use different formats (e.g., writing); resident declined wanting to write or type due to arthritis in his hands and expressed frustration with the communication difficulties (both with himself and with my need to ask for repetition/clarification often). Attempts by three separate people (myself and two R.A.s) were all unsuccessful in transcribing any substantive portion of the interview.

Demographics. The social worker provided demographic data for the residents meeting the inclusion criteria and who consented to participate. See Table 1 for a summary of these data. Of the final 8 residents whose interviews were used in the study, two were male and all identified as White. Mean age of these residents was 88.3 years old (SD = 4.9), with a range of 82-96 years. Resident’s length of stay was provided in ranges: (a) less than 1 year, (b) between 1 - 3 years, (c) between 3 - 5 years, and (d) greater than 5 years. The mean length of stay for residents in this study was between 1-3 years. Only one resident had been at the facility for greater than 5 years. Of those residents who had lived at the nursing home for less than 1 year, the social worker verified that they had been there at least 3 months. Nearly all of the residents (87.5%, N = 7) who completed the interviews had a BIMS score of 15, which is the highest possible score and indicates minimal or no cognitive impairment. One resident had a score of 12 out of 15 on
the BIMS measurement, which is in the range of none to minimal cognitive impairment compared to peers of similar age and education levels.

Although the residents were overwhelmingly female and exclusively White, this is reflective of nationwide trends of nursing home consumers and of Kansas in particular. According to the Centers for Medicare and Medicaid Services’ Nursing Home Data Compendium for 2012, women constitute more than two-thirds (67.2%) of the nursing home population, and nearly 4 of 5 nursing home residents (78.9%) are non-Hispanic Whites. According to the same source, in 2011, nearly 93% of nursing home residents in Kansas were non-Hispanic Whites and about 68% were female. However, it is possible that more residents of color may have been eligible for inclusion if residents were sampled from different nursing homes, such as Medical Lodge nursing homes, rather than a private nursing home.

Procedure

**Approach and consent.** The first step in gaining access to the residents was to contact the administrator at the nursing home. After meeting with the administrator and explaining my project, he consulted with administrators at the corporate level to ascertain my request to approach and interview residents was allowable by their standards. Per administration’s requirement, I completed background checks and other documentation with the human resource department at the nursing home. After satisfactory completion of this documentation and gaining the administrator’s approval, he introduced me to the director of nursing (DON) and to a social worker at the facility.

The DON was helpful in assisting me in identifying residents who met the inclusion criteria (based on BIMS and length of stay in nursing home area) using their chart. She then provided this information to the social worker, who introduced me to each individual identified
as a potential participant. During this introduction, I spoke with the resident about the nature of my research and requirements of participation. If the resident indicated s/he was interested in participating, a meeting was scheduled and a copy of the informed consent, printed in large font, was left for the resident to review prior to the interview. The social worker kept track of the scheduled meetings and provided each interested resident with a written reminder of the appointment time.

**Interviews.** I met each participant at the agreed upon time and location for the in-depth, 45-60 minute, semi-structured interview. Most residents met with me in their rooms with the doors closed, with the exception of two residents, who had shared rooms. These residents were interviewed in a private room specifically used by mental health clinicians from a local agency for conducting psychotherapy.

At the beginning of each interview, I reviewed the purpose of the study, procedures, risks and benefits, and confidentiality as outlined in the informed consent form. I verbally went over the informed consent form with each participant, making sure they understood and offered to answer any questions. Following this explanation, each participant was asked to sign the consent form, acknowledging they fully understood their involvement in the study and associated risks. Residents were reminded that they could withdraw from the study at any time without any effect on the services they receive at the nursing home. I made a point to distinguish myself from staff at the facility to promote greater freedom of expression and reduce fear of potential backlash if the resident spoke negatively of their experience in the nursing home. During the interviews, I wore a WSU nametag that stated my name as another means of differentiating myself from staff members at the facility. Interviews were audio-recorded using a digital voice recorder (with resident knowledge and consent). Although I prepared a semi-structured set of questions for the
interview, efforts were made to make the interview feel conversational, in hopes of reducing
demand characteristics and increasing rapport. See Appendix A for interview questions.

As a general overview, the first objective of the interview was to establish rapport and
obtain buy-in by explaining that the purpose of the study was to understand their experiences in
hopes of being able to improve the experiences and quality of life among other nursing home
residents. Secondly, I focused on continuing to build rapport while also gathering pertinent
background information from the resident. Thirdly, I transitioned into inquiring about the
resident’s goals and strategies of goal pursuit in the nursing home. Most residents (5 of 8)
explicitly denied having goals. In this case, I asked about what activities the resident engages in
and what things are of importance to the resident, attempting to explore goal-related behavior in
other ways. Of particular interest was whether residents mentioned any staff or CNAs as being a
part of their goal pursuit. At the conclusion of the interview, I administered three brief measures:
(a) a quality of life measure called the Control, Autonomy, Self-Realization, and Pleasure scale
(CASP-12; Hyde, Wiggins, Higgs, & Blane, 2003), (b) Acceptance and Action Questionnaire-II
(Bond et al., 2010), and (c) a shortened version of the Geriatric Depression Scale (10-item scale;
Yesavage et al., 1983). Participants were thanked for their participation at the time of the
interview, as well as mailed a handwritten card similarly expressing gratitude.

**Measures.** To provide important contextual information, three empirically validated
measures were administered to residents. Logistically, this was accomplished by providing large
print prompts of the standardized questions, response choices, and any verbal instructions. These
measures were selected because it was thought that they may aid in interpretation of the data. For
example, a resident who scores high on the depression scale may not articulate many goals,
because depression is associated with apathy, amotivation, and reduced ability to experience
pleasure (American Psychiatric Association, 2013). Questionnaires were administered via pencil-and-paper that I read aloud while residents looked at the written prompts (see Appendix B).

**Control, Autonomy, Self-Realization, and Pleasure (CASP-12).** Quality of life was measured with the CASP-12 questionnaire, a psychometrically-validated short version (Cronbach’s alpha = .83; Wahrendorf, von dem Knesebeck, & Siegrist, 2006) of the original 19-item version specifically developed for older adults (CASP-19; Hyde et al., 2003). This assessment assumes that quality of life refers to three conceptual domains of individual needs that are particularly relevant in later life: (a) control and autonomy, (c) self-realization, and (d) pleasure (or CASP). Items measuring the three respective scales assess the degree to which these aspects are perceived as being satisfied. The questionnaire presents a statement and then asks participants to choose how often, if at all, the statement applies to them. Given the statement, “My age prevents me from doing the things I would like to do”, participants may choose “Often”, “Sometimes”, “Not often”, or “Never”. As a common latent construct is considered to underlie the three scales, a summary measure provides an overall quality of life score (range 12–48), with higher scores indicating better quality of life (Sexton, King-Kallimanis, Conroy, & Hickey, 2013). See Appendix B.

**Acceptance and Action Questionnaire II (AAQ-II).** The AAQ-II is a measure of experiential avoidance, or the inability/unwillingness to take value-directed action in the face of thoughts or emotions deemed negative. For instance, a resident may choose to completely avoid engaging in a previously enjoyable hobby if doing so serves as a reminder of decreased autonomous functioning. SOC involves adapting to losses, while still maintaining important goals, so knowing about a residents tendency for avoiding engaging in valued goals due to potential unpleasant emotions is a relevant variable to measure. The 7-item version of the AAQ-
II, used in this study, exhibited stronger psychometric properties than both the 10-item version of the AAQ-II and the original AAQ (Bond et al. 2011). Findings supported a unidimensional structure for the scale, and alpha coefficients ranged from .78 to .88 across different samples. Test-retest coefficients at 3-month and at 12-month were .81 and .79, respectively. Participants rate each item on the AAQ-II on a 7 point Likert-type scale from 1 (never true) to 7 (always true). Items on the AAQ-II include, “It’s OK if I remember something unpleasant” and “My painful memories prevent me from having a fulfilling life”. High scores on the AAQ-II are reflective of greater experiential avoidance and immobility, while low scores reflect greater acceptance and action. See Appendix B.

**Geriatric Depression Scale (GDS).** The original GDS is a 30-item, dichotomous self-report measure used to identify depression in the older adult population (Yesavage et al., 1983). It is the most widely used age-specific screening test for depression and is preferred to other commonly used scales such as the Beck Depression Inventory II for older adults, as the GDS minimizes somatic items that may increase false positives in older adults with comorbid health concerns. Participants are asked to respond “yes” or “no” in reference to how they have felt over the past week. Example questions include, “Are you basically satisfied with your life?”, “Have you dropped many of your activities and interests?”, and “Do you feel helpless?” See Appendix B.

Several short forms for the GDS have also been developed in order to minimize the time and burden involved in screening, which are more appropriate both for nursing home residents (Jongenelis et al., 2005) and for the purposes of this study. The GDS-10 was selected for use in the present study because it has published evidence for solid psychometric properties (Almeida & Almeida, 1999; D’Ath, Katona, Mullan, Evans, & Katona, 1994; Jongenelis et al., 2005)
combined with the brevity of only 10 dichotomous questions. Scores can range from 0-10, with higher scores indicating greater depressive symptomatology. In a large sample of nursing home residents, the GDS-10 reliably ($\alpha = .75$) detected the presence of a clinically relevant depression among residents with no or mild-moderate cognitive impairment; a cut-off score of $\geq 4$ produced sensitivity rates of 96.3% for major depression and 78.7% for milder forms with a specificity of 69.5% and negative predictive value of 94.5% when DSM-IV (APA, 1994) research criteria for major depression or minor depression were used (Jongenelis et al., 2005).

**Data analysis.** The interviews were transcribed with help from two research assistants. For interviews transcribed by research assistants, I checked for the transcription for accuracy. The initial plan for analysis was to employ two types of qualitative analyses to explore the goals of the study, with the primary focus of the analysis being a line-by-line coding for data that fit with the SOC framework (Freund & Baltes, 2002) and on goal typologies established in the literature. The SOC coding categories were developed prior to the data collection by drawing on Figure 1 (see p. 9) and questions from the SOC questionnaire (Freund & Baltes, 2002) as well as general principles of the SOC model.

**Modification of initial plan.** During the data collection and transcription stages, I sensed a lack of fit between these coding categories, based on the literature, and what the residents were actually saying. In light of this hunch, it seemed a better use of the data to use a qualitative analysis, allowing the content of the interviews to emerge rather than only look for instances that could be classified into the a priori SOC and goal-coding categories. In consultation with the dissertation committee, this change of analysis was accepted and supported with the suggestion that I do some of the initial coding to document this perceived lack of fit in an empirical manner.
**Goal coding.** A modified coding plan was proposed and approved by the committee that entailed coding the meaning units that were selected during the qualitative analysis (see more about this below). A list of nonrepetitive meaning units or statements was created for each resident’s interview that represented the most salient parts of the residents’ descriptions of their experiences. These units were then coded using an adapted set of coding categories (see Appendix C). As SOC assumes a selection of a goal as the first part of the process, the focus of the revised process I developed for goal coding revolved around: (a) documenting resident’s outright denial of having goals, (b) coding for goal typologies, and (c) calculating the percentage of meaning units that involved either goal selection, pursuit, or progress. The second-coder also coded transcripts using the last step just described, which involved coding the meaning units in terms of whether they involved goal selection, pursuit, or progress. The second coder coded two of the eight interviews (25%) using these goal-coding categories and a rate of agreement was calculated. Average agreement for the two interviews was .75.

For the purposes of the analysis, it was necessary to define a goal as there was no record that the SOC theory has provided a specific, operational definition. The definition used in this study was very general and broad, defining a goal as “desired states that people seek to obtain, maintain, or avoid” (Emmons, 1996, p. 314). As such, it did not require that the resident acknowledge the behavior as a goal or any action orientation or plan. This process of coding goals was difficult and conflictual, lacking specification from the definition or a history in the SOC literature to draw upon for guidance. The discussion section will further explore the speculated sources of this difficulty and lack of precedent. Data pertaining to this analysis were recorded in SPSS v. 21.
Qualitative analysis. Although it has been noted that the residents spoke minimally about goal-related content, their interviews were interesting and rich in information in other ways. To capture this richness, it was decided to use qualitative analysis. The steps followed in this process are outlined below. However, just a note on terminology may be clarifying. The process is loosely based on phenomenology, a type of qualitative analysis that attends to uncovering the essence or basic structure of a phenomenon that involves a series of steps (Moustakas, 1994). However, given that this study and the research questions guiding it did not start out being a phenomenological study, the interview is more probing and less open-ended than would be expected in a truer phenomenological study. Additionally, there is not an “essential structure” finding in this study, as the themes that emerged do not yet stand up to imaginative variation (Moustakas, 1994), in which the experiences described are so elemental that they cannot be imagined to differ for others experiencing the same phenomenon. Therefore, this analysis will be referred to simply as “qualitative”.

In this approach, I did not impose a set of codes or criteria, but analyzed the data for emergent themes. This analysis was inductive, analyzing each individual interview for themes, then themes from all the interviews were considered in order to identify any overarching patterns. To do this, I considered the audio recording, the transcript, questionnaire information, and my notes (memos) regarding the interview. For this stage of analysis, an attempt was made to set aside the initial research question regarding goals and SOC theory. An outline of the method follows:

For each individual interview:

1. I took time to reflect on and write down my assumptions, expectations, theoretical ideas that may influence my interpretation of the data. The goal of this step is to help clarify
my expectations and assumptions, with the hope that such awareness assists in
broadening my interpretation of the data beyond that perspective. Throughout the
analysis stage, I kept memos on my experiences.

2. Read through interview and listened to the audiotape, focusing on understanding the
interview as a whole and with the emotional content reflected in participants’ verbal
expression. I reviewed any field notes from my meeting with that resident and tried to
bring to mind the experience of being in the room with that person.

3. Then I read through the interview again, this time marking off what appeared to be the
meaning units, or significant words, statements, expressions. At this point, I also wrote in
the margins ideas of themes or categories as they occurred.

4. Reading meaning units again, I then grouped them by potential theme and removed any
repetitive units.

5. Lastly, I wrote an idiographic narrative to summarize the meaning units, and therefore the
experience described by the resident, in a coherent way, making an effort to capture the
emotional undertones as well as the content of the interview.

First group of interviews (i.e., 1-4)

6. After having used the above procedure for four interviews, I considered the meaning
units from each of these interviews, looking for commonalities and differences. At this
point, I collated meaning units across interviews that seemed to share some commonality,
and provided it a name and description.

7. Then I presented the interviews 1-4 in their entirety and their identified meaning units to
the second coder, Carissa Coleman, who also has background in person-centered care.

After engaging in a similar reflective process of examining assumptions and expectations,
she reviewed the interviews and created, independently, the themes and descriptions as she interpreted the data.

8. First (Amanda) and second coder discussed the sets of themes each created and engaged in a collaborative process, referring back to the data frequently, to come to agreement on themes that captured the primary tenets of the interviews and the titles/descriptions.

Second Batch of interviews (i.e., 5 and 6)

9. For the next two interviews, I followed the procedure detailed in steps 1-5 above.

10. Next, I considered the meaning units identified from this set of interviews and how they fit or did not fit with the working set of themes and made alterations as needed.

Third Batch of Interviews (i.e., 7 and 8)

11. For the last set of interviews, I again followed the protocol in steps 1-5 and again I considered how these meaning units fit with the set of themes.

12. I made changes to the themes as necessary to incorporate the new meaning units.

13. In order to obtain some sort of measure of reliability, I provided the second coder with the lists of meaning units found in each of these last two interviews. Both coders then individually sorted the meaning units into the existing themes.

14. Cohen’s kappa was calculated to ascertain degree of interrater reliability in sorting of meaning units into existing categories between coders. For both interviews, agreement was good (κ = .81 and .82, respectively).

15. A similar qualitative approach was used to analyze the residents’ descriptions of how CNAs may have been helpful to them in attaining their goals.

_Pencil-and-paper measures._ Questionnaire data were scored according to protocol and entered into SPSS v. 21 so that reliability, descriptive, and nonparametric analyses could be
conducted. Reliability was calculated using Cronbach’s alpha (Cronbach, 1951) and all were found to be acceptable: $\alpha = .75$ for CASP-12, .70 for AAQ-II, and .79 for GDS-10. Means and standard deviations were calculated to provide context on the quality of life, depression, and experiential avoidance within the sample. Owing to the sample, nonrandom sample size, a nonparametric procedure, the Spearman’s rank order correlation coefficient (i.e., Spearman's rho) was performed to further explore the relationships among the goal coding data and the questionnaire data.
CHAPTER IV
RESULTS

Goal Coding

In the interviews, residents were asked about what goals they have. In response, 5 out of the 8 residents (63%) explicitly denied having goals. One woman asked, “How can you form a goal when you’re 84 and a half years old?” An 87-year-old man stated, “The goals I’ve had over the years, I’ve left behind”. Of the three residents who did not explicitly deny having goals, one reported that “[physical] therapy has a goal”, but did not talk about a specific goal he had identified and/or was working towards. The other two residents who did not outright deny goals were similarly focused on physical goals.

Although most residents rejected having goals, the interview continued to ask what residents spent their time doing and what was enjoyable to them to try to discover if there was a disconnect with the languaging of “goals.” Coding the interview data using a broad definition of a goal, “desired states that people seek to obtain, maintain, or avoid” (Emmons, 1996, p. 314), 17 total goals were identified across the eight interviews. Of these goals, six fit into the achieve / re-achieve category, four fit into the maintenance category, and seven fell into the prevention/avoidance category. Note that this definition only required a vague alluding to wanting something, and did not require any plan or action to qualify. The range of goals was 0-5 per resident, with two residents still not describing any goals using this definition.

Out of the interviews, 317 nonredundant meaning units were demarcated. Approximately 15.8% of these meaning units were coded as pertaining to goals (identification, pursuit, progress). This statistic suggests that even though residents were found to have an average of
2.12 goals using the criteria described above, goal-related content made up very little of their interviews, even with the lenient definition and with having nonrelevant information (e.g., conversational interjections) screened out. See Table 2 for a summary of this data.

**Qualitative Themes**

Because the goal-specific content comprised such a small part of the meaning units, the data were analyzed qualitatively as well, looking for overarching themes that extended across the interviews. From this analysis, the follow themes were identified:

1. **Acceptance.** Residents expressed that their current living situation was not a preferred/ideal one. It is, however, what it is, and dwelling on other scenarios does not improve one’s experience. When speaking about her experience of being a resident, one woman spontaneously commented on how she perceives this acceptance piece as being key to allowing her to enjoy her time at the facility as compared to other residents:

   “I’ve heard of people who don’t like it here. They want to live in their own home; that’s the only thing that will make them happy. That’s the sad part—they won’t be able to go back home. Not on this planet. .. I wish I could [go home], same as them. ... I’ve accepted that I’m not going to be able to. ... I’ve accepted it. They haven’t.”

   This acceptance appears to be derived from a sense of flexibility or changing of expectations related to one’s age, developmental stage, physical health status, and setting, as represented by this quote from one resident:

   “There’s no use in beating yourself up for thinking you can be young when you can’t”. Importantly, the acceptance as described by the residents in the sample is not equitable to resignation, seeking approval from others, or just "waiting to die". Acceptance is lived as an
active process, suggested by frequent references to “adjusting”, “transitions”, taking ownership, or finding a way of perceiving the situation differently:

“But it’s, basically I got a good place to live and got security. It’s just now a matter of adjusting.”

“Where else am I gonna go? I can’t go back. ... I got comfortable. It was a huge adjustment, like I said, to have reduced down from a house to one room. But it’s my room.”

“You got to make a home somewhere, and this is my home. At first I thought no, no. No way. But now, it is my home.”

“I don’t know why I’m still here, but I’m trusting that there’s a reason for it.”

For some this goes so far as a “looking on the bright side” mentality, in which they focus on the positive aspects of their experience as a way of coping/coming to terms with their experience, as exemplified by this statement:

“I get to thinking I’m getting tired of this place. I wish I could get out and do things but I can’t so I just kind of think it over and think of the good part of it. I think about that [positive relationships with staff], and then the feeling [of not wanting to be here] passes.”

2. Burden minimization. Residents spoke of choosing living arrangements, finalizing affairs (e.g., financial), and interacting with staff as revolving around the goal of minimizing one’s perceived burden on others. Many residents spoke of choosing to enter long-term care for the sake of minimizing perceived burden on family, either occurring at that time or anticipated:

“If I lived at home, I’m afraid it would be too much of burden for them [kids]. They’d have to do everything for me.”
“And my daughter who is my right-hand-man said ‘we’ll take you home with us.’ We talked about it for years, and so I was there for two nights, but I was too much for her. I couldn’t do anything for myself hardly, and an adult is heavy. She just couldn’t handle it, so I decided it was time to make a decision. And I knew about [facility name] because I had a friend that was here for five years. I looked at one other place and that’s all.”

Residents described making decisions about what they did/do (or do not do) as centering on the perceived burden that it may impose on others. For example, this female resident described getting her funeral and burial arrangements settled to relieve this pressure on her children:

I’ve chosen the mortuary and I’ve paid most of the cost. I’ve left a few things for them [kids] to decide but most of it I’ve already decided and took care of it. I did that many years ago. ... Because there’s a heck-of-a-lot of decisions to make (laughs). There’s a lot of them, so the most expensive ones, I took care of.

One resident was describing how she has mixed feelings about leaving the facility with her son. She said that although she likes getting out, “I’m worried about him. But he always says he doesn’t mind. And he’s always on me about it [to go on outings].”

For some residents, minimizing burden was not reserved only for family, but also for staff at the nursing home. When a CNA entered the room during the interview, one resident said to me, “Excuse me for interrupting our conversation but I know if they don’t stay on schedule it really is hard for them.” She then received medication from the CNA, despite the CNA’s offer to come back at a different time. Another resident replied, “I don’t give them [staff] fits. I don’t give them problems at all.” when asked about his interactions with the nursing staff.
3. **Autonomy.** As opposed to the goal regarding burden minimization, which is more themed around others, residents described the importance of doing what they could for themselves, for their own sake. Although there is acknowledge of needing help, there is a striving to maintain an active role in certain behaviors. Within this theme, residents spoke of not wanting to be or to be viewed as helpless/infantilized:

> “I feel like sometimes my youngest daughter is always worrying about me falling. I tell her, you can’t keep me from falling. Not that I try to. But she can’t always be looking after me—thank God she can’t. I mean, sometimes I feel like the child and she’s the mother. … she tells me, ‘Mom, I just love you so much I don’t want you to fall’. And I have to tell her that I need to do somethings by myself.”

> “You feel a lot better if you can dress yourself.”

> “If I can do it myself, I will.”

the importance of making significant decisions oneself:

> “About a year ago, I sold my car and last June my driver’s license was due to be renewed and I let it expire. So I can’t go anywhere by myself anymore. But I didn’t enjoy driving and I felt like I really probably shouldn’t. That was my choice, nobody told me, ‘you better stop driving’.”

> “My second husband died in 1978, so I’ve been a single person since then, so I’m used to making decisions. I’ve been very independent; it’s hard not to be. And I made the decision to come here. I did the research on the other places and made the decision myself – nobody pushed me.”

and wanting to preserve abilities to maximize independence:
“I think that when the time comes that I would need a wheelchair, I will be able to accept it without complaining. But I’d like to be able to do most things by myself as long as I can.”

“Each person in this home has to help themselves, you know; And there’s always books in the library I can get to read if I want to. If you help yourself, you can always find something to do.”

4. Lack of specifically-defined goals. As has been noted in an empirical way above, residents tended to deny having “goals”. This was not a word or concept that they felt was fitting or relevant to their situation. A few residents laughed or indicated surprise when posed this question. Residents generally saw themselves as too old or as having too many limitations to have goals:

“How can you form a goal when you’re 84 and half years old?”

“So, no, I don’t have any actual goals.”

“The goals I’ve had over the years, I’ve left behind.”

“I can’t do anything. I can pretty much just sit, so I don’t have any goals. I can’t even go to the bathroom without one of the girls helping me.”

The idea of goals seems to be associated with a younger stage of life. Goals also appeared to have been perceived as active, promotion-types of goals, not maintenance or prevention-based goals. Many residents described goal-directed behavior, although they did not acknowledge these as goals explicitly:

“No, I don’t have any goals. I just try to stay healthy.”

5. Prevention/avoidance goals. After introducing the idea of goals by asking residents if they had any, a prominent sentiment regarding the fear of losing abilities surfaced. Residents
tacitly described goals that were aimed at avoiding feared future selves, such as one who has significant cognitive and/or physical impairments, requires substantial assistance, or lacks financial means.

“Well, I don’t mind being old. I just hope I keep my mind.”

“As long as I’m going to be here, I figure if I can keep myself healthy, I don’t have the pain. … I know from the times I’ve been in the hospital and fallen, that it’s in my best interest to not have to take a lot of medication for pain and be able to do what I want to do, maybe not without my walker, but I can be happy and do things.”

“I don’t want to be in a wheelchair for the rest of my life.”

A desire to maintain cognition/avoid cognitive decline seemed to be especially important as residents are frequently reminded of what this looks like via other residents with more impairment:

“What I fear more than anything else is having a stroke and end up in full care. I pray to the Lord He takes me, He takes me, don’t disable me. There’s some cases in here--I don’t know how people survive.”

“I would hate to be in a wheelchair or in bed. There are some people who have had a stroke and they just don’t function right. They’re just in bed. That would be a terrible existence, to be semi-awake. I hope that I just die suddenly, whatever it is. And fairly quickly.”

6. Importance of relationships

Outside the facility (family/friends). Residents still see their family as important sources of support:

“They’re here when I need them.”
“[Daughter] comes on Wednesday and has lunch with me and runs any errands for me and she picks up the laundry and then Sunday, she comes back--Sunday afternoon about 4:15--and brings back the laundry and puts it away and all. Now [other daughter], she works at [employer] and can’t get off; she’s got a very demanding job, sometimes she can’t get off. But there is a time or two she’ll stop by when she gets off or goes home and comes back.

And residents tended to emphasize enjoy visits and outings (health/energy-permitting).

“Last Saturday [daughter] took me for a ride and I’m going to ask if she’ll do that tomorrow for me. Take an hour and take me out and just go through the park, run around a little bit.”

“When my family comes, we go out[side]. And when they come, we do things, and they like to see what they are doing with me and for me. And so we get along just fine. They will be here this weekend for Mother’s Day. I’m not sure what we’ll do, but them just being here is enough for me.”

“I hate to see them leave. But I know they have their things they need to do.”

Although relationships were described as pleasant and vital ways of maintaining a sense of identity, the language also described some changing/shifting of relationship roles (e.g., children taking care of responsibilities, greater degree of passivity or understanding that their families have lives that they are less integrated in by virtue of their lack of mobility, etc.).

“Well, I just don’t get to see them all that often.”

“And sometimes, my son bugs me about going out to eat with everybody. When we did that last summer, it went good. He’s been bugging me about going next Sunday. I said, ‘Let’s just wait til Sunday gets here’.”
“I can’t go to their house, because they’ve got steps. I can’t climb steps.”

“I don’t have any way for [grandchildren] to stay overnight. This is my domain, and it’s not very easy to entertain anybody.”

“Of course everybody has computers except me so they do e-mail and text messages and stuff. So I get most everything second-hand.”

**Within the facility (staff/residents).** Friendly relationships with staff are also valued and seen as positive aspects of the experience of living in the nursing home. There is a sense that some staff are family, but in a different, more distant way due to the continual turnover with staff. Few residents identified specific staff members they were close to, or why, but most conveyed a general sense of staff as friendly, caring, and helpful.

“The girls [staff] have been real good to me. I’ve got two girls on each shift that really take care of me, look after me. Some of the others, too.”

“This is family. One thing about that there, there comes some of these girls, get pretty close to some of the older patients although they may not be older than me, I’m 87, but it is a loving community. It’s with its faults. It’s--sometimes we get understaffed and call for help, me I have to have help every time I move, I have to call. Sometimes...well, 15 minutes...I’ll pee my pants.”

“Here all the nurses seem to speak and the families come in. They’d only been here a couple of times, but they seem to wave hi to them.”

“One thing you get accustomed to is changing the nursing group because they keep moving around. They get disgusted with something and they may feel like they have a better chance to advance someplace else or whatever. Right now we’re going through that here.”
“The people that attend to you are very good. They’re wonderful. And that makes it worthwhile. When you know that people attending to you want to do it, because some people don’t want to do it.”

7. Time. The dimension of time is experienced differently by residents at this point in their lives and functional status. Simultaneously, paradoxically, residents find themselves with more time, yet quite occupied with the tasks of caregiving and often fatigued. Time is more salient then, as much of their time is occupied, but not always in meaningful/enjoyable ways and energy is perceived as a highly limited resource.

“I don’t think I’m doing anything particularly meaningful.”

“Almost been here a year. It goes by pretty fast even though it’s a very boring life.”

“I just spend the day reading and watching TV, mostly. Going to meals, taking my medicine…It doesn’t sound like much, but I’m tired, and so it is for me.’

This is noted as drastically different than how residents used time previously; it is a paradoxical change, having fewer obligations, yet somehow finding themselves inexplicably busy, spending time and energy on basic tasks that were previously completed with little thought. For some residents this is a “traumatic” change; for others it is just surprising or logistical.

“But I have not been able to adjust to time on my hands.”

“I’ve been too busy”. And [my daughter] said, ‘well, what have you been doing?’ And I said, ‘well, I’ve been busy!’.”

“I told them the other day that I thought I was just going to make my permanent residency the bathroom – I spend most of my time in there.”

“They don’t give you time to do anything. Somebody’s here with pills or somebody’s here to take your vitals. There’s just somebody all the time it seems like - I don’t know. … I
really don’t have a lot of time. It seems like there’s somebody here with pills or to take your vitals; then I have that breathing machine that I use all the time; I have drops I have to put in my eyes.”

“Actually I have ‘bowel time’ – I really don’t have any control over my bowels or my kidneys. When they say ‘go!’ you better go!”

“One thing that I do now that I never used to before is watch the TV. I’m rather…attached to the TV now. I used to see it as a waste of time. I never thought that’d happen, that I’d watch programs. And especially sports…. And I just didn’t need [TV] before. I was busy and I liked to spend my time with my family.”

8. Neutrality. Residents tended not to describe their experiences as particularly good or bad. Staff were mostly described positively, but there was also noting of understaffed periods and staff rotations. Pleasure was experienced when it is available to them, but the overall emotional valence of the residents’ perspectives on their experiences living in a nursing home are neutral and balanced.

“Well, I feel neutral.” (In response to GDS-10 question asking if she felt happy)

“I don’t know what caused that [last fall], but it happened. But I’m glad I’m here, and if I have to stay here, I have to stay here. It’s realistic.”

“None of its easy, but you know, it’s my problem – or my challenge, I should say.”

“This place is wonderful, but being taken out of your own home, that’s difficult.”

“I sit in this room, I watch TV and I read a lot. Every day is just neutral. I like the place, I’ve gotten know the nurses and everybody so well. But every day is pretty much the same: not too good and not terrible either.”
9. Setting/environment effects. Residents described the setting as playing a role in their experience—limiting for some, such as inability to play instruments or have a garden, but also suggesting an increase in group interactions, such as activities or meals.

“What I’d like to do I can’t do in here. I’d like to have my big computer and printer and all that stuff in here.”

“The only thing I miss is my flower garden and my garden. Which you can’t do here. However, some people have flowers out back. There’s a place you can plant flowers and garden if you want to. I haven’t done that because it’s too hard for me to get out there. And when I do get out there, I can’t get down to do it. So I have to do something else.”

“I got so that I go to most of [the activities] now. To me, that’s part of living here.”

“I’d like to [sew] but they won’t let me have a sewing machine in here. Well, some of the people here aren’t...with us, you know. And I guess they are concerned they may get a hold of one and get their fingers caught with the needle and get hurt.”

Some residents preferred engagement in group interactions, while others preferred to spend time alone to minimize interactions with cognitively-impaired residents.

“There are a lot people at the event you’ve gone to that don’t remember coming here from sicccum. It’s kinda hard to associate with some of the people sometimes. Sometimes you get a good group together that knows what’s going on.”

“We got to have activities going on and the activities have to be planned around who is your major patient, residents”. [Cognitive impairment]

“I’ll go only if it’s something that really appeals. Otherwise, I prefer to stay in here and read. Because the instructors, they have to go down to the level of those people, so that everybody can do it. Me, I’d just like to get in and get my thing done and get out. And
there are a couple others like me, too. But there are some that try and the instructor basically has to do it for them."

Content related to the service aspect of the setting also emerged. Whether embraced or minimized, the setting is perceived as the most dependent, which offers both opportunities and disadvantages.

“The [CNAs] are really good. I wanted pancakes and they got me pancakes (laughs). They told the kitchen to fix me some pancakes and they did.”

“I don’t have to do anything. They make my bed and if I needed it, they would help me dress. No, I’m where you get everything.”

“Now I’m here—this is as low as you can go laughs. We get three meals, laundry, everything done.”

10) Positive coping. Residents find ways of passing time in enjoyable and/or instrumental ways. Many residents point to identification with/participation in organized religion and/or spiritual practices such as reading the Bible or listening to gospel music as enjoyable/meaningful activities, important coping strategies for adjusting to this situation. Others spoke of reading, watching TV, or playing computer games as activities they do for pleasure and to regulate emotion.

“Well one of my big concerns was I hadn’t filed my income tax, I had all the information together, but it wasn’t where I could turn it over to anybody and I prayed, prayed, prayed.”

“I got all this gospel music I listen to.”

“I can still live like a Christian and I can still tell people how I believe. / Because my bible tells me that if I have faith in the Lord that I will be with Him; He died for my sins, so I really
don’t have much to worry about. / My eyes sometimes won’t let me read it, but, uh...I still know it’s there and I will read when I’m able to, when my eyes let me.”

“Just to be with somebody. That’s why I keep my TV on 24hrs a day, keeps you busy, keeps your head open. Like Flight 307 that went down, get interested in that to see what all they’re doing and I’d always say, I’d done something else with it, I’d done this first.”

11) Age as referent. Age was referenced as a sort of standard by which one compares one’s own functioning, with particular focus on independence and cognitive performance. Either one is doing well by this standard, or not so well. Standard may be in comparison to both real individuals (past or presently known) or as a general schema of what a particular age means.

“I’ll be 85 in June, but gosh, there are people here in their 90s who are just as sharp as can be. It’s amazing.”

“And the residents I’ve met are all friendly. We have a lot of older ones – older than 80 – and most of us don’t remember. You can tell a story one day and hear it the next day (laughs). Which is okay, I’m that way too.”

“You gotta think, when you’re 95 years old, you still have energy, but it doesn’t last long. There’s no use in beating yourself up for thinking you can be young when you can’t.”

Nurse Aide Relationships

In the introduction, I stated that in the study I hoped to learn more from residents about their experiences with CNAs who have been helpful to them in pursuing their personal goals and what resources have been helpful to them in engaging CNAs to create relationships in which the CNAs have helped them to pursue their personal goals. In response, residents responded with sparse and vague answers, when considered overall. The overarching themes pertaining to nurse aides are captured in the themes above; namely, that staff are generally seen as friendly which is
very helpful to the adjustment to the nursing home, but that turnover is frequent and undesired/unpleasant. Most residents alluded to wanting to reduce burden for these formal caregivers as well, such as not using the call button as often as they actually felt they needed or wanted to, or by making up their beds.

The questions regarding what, if anything, could assist residents in creating or maintaining relationships with staff (such as biographical information) was unanimously answered with some variation of “I don’t know”. This response was not altogether surprising, but as of yet there is not any extant published research that had posed this question to residents, although the idea of bridging the “information gap” between residents and staff has been suggested in conference presentations and articles. It was of interest to see if the residents in this sample had any ideas to offer, although in this sample, their spontaneous answer was uncertainty, suggesting this was likely not a topic they had considered before my asking during the interview.

Although they do not represent themes and certainly are not generalized sentiments from the sample at large, a few statements from residents did provide more illumination into the types of roles and relationships that can exist. For example, one female resident spoke of going outside, rain or shine as being her favorite thing to do but that she was unable to go outside by herself due to physical and setting limitations. This resident stated that she asked to be taken outside often enough that eventually a couple nurse aides started coming to her when they had time and asked if she wanted them to take her outside. This was experienced by the resident very positively, and exemplifies the sort of person-centered caregiving that I was interested in at the outset of the project. The resident did not know or was not able to articulate ways in which she influenced this relationship. This inexplicability was common across the responses given regarding interactions and relationships with nursing staff. Further analysis of these data was not
conducted as responses were too brief and vague to provide meaningful information. Residents may not have considered themselves as existing in a relationship with the nursing staff and/or had not reflected on the interactions explicitly.

**Contextual Variables**

**Depression.** The mean GDS-10 score for the sample (M = 3.5, SD = 2.4) was under the cut-off score of 4 suggesting likely clinical depression, although the scores ranged from 0 – 6. Half of the participants endorsed four or more of the items, suggesting they may be at risk for clinical levels of depression. This rate is consistent with estimates of depression in nursing home facilities across the country (Kramer, 2009). Depression scores were significantly associated with residents’ percentage of goal related meaning units ($r_s = -0.71$, $p < .05$) and the total number of goals mentioned ($r_s = -0.74$, $p < .05$). Scores on the depression scale were also strongly associated with the scores on the CASP-12 ($r_s = -0.83$, $p < .05$) and the AAQ-II ($r_s = .83$, $p < .05$). See Table 2 for a summary of these data.

These results suggest that a resident’s experience of depression does play a role in their goal-directed behavior; however, it is still such a small percentage of meaning units overall that were pertained to goals (approx. 16%), indicating that even for those with lower depression scores, goals were still a very minor part of their interviews. For example, for the four residents with a score below the GDS-10 cut off, this percentage rises only slightly to 24.7% of the meaning units (not of the entire interview).

**Quality of life.** The mean score for the CASP-12 for the sample was 32.13 (SD = 5.5) with scores ranging from 9-29. The theoretical range for this scale is 12-48, with higher scores indicating higher quality of life. There are not any standard cut off scores for this measure, but the average score for the sample suggests somewhat middling quality of life, as the average
answer was 2.68 out of a possible 4. CASP-12 scores were significantly associated with residents’ percentage of goal related meaning units \((r_s = .97, p < .01)\) and the total number of goals mentioned \((r_s = .93, p < .01)\). Scores on this scale were also strongly associated with the scores on the AAQ-II \((r_s = -0.97, p < .01)\). As described above in reference to depression, these results do indicate there is an interesting relationship between quality of life and goal setting and/or pursuit, however, the small percentage of meaning units mentioned regarding goals limit ability to interpret and understand this relationship in a more qualitative sense.

**Experiential avoidance.** The mean score for the sample on the AAQ-II questionnaire was 17.38 (SD = 6.8), with a range of scores from 9-29. The possible range of scores for this measure is 7-49, with higher scores indicating a greater tendency for experiential avoidance. Like the CASP-12, the AAQ-II is not a diagnostic scale and thus there is not set cut off points. Proposed cut off scores that may indicate a level of distress have been suggested to be between 24 and 28 (Bond et al., 2011), and thus the sample mean is well below this reference point and only two individual scores in or above this range. AAQ-II scores were significantly associated with residents’ percentage of goal related meaning units \((r_s = -0.95, p < .01)\) and the total number of goals mentioned \((r_s = -0.90, p < .01)\). Scores on the AAQ-II were also strongly associated with the scores on the CASP-12 and the GDS-10, as indicated above. Again, these scores are interesting in that they demonstrate a relationship between goal setting and/or pursuit and experiential avoidance. However, there is not much known about resident’s goal identification and pursuit to meaningfully interpret this relationship.
CHAPTER V
DISCUSSION

This dissertation set out to learn more about how care recipients—residents of nursing homes in this case—can promote and sustain their own autonomy using the underlying principles of Selection, optimization, and compensation (SOC) model on which Margret Baltes based her work with caregivers and types of dependency. In a small sample of residents living in a Midwest nursing home, we learned that having a goal—in the sense of intentionally-defined, behaviorally-driven goals—was not a construct around which residents were primarily oriented in an explicit way. Residents had important things to say regarding how they spend their time and what was important to them, but just a small fraction of their interviews involved goals, even when a very broad definition of goal was used.

This finding was perplexing at best, as the large body of research on SOC theory led me to expect to find goals, even if they were not identified verbally as a ‘goal’ by the residents. In some cases, this was true. For example, the interviews revealed that these residents had an implicit goal of minimizing the burden they perceive themselves as imparting onto others. Some further discussion on this follows in the section below. However, at worst, this finding was demoralizing—for me, the researcher. As someone who considers herself an advocate for older adults and for the perception and for treatment of older adults in a personhood-affirming manner, the finding of residents not being oriented around goals felt like exactly the opposite of what I felt would further this cause. These concerns are developed further later in this discussion. In the sections that follow immediately, I explore SOC theory as it pertains to nursing home residents,
the theory’s use of the term “goals”, the extent to which the theory may assume a goal orientation, and how methodology may have impacted the nature of the findings.

Resident Goal Selection and Pursuit

The first three goals of the present study were to: (a) learn about the personal goals of residents and how they pursue these goals in the nursing home; (b) explore the applicability of SOC principles to residents’ goal selection and pursuit; and (c) gather information on potentially relevant contextual conditions that may influence residents’ goal setting and pursuit (depression, quality of life, and experiential avoidance). What we learned from the interviews in response to the first question was that for this sample, goals were not of particular relevance, if they existed at all, in the way that they have been operationalized in the SOC literature. The majority of residents denied having goals when asked, and of the ones that did, the focus was on physical therapy-related goals. This was also evidenced by the small percentage of the meaning units that were related to goal identification or pursuit, again, using the operational definition from the SOC literature. Given the limited information pertaining to goals and how goals are pursued in the nursing home, ability to assess for the second question was severely limited. It cannot be said that SOC does not apply given this small sample, but neither do the data show strong evidence to support the use of SOC strategies by these residents at this time.

The more interesting findings pertain to the relationships among goals and the contextual variables of depression, quality of life, and experiential avoidance. These variables correlated strongly with the number of goals a resident had, as well as the percentage of meaning units a resident had related to goals. These variables correlated in the direction that would have been expected, given the literature, and it is somewhat remarkable the levels of statistical significance were so high given the small number participants. To the extent that the residents did have goals,
depression, experiential avoidance, and quality of life were related, strongly. However, these variables still do not account entirely for the lack of importance linked to explicit, operationalized goals. Considering only the residents who scored below the cut-off score on the depression scale, the percentage of meaning units related to goals rises, but still only makes up 25% of their total meaning units. Recall that this was an interview that set out learn about goals and that this percentage was of the extracted meaning units, not the interview in its entirety. The contextual variables were clearly related to the existence and pursuit of goals, but there appeared to be some other factors at play to produce such low relevance of goals.

One such factor that warrants consideration is the methodology. This study used a qualitative method in exploring SOC, wherein participants were asked both directly and indirectly about their goals and what was meaningful to them. These were mostly opened-ended questions, allowing the residents to related their own thoughts and experiences. This approach is not one that is typically used in SOC studies, as will be discussed more in the following section. What seems important to note in the current study is that the finding of residents having low goal relevance may be an artifact of this study using operationalized definitions with an open-ended, qualitative approach to data gathering, which may not have aligned well. In retrospect, and in consideration of the nature of the qualitative themes found, the way in which the data were analyzed for goals and the operational definition of a goal may have been overly narrow and limited, thus contributing to the finding that only 16% of the meaning units pertained to goals. Given that the data gathering was flexible and the data itself was qualitative, a more flexible definition and analysis may have better represented the relevance of goals to the residents. SOC is a well-supported theory in human development; however, qualitative research in the area
appears to be rare. It is of interest, given the paradoxes arising in this study, how such qualitative work may enrich the theory of SOC, as well as provide useful information for dissemination.

**SOC, Revisited**

Paul and Margret Baltes, Freund, and colleagues have published an impressive body of research on SOC and goals across the lifespan. Notably, these studies have focused on presenting individuals with a goal-related scenario (e.g., “if you were trying to quit smoking”) or identified participants with a known goal (e.g., members of a weight-loss group) and asking their input on the situation to see how the person may use selection, optimization, and compensation strategies to manage resources and dependency. This is to say that in these studies, the goals are imposed as part of the research design or serve as a criterion for participation. A nonexhaustive review of the SOC literature found no examples of studies without one of these two characteristics. Akin to my expectation at the outset of this study, there seems to exist an a priori assumption regarding the relevance and existence of goals among older adults. At the very least, there does not seem to be a solid explanation of the concept as it applies to the theory.

Paul Baltes in the American Psychologist says “development always has a specific set of targets (goals) of functioning” (Baltes, 1997) and then proceeds to describe language acquisition and cognitive development in infancy/childhood as examples of selection, from an ontogenetic perspective. In this example, then, he highlights goal-directed action that is automatic, built in through evolution, which could also include homeostasis, the beating of the heart, and digestion of food. These are not the kinds of goals targeted in this study, nor the types of goals that tend to occupy the SOC literature. The latter focuses on what may be categorized as volitional or behavioral goals. This differentiation is meant to draw attention to the broad and varying usage
of the term goal under SOC theory, by no less than the theory’s key author in the field’s flagship North American publication.

Tangentially, the autonomic development example brings up the question regarding the degree to which behavioral goals and goal strategies operate on a conscious, intentional level, as opposed to a more implicit and autonomic level. Given the methodologies described above, this has not been a major concern of SOC theory, and thus other published SOC studies in the literature have not addressed this question, or potential limitation, of the theory. Examples of SOC in action cited in the literature often describe goal setting, identification, and prioritization as though they are active, conscious efforts (unknown if they are based on real persons or theoretical). In this study, the majority of residents denied having goals; however, the coding and qualitative analysis revealed more goal-related content than they were able to acknowledge.

Research in the area of dual cognitive processes (implicit/explicit) may provide some useful information in the respect. Arriaga (2013) recently updated Interdependency Theory to include this perspective, as research has suggested implicit strategies that have not been consciously articulated play a larger role in our relationship behaviors than was known when the theory was formed. In thinking of SOC’s clinical applications, understanding the interplay of implicit/explicit goal-directed behavior would be helpful. Or perhaps by way of the third-wave behavioral therapies, SOC could benefit from incorporating mindfulness (Hayes et al, 2012 for example) into its theory to increase awareness of behaviors (goals and strategies) and their utility to the individual.

Additionally, although the SOC literature does include preventative and maintenance goals in their conceptualization, this did not seem to mirror the participant’s idea of a goal. In this study, residents denied having goals, and then subsequently described goals using other
language. The few goals that were described explicitly by residents were primarily promotive/achievement goals, often associated with physical functioning and physical therapy. It is suspected that this aligns with the use of ‘goal’ language in physical therapy. The qualitative analysis found goals that were primarily associated with prevention, maintenance, and avoidance. Both future work in SOC and in applied work with this population should note that the term ‘goal’ may have a specific—and narrow—connotation as this can impact how we ask questions and interpret responses.

The results of this study are not sufficient to say that SOC theory does not apply to nursing home residents, given the small and homogenous sample and the limited investigation methods (e.g., no behavioral observation or contact with collateral sources). The study does, however, raise important questions regarding the assumptive bases of SOC theory that may potentially affect the theory’s application to nursing home residents, namely the assumptive stance of explicit goals. Residents in this study typically did not think in terms of goals, and to the extent that goals were identified in their interviews, they only comprised a small part of what the residents said in their interviews. In an effort to listen to what was being communicated in the rest of the interviews, the interviews were analyzed qualitatively in an effort to hear what some members of this understudied population were imparting about their experiences. A discussion of these qualitative findings follows.

**Qualitative Findings**

The qualitative themes that emerged from the interviews give a snapshot of the aspects of their experience that were important or relevant to residents. Many of these themes resonate or align with existing literature in the field of aging and person-centered care and beyond.
Acceptance. Accepting of one’s circumstances—particularly the need to be in a restrictive care setting—was the most salient theme across the interviews. In the process of moving into a LTC facility, Heliker and Scholler-Jaquish (2006) also found a theme they called “Making the Best of It”, which overlaps considerably with the theme in the present study as it describes the process by which residents saw themselves as adjusting to life in the nursing home, “learning the ropes”, and finding ways of maximizing their experience given this set of “ropes”. Roberts and Bowers (2015) describe “Having a Life” and “Creating a Positive Atmosphere” as two “ways of living” in the nursing home. Although these themes do not sound overlapping with acceptance, the descriptions functionally involve an acceptance of one’s circumstances, coupled with strategies for maintaining one’s sense of self and again maximizing experiences within the accepted parameters of the situation, and so are related in a functional sense.

In this current study, I opted to use the term ‘acceptance” because it seemed to succinctly and accurately capture the process as shared by the residents and also because it connects with the concepts in the third-wave behavioral psychotherapies, such as Acceptance and Commitment Therapy (Hayes et al., 2012), that have a precise definition of acceptance as being distinct from a passive resignation. This type of acceptance involves a relinquishing of struggle with aspects that are beyond one’s control and leads to a flexible approach to living in alignment with one’s values. This seemed to me to be very applicable to what the residents described as their process of adjusting, and moving from resentment and anger to acceptance and, for some, even appreciation of living in this setting.

Burden minimization. This theme is not one that has been found in the literature. Reviewing the limited research on reasons why a move to LTC is made, the focus tended to be on the caregiver’s or family’s reason to place the individual in a LTC facility. One study of 100
residents found that only 4 made the decision themselves to enter the nursing home (Scocco, Rapattoni, & Fantoni, 2006). Certainly the decision to move into LTC is a complex and highly varied situation for the individual and their family. Residents in the current study often felt that they made this decision, and reflected that a key determinant in this decision was wanting to avoid being a burden on their children or others in the social networks that would provide them with care and assistance. It is of interest if their rationale has adapted over time, with this notion of reducing burden perhaps being helpful to the residents in resolving any psychological conflicts (e.g., cognitive dissonance) and increasing acceptance regarding their living situation.

However, the decision to move into long-term care was only one aspect of this theme; additionally, evidence of residents seeking to avoid being a burden both on staff and on family while in the nursing home was found. This is an interesting finding for several reasons. The first is that this appears to be a novel finding, which may underscore the paucity of research on resident’s role in person-centered care and culture change. Typically person-centered care is viewed as something that the staff and facility do, excluding how residents’ behavior may influence this practice (Runyan, 2012). Secondly, while seeking to minimize perceived burden on staff could be motivated by the resident’s attempts to maintain a sense of their own agency or identity, it could also point to a consideration of the nursing staff. Given the high price of LTC, which several residents mentioned in their interviews, it would also be reasonable that residents not feel obligated to minimize the work required by the staff. This theme then raises the possibility that although residents may not describe themselves as having a relationship with staff, they act in ways that support a consideration for staff and a “tending” of the rapport between them.
**Autonomy.** This theme resonates with Margret Baltes’ work on dependency (1999; with Neumann & Zank, 1994), which emphasizes an adaptive dependency that builds agency and autonomy in certain areas. Where the descriptions attained here may differ with Baltes’ thoughts regards whether residents prioritize the areas that they would like to exercise autonomy, or whether it is simply the ability to act independently on one’s own behalf, as done for most of the person’s life, that is of importance. Within the person-centered care/culture change model, efforts are made to ensure that residents receive help with the daily activities that are necessary, but not more than what is necessary to try to avoid fostering dependency. The descriptions provided by the residents here underscore the importance of allowing the residents room to act autonomously, if appropriate to care needs and resident preferences, regardless of extra time added to care routine. It is of interest going forward if the psychological benefits of acting autonomously could be enhanced through residents selecting behaviors most important to their sense of self, as Margret Baltes encouraged in her work.

**Lack of specifically-defined goals.** Across the interviews, there was a notable lack of specific goals as perceived by the residents, with most straight-forwardly rejecting the idea of goals at this stage of their life altogether. This finding contrasts with the existing literature on goals in older adulthood. Most of the research on goal pursuit among older adults tended to be in the form of comparison studies looking for changes in goals commiserate with changes in development (e.g., Bauer & McAdams, 2004; Sheldon & Kasser, 2001). None of the literature found on goals in older adulthood were specific to nursing home residents, which may account for the discrepant findings. Older adults are the most heterogeneous age group, in terms of health (Lowsky, Olshansky, Bhattacharya, & Goldman, 2013) and social factors (Gergen & Gergen, 2000). It is possible that the research described above is more pertinent during younger-old
stages, when individuals are living in the community or at the independent living level of care. The minimal goal related content in the interviews may also have been impacted by depression levels, as described above. It is of interest to see if this finding would be replicable with residents of more diverse settings and demographics. If it is replicable over a broader sample of nursing home residents, it would hold implications for the application of SOC theory to this population.

**Prevention/avoidance goals.** Although in most cases, residents did not perceive or describe explicit prevention or avoidant goals, a theme acknowledging their worst fear(s) for themselves emerged across the sample. Future fears pertaining to physical disablement and dementia/cognitive impairment were particularly salient. Existing literature in the area of possible selves in aging has documented the cognitive decline feared self (Dark-Freudeman, West, & Viverito, 2006) as well as in physical and functional health (Smith & Freund, 2002). This latter study also found that older adults described hopeful possible selves, which was not a finding that was replicated in this study. Fears related to declines were described by residents as arising in part from their interactions and observations of residents in the facility who currently had such declines. In terms of culture change, providing information to residents on decline and proactive ways to mediate risk factors may be helpful. Also, offering increased opportunities for engagement with other high functioning residents, including those in assisted and independent living, may be interesting options to explore.

**Importance of relationships.** Relationships of nursing home residents have been studied in a number of ways. In the literature review of this study, work regarding the types of relationships between residents and staff that have been observed were highlighted. This background is of limited applicability to these findings, which center more closely on residents relationships with friends and family outside the facility.
That residents placed the greatest value on kin relationships is in alignment with socioemotional selectivity theory (Carstensen et al., 1999), which predicts that people’s social goals will tend towards maintaining or deepening existing relationships rather than expanding one’s social network. However, other research adds more variability to this picture. Powers (1991) developed a typology of different social networks, based on the number and type of individuals residents described having friendships with, and the degree of closeness within these relationships. She also examined how each network type impacted resident’s willingness and desire to form new relationships within the facility. For instance, residents with kin-centered networks often resisted forming relationships with others within the facility, choosing to focus on maintaining existing relationships. Clustered network types, a mix of friendships within and outside of the facility organized in “cliques”, and balanced networks, marked by a wide distribution of relationships, were both more likely to be motivated for creating new relationships with staff and other residents at the facility.

Regarding the relationships inside the nursing home, it is interesting to note that resident-resident relationships were not mentioned. This is in contrast to Roberts and Bowers (2015) observations, which noted that the most meaningful relationships residents had inside the nursing home were with other residents, not with staff. It also raises the question of whether continued focus on enhancing resident-staff relationships is as important as developing and assisting residents in finding ways of connecting with their kin relationships. Residents in this study noted a shift in their kin relationships, particularly in how contact is maintained, given residents increasing limitations in mobility. In the spirit of culture change, including efforts to aid residents in living in accord with their valued domains, and in light of the evidence provided by Powers (1991), it seems that both pursuits could be helpful and relevant. Recent interventions
incorporating technology in nursing homes to help residents maintain kin relationships have demonstrated promising results (e.g., Tsai & Tsai, 2011).

**Time.** Roberts and Bowers (2015) also noted time as a salient dimension of the life in the nursing home, particularly that it was lived in a different way than in previous stages of their residents’ lives. Both Roberts and Bowers (2015) and the present study captured a seemingly impossibility of being busy and having too much time, simultaneously. It is of interest whether the feeling of having too much time or being bored was a reflection of not filling time in a meaningful way, or the ways that residents would like to. Another consideration, again derived from both this study and Roberts and Bowers (2015) is that much of the residents energy is expended doing basic activities, leaving them with time, but minimal energy to use the time in enjoyable ways. There may exist a gap between doing things for the sake of being busy and doing things because they have meaning/purpose. More exploration on how to maximize constructive and meaningful passage of time could help to improve resident’s quality of life.

**Neutrality.** Resident’s responses revealed a pervasive perception of neutrality, evidenced by balanced descriptions (e.g., the nursing staff are excellent, but have frequent turnover) or depiction of their daily experience as mundane, although not pejoratively. This is an interesting theme, given the positivity bias common among older adults (Charles, Mather, & Carstensen, 2003). The positivity bias describes an emotional regulation strategy common among older adults wherein less weight is attributed to negative experiences and stimuli. It does not describe a lessening frequency or intensity of negative experiences, but rather a difference in the way these are held on to or allocated cognitive resources. This is not seen in regard to stimuli that are perceived as positive, resulting in greater awareness of and memory of positive stimuli. It is beyond the scope of this dissertation to tease apart whether the positivity bias was less influential
in this situation (and why) or if neutrality noted in this study was achieved due to influence of this positivity effect.

One study that may be relevant both to this theme of neutrality as well as to acceptance is by Mogilner, Kamvar, and Aaker (2011). They found that the meaning of happiness shifts systematically over time, with younger adults tending to find happiness in excitement and novelty, whereas peacefulness became more important as one aged. Although neutrality is not necessarily equated with peacefulness, it seems that this may be related to resident’s emotional experience living in the nursing home.

**Setting/environment effects.** Roberts and Bowers (2015) similarly had reports from residents regarding the constraints of this environment, particularly in having little choice in daily operations (e.g., roommate choice) and in reduced freedom (e.g., needing to notify staff before leaving building). This setting is very different for the individuals from their previous living settings in the level of care needed and the reduced ability to manipulate their environment, including leaving it. Although giving residents increased choice and control is a primary component of person-centered care/culture change, the findings from these studies suggest there is still work to do in optimizing residents’ experiences.

However, this study also found that, in some scenarios, the setting offered benefits. While this balancing of setting effects could be considered more evidence of the neutrality theme, it seemed to be a fairly novel finding in this area of research. The research on how the setting of the nursing home impacts residents is heavily negative in tone, emphasizing the constraints and limitations. It was interesting that residents in this study cited those, but also found things to appreciate about their situation that is just as much a part of the structure and level of care as the
negatively-perceived aspects. This information could be helpful to individuals and caregivers considering a move to a LTC facility.

**Positive coping.** Residents spoke of engaging in activities that could be consider coping strategies—coping with anxiety, boredom, fear, etc. Roberts and Bowers (2015), in their theme of “passing time” discuss use of activities for a similar purpose. Several residents in this study mentioned religious activities and/or beliefs as being a source of comfort. Koenig has accumulated a sizable body of research examining the role of religiosity and spirituality in mental health (2009, for a review). It is unknown how resident’s use of religion may have affected their mental health; however, it was clear that the residents felt these were positive and useful ways of managing their situation.

**Age as referent.** Residents spontaneously reported their chronological age in an apparent social comparison. Age was used as a measure of self against other, especially in domains of physical and cognitive functioning. This type of comparison seems to fit well with Festinger’s (1954) social comparison theory, which describes one way that individuals make judgements regarding their abilities. Under this theory, people can enhance their sense of self through comparing one’s own abilities with those of others who are functioning at a lower level, such as other residents at the facility with significant cognitive impairment. In the case of upward comparisons, comparing one’s situation with someone they consider to be better off can decrease self-esteem, or provide motivation for improvement. Comparisons may be made in regards to actual people whom the resident knows or has known, such as other residents with dementia at the facility or one’s mother. In other cases, one’s functioning may be compared to a fictive standard, such as saying that one is “doing well for being 85”, although there are not any known norms for typical functioning at 85-years-old available. Comparisons in this study were typically
downward in nature (e.g., “I’m doing well compared to others”), and thus may be related to emotion regulation and the positivity bias (Charles et al., 2003), wherein residents draw on strategies that allow them to neutralize negative thoughts and feelings.

**Goals v. Values**

These themes provide some interesting data on the residents’ experiences living in a nursing home. Moreover, they demonstrate two important factors. The first is that residents did have some implicit goals, minimizing the burden they perceive themselves as imparting onto others. Secondly, arguably importantly, the themes exhibit that these residents had things they wanted to talk about that they cared about and considered important. These did not fit into the definition or connotation of a “goal”; however, as they were important to residents, it may be appropriate to consider them as values. In some clinical psychological theories, goals and values are differentiated (Hayes et al., 2012). Values are considered what a person finds meaningful in their life; they are more like domains or general directions. They vary by individual and can evolve over time. Most individuals have multiple values. Balancing and, at times, prioritizing values is a critical aspect of managing mental health and quality of life. Goals, on the other hand, are concrete, potentially achievable objectives. Within acceptance and commitment therapy (Hayes et al., 2012), positive outcomes occur when people are able to define their values and commit to goals that move them towards their valued ends. For example, someone may hold the value of being a good Christian (value) and one way of doing this is through attending church (goal) or reading the Bible weekly (goal).

Given the content of several of the themes (i.e., importance of relationships, positive coping, acceptance, autonomy, burden minimization) values appear to be a more appropriate construct for this sample than that of goals. However, what is unknown is how this alteration
may or may not affect SOC theory. As mentioned several times, SOC has not clearly defined what a goal is, except to invoke Emmons (1996) definition of a “desired state that people seek to obtain, maintain, or avoid”. In addition to lacking an operational component, this definition is broad and sufficiently vague to encompass both values and goals. Notably, it could be intentionally broad and vague. Distinguishing between goals and values has been helpful in promoting flexibility in pursuing values (Hayes et al., 2012). In a similar way, SOC considers strategizing resources using the three components (selection, optimization, and compensation), but with lesser focus on meaningful behavior. Perhaps SOC theory could apply to values as usefully as it has been applied to goals, or perhaps SOC theory could be enriched by considering this goals/values distinction in the selection stage. These theoretical questions are beyond the score of this dissertation. However, it seems an important question to raise as further exploration of this distinction and its potential role in influencing the basis or implementation of SOC theory may be warranted.

Implications for Personhood and Person-Centered Care

In the opening of the discussion, I disclosed my initial discomfort and disdain with the finding that goals were not particularly important or relevant for these residents. In revisiting the roots of person-centered care, this finding was of little importance. Person-centered care was originally developed in working with dementia patients in order to increase the humanity of their care by illuminating the ways that cognitively-impaired persons could still have connection with others and maintain meaning in their lives (Kitwood, 1997). As Sabat and Harre (1994) implore, it is important to “assume the person is not bereft of the ability to attach meaning to his or her circumstances” (p. 158), rather than assume the opposite. In thinking about the findings here in light of this background, whether or not they had explicitly-defined goals and behavioral plans to
implement them does not reflect on the degree or nature of their personhood. What they told me in their interviews is that they are attaching and creating meaning, they have values, such as relationships, and they are seeking to adjust and accept their situation in the best way they can. Framed in this way, the lack of goals or the small importance allotted to them perhaps signifies a more present-focused orientation, a finding that has been documented among older adults previously (Carstensen et al., 1999), as well as a past-focused orientation in that they find their identity in the stories from their personal history (Heliker & Scholler-Jaquish, 2006). Moreover, rather than negating the finding of the low relevance to goals (i.e., 16% of meaning units), this creating of meaning and endeavoring to adapt and accept may represent a more flexible, nuanced, and developmentally-appropriate proxy for the concept of ‘goals’. Applying this definition, the interviews were heavily goal-related. This is a less behaviorally-defined goal, but it may better capture the emotional and existential developmental stage and befit a qualitative methodology.

Residents’ interviews were remarkably similar in the way they unfolded; interview prompts regarding goals and experiences led to residents speaking candidly about who they are, their history, their struggle to adjust to this setting and developmental stage, their beliefs, and their values. Although this study learned less about resident’s goal selection and pursuit than intended, it did reveal several common themes across the sample concerning residents’ real challenges, struggles, and desires. It revealed that while, for this sample, goals (operationally-defined and explicitly-known) were not of high priority, stories, experiences, and values were. One suggestion that arises from this experience of talking with residents involves the idea of expanding the idea of person-centered care to include not only catering residents’ preferences for tasks, but also understanding what is meaningful to the residents. As Heliker and Scholler-
Jaquish (2006) similarly recommended following their study of interviewing residents immediately after being admitted to a nursing home, consumer-driven care should begin with hearing their stories; staff that are able to hear and understand what matters to residents are better able to interpret a plan of care that is meaningful—and thus person-centered. I echo this sentiment, and add that the asking and seeking to understand residents experience should occur at admittance, and also every several months as it seems that there are various stages of accepting/adjusting to living in this drastically different setting.

Crafting a plan of care that reflects both the resident’s preferences and values would not only be a high-level of person-centered care, it could also fit with Margret Baltes’ idea of an adaptive type of dependency wherein the care recipient receives help as needed in areas that are of lesser importance to the individual, allowing the resident to have greater resources to focus on more valued behaviors. In order to create such a plan, the resident would need to be actively engaged and have the opportunity adjust the plan as his/her needs and or experiences warrant.

This idea strikes a balance between being caregiver focused, as Baltes was, and being exclusively interested in the resident, as this study was. For residents who may have cognitive impairments, a similar plan could be developed with collateral input from family or other relevant social contacts. The goal of such a practice would fit with the culture-change model espoused by facilities as well as the emergent theme above regarding autonomy; allowing residents to maintain autonomy within a dependency (i.e., caregiving) frame, in a manner that aligns with resident’s values, would seem to be the highest order of person-centered care from a facility standpoint.

Given that residents appeared to enjoy the interviews and were willing to disclose their stories to someone they had just met, the other suggestion made by Heliker and Scholler-Jaquish
(2006) may also be supported by this study. They suggested that facilities create opportunities for residents to share their stories and to listen to others. Such a group, focused more on meaningful sharing than entertainment (e.g., bingo, movies) or creativity (e.g., crafts), could provide a space for residents to speak, to be heard, and to create new meaning and new relationships. This experience could also include some staff, who would also be encouraged to share their experiences, engaging in a reciprocal process of telling and listening as the individuals may be able to come to know one another, finding common ground, and building community.

**Relationships with CNAs**

The final two research questions involved residents’ interactions with CNAs, and how these interactions may relate to their goals. The first of these questions was to explore residents’ experiences with CNAs who have been helpful to them in pursuing their personal goals. The second of these questions was to learn about residents’ perspectives on what resources were helpful to them in engaging CNAs to assist them in pursuing their personal goals (e.g., biographical information about the CNAs, skills for communicating, more opportunities to share information, etc.) The first obstacle in exploration of these questions again stems from the assumption that residents would have explicit goals. Given this lack, it was difficult to understand how residents may draw on the caregiving relationship as a strategy for goal pursuit.

The second barrier encountered in attempting to learn about these research questions was that the residents, all cognitively intact, had difficulty in articulating or expressing thoughts about relationships with aides. For example, broad, open-ended questions were typically met with answers such as “I don’t know”, “I can’t think of anything”, or “probably”. As individual interviews were the primary source of data, a heavy reliance was afforded to resident awareness
of relationships, which did not seem to be warranted across the sample. It is worth reiterating that residents may have been unable, unaware, or unwilling to make judgments about relationships with staff. Although efforts were made to differentiate the interviewer from the facility, it is possible that residents did not feel comfortable to speak candidly. Moreover, given what we know about older adults emotional regulation, specifically the positivity bias (Carstensen et al., 1999; Charles et al., 2003), residents may not focus on or recall negative aspects of their experiences.

Residents in this study tended to speak generally, noting a general satisfaction with the nursing staff, many noting that some staff members were more friendly than others. In thinking of the typologies of caregiving relationships described in the literature review of this study, the minimal descriptions of residents tended to fit with Bowers et al. (2003) categories of care-as-service and care-as-comfort. Very few residents spoke of their interactions with the nursing staff in a care-as-relating manner. Roberts and Bowers (2015) found in their study of interviewing residents, although relationships in the nursing home were found to be important to residents, relationship development was more unintentional, arising through residents simply trying to have the best experience they could in their current circumstances. Coleman and Medvene (2013) discovered at the outset of their study evaluating a person-centered caregiving intervention for CNA that residents generally did not consider themselves to be in a relationship with the CNAs. However, as a result of the skillful intervention, the residents did become closer to the CNAs and expressed interest in them as people. This finding fits with the current finding of residents having little to say about relating to CNAs in an interpersonal, rather than task-focused way, and also suggests that this initial lack of reflection and/or awareness should not be interpreted as
residents generally not wanting close relationships with staff—for the intrinsic value of having a 
close relationship and/or as a means of increasing engagement with other meaningful domains.

There is a growing body of research exploring the types of relationships that residents 
and staff have in the nursing home and the types of relationships that residents prefer (Bowers et 
al., 2001; Brown-Wilson et al., 2009; Heliker and Nguyen, 2010; White et al., 2008) but few have 
attempted to explore the process by which residents develop relationships. The current study 
desired to learn about what resources residents use to develop relationships, how these 
relationships may have been helpful to them in living out what is important to them, and what 
resources residents perceived as helpful to them in managing their lives in this setting. Although, 
residents had little to say in regards to these questions when asked in this open-ended way, it is 
believed that this is still an important aspect of person-centered care to be further research and 
developed. Giving more agency to the residents who desire it, including in relationship 
management, should be a focus of future research in person-centered care.

Although this dissertation has posited interpersonal connecting as one of the highest 
forms of person-centered care, it is important to remember that the whole premise is on 
understanding and incorporating the individual’s preferences and values. The literature 
documents that not all residents want close relationships or even friendly relationships with 
others in the nursing home, and this should be respected. However, those residents who do desire 
to know and be known should also have opportunities and resources to help them to this end. 
Further research in learning what resources could be helpful to residents who want interpersonal 
connections with staff is needed.
Limitations

Except for demographic information, data were exclusively self-report and all were gathered in a single meeting. It is possible that residents may have had more information to impart on goals and relationships if multiple, short interviews were used, allowing for time reflecting between interviews and increased comfort with interviewer. Additionally, involving others in the residents’ social networks may have helped to get a sense of the types of goals that residents had prior to their admittance to the nursing home, and thus sense of how goals have changed as the circumstances have changed.

This was a very small study with a very homogeneous sample. All residents lived in the same nursing home, which purports to promote person-centered care. Lastly, the sample was not only small it was restricted to residents who were considered cognitively intact based on cognitive impairment screening. However, some degree of cognitive decline is more common among nursing home residents, as this is the setting of greatest assistance. The cognitive criterion was included for methodological purposes rather than due to assumptions that individuals with cognitive impairments would or could not have goals and values. This lack of diversity poses substantial limits to generalizability.

Future Directions

A recommendation for further study includes incorporating a similar approach with a more diverse group of residents to determine the generalizability of the lack of goal relevancy reported here to different settings and populations of residents. Another area for further exploration includes SOC’s assumption of intentional goals with reference to residents of long-term care facilities. However, it is of interest how younger individuals over 65-years-of-age might respond to similar open-ended questions pertaining to goal selection/pursuit. This may
help to shed light on how the lack of interest in explicit goals found in this study is be related to the stage of life a nursing home resident is living and their perception of time as limited rather than expansive (Carstensen et al., 1999) versus how much this may be a factor of individuals across the lifespan having more implicit goals. Finally, as noted above, it is of interest how the values/goals distinction may affect and potentially enrich the theory’s application, particularly with populations for whom values, but not concrete goals, seem to be more pertinent.

Concluding Thoughts

This dissertation set out to learn about the goals of nursing home residents, an understudied population in general and especially as active agents in their physical and psychological worlds. In asking about goals qualitatively, several paradoxes arose, such that residents denied having goals, yet provided descriptions that indicated they have values and goals, are creating and attaching meaning, and endeavor to live the best they can given their circumstances. This led to several observations on methodological implications, operationalization, goal language/connotation, and the difference between goals and values. Determining the applicability of SOC model to this population was hindered by these issues. However, the emergent themes demonstrate that nursing home residents do have goals, such as striving for acceptance and minimizing burden. Further qualitative research on this subject would benefit from a more flexible and developmentally-sensitive operationalization of goals and the means through which they are pursued in the setting of a nursing home.
REFERENCES


Runyan, A. M. (2012). *Nursing home residents’ role in person-centered care*. (Unpublished manuscript). Wichita State University, Wichita, KS.


Tsai, H. H., & Tsai, Y. F. (2011). Changes in depressive symptoms, social support, and loneliness over 1 year after a minimum 3-month videoconference program for older nursing home residents. *Journal of Medical Internet Research, 13*(4), e93. doi:10.2196/jmir.1678


APPENDIX A

INTERVIEW

Express Interest and Convey Purpose

- I am very interested in learning about how you decide which things in life are important for you and how you go about accomplishing what you want in life. I’m interested in your experiences and what makes your time here worthwhile because I plan to work in nursing homes, and I’m hoping your experiences can help me and others to be helpful to nursing home residents.

Establish Rapport and Learn Contextual Factors

- Could you tell me about yourself?
  - Possible probes: length of time in nursing home, what brought them to nursing home, family/occupational history
  - What was the transition to the nursing home like?

Learn about Goals

- Could you tell me about what is important to you?
- Do you have any goals?
  - If resident says “I don’t know” or “I don’t have any”: Ask, “What is important to you?”
  - Other possible probes: What kinds of goals did you have before you entered the nursing home? How are your goals now similar/different to the goals you had before you entered the nursing home?

Learn about Goal Pursuit

- How do you pursue your goals
• APPENDIX A (continued)

• Does being here make a difference in how you work towards your goals?
  o Possible probe: Can you give me an example of how you try to work on
    (reference specific goal)?

Explore CNA as Compensatory Function

A: You mentioned your CNA earlier. Does s/he help to achieve your goals? Can you tell
me about that?

B: You mentioned how (someone other than CNA) helps you to achieve your goals.
I’m curious if any of the CNAs here help you with your goals?

C: You have told me about how you work on your goals, but I’m wondering if there
has ever been a time when you felt like a CNA helped you to pursue your goals?
APPENDIX B

PENCIL-AND-PAPER QUESTIONNAIRES

CASP-12

Here is a list of statements that people have used to describe their lives or how they feel. We would like to know how often, if at all, you think this applies to you.

1. My age prevents me from doing the things I would like to do

<table>
<thead>
<tr>
<th>Often</th>
<th>Sometimes</th>
<th>Not often</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

2. I feel that what happens to me is out of my control

<table>
<thead>
<tr>
<th>Often</th>
<th>Sometimes</th>
<th>Not often</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

3. I feel left out of things

<table>
<thead>
<tr>
<th>Often</th>
<th>Sometimes</th>
<th>Not often</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
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<td>4</td>
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</tbody>
</table>

4. I can do the things that I want to do

<table>
<thead>
<tr>
<th>Often</th>
<th>Sometimes</th>
<th>Not often</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
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<td>4</td>
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</tbody>
</table>
5. Family responsibilities prevent me from doing what I want to do

<table>
<thead>
<tr>
<th>Often</th>
<th>Sometimes</th>
<th>Not often</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
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<td>4</td>
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</tbody>
</table>

6. Shortage of money stops me from doing the things I want to do

<table>
<thead>
<tr>
<th>Often</th>
<th>Sometimes</th>
<th>Not often</th>
<th>Never</th>
</tr>
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<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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</table>

7. I look forward to each day

<table>
<thead>
<tr>
<th>Often</th>
<th>Sometimes</th>
<th>Not often</th>
<th>Never</th>
</tr>
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<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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</table>

8. I feel that my life has meaning

<table>
<thead>
<tr>
<th>Often</th>
<th>Sometimes</th>
<th>Not often</th>
<th>Never</th>
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<tr>
<td>1</td>
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</table>
9. On average, I look back on my life with a sense of happiness

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<tr>
<th></th>
<th>Often</th>
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<th>Not often</th>
<th>Never</th>
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<td>1</td>
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</table>

10. I feel full of energy these days

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<tr>
<th></th>
<th>Often</th>
<th>Sometimes</th>
<th>Not often</th>
<th>Never</th>
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<td>1</td>
<td>2</td>
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</table>

11. I feel that life is full of opportunities

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<th></th>
<th>Often</th>
<th>Sometimes</th>
<th>Not often</th>
<th>Never</th>
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<td>1</td>
<td>2</td>
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</table>

12. I feel that the future looks good for me

<table>
<thead>
<tr>
<th></th>
<th>Often</th>
<th>Sometimes</th>
<th>Not often</th>
<th>Never</th>
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</tbody>
</table>
APPENDIX B (continued)

AAQ-II

Below you will find a list of statements. Please rate how true each statement is for you by circling the number next to it. Use the scale below to make your choice.

1. My painful experiences and memories make it difficult for me to live a life that I would value.

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never true</td>
<td>Very seldom true</td>
<td>Seldom true</td>
<td>Sometimes true</td>
<td>frequently true</td>
<td>Almost always true</td>
<td>Always true</td>
</tr>
</tbody>
</table>

2. I’m afraid of my feelings.

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<th>6</th>
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</thead>
<tbody>
<tr>
<td>Never true</td>
<td>Very seldom true</td>
<td>Seldom true</td>
<td>Sometimes true</td>
<td>frequently true</td>
<td>Almost always true</td>
<td>Always true</td>
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</table>

3. I worry about not being able to control my worries and feelings.

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<th>5</th>
<th>6</th>
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<tbody>
<tr>
<td>Never true</td>
<td>Very seldom true</td>
<td>Seldom true</td>
<td>Sometimes true</td>
<td>frequently true</td>
<td>Almost always true</td>
<td>Always true</td>
</tr>
</tbody>
</table>
4. My painful memories prevent me from having a fulfilling life.

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<tr>
<th></th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Never true</td>
<td>Very seldom true</td>
<td>Seldom true</td>
<td>Sometimes true</td>
<td>frequently true</td>
<td>Almost always true</td>
</tr>
</tbody>
</table>

5. Emotions cause problems in my life.

<table>
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<tr>
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<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Never true</td>
<td>Very seldom true</td>
<td>Seldom true</td>
<td>Sometimes true</td>
<td>frequently true</td>
<td>Almost always true</td>
</tr>
</tbody>
</table>

6. It seems like most people are handling their lives better than I am.

<table>
<thead>
<tr>
<th></th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Never true</td>
<td>Very seldom true</td>
<td>Seldom true</td>
<td>Sometimes true</td>
<td>frequently true</td>
<td>Almost always true</td>
</tr>
</tbody>
</table>

7. Worries get in the way of my success.

<table>
<thead>
<tr>
<th></th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Never true</td>
<td>Very seldom true</td>
<td>Seldom true</td>
<td>Sometimes true</td>
<td>frequently true</td>
<td>Almost always true</td>
</tr>
<tr>
<td></td>
<td>Question</td>
<td>YES</td>
<td>NO</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>--------------------------------------------------------------------------</td>
<td>-----</td>
<td>-----</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Are you basically satisfied with your life?</td>
<td>YES</td>
<td>NO</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Have you dropped many of your activities and interests?</td>
<td>YES</td>
<td>NO</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Are you in good spirits most of the time?</td>
<td>YES</td>
<td>NO</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Do you feel happy most of the time?</td>
<td>YES</td>
<td>NO</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Do you feel helpless?</td>
<td>YES</td>
<td>NO</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Do you prefer to stay in your room rather than going to events or trying new things?</td>
<td>YES</td>
<td>NO</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Do you feel pretty worthless the way you are now?</td>
<td>YES</td>
<td>NO</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Do you feel full of energy?</td>
<td>YES</td>
<td>NO</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Do you think that most people are better off than you are?</td>
<td>YES</td>
<td>NO</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Do you often get bored?</td>
<td>YES</td>
<td>NO</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### APPENDIX C
### MODIFIED GOAL CODING CATEGORIES

<table>
<thead>
<tr>
<th>Category</th>
<th>Description/Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Achievement/Gains</td>
<td>Speaks of working toward accomplishing a new goal, or towards working on reaching a greater level/degree in a domain with proficiency already. E.g., “I hope to go outdoors because I love to go outdoors. So I hope to find a nurse who has time to take me out.”, “I’m working on learning to walk, because I can’t walk right now.”</td>
</tr>
<tr>
<td>2. Maintenance</td>
<td>Resources and values are aligned with maintaining a level of functioning already achieved. Can include using different strategies, as long as the goal is to maintain status quo, not increase/deepen. E.g., “I’d just like to be able to take care of myself as much as I am doing now.”</td>
</tr>
<tr>
<td>3. Avoidance/Prevention</td>
<td>Goals are negatively phrased, seeking to avoid a feared/undesired situation. E.g. “I would hate to be in a wheelchair or in bed, completely unable to walk”, “I want to die before I lose my mind”</td>
</tr>
<tr>
<td>4. Goal Pursuit</td>
<td>A behavior perceived by the individual as a means or strategy for moving the resident towards their desired goal. E.g., “I try to read a lot and watch so-called educational things on TV. I do not watch soap operas”</td>
</tr>
<tr>
<td>5. Goal Progress</td>
<td>Content that describes or pertains to progress of the goal or the pursuit strategies. “I’m not able to walk on my own yet, but I can tell that I’m getting stronger, getting closer”</td>
</tr>
</tbody>
</table>

Coding notes:
GOAL DEFINITION: A state that is desired to avoid, maintain, or re/achieve

Do not code denial of goals as an occurrence. For instance, saying “I don’t have any goals” or “I’ve given up my goals” does not count towards the number of units related to goal selection or pursuit and should be coded 0.
### APPENDIX D

### RESULTS TABLES

Table 1

*Demographic Characteristics of Residents*

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>(N = 8)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>25%</td>
</tr>
<tr>
<td>Female</td>
<td>75%</td>
</tr>
<tr>
<td>Age ( M (SD) )</td>
<td>88.3 (4.9)</td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>100%</td>
</tr>
<tr>
<td>Length of Stay in NH</td>
<td></td>
</tr>
<tr>
<td>&lt;1 year</td>
<td>50.0%</td>
</tr>
<tr>
<td>1-3 years</td>
<td>37.5%</td>
</tr>
<tr>
<td>3-5 years</td>
<td>0.0%</td>
</tr>
<tr>
<td>&gt;5 years</td>
<td>12.5%</td>
</tr>
<tr>
<td>BIMS Score ( M (SD) )</td>
<td>14.63 (1.6)</td>
</tr>
</tbody>
</table>

*Note: BIMS = Brief Interview for Mental Status (possible scores 0-15), with lower scores indicating greater cognitive impairment.*
APPENDIX D (continued)

Table 2

Summary of Spearman’s rho Intercorrelations, Cronbach’s alphas, and Descriptive Statistics for Goals and Scores on the CASP-12, AAQ-II, and GDS-10

<table>
<thead>
<tr>
<th>Measure</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Goal Units (%)</td>
<td>--</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Total goals (#)</td>
<td>.93**</td>
<td>--</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Re/achieve goals (#)</td>
<td>.64</td>
<td>.51</td>
<td>--</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Maintain goals (#)</td>
<td>.52</td>
<td>.74*</td>
<td>-0.15</td>
<td>--</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Prev/Avoid goals (#)</td>
<td>.71</td>
<td>.77*</td>
<td>.30</td>
<td>.52</td>
<td>--</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. CASP-12</td>
<td>.97**</td>
<td>.93**</td>
<td>.64</td>
<td>.51</td>
<td>.70</td>
<td>.75</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. AAQ-II</td>
<td>-0.95**</td>
<td>-0.90**</td>
<td>-0.69</td>
<td>-0.46</td>
<td>-0.66</td>
<td>-0.97**</td>
<td>.70</td>
<td></td>
</tr>
<tr>
<td>8. GDS-10</td>
<td>-0.71*</td>
<td>-0.74*</td>
<td>-0.55</td>
<td>-0.41</td>
<td>-0.43</td>
<td>-0.83*</td>
<td>.83*</td>
<td>.79</td>
</tr>
</tbody>
</table>

| M                                | .16 | 2.1 | .75 | .50 | .88 | 32.13 | 17.38 | 3.50 |
| SD                               | .15 | 1.6 | .71 | 1.1 | .64 | 5.5   | 6.8   | 2.4  |
| Range                            | 0.0-0.4 | 0-5 | 0-2 | 0-3 | 0-2 | 24-39 | 9-29  | 0-7  |
| Theoretical Range                | 0.0-1.0 | -- | -- | -- | -- | 12-48 | 7-49  | 0-10 |

Note: Figures in diagonal represent Cronbach’s alpha statistics for this sample (N = 8). For all scales, higher scores are indicative of more extreme responding in the direction of the construct assessed. CASP-12 = Control, Autonomy, Self-Realization, and Pleasure, 12 item scale (measures geriatric quality of life); AAQ-II = Acceptance and Action Questionnaire II (measures experiential avoidance); GDS-10 = Geriatric Depression Scale, 10 item scale. *p ≤ .05; ** p < .01.