Ways That Families Engage with Staff in Long-Term Care Facilities*

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RÉSUMÉ

Le but de cette étude qualitative était d'analyser les styles d'engagement auxquels les familles ont recours avec le personnel des établissements de soins prolongés. Des données ont été recueillies lors d'entrevues personnelles avec 35 membres de familles. Cinq styles d'engagement ont été dégagés: positif, négatif, péremptoire, prudent et limité. Les facteurs associés à ces divers styles ont aussi été déterminés. Les possibilités de leur mise en pratique font l'objet de discussion.

ABSTRACT

The purpose of this qualitative study was to explore styles of engagement used by families with staff in long-term care facilities. Data were gathered through personal interviews with 35 family members. Five styles of engagement were identified: positive, negative, peremptory, cautious, and limited. Factors associated with these different styles were also identified. Implications for practice are discussed.

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Introduction

Research demonstrates that family members remain involved with their relatives following a move to a long-term care facility (Aneshensel, Pearlin, Mullan, Zarit, & Whitlatch, 1995; Port et al., 2001). Families, however, also have significant relationships with staff in the facility as well as with their relatives, and this involvement can have a major impact on their caregiving experience. This study examines the ways that families engage with staff in long-term care facilities as well as the circumstances surrounding different types of engagement.

Most of the studies that have explored family–staff relationships in long-term care settings have been conducted in nursing homes or homes for the aged. Studies have found that families and staff differ in terms of the expectations that they have around the assignment of various tasks (Schwartz & Vogel, 1990; Shuttlesworth, Rubin, & Duffy, 1982). Families in both nursing homes (Bowers, 1988) and chronic-care hospitals (Ross, Rosenthal, & Dawson, 1997) have been found to evaluate care more highly when it is based on collaboration rather than on a sharp division of tasks. Of central importance to families is that staff provide preservative care and relate to their

relatives in a dignified way (Bowers, 1988; Duncan & Morgan, 1984).

The literature that focuses on family–staff relationships suggests that conflicting expectations around caregiving roles create tension between family members and staff (Ryan, 2002). Frustration may also be related to poor communication and lack of feedback between families and staff (Hertzberg & Ekman, 2000), facility policies concerning family involvement (Friedemann, Montgomery, Maiberger, & Smith, 1997), work-stress experienced by staff (Gladstone & Wexler, 2002b), and staff's lack of awareness of families' needs (Sandberg, Nolan, & Lundh, 2002). Families appear to feel closer to staff who provide them with information (Whitlatch, Schur, Noelker, Ejaz, & Looman, 2001), acknowledge their contributions (Gladstone & Wexler, 2000), and offer an individualized care program to their relatives (Iwasiw, Goldenberg, Bol, & MacMaster, 2003), while staff feel more positively towards families who appreciate their efforts and communicate with them openly (Gladstone & Wexler, 2002b). Findings also suggest that family members who have a greater sense of role captivity prior to the relocation of their relative and who have a supportive social network during her/his transition to a long-term care facility are less likely to experience tension with staff (Gaugler, Leitsch, Zarit, & Pearlin, 2000).

A few studies have looked at the type of relationships that families and staff develop with one another. Ward-Griffin's (2001) and Ward-Griffin and McKeever's (2000) studies of community nursing care identified four types of nurse–family caregiver relationships. These included manager–worker, nurse–patient, nurse–helper, and worker–worker relationships, with the stability of these relationships appearing to centre around the clarity of boundaries and role expectations. Ward-Griffin (2002) has also made comparisons between the perceptions that formal and informal caregivers have of their experiences as caregivers. In a study conducted in a long-term care facility for war veterans, Ward-Griffin, Bol, Hay, & Dashnay (2003) discussed four types of nurse–family relationships: conventional, competitive, collaborative, and carative. The relationships were distinguished in terms of family involvement in the resident's care and the extent to which staff took a resident-focused or family-centred approach. A study by Gladstone and Wexler (2002a), which was conducted in long-term care facilities, described five types of relationships between families and staff, including collegial, professional, friendship, distant, and tense. Relationships appeared to be more positive when they were characterized by a sense of purpose, shared experiences, and trust. As pointed out by Bauer and Nay (2003), the role families have in a long-term care facility, however, can remain ambiguous, making it difficult for them to establish clear and satisfying relationships with staff.

This study adds to our growing understanding of family–staff relationships. Previous research (e.g., Gladstone & Wexler, 2002a; Ward-Griffin et al., 2003) has identified and categorized various types of relationships between caregiving families and helping professionals. By examining styles of engagement, this study looks more at the ways that relationships unfold. To paraphrase Ward-Griffin and McKeever (2000), we need to know not only what type of family–staff relationships are formed but also how these relationships are constructed. This study makes a unique contribution in three ways: It focuses on the dynamics surrounding family engagement with staff, it pays specific attention to the ways that families engage with staff soon after a relative's move to a facility, and it points to factors influencing the selection of various engagement styles.

Guiding Theoretical Framework

Although it has been argued that grounded theory approaches should not be influenced by preconceived notions of the phenomena being studied (Glaser & Strauss, 1967), it has also been pointed out (Strauss & Corbin, 1994; 1998) that relevant theoretical and empirical literature can stimulate theoretical sensitivity and serve as guiding perspectives in grounded theory research (Murphy, 1992). Existing theory can provide a set of initial sensitizing concepts that help the researcher recognize the appearance of new concepts as they emerge from the data.

In critiquing traditional task-assignment approaches to family roles, Dupuis and Norris (1997) introduced an alternative, more dynamic and contextual framework—the Diversity of Experiences Model—for understanding familial caregiving roles in long-term care settings. This framework served as a guiding theoretical framework for the study and was especially useful because of its roots in symbolic interactionism, which says people are active players in the development of their relationships (Blumer, 1969; Turner, 1962).

Symbolic interactionists maintain that people, in this case family members (and staff), do not merely passively conform to others' expectations but instead actively and creatively construct and modify roles through interaction in specific social settings based on the meaning that they attach to actions or situations. Family member caregiving roles, as well as staff roles, are constructed and reconstructed over time in a

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dynamic and fluid role-taking and role-making process. This role-taking and role-making process includes defining and re-defining the situation, interpreting and re-interpreting the behavioural and verbal gestures and expectations of others, and ongoing negotiation processes (Turner, 1962). These micro-processes are influenced by larger structures and personal circumstances that represent the context within which meanings and behaviours are embedded. People, therefore, will perceive the same event differently, depending on their interpretations and understanding of a given situation. This, in turn, guides the way that people interact with others.

The model also suggests that, in order to understand the institution-based caregiving role and family–staff relationships within long-term care facilities, it is important to understand the structural and personal contexts within which family-member and staff roles are negotiated and played out. In discussing the ''obdurateness'' of our world, Fine (1992) emphasized that an understanding of meaning and the role-making process could not be understood apart from their broader contexts:

> Even an understanding of the definition of the situation that stresses the role of the agent in creating meaning must be understood with reference to institutional orders, if we wish to understand what definitions are possible and what effects can come about. I contend that this is not a merging of two separate approaches—one based on agency and the other on structure—but part of a seamless analysis of obdurate constraints. Agency is constrained at the same time as structure can be enabling. (p. 93)

Context, here, not only refers to the institutional setting with its policies and procedures, especially as they are applied to families, but also to the *positionality* (Jaffe & Miller, 1994) or the unique personal circumstances or situations of individual family members and staff. Family members and staff bring to the caregiving situation a unique set of interconnected characteristics and unique biographies of experience, including knowledge based on past experiences in the caregiving role, health and physical factors, and life circumstances (e.g., marital status, relationship to care receiver, working status, length of time working in long-term care or caring for the relative). These varied characteristics and *order experiences* are combined and re-combined in order to interpret meanings in particular contexts (Turner, 1968).

Purpose

The purpose of this study was to extend our understanding of family–staff relationships by focusing on the ways that these relationships take shape. Two central questions were addressed:

1. What styles of engagement do families use when interacting with staff in long-term care facilities?
2. What factors are associated with these different styles of engagement?

Methods

The data for this paper were drawn from a longitudinal study designed to examine family-member roles in long-term care settings and explore how those roles change over time. Family members in the study were caring for relatives with cognitive impairments who had been living in one of two nursing homes in Ontario. The nursing homes, a 206-bed facility and a 217-bed facility, were proprietary facilities located in urban areas. The facilities had family-oriented policies (Montgomery, 1983). For example, post-admission care conferences were held with families, visiting hours were open, and family efforts to assist their relatives were endorsed. Consistent with the interpretivist framework guiding the study, qualitative data were gathered through personal, active interviews (Holstein & Gubrium, 1995) using an interview guide. Active interviews emphasize a collaborative and interactional process that involves both researcher and participant and recognizes that knowledge is co-constructed. Participants, for example, were asked, ''How would you describe your relationship with staff?'' and ''Could you describe an experience with staff that was pleasant/unpleasant?''

Sample

The sample consisted of 35 family members, including 2 spouses, 19 adult daughters, 8 adult sons, 3 grandchildren, 2 siblings, and 1 friend who had power of attorney for personal care. Each family member represented a different resident living in the facility. The majority of family members (67%) were in their forties or fifties. Most (68%) were female, were employed full-time (51%) or part-time (12%), and were either married or in common-law relationships (78%).

While our longitudinal design called for 12-month follow-up interviews, data presented in this paper were gathered from first interviews occurring within 9 months of a relative's move to the facility. The average length of residency was 6 months; the range was 1–9 months. We were particularly interested in the way that engagement styles become formed soon after relocation. This 9-month period of time was selected to provide a diverse sampling of family experiences while remaining as close as possible to the peak adjustment period for families,

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which appears to be around 6 months post-relocation (Aneshensel et al., 1995).

Procedure

Two senior managers, one in each facility, contacted key family members listed on the chart of each resident who had been admitted to the facility in the previous 9 months. The managers described the study and asked family contacts whether they would give permission to have their names forwarded to the researchers. This was done to avoid intruding on family members' privacy. Those who agreed were contacted directly by the researchers, and the study was described in greater detail. If they were interested in participating, an interview time was arranged. Prior to each interview, family members were given an information letter and were asked to sign a consent form, a requirement of our university research ethics board. Family members were informed about confidentiality and anonymity. Although names of potential participants had been provided by the facility, the names of those who ultimately agreed to be interviewed were not revealed to managers or administrators of the facilities.

Interviews were conducted between 2001 and 2002 by the authors and by four research assistants who had had interviewing experience and who received training in active-interview procedures. Data were collected through interviews rather than by other methods (e.g., through observation), since we were interested in learning about engagement from the perspectives of participants themselves. Interviews were approximately 1.5 hours in length and were tape-recorded and transcribed verbatim. In the majority of cases, interviews were held in the family member's home, though some took place in a private location in the facility.

Analysis

Thematic categories relating to the ways that families engaged with staff and to factors associated with these styles of engagement were inductively derived from the data, using the constant comparative method (Strauss & Corbin, 1998). Transcripts were first read in their entirety, with notations relating to emerging themes made in the margins (Luborsky, 1994). Categories were distinguished through open coding by identifying key words, phrases, or common ideas expressed by participants. Properties that characterized these categories were then developed through the process of axial coding. These properties included confidence in staff expertise; contact with staff, including frequency and nature of contact; and presence or absence of conflict. The emerging thematic categories were compared until the central categories became distinctive and inclusive of all the data gathered.

Trustworthiness was established in a number of ways. Efforts were made to develop an open, trusting relationship with participants and to allow them to take the role of storyteller (Gubrium & Holstein, 1997). Negative case analysis (Lincoln & Guba, 1985) was conducted to ensure that no *outlying* themes were omitted from the analysis and that all family members' experiences were taken into account. Finally, returning transcripts through member checks enhanced the credibility of the data. Once the transcripts were coded, they were returned to participants, who were asked to comment on the accuracy of the interpretations.

Findings

Styles of Engagement

Family members used various styles of engagement to shape their relationships with staff.

Positive Engagement

Some family members used positive engagement in their efforts to develop relationships with staff. These family members "worked on" their relationships with staff to make them as harmonious as possible. Mr. Fontana,[1] for example, stated, "I'm pretty much bought and sold on the fact that you have to go in there and you have to present an image that you're approachable and that you want to be approached and that you want to communicate." Family members wanted to be informed of staff concerns or decisions regarding their relatives but generally had confidence that staff had the expertise to provide good care. As Mr. Fontana said, "I liked the idea of deferring to the professionals. They deal with this all the time." Family members such as Mr. Fontana would express their appreciation towards staff; Mr. Fontana, for example, bought staff Christmas gifts "from my mom". Moreover, he socialized not only with staff but with other residents as well. Some of these family members moved beyond small talk and discussed personal issues in their lives and in the lives of staff. Most felt that they had a "nice relationship" with staff, without being "friends".

Negative Engagement

The actions of some family members reflected negative engagement with staff. Ms. Tremello's constant frustration with staff kept driving her complaints and pushed her "to tell them what to do". While Ms. Tremello realized that "I might be making the situation worse . . . a lot of them (staff) when they

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see us, really get their back up even before we say anything'', she maintained her role in this process because she felt that it was the only way she could protect her grandmother. Unlike Mr. Fontana, who ''worked on'' getting along with staff, Ms. Tremello felt that she had no recourse but to get angry with staff. Her reasoning was that

> if I tell you in this tone, then you do something and if I don't, then it doesn't get done or you'd overlook it. It's almost like if you don't get upset about something then they view it that it's not as important. So it's like if I go there totally livid, then they notice.

Family members who had negative engagement with staff questioned staff's competency. Unlike Mr. Fontana, who would consult with staff, Ms. Tremello said that ''when it comes to her (grandmother's) welfare, I just do it. I don't even ask because I don't really care what they say.'' While family members had issues with staff, they themselves did not feel recognized. Ms. Tremello, for example, said she would ask staff questions and would receive a vague response such as ''I don't know''. Consequently, the relationships that evolved were filled with tension and minimal contact.

Peremptory Engagement

A few family members demonstrated a peremptory style of engagement with staff. These family members were assertive and confident and tended to present themselves as imposing figures. Mrs. Greenbaum, whose mother lived in the facility, stated,

> I'm not exactly what you'd call a shrinking violet . . . I come across as a fairly professional sort of individual. I walk in dressed in my blue suit and I mean they see a little different kind of individual perhaps than maybe some of the other people that come to visit.

Although tension may have permeated the relationships that both Ms. Tremello and Mrs. Greenbaum had with staff, Ms. Tremello engaged in more open conflict, while Mrs. Greenbaum avoided hostilities through her firm but composed tone. Asked whether she had ever had an unpleasant experience in the facility, for example, Mrs. Greenbaum responded, ''No, I don't allow tense experiences to happen to me . . . I think I come across as the kind of individual, you cause me trouble, I'm gonna cause you bigger trouble, so don't push my buttons.'' Family members who used this type of engagement did not necessarily believe that staff were not capable of doing their job. They did, however, feel that they had to be ''pushy'' to get their needs met. These family members would be cordial with staff, though most of their exchanges were simple greetings or dialogue around their relative's care.

Cautious Engagement

Some family members were noted for what they refrained from doing, illustrating a more cautious engagement. As Mrs. Shamm explained, ''I walk a fine line between trying to make sure that mom's cared for and not ruffling any feathers, not pushing too hard.'' Cautious and positive styles of engagement were often employed for the same purpose. Mr. Fontana believed that ''if the people like you, they're gonna like your mother and they're gonna do something special''. Mrs. Shamm's message was the reciprocal: ''[I]f you're getting someone's back up, then it's a boomerang and it's my mom that suffers, not me.'' Like family members who used a negative style of engagement, these family members saw problems in staff's approach to their relatives and voiced some of their concerns. They were, however, more likely also to recognize areas of competency, and if they did have an issue, to stop short of allowing it to turn into a highly conflictual situation. Some family members exercised caution in other ways. Mrs. Shandelle, whose mother lived in the facility, was careful in terms of whom she interacted with, categorizing staff as either ''clinical'' or ''non-clinical''. She explained,

> [T]he clinical ones are the ones who keep doing what they're doing and just have their eye on their paperwork and the other ones, they see you coming and say 'hi' and know your name and that type of thing. And you know that they're approachable and you don't feel hesitant going up and talking to them.

Limited Engagement

Some family members had limited engagement with staff. These family members were cordial with staff when they saw them, though their desire was to have no more than minimal contact with them. Mrs. Christie, whose mother lived in the facility, did not have much interaction with staff because ''I haven't needed to''. Their relative was relatively stable and their intention upon entering the facility was to go directly to visit their relative and then leave. A number of sons fell into this category. They depended on their wives or, in one case, a sister, to take the lead with staff. Other family members viewed staff as being busy and did not want to interrupt them unless they had a specific question or concern. Conversations might take place, for instance, when a family member was in their relative's room and a staff person entered, but these interactions were usually brief and were initiated by staff. Mr. Fiversky, whose wife lived in the facility, expressed his outlook

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this way: ''[T]hey don't spend a great deal of time talking to the visitors because they're looking after the people who are there which is their job. That pleases me more than having a conversation with them.''

It should be noted that family members appeared to use one type of engagement style primarily in their interactions with staff. Families, however, often had one or a couple of staff persons who they particularly liked or disliked and with whom they would use a different engagement style depending on how they perceived that staff member. This appeared to be the case across all engagement styles. For example, Ms. Tremello's general style of engagement with staff was negative (''they're not helpful at all''). Asked, ''[I]s there any particular staff whom you have a better relationship with?'' Ms. Tremello answered, ''[T]here's actually two. I mean if everybody was like them, there would be no problem.... [L]ike if you ask her a question, she'll go out of her way to help.'' Mrs. Shandelle, who had a more cautious style, responded to the question above by saying, ''I liked one particular staff but she left. She was cheerful and recognized the emotional problems we might be feeling.'' On the other hand, Mrs. Dimucci, who had a positive style of engagement with staff, indicated that ''there's one nurse that's never been my favourite and I probably don't communicate with her better . . . I find she's abrupt with some of the residents.'' There did not appear to be any connection between engagement style, on the one hand, and the relationship between family member and resident, on the other. While males were more likely to have limited engagement styles and females were more likely to have negative or peremptory styles, these styles were not exclusively linked to a particular gender.)

Influencing Factors

Several factors were associated with the ways that relationships between families and staff unfolded.

Prior Experiences

Some family members made comparisons between staff in the nursing home and staff in other facilities where their relative had stayed previously. When earlier experiences were positive, family members may have had expectations of the new facility which, when not met, coloured their relationships with staff. Ms. Tremello, for example, thought highly of the staff in the hospital where her grandmother stayed prior to moving into the nursing home and admitted,

> I was at a stage when she (grandmother) went to the nursing home that I was completely opposed to everything that they did because I was comparing every little thing to the hospital, which isn't fair. But you know, their job is to look after these people . . . that's what they're there for.

Mrs. Lemigne felt that the home care workers who provided care to her mother when she was in her own home were more flexible and sensitive towards her mother's needs than the staff in the nursing home where her mother now lived. Mrs. Herman had had a positive experience with staff in the retirement home where her mother previously lived. She attributed the greater distance between the current staff and herself to the fact that staff were working with more impaired residents and did not have as much time to cultivate relationships with families. Families who rated current staff lower because they were perceived to be less competent appeared more likely to use a negative style of engagement. When lower ratings were tied to some other reason, such as staff's heavy workload, styles of engagement seemed to be more cautious.

Information

Families felt closer to staff whom they felt provided them with information, either by initiating dialogue or by answering their questions. Some family members seemed to measure the quality of their relationship with staff in terms of the amount of information they received. Mrs. Vanelli, for example, described her relationship with staff in the following way: ''I think it's good. Anytime I have had a question, they've taken the time to answer it. If I want to know about her (mother's) medication, they'll tell me, or how she's been doing that day. So I think it's very good.'' Family members, in fact, not only wanted to receive information but were sensitive to the way that the information was communicated. Mrs. Puckett, for example, referred to her efforts to get information about her mother from one nurse who ''might be a very good nurse, but she needed an attitude adjustment, she was very abrupt''. Family members who received information in a non-offending way and who felt that staff not only answered their questions but initiated information sharing on their own, appeared more likely to use positive styles of engagement. Otherwise, engagement seemed to be negative, cautious, or limited.

Interpersonal Skills

Strong interpersonal skills had an impact on the way that relationships developed between families and staff. Staff who were perceived to remain non-reactive and who defused potentially conflictual situations were more likely to have positive relationships with families. Ms. Tremello, for instance, was ''livid'' when she saw her grandmother being transferred by only one nursing aide. Another staff member entered the

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room and, rather than arguing with Ms. Tremello, ''she said, 'OK, fine. If it says a two-person transfer, then that's exactly what she should be getting . . . I'll go call the supervisor.' And it all got sorted out.'' Conversely, Ms. Lemigne perceived some staff as ''defensive'', recounting an experience with staff that escalated into a tense situation.

> Mom went to the bathroom and was sitting on the toilet. And I said (to the nursing aide), ''You can't wash her like that with her legs closed sitting on the toilet.'' And she says, ''I'd like you to leave the room because you're not supposed to be here.'' And I said, ''I have every right to be here. My mom's a resident and I'm overseeing what you're doing right now.'' So I went outside, but I was very upset.

Other skills used by staff to solidify relationships with families included taking the time to talk, being emotionally supportive and empathetic, and promoting self-determination in decision making. Mrs. Harry, for example, was struggling with whether to place an end-of-life directive on her mother's chart. She said that

> people took the time to comfort me and to talk to me about the situation and about the ramifications . . . they didn't try to influence the decision. After I had made the decision . . . the lady I was talking to said, ''You're right.'' I'd already made the decision, but she affirmed.

Not surprisingly, staff who employed strong interpersonal skills usually elicited positive styles of engagement from families. Even family members who used a peremptory approach were likely to respond to positive communication cues from staff. For example, Mrs. Greenbaum would simply launch into a statement about what she needed. Nevertheless, the skills that staff used in responding to family members such as Mrs. Greenbaum helped to determine whether the conversation remained on a ''business-like'' level or turned into a tense situation.

Involvement with Care

The majority of family members wanted to be involved in the provision of care, albeit to varying degrees. Some wanted the opportunity to continue providing hands-on care. Most, however, were looking for other ways of becoming part of the care team, such as being consulted around important decisions or, as mentioned above, being informed about the progress or situation of their relative. As Mrs. Dimucci remarked, ''I know the staff by name and they're not afraid to call me. They called me to tell me Mom wouldn't take her pills.'' Family members who wanted to be involved in their relative's care and who felt thwarted by staff often became resentful of staff, a resentment that was expressed as a cautious or negative style of engagement. Mrs. Shandelle, for instance, commented, ''[T]he longer (mother's) here, the more adversarial we feel. We wanted to be involved, but didn't feel needed.'' Mrs. Shamm stated, in an upset tone, that

> I really think that some staff felt that family involvement was an intrusion . . . I think because they were so busy. They didn't want to stop and talk to you about maybe what your mom needs. They just wanted to do what they had to do and anything that we discussed with them was extra, just keeping them from doing what they were supposed to be doing.

On the other hand, Mrs. Harry was pleased with staff who ''seemed to be willing to let me do anything I wanted'', while other family members assumed that staff would inform them if greater involvement on their part was needed. These family members used more positive styles of engagement. They had confidence in staff's judgement and deferred to their expertise.

Structural Issues

Two structural issues appeared to be associated with the ways that family–staff relationships were formed. Staff turnover and staff workload were two issues that were perceived to make it difficult for some families to develop relationships. A lack of familiarity because of changes in staff personnel prohibited these families from having even brief chats with staff and thereby getting to know them. A related factor for some families was the perception that staff were too busy to stop and chat. Mrs. Davies, whose husband was in the facility, described staff as being ''accommodating, they seem very busy though, so they don't have a lot of time to socialize''. Mrs. Ellis, whose mother lived in the facility, stated, ''I never see the staff. I absolutely have no relationship with them . . . they're always so busy. Sometimes you'll see them and they'll say, 'Well, we're really late giving out the meds. It's just been crazy here this morning.'" The tendency for these family members was to have cautious or limited styles of engagement. For most family members, the benefit of chatting with staff was not to establish personal relationships with them but to get information about their relative's care or to establish a working relationship so that the family's expectations would be met. Mr. Anthony, an adult son, stated, ''I don't really want to be chummy or anything like that. I don't think they've got the time for it either. I'd like us to be on a fair and positive footing so I could ask them for something and they would be happy to comply, rather than feel threatened.'' Conditions that

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brought families and staff together for informal contact accomplished these objectives and may even have led to positive types of engagement. Mr. Jayson, for example, who was visiting his father, would sit outside the facility to smoke and informally socialize with staff who were doing so as well. Sharing personal experiences, Mr. Jayson considered these staff members to be ''friends''.

Discussion

Findings showed that families use various styles of engagement when interacting with staff. While preferences are usually shown for one style or another, the same family member will use different engagement styles depending on her/his relationship with particular staff members. Dupuis and Norris (1997) have presented a framework that identifies factors that influence the roles of family members in long-term care settings. These factors also appear to be associated with the use of the different engagement styles used by families. They include prior experiences, which contextualize the way social actors participate in current exchanges; interpersonal skills, which guide and direct patterns of communication; and structural characteristics of the environment, which influence opportunities for social interaction.

Our findings suggest that family members may be particularly sensitive to the perceived quality of service currently provided by staff when they have had a positive experience with other staff in the past. This relates to the concept of positionality or biography of experience developed by Jaffe and Miller (1994) and incorporated in Dupuis and Norris's (1997) caregiving framework. A negative style of engagement is likely to occur when family members have had a positive experience with staff in the past but view current staff as incompetent due to lack of skill or expertise. Family members are likely to have a more cautious style when their prior experiences were positive and when current staff appear to be ineffective for some other reason, such as heavy workload.

The use of interpersonal skills is a critical element in the way that family roles and relationships are defined in a long-term care facility. Families are more likely to be positively engaged with staff who take the time to talk, who are perceived to be empathic, and who communicate information in a timely and non-offending way. Just as importantly, strong interpersonal skills on the part of staff defuse tension and minimize the likelihood of negative engagement styles emerging. While our data do not refer to interpersonal skills on the part of family members, it is possible that strong interpersonal skills of some families elicit welcoming responses from staff, thereby contributing to the development of positive engagement styles.

According to Dupuis and Norris's (1997) framework, structural factors help shape the roles and relationships that families have in long-term care facilities. Our findings point to two such factors, staff turnover and staff workload, as being particularly relevant in this regard. The consistent presence of staff and their having the time to have even brief chats with families enabled families and staff to get to know each other, which contributed to positive, rather than cautious or limited styles of engagement. In addition, families who wanted to be involved in their relative's care may have been put off by staff who appeared to be too busy to share information about their relative. Families' desire for information and the opportunity to be involved in the care of their relatives has also been documented in previous studies (Bowers, 1988; Duncan & Morgan, 1984; Gladstone & Wexler, 2000). When families felt frustrated in these areas, cautious or negative styles of engagement were more likely to occur.

Our findings extend our understanding of engagement, particularly in the area of long-term care. While researchers have found an association between client engagement and positive service outcomes, their studies to date have been conducted in other settings; namely, child welfare (Littell, 2001; Littell & Tajima, 2000), addictions (Dearing, Barrick, Dermen, & Walitzer, 2005; Joe, Simpson, Greener, & Rowan-Szal, 1999), homelessness and mental health (Mobray, Cohen, & Bybee, 1993), and social group work (Macgowan, 2003). From a client's perspective, a warm, empathic, trusting approach by service providers enhances her/his level of engagement (Fiorentine & Hillhouse, 1999; Fiorentine, Nakashima & Anglin, 1999; Lee & Ayon, 2004; Simpson, Joe, Rowan-Szal, & Greener, 1995), as does the provision of information and practical assistance (Jack, DiCenso, & Lohfeld, 2002).

Our research suggests that the styles of engagement that families have with staff in long-term care settings come about under different circumstances and consequently may be attached to different dynamics. Family members, like clients in therapeutic settings, are looking for staff to employ interpersonal skills and provide them with information. However, the role relationships between families and staff (Gladstone & Wexler, 2002a; Ward-Griffin et al., 2003) are not necessarily defined in the same way as those between clients and helpers, where the readiness to receive help, expectations of benefit, and notion of reciprocity

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(Yatchmenoff, 2005) may be quite different. Families in long-term care facilities are not being monitored for risk as are, for example, many in child welfare and child protection settings (Spratt & Callan, 2004). They may thus be more proactive in deciding what types of relationships they would like. As many are apt to be looking for a collaborative type of relationship (Bowers, 1988; Ross et al., 1997), they may choose a style of engagement that reflects their perceived sense of success in this area. Family members are also present in the facilities voluntarily. Not feeling that they have to navigate the system by demonstrating compliance in order to extricate themselves from their situation (Reisinger, Bush, Colom, Agar, & Battjes, 2003), they may feel freer to adopt certain styles of engagement, including being negative, which they otherwise would have avoided.

Our research also shows that family members use particular strategies to engage with staff and thus are active players in determining the type of relationships that are defined with them. While structural conditions can influence opportunities for contact and previous history may colour the meanings that are attached to interactions with staff, family members make an effort to control their situations as best they can. This reflects family members' efforts to retain a sense of mastery (Pearlin & Schooler, 1978) in their role as caring family member or ongoing family caregiver, roles that may have been re-shaped following their relative's move to the facility. Central to both these roles is the importance of ensuring that a relative is being well taken care of in the facility (Gladstone, Dupuis, & Wexler, 2006). Whether families make an intentional effort to socialize with staff (positive engagement), challenge staff (negative, peremptory), or keep their distance from staff (cautious, limited), they do so in a way that offers them a sense of mastery and allows them, at least partially, to drive the role-making process (Turner, 1962). Continuing to experience a sense of mastery in these as well as other roles has been associated with greater well-being and life satisfaction (Christensen, Stephens, & Townsend, 1998).

Finally, the Diversity of Experiences model focuses primarily on factors that can influence how family members' roles in the care of their relatives are developed and modified in long-term care settings over time (Dupuis & Norris, 1997). Our findings expand this model by highlighting the importance of these factors in influencing how families actively choose to engage with staff in their caring roles and by identifying specific ways of engagement adopted by families in long-term care settings. The findings emphasize the importance of interpersonal factors, such as the nature and quality of relationships between the family member and others within the immediate setting, to the role-making and role-taking process.

Study Limitations

It would be useful to learn how various styles of engagement identified in this study are associated with the different types of relationships described in previous research. For instance, how might negative or peremptory styles of engagement be associated with Gladstone and Wexler's (2002a) tense type of relationship or Ward-Griffin et al.'s (2003) competitive relationship? Moreover, it is not known how various styles of engagement are related to client outcome (e.g., family morale, satisfaction with care, quality of care provided by staff to residents). Our sample was relatively small; a more thorough analysis of engagement styles and how they may be related to gender and to the relationship between family member and resident is needed. A large number of caregivers are adult children and, as Mathews (1995) and Mathews and Heidorn (1998) have shown, sons and daughters may attach different meanings to their filial obligations. Data collected in this study are cross-sectional. A longitudinal design would offer a more complete understanding of engagement styles and how they may change over time. Factors that influence the way that engagement styles take shape (e.g., availability of information, structural issues, opportunities for family involvement with care) may be particularly fluid and may affect engagement styles differently at different points in time. The focus of this study has been on engagement from the perspective of family members. Little is known about this process from the perspective of staff, who themselves are not a homogeneous group. Registered nurses, for example, may have experiences that are different from those of nursing assistants. The overall sampling frame should also be expanded, particularly with regards to ethnic and cultural diversity. Differing values attached to social location may affect exchanges and the way that engagement comes about. These limitations point to directions for future research.

Implications

Findings from this study have several clinical implications for staff working in long-term care facilities. It should be noted that contact with formal systems in the past may be part of a family member's ongoing caregiver career. These past experiences may affect the meanings that families attach to current situations. It would be useful for current staff to listen to these experiences while trying to determine what families are really trying to say to them now. In many cases,

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there may be an underlying message: The family member may be asking whether staff in the facility will care for her/his relative with dignity and respect and acknowledge her/his own presence as well.

Secondly, providing information to relatives, both in terms of answering their questions and of initiating updates, can help families feel connected and allow them to retain a sense that there is a purpose in their relatives' lives. This might be especially important to family members who experience guilt and a sense of loss when their relatives move to a long-term care facility. Family members who are given information may be more likely to feel that they still have an important role in their relative's lives and to experience successful adaptation following their relative's move.

Thirdly, staff influence the attitudes and responses of family members based on what their interpersonal skills are and how they communicate with them. Understanding the sequence of communication patterns, especially ways that tension builds or de-escalates, is a particularly useful skill that will enhance positive social exchanges between families and staff. Learning conflict resolution and problem-solving methods, being empathic, being non-defensive, and validating are other skills that establish a climate of openness and trust. Communication skill training, possibly in the form of a series of workshops (Pillemer, Hegeman, Albright, & Henderson, 1998) or family–staff conferences (Maas et al., 2004), may help in this regard.

Fourthly, family members will differ in terms of how they define their roles in a long-term care setting and, consequently, their desired levels of involvement in the care of their relative. Particularly useful would be talking to family members who want to continue providing hands-on care to their relatives. On the other hand, families may only want to be updated and consulted around care decisions or informed about difficulties that staff have caring for their relative. Differences among families may depend on whether they continue to identify themselves as caregivers as well as on their ways of coping with burden following their relative's move (Ross et al., 1997). It would be beneficial for professional staff to have open discussions with families about their desired level of involvement, both in terms of quantity and form, and reach an understanding of what is practical and acceptable to both parties.

Finally, structural issues such as workload have a bearing on the amount of time staff can spend with families. And, listening to family experiences, giving information, being attentive to communication patterns, and discussing the involvement that families want to have in terms of caring for their relatives takes time. While spending additional time with families can be challenging, there may be potential benefits to staff. Families may be more likely to respond to the time and effort put in by staff with more positive engagement styles and, as a consequence, are likely to be less demanding, more supportive, and more cooperative (Gladstone & Wexler, 2002b), thereby paradoxically, reducing staff workload in the long term. This issue is not only relevant to individual staff; it is a policy issue. Ward-Griffin et al. (2003), for example, found that nurses who had competitive relationships with families tended to spend less time with them and did not feel supported by supervisors to do otherwise. If organizational policy recognizes and rewards staff's spending more meaningful time with families, then it may be more likely to come about.

Note

1 All names in this paper are pseudonyms.

References

Aneshensel, C.S., Pearlin, L.I, Mullan, J.T., Zarit, S.H., & Whitlatch, C.J. (1995). *Profiles in caregiving: The unexpected career*. San Diego: Academic Press.

Bauer, M., & Nay, R. (2003). Family and staff partnerships in long-term care: A review of the literature. *Journal of Gerontological Nursing*, *29*, 46–53.

Blumer, H. (1969). *Symbolic interactionism: Perspective and method*. Englewood Cliffs, NJ: Prentice-Hall.

Bowers, B.J. (1988). Family perceptions of care in a nursing home. *Gerontologist*, *28*, 361–368.

Christensen, K.A., Stephens, M.A., & Townsend, A.L. (1998). Mastery in women's multiple roles and well-being: Adult daughters providing care to impaired parents. *Health Psychology*, *17*, 163–171.

Dearing, R.L., Barrick, C., Dermen, K.H., & Walitzer, K.S. (2005). Indicators of client engagement: Influences on alcohol treatment, satisfaction and outcomes. *Psychology of Addictive Behaviors*, *19*, 71–78.

Duncan, M.T., & Morgan, D.L. (1984). Sharing the caring: Family caregivers' views of their relationships with nursing home staff. *Gerontologist*, *34*, 235–244.

Dupuis, S.L., & Norris, J.E. (1997). A multidimensional and contextual framework for understanding diverse family members' roles in long-term care facilities. *Journal of Aging Studies*, *11*, 297–325.

Fine, G.A. (1992). Agency, structure, and comparative contexts: Toward a synthetic interactionism. *Symbolic Interaction*, *15*, 87–107.

https://doi.org/10.3138/cja.26.4.391 Published online by Cambridge University Press

Fiorentine, R., & Hillhouse, M.P. (1999). Drug treatment effectiveness and client-counsel or empathy: Exploring the effects of gender and ethnic congruency. *Journal of Drug Issues*, *29*, 59–74.

Fiorentine, R., Nakashima, J., & Anglin, M.D. (1999). Client engagement in drug treatment. *Journal of Substance Abuse Treatment*, *17*, 199–206.

Friedemann, M-L., Montgomery, R.J., Maiberger, B., & Smith, A.A. (1997). Family involvement in the nursing home: Family-oriented practices and staff-family relationships. *Research in Nursing Health*, *20*, 527–537.

Gaugler, J., Leitsch, S.A., Zarit, S.H., & Pearlin, L.I. (2000). Caregiver involvement following institutionalization: Effects of preplacement stress. *Research on Aging*, *22*, 337–359.

Gladstone, J.W., Dupuis, S.L., & Wexler, E. (2006). Changes in family involvement following a relative's move to a long-term care facility. *Canadian Journal on Aging*, *25*, 93–106.

Gladstone, J.W., & Wexler, E. (2000). A family perspective of family/staff interaction in long-term care facilities. *Geriatric Nursing*, *21*, 16–19.

Gladstone, J.W., & Wexler, E. (2002a). Exploring the relationships between families and staff caring for residents in long-term care facilities: Family members' perspectives. *Canadian Journal on Aging*, *21*, 39–46.

Gladstone, J.W., & Wexler, E. (2002b). The development of relationships between families and staff in long-term care facilities: Nurses' perspectives. *Canadian Journal on Aging*, *21*, 217–228.

Glaser, B.G., & Strauss, A.L. (1967). *The discovery of grounded theory.* New York: Aldine.

Gubrium, J.F., & Holstein, J.A. (1997). *The new language of qualitative method*. New York: Oxford University Press.

Hertzberg, A. & Ekman, S-L. (2000). ''We, not them and us?'' Views on the relationships and interactions between staff and relatives of older people permanently living in nursing homes. *Journal of Advanced Nursing*, *31*, 614–622.

Holstein, J.A., & Gubrium, J.F. (1995). *The active interview.* Thousand Oaks, CA: Sage.

Iwasiw, C., Goldenberg, D., Bol, N., & MacMaster, E. (2003). Resident and family perspectives. The first year in a long-term care facility. *Journal of Gerontological Nursing*, *29*, 45–56.

Jack, S., DiCenso, A., & Lohfeld, L. (2002). Opening doors: Factors influencing the establishment of a working relationship between paraprofessional home visitors and at-risk families. *Canadian Journal of Nursing Research*, *34*, 59–69.

Jaffe, D.J., & Miller, E.M. (1994). Problematising meaning. In J.F. Gubrium, & A. Sankar (Eds.), *Qualitative methods in aging research* (pp. 51–64). Thousand Oaks, CA: Sage.

Joe, G.W., Simpson, D.D., Greener, J.M., & Rowan-Szal, G.A. (1999). Integrative modeling of client engagement and outcomes during the first 6 months of methadone treatment. *Addictive Behaviors*, *24*, 649–659.

Lee, C.D., & Ayon, C. (2004). Is the client–worker relationship associated with better outcomes in mandated child abuse cases? *Research on Social Work Practice*, *14*, 351–357.

Lincoln, Y.S., & Guba, E.G. (1985). *Naturalistic inquiry.* Newbury Park, CA: Sage.

Littell, J.H. (2001). Client participation and outcomes of intensive family preservation services. *Social Work Research*, *25*, 103–113.

Littell, J.H., & Tajima, E.A. (2000). A multilevel model of client participation in intensive family preservation services. *Social Service Review, 74*, 405–435.

Luborsky, M.R. (1994). The identification and analysis of themes and patterns. In J.F Gubrium, & A. Shankar (Eds.), *Qualitative methods in aging research* (pp. 189–210). Thousand Oaks, CA: Sage.

Macgowan, M.J. (2003). Increasing engagement in groups: A measurement based approach. *Social Work with Groups*, *26*, 5–27.

Maas, M.L., Reed, D., Park, M., Specht, J.P., Schutte, D., & Kelley, L.S., et al. (2004). Outcomes of family involvement in care intervention for caregivers of individuals with dementia. *Nursing Research*, *53*, 76–86.

Mathews, S.H. (1995). Gender and the division of filial responsibility between lone sisters and their brothers. *Journal of Gerontology: Social Sciences*, *50B*, S312–S320.

Mathews, S.H., & Heidorn, J. (1998). Meeting filial responsibilities in brothers-only sibling groups. *Journal of Gerontology: Social Sciences*, *53B*, S278–S286.

Montgomery, R.J.V. (1983). Staff–family relations and institutional care policies. *Journal of Gerontological Social Work*, *6*, 25–37.

Mobray, C.T., Cohen, E., & Bybee, D. (1993). The challenge of outcome evaluation in homeless services: Engagement as an intermediate outcome measure. *Evaluation and Program Planning*, *16*, 337–346.

Murphy, S.O. (1992). Using multiple forms of family data: Identifying pattern and meaning in sibling–infant relationships. In J.F. Gilgun, K. Daly, & G. Handel (Eds.), *Qualitative methods in family research* (pp. 146–171). Newbury Park, CA: Sage.

Pearlin, L.I., & Schooler, C. (1978). The structure of coping. *Journal of Health and Social Behavior*, *19*, 2–21.

Pillemer, K., Hegeman, C.R., Albright, B., & Henderson, C. (1998). Building bridges between families and nursing home staff: The partners in caregiving program. *Gerontologist*, *38*, 499–503.

https://doi.org/10.3138/cja.26.4.391 Published online by Cambridge University Press

Port, C.L., Gruber-Baldini, A.L., Burton, L., Baumgarten, M., Hebel, J.R., & Zimmerman, S.I., et al. (2001). Resident contact with family and friends following nursing home admission. *Gerontologist*, *41*, 589–596.

Reisinger, H.S., Bush, T., Colom, M.A., Agar, M., & Battjes, R. (2003). Navigation and engagement: How does one measure success? *Journal of Drug Issues*, *33*(4), 777–800.

Ross, M.M., Rosenthal, C.J., & Dawson, P.G. (1997). Spousal caregiving in the institutional setting: Task performance. *Canadian Journal on Aging*, *16*, 51–69.

Ryan, A. (2002). Transitions in care: Family carers' experiences of nursing home placement. *Focus*, *7*, 324–334.

Sandberg, J., Nolan, M.R., & Lundh, U. (2002). Entering a new world: Empathic awareness as the key to positive family/staff relationships in care homes. *International Journal of Nursing Studies*, *39*, 507–515.

Schwartz, A.N., & Vogel, M.E. (1990). Nursing home staff and residents' families role expectations. *Gerontologist*, *30*, 49–53.

Shuttlesworth, G., Rubin, A., & Duffy, M. (1982). Families versus institutions: Incongruent role expectations in the nursing home. *Gerontologist*, *22*, 200–208.

Simpson, D.D., Joe, G.W., Rowan-Szal, G., & Greener, J. (1995). Client engagement and change during drug abuse treatment. *Journal of Substance Abuse*, *7*, 117–134.

Spratt, T., & Callan, J. (2004). Parents' views on social work interventions in child welfare cases. *British Journal of Social Work*, *34*, 199–224.

Strauss, A., & Corbin, J. (1994). Grounded theory methodology: An overview. In N.K. Denzin, & Y.S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 273–285). Thousand Oaks, CA: Sage.

Strauss, A., & Corbin, J. (1998). *Basics of qualitative research*. Newbury Park, CA: Sage.

Turner, R.H. (1962). Role-taking: Process versus conformity. In A.M. Rose (Ed.), *Human behavior and social processes: An interactionist approach* (pp. 20–40). Boston: Houghton Mifflin.

Turner, R.H. (1968). Social roles: Sociological aspects. In D.L. Sills (Ed.), *International encyclopedia of the social sciences* (pp. 552–557). New York: Macmillan and Free Press.

Ward-Griffin, C. (2001). Negotiating care of frail elders: Relationships between community nurses and family caregivers. *Canadian Journal of Nursing Research*, *33*, 63–81.

Ward-Griffin, C. (2002). Boundaries and connections between formal and informal caregivers. *Canadian Journal on Aging*, *21*, 205–216.

Ward-Griffin, C., Bol, N., Hay, K., & Dashnay, I. (2003). Relationships between families and registered nurses in long-term-care facilities: A critical analysis. *Canadian Journal of Nursing Research*, *35*, 150–174.

Ward-Griffin, C., & McKeever, P. (2000). Relationships between nurses and family caregivers: Partners in care? *Advances in Nursing Science*, *22*, 89–103.

Whitlatch, C.J., Schur, D., Noelker, L.S., Ejaz, F.K., & Looman, W.J. (2001). The stress process of family caregiving in institutional settings. *Gerontologist*, *41*, 462–473.

Yatchmenoff, D.K. (2005). Measuring client engagement from the client's perspective in nonvoluntary child protective services. *Research on Social Work Practice*, *15*, 84–96.

https://doi.org/10.3138/cja.26.4.391 Published online by Cambridge University Press