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Although the ability to provide support to others may diminish with age, the desire to reciprocate persists. Using social exchange theory, this article examines deference as one form of exchange. Based on a sample of 31 residents age 85 and older in assisted living facilities, data were gathered via a semi-structured interview that was audiotaped and transcribed. This study analyzes their responses to open-ended questions using qualitative methods. Findings indicate that these "oldest old" respondents reciprocate for the support they receive from family and staff via deference. Four forms of deference are identified: participation, pleasantness, cooperation, and gratitude. In addition, the psychological costs and rewards of deference are examined from the elders' perspective.

Keywords: *dyadic relationships; caregiving; compliance; oldest old; reciprocal exchanges; social exchange theory*

The ability to reciprocate is a fundamental component of satisfying social relationships (Wentowski 1981). Though reciprocity becomes increasingly difficult as people experience physical and cognitive decline

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(Lustbader 1991), older people continue to find ways to contribute to others (Ingersoll-Dayton and Antonucci 1988; Walker, Pratt, and Oppy 1992). Thus far, much of the research on relationships between older care receivers and their caregivers has examined these exchanges from a unilateral perspective. That is, the contributions of caregivers have been highlighted while those of the care recipients have been overlooked. This article addresses this gap by focusing on the contributions of aging care recipients to their social relationships. Specifically, we examine the ways in which elders in assisted living attempt to reciprocate for their care via deference.

Literature Review

For those 85 and over—the oldest old—increasing frailty often leads to greater dependence on others, with concomitant changes in social relationships (Dunkle, Roberts, and Haug 2001; Lawrence and Schigelone 2002). As frailty increases, the oldest old may need to relocate to facilities in which more care is provided. This relocation entails the development of new relationships with staff and the modification of relationships with family. One rapidly growing model of care is assisted living (AL) in which help with activities of daily living can be provided on a 24-hour basis (Zimmerman et al. 2003, 2005). AL facilities may soon become more prevalent than nursing homes (Meyer 1998) and, as such, offer an important setting in which to consider the social exchanges of older care recipients (Rakowski et al. 2003). The present study focuses on ways in which the oldest old in AL facilities use deference in their exchanges with family and staff.

Social Exchange Theory

Our work is guided by social exchange theory (Blau 1986), which emphasizes the importance of reciprocity in dyadic relationships. Social exchange theory posits that the receipt of help obligates individuals to reciprocate. That is, partners in a relationship attempt to maintain a balanced ledger between giving and receiving support. Central to our work are two propositions from social exchange theory.

The first proposition is that when individuals in a relationship have fewer resources to contribute, this imbalance places them in a more dependent position and makes them more subject to their partner's power. Blau (1986) hypothesizes that one way in which those in less powerful positions

may reciprocate is via compliance or deference. Pyke (1999) elaborates on this hypothesis by explaining, "Deference is a means of reciprocation. It can balance an otherwise unbalanced relationship" (p. 670). This proposition suggests that care recipients may use deference to their caregivers as a way of balancing their social exchanges.

The second proposition is that the behaviors of both participants involved in social exchanges result in psychological costs and rewards. This proposition suggests that deference accorded by care recipients to their caregivers may result in psychological costs and/or psychological benefits for the care recipient. Blau (1986) highlights the psychological costs to those in subordinate positions, including the potential for their exploitation and oppression.

Deference Among Care Recipients

Because care recipients in AL facilities rely on support from staff and family members, we examined the research literature that applies social exchange theory to both sources of support. The literature that pertains specifically to deference as a form of exchange is sparse and examines this construct either in relation to staff or in relation to family.

Deference to staff. Our understanding of deference accorded to staff by older care recipients is based on research conducted in nursing homes. Using social exchange theory as an organizing framework, Nelson (2000) provides a review of this literature. He contends that imbalanced exchanges between older residents and staff are a central characteristic of nursing homes. The older care recipients are dependent on the staff, and their powerless position allows them few opportunities to reciprocate for the care they receive. Instead, nursing home residents often use submissive and subservient methods (Lidz, Fischer, and Arnold 1992) that include deferring to staff.

Little is known about the various ways in which residents defer to staff. One nursing home ethnographer observed that residents purposely limited their requests for assistance from staff and refrained from arguing and complaining in an attempt to redress their inequitable relationships with staff (Shield 1988). Other researchers have noted residents yielding to the staff's desire for passive, easygoing, dependent behavior (Baltes, Wahl, and Reichert 1991; Shield 1988; Teitelman and Priddy 1988). This form of deference has been referred to as "learned compliance" and may be expressed in a number of ways, including pretending to be confused, helpless, or indecisive (Nelson 2000).

Deference to staff can have both costs and benefits to the older care recipient. The costs of deference may result in greater dysfunction for care recipients. Specifically, residents in nursing homes may become more dependent in an effort to attract the attention of staff (Baltes 1996). However, benefits may also accrue from deference to staff. Specifically, deference may result in more interaction with and approval from staff, reduced isolation, and increased feelings of control (Baltes et al. 1991; Teitelman and Priddy 1988). Taken together, these benefits may result in increased feelings of stability and security among older care recipients (Nelson 2000).

Deference to family. With a few exceptions (Matthews 1979; Pyke 1999), the examination of older people's deference to their family members from a social exchange perspective has also been an underexplored area of research. The studies by Matthews (1979) and Pyke (1999) find that as older parents become increasingly frail and lose other sources of support, their relationships with their adult children can become imbalanced. That is, the older parents become more dependent on receiving support from their adult children, but are less able to reciprocate in kind. In such cases, as Pyke (1999) explains, "Parental deference appears to be an important way for elders to pay back their children for their services" (p. 669).

Deference to family members may assume different forms. Based on the research of Pyke (1999) and Matthews (1979), it appears that older parents avoid opposing their adult children. They do so by accepting their children's advice while refraining from offering their own. They also avoid criticizing their offspring and attempt to limit their requests for assistance. In summary, the adult parents defer to the suggestions and the needs of their adult children caregivers in numerous ways.

Deference to family members can result in both costs and benefits to the older care recipient. Pyke (1999) and Mathews (1979) observe that deference results in a loss of decision-making power. Older adults may accept the decisions of their adult children even when they conflict with their own judgments and wishes. Thus deference is sometimes costly to their autonomy and their self-esteem. These two researchers note that parental deference can also be beneficial in that intergenerational tensions and conflict with adult children are avoided. This avoidance of conflict may result in more harmonious relationships and continued support to older parents from their adult children.

The present study adds to the small body of research on deference among care recipients by using qualitative methods. Such methods are especially appropriate for the discovery phase of scientific inquiry when a topic has been relatively unexplored (Dey 1999). Qualitative methods provide insights about how individuals perceive their world (McCracken 1988). Analyzing the answers of our research participants to open-ended questions allows us to understand the domains and consequences of deference from their perspective. In so doing, we can identify a typology of deference among older care recipients and enhance our understanding of the costs and benefits associated with deference from their perspective.

Method

Selection Criteria

Recruitment for this study was conducted through AL facility administrators. The research staff explained the study and the sample selection criteria to the administrators from each of three AL residences in a Midwestern state. The inclusion criteria were as follows: (1) in residence at the AL for at least four weeks, (2) age 85 or older, (3) cognitively intact (based on the judgment of the facility administrator), and (4) in need of assistance with at least one activity of daily living (ADL) or instrumental activity of daily living (IADL). When residents who met these criteria expressed interest in participating and gave their permission, the facility administrators provided the residents' names to the interviewers, who then obtained their consent to participate in the interviews.

Interview Schedule

In 2003, we began pilot testing our semistructured interview. A social work student interviewed four AL residents to clarify wording, to identify additional questions, and to determine the optimal length of the interview. Subsequently, all the interviews reported in this study were conducted by either the first author or one of two trained social work students. Interviews took approximately 1 hour to complete; they were audiotaped and transcribed for further analysis.

The interview schedule included close-ended questions about: (1) demographics, (2) self-rated health, (3) ADL (Katz et al. 1963), (4) IADL (Katz

et al. 1963), and (5) depression (Yesavage and Brink 1983). In addition, the interview included a number of open-ended questions, which are the focus of this article. Central to the present research were questions pertaining to the support exchanges of residents with their family members and AL staff. Questions included were as follows:

1. Which of the following statements (I give more support, I get more support, support is balanced) best describes your situation?
2. What do you do to be supportive to others?
3. What do other people do to be supportive to you?
4. Do you have any problems with others?
5. Do others ever do things for you that you wish they would not do?
6. How did you decide to move to this place?
7. Who made this decision?

Each question was followed by a probe such as: Tell me more. Can you give an example?

Data Collection and Analysis

The original aim of this study was to explore the social exchanges of the oldest old residing in AL facilities. We did not begin by systematically seeking information about deference as a form of exchange. Instead, this information emerged spontaneously during the interviews with the residents.

After the data were collected, the three authors began the analysis process by independently reading a subset of the transcripts to identify conceptual themes. It was during this initial conceptualization phase that the theme of deference emerged as a salient aspect of residents' social exchanges. Of the 31 participants in this study, 29 talked about deferring in some manner to staff and/or family members. Subsequently, the authors decided to focus their coding of each transcript on deference. Using NVIVO 2.0, a software package designed for qualitative data analysis, the transcripts were coded by at least two of the authors in relation to (1) forms of deference and (2) consequences of deference. This approach was taken to ensure a comprehensive analysis of the data and to minimize subjectivity. Then in ongoing discussions, the authors continued to clarify and refine the conceptual categories that emerged from the data. In the section that follows, the results of this analysis are presented using illustrative quotes from the study participants. Names and identifying information are omitted to protect confidentiality.

Findings

Our convenience sample consisted of 31 older adults living in three independent, nonprofit AL residences. All respondents were Caucasian. They ranged in age from 85 to 97, with an average age of 88. Of the total sample, 21 were female and 10 were male. With regard to marital status, 28 were widowed, 2 were married, and 1 had never married. Respondents were retired from a variety of occupations. The most common were clerical ($n = 7$), managerial ($n = 4$), and homemaker ($n = 5$). The participants' length of stay in the AL facility ranged from 1 month to 8 years, with an average of 2 years.

With regard to health status, 4 rated their health as excellent, 19 as good, 7 as fair, and 1 as poor. Only two respondents were depressed, as indicated by their scores on the Geriatric Depression Scale (Yesavage and Brink 1983). Their average ADL score was 7.29, based on a scale that ranged from 6 (*totally independent*) to 18 (*totally dependent on others*). Bathing was the most frequent ADL requiring the assistance of others. Their average IADL score was 15.84, based on a scale that ranged from 7 (*totally independent*) to 21 (*totally dependent*). Cleaning and driving were the most frequent IADLs that required help from others. Taken together, these scores indicate that our research participants needed minimal assistance with basic ADLs but required considerable help with IADLs.

When asked to describe the ways in which they provided support to their family and to the AL staff, residents sometimes talked about direct forms of help, such as giving money or assisting with tasks in the facility. However, they more frequently described the indirect ways in which they provided help to staff and family. For example, when asked what she did to support her family, one 93-year-old widowed mother explained, "I do just as my son says. . . . can't do much of anything else." This woman, like many of our respondents, felt that she had a limited repertoire of ways in which she could reciprocate support. Our respondents' experiences are consistent with Blau's (1986) proposition that those with few resources use deference as a form of social exchange. Here, we use their rich narratives to examine the forms and consequences of deference.

Forms of Deference

From our interviews with AL residents, we identified four distinct kinds of deference: participation, pleasantness, cooperation, and gratitude. We found that each form of deference served as a means by which the residents attempted to play a part in social exchanges with staff and family.

Participation. One way in which residents demonstrated deference was by participating in activities. That is, residents consciously chose to become involved in the AL facility's activities as a way of showing support for staff and family. An 89-year-old man, a former carpenter who could carry a tune, explained that his way of helping staff was to participate during hymn singing. He reasoned, "Well, they know that I can sing and that's what they ask me to do . . . That's what I can do. I think when you come here, you should do what you have to do . . . and be involved." For this older gentleman, participating in singing was not so much for him; rather, his participation was for the staff. By complying with their request that he sing, he felt that he was contributing to the staff's ability to do their job.

Participating in AL activities was also a way of showing deference to family members. The residents knew that their adult children wanted them to be content with their move to the AL facility. One way to defer to their children's wishes was to demonstrate an interest in AL activities. When asked how she supported her adult children, a 93-year-old widowed drug store owner explained very simply, "I tell them I play bingo." She then showed the interviewer a shelf in her room filled with stuffed animals that she won during bingo sessions at the facility. This elderly woman did not seem enthusiastic about the game itself; instead, her involvement in this activity appeared to be a response to her children's wish that she be engaged and happy. The stuffed animals were concrete symbols of her participation in AL activities, and they demonstrated her deference to her children's wishes.

Pleasantness. A second way in which residents showed deference was via their efforts to be agreeable. When asked how they supported staff and family, residents talked about trying to avoid complaining or criticizing. For example, despite their displeasure with meals at the AL facility, residents described their efforts to be pleasant to staff by not complaining about the food. Also, when staff provided unwanted help, residents tended to accept the help without complaint. One 86-year-old elderly woman with a college degree told about an activity director who provided unsolicited advice to residents during painting classes. The activity director wanted to add "little squiggles and things" to her picture, but the older resident vehemently resented the activity director's intrusion which she explained by saying "when I'm doing something, I want to do it, don't want anybody else to be doing it!" Nevertheless, she tried to suppress her resentment and, instead, deferred to the activity director's unwanted advice. She did so by being pleasant to the activity director and proudly explained her approach, "I have kept my mouth shut, and I have a big mouth, I kept it shut quite well."

Similarly, respondents deferred to family members by being pleasant and agreeable even when they felt critical. One 92-year-old woman was hurt when her family cancelled her biweekly visit to see them so that they could attend a concert. However, rather than voicing her complaints to her family, she described her efforts to avoid saying "anything that would indicate that I might be irritated." Residents also chose to be pleasant rather than critical when they observed problematic family dynamics. A spry 97-year-old widow strongly disapproved of the way in which her niece interfered in the lives of her own grown children. She stated, "I wish I could tell her. She has a son and she just babies him and I wish I could tell her that. It bothers me but it's none of my business so I'm not going to say anything about it." This older woman wished to be open with her niece about her poor parenting behaviors; however, she opted to defer to her niece by not voicing her criticism. In a related vein, other residents talked about providing support to their family members by avoiding conflict. Attempts to avoid arguments by being agreeable rather than critical were perceived as their contributions to relationships. As a 93-year-old man who had been both a factory worker and farmer stated, "I try to agree with them [children and wife] as much as I possibly can and then when I don't, well, I just shut up because you get into an argument." Although residents had opinions and advice that they wanted to offer, they reasoned that these forms of support would be unwelcome. Instead, they chose to be supportive by deferring to the views of their family members and thus opted to remain silent.

Cooperation. A third way in which residents demonstrated deference was by acquiescing to the wishes of others. When asked what he did to support staff, one resident, a 96-year-old retired minister succinctly replied, "I try to be as cooperative as possible." Others elaborated on this form of deference by describing the specific ways in which they cooperated with staff. One resident, an 87-year-old retired kindergarten teacher, described her efforts to follow the directions of staff concerning her daily schedule. "If they tell me what . . . time I'm suppose to be someplace, why I . . . try to do that." Similarly, the earlier-mentioned widowed mother, age 93, explained that she tried to support the staff by complying with their medical instructions. "I do as I'm told. . . . take all my medications."

Residents also made special efforts to cooperate with their family members. For example, our participants often described their move to the AL facility in terms of providing support to family members. Some explained that it was their sons and daughters who made the decision about where or when to move. One 85-year-old man's move to the AL facility was

prompted by his son following a significant fall. He elaborated, "One day (my son) was over here and he was inquiring and they said this room was available. So he just took it right away. And I didn't object." The residents' willingness to go along with their children's decision was a form of deference that was intended to help ease their concern. Our respondents reasoned that, because their children were worried about their safety, acquiescing to live in an AL facility was one way they could give their children greater peace of mind and thereby reciprocate for their ongoing support. An 85-year-old mother, who moved to the facility as a way of helping her son and daughter-in-law, described her rationale. "My being here will take the load off my son. Getting the house ready to sell has kept him busy and his wife too; taking me to the doctor and hair appointments and to get groceries. Now I'm here and it takes a bit of load off him." For this woman, as for several of our study participants, the move to the AL facility was a way of deferring to the concerns of family members and thereby reciprocating for their help.

Deferring to family members by cooperating with them took other forms as well. Sometimes, for example, residents graciously accepted and used gifts from family members that they did not want. The spry 97-year-old widow told an especially humorous story about receiving five pairs of black slacks for her birthday. She would have much preferred slacks in brighter colors. However, she ultimately acquiesced to her family's wish that she enjoy the slacks. "I just didn't say anything and I kept them anyway." Other times, residents cooperated by working around their family's schedule. The woman who had received the unwanted black slacks also described her approach to making doctor's appointments. "I'd have (my niece) make the appointment when it would be easier for her to go with me because I could go most anytime." This same kind of deference vis-à-vis scheduling their lives around family members was also expressed in relation to requests for help. By carefully planning ahead, residents tried not to impose on their family members. They purposely limited their requests for items from the store or trips to the bank and tried to make requests only when they knew family members were planning such trips for themselves.

Gratitude. Finally, residents demonstrated deference by verbalizing their appreciation of support from others. For some residents, such as a 91-year-old widowed housewife who had problems with incontinence, gratitude was the only remaining form of social exchange in her repertoire. When asked how she gave support to staff, this elderly woman explained that she did so by "just saying thank you often . . . I can't do much except just appreciate what they are doing for me, that's about all I can do for them."

Residents also used gratitude as a form of deference in relation to family members. A 90-year-old single woman had grown especially close to the family of the man for whom she had worked over the years. Eventually, they became surrogate family for her and continued to visit regularly after she moved to the AL facility. When asked how she provided support to her "adopted" family, she explained, "I tell them all the time how fortunate I am to have them because I have no worries or anything." For this woman, who had little to reciprocate, her verbalization of appreciation to these surrogate family members was a key element in her support exchange repertoire. Gratitude as a form of deference was also expressed when residents faced unwanted help. One 86-year-old retired factory worker described his response to help that was provided even when he preferred to be self-sufficient. He stated, "I'd try not to be inhospitable about it . . . I would just try to say thank you and make it sound like I was appreciative." Thus, according to the residents in our study, gratitude was an important way of reciprocating for the support that they received, whether the support was wanted or not. For those with the fewest resources, gratitude appeared to be one of their only forms of social exchange.

Consequences of Deference

Applying Blau's (1986) proposition that social exchanges result in psychological costs as well as rewards, we examined the consequences of deference from the perspective of our older respondents.

Psychological costs. Residents sometimes paid a high price for being deferent. Deference was associated with a belief that if critical feelings were expressed, problems would escalate. When asked what she would do if staff made her upset, a 92-year-old widowed factory worker responded, "I wouldn't make a fuss about it. Because if we make a fuss, then it gets bigger." Given their concern that they might make matters worse by expressing criticism, residents were on guard about what they said. They often decided not to voice negative opinions and, in so doing, limited their opportunities for self-expression. To avoid problematic encounters with staff, one woman, an 88-year-old retired receptionist explained that she had arrived at a simple solution: "All I have to do is keep my mouth shut and stay in my room." Thus, deference to staff sometimes inhibited residents from freely expressing themselves and from socializing. For some, like the retired receptionist, deference resulted in withdrawal and isolation.

Another cost of deference was the inability to change problematic situations. Being deferent to family members was used as a means by which to avoid conflict; thus problems were not openly acknowledged and discussed. If residents had chosen to voice their feelings, they might have found a resolution. Instead, by stifling their opinions they were impotent to engage in problem-solving efforts and the problems persisted. For example, the 85-year-old widowed mother described the way she felt when her adult children helped her get in the car. "My daughter-in-law buckles me [in the seatbelt], you know, and sometimes they grab my arm and walkin' and it makes me feel like—well they do everything for me, makes you feel like an invalid." As with other residents who chose to be silent rather than voice their negative reactions to a family member, the situation remained unresolved.

Psychological costs also occurred when residents tried unsuccessfully to be deferent. AL residents went to considerable lengths to be pleasant and to express gratitude. They tried to participate in activities and to be cooperative. However, sometimes the need to express negative feelings surpassed their ability to suppress these feelings. Residents needed to complain, but then felt guilty when they did. The 93-year-old woman who played bingo to please her children explained that the way she supported her family was "not to complain." She tried to defer to her family's wish that she be content, but sometimes her sadness was overwhelming:

> I don't want to complain that I get tired and I get homesick. It's a long day here . . . I know they feel bad because I'm here, you know, and they want me to be happy . . . They don't like to hear me complain. They don't. They want me to be happy . . . but it's impossible.

Thus for AL residents like her, who found that deference was not always possible, the psychological cost included feelings of inadequacy and guilt.

Psychological rewards. Deference offered the residents a number of rewards as well. Being deferent to staff enabled residents to feel like they were actively contributing partners in their social exchanges. Attempts to cooperate with staff and to be pleasant were opportunities to be reciprocal. For example, by not being critical, the 91-year-old woman with incontinence problems hoped that she was repaying the support that she received from staff. She reasoned, "Maybe that means something to them that I don't criticize them." Similarly, as evidenced by the older gentleman who participated in hymn singing for the sake of the staff, residents felt that their

involvement in AL activities assisted staff and helped sustain these activities. A 96-year-old widow explained that she participated in programs when invited by staff because "they have these things [groups] and I will go because they have them and I want them to continue." Like Nelson (2000), we found that deference to staff contributed to positive relationships. However, the AL residents in our study appeared to be less passive than the nursing home residents described by Nelson (2000). Some of our participants actively chose deference as a way of reciprocating for staff support. That is, being deferent was perceived as contributing to the efforts and well-being of the staff.

Deference to family members also offered significant psychological rewards for the AL residents. Through deference, our respondents felt they were contributing to greater harmony within their families and thereby ensuring ongoing support from them. The study participants, like Matthews' (1979) widowed mothers, used deference to ease the minds of their adult children. Even their willingness to move to an AL facility was often prompted by concerns about the well-being of family members. In particular, they wanted to avoid becoming a source of anxiety for their families. The 86-year-old woman who deferred to the activity director during art class explained that she had made the move to the AL facility, "so that my kids didn't have to worry about that I would fall down at home and nobody would be able to pick me up or anything." Similarly, by deferring to their family's schedule and by limiting their requests for assistance, residents felt that they were lightening the load of their family members. The 91-year-old woman with incontinence problems described her attempts to support her family in the following terms. "[I do] not ask for too many favors." The 97-year-old woman who kept the black slacks told about how, though she needed prunes, she asked her family to wait and buy them only when they were already shopping for themselves. In these ways, AL residents consciously deferred to the needs of their family in an effort to reduce their burden and increase family harmony. Consistent with Pyke's (1999) findings, our study participants used deference toward family members "to maintain the peace and avoid costly conflicts" (p. 662). By steering clear of arguments and remaining silent when they felt judgmental and critical, the AL residents sought to sustain the good will of their family. By expressing positive feelings and avoiding conflictive situations, AL residents made it easier for staff and family to provide care. Ultimately, their deference served as a way of ensuring the continuation of this care.

Discussion

As their ability to reciprocate dwindles, it becomes increasingly important to understand how recipients of care attempt to provide support to others. Our study examines reciprocity by focusing on the deference of care recipients toward their caregivers. Here, we discuss the limitations of this study, then its contributions to the literature, future research directions, and implications for practice.

The findings of the study should be viewed with caution based on several limitations. First, deference as a form of exchange was never a focus of the interviews with residents but emerged from our analysis of the open-ended interviews. Because the topic of deference emerged from the data, we did not ask questions about, for example, forms of deference prior to their move to AL facility. A second limiting factor of our study was its small, homogeneous sample. This research was based on a convenience sample of 31 Caucasian respondents who lived in three AL facilities in one Midwestern state. Also, by focusing on AL residents, the exploration of deference was limited to care recipients who had fewer options for reciprocity within their social exchanges. Finally, this study was limited by its focus on qualitative methods. Although we gained some insights in this exploratory phase of research, it will be important to conduct quantitative research that can determine the extent to which older recipients use different forms of deference and to assess the relationship between deference and well-being.

Despite the limitations of this research, our work contributes to the sparse literature on social relationships within AL, a residential care option that is growing rapidly. Although previous research (Rakowski et al. 2003; Zimmerman et al. 2003) used quantitative methods to explore the relationships of AL residents, our qualitative approach has led to additional insights. Specifically, our research enabled us to identify the hidden ways in which AL residents exchanged support with their caregivers. Like the aging parents in other qualitative studies (Matthews 1979; Pyke 1999), our AL residents attempted to reciprocate for the support they received by not asking for help and not speaking their mind when they felt critical. In so doing, they seemed to be trying to ease the demands on their care provider. Our use of open-ended questions and qualitative analysis allowed us to uncover these otherwise invisible forms of support and to illuminate their potential importance in the AL residents' exchange repertoire.

Second, we contribute to a beginning understanding of the ways in which oldest old care recipients perceive their social exchanges with AL

staff and family members. Similar to the deference accorded to staff by nursing home residents (Nelson 2000), we discovered that AL residents tried to help staff and family by complying with their instructions. However, we also found that residents deferred in other ways that were less straightforward. For example, some of our residents talked about how they deferred to the invitations of staff to become involved in AL activities. They regarded their participation in AL activities as a form of support for the staff. That is, their involvement in activities was not so much for themselves but was a means by which they could contribute to the well-being of the staff. Similarly, in relation to family, some residents felt that by deferring to the wishes of their children to move to the AL facility, they were supporting them. Thus residents often viewed their move to the facility as more for their children than for themselves. In so doing, they felt they were contributing to their children's well-being. By examining deference to both staff and family, we were able to illuminate some of the complex ways in which the oldest old think about reciprocity within their relationships.

Third, our work helps uncover the nature of deference, which is a construct that is underdeveloped in Blau's (1986) theory of social exchange. In his first proposition, Blau posits that persons who are more dependent on others and have fewer resources to contribute to relationships attempt to balance their social exchanges via compliance or deference. That is, deference provides a way by which to reciprocate for the support they receive from their caregivers. Although Blau's proposition points to the possible role of deference in social exchanges, our work clarifies the meaning of deference for older care recipients by identifying several distinct kinds of deference. The resulting typology includes two forms of deference (i.e., cooperation and pleasantness) described by others (Baltes et al. 1991; Shield 1988; Teitelman and Priddy 1988). However, two other forms that emerged from this research (i.e., participation and gratitude) represent additions to the literature on deference.

Our work enriches Blau's (1986) first proposition by identifying several nuanced approaches to deference. Consistent with Nelson's concept of "learned compliance" (2000), some of our participants exhibited deference by passively acquiescing to the requests of staff and family. In addition, we discovered that some participants exhibited a more proactive approach to deference, as evidenced by those who deliberately chose to participate in activities or consciously expressed their gratitude. That is, they intentionally decided to be deferent as a way of contributing to the well-being of staff and family. Moreover, our work expands on Blau's (1986) social exchange proposition by suggesting that individuals may use different

forms of deference based on their resources. For example, those with more physical energy and psychological reserves may defer by participating in activities, whereas those who are frail may defer via gratitude. Indeed, expressing appreciation may be the default form of deference for those with the fewest resources.

Our research also enriches Blau's (1986) second social exchange proposition positing that exchanges are associated with costs as well as rewards. Blau highlights the costs associated with compliance and deference. Our findings identify some of these costs such as inhibiting the expression of feelings and the ability to resolve problematic situations. Such costs may eventually lead to significant psychological problems. That is, avoidance of criticism can maintain the status quo so problems persist. This, in turn, can increase feelings of powerlessness. Also, stifling self-expression and limiting self-determination may lead to feelings of depression and hopelessness. Our work also adds to Blau's proposition by highlighting the possible rewards associated with deference. We found that respondents' deference seemed to be related to feeling that they were contributing partners in an exchange. AL residents felt that deference to their caregivers helped ease the caregivers' burden. Consistent with previous research (Baltes et al. 1991; Pyke 1999), older residents in this study appeared to view their deference as a way of contributing to good will within their relationships and, ultimately, to the maintenance of crucial support. Taken together, these findings enrich Blau's (1986) propositions and suggest a number of hypotheses that could be tested in future research.

We suggest that future research not only continue to explore deference as a form of social exchange in the oldest old but that it also expand the exploration of deference to different contexts. It would be interesting to pose more specific questions about deference and examine changes in this construct as a function of moving to an AL or other kinds of residential care. It would also be informative to explore the meaning of deference among older adults who have greater resources and more ways in which to reciprocate. In addition, it would be fruitful to examine cross-cultural differences in deference among aging care recipients. Finally, future studies might explore in greater depth the nuanced complexities of deferential behavior used to demonstrate honor, worth, and value within relationships.

Our findings also have implications for practice. Gerontological practitioners (e.g., nurses, social workers) can help staff and family understand that care recipients need to experience reciprocity in their relationships and that, when they have few alternatives, deference may become increasingly salient. Practitioners can assist staff and family to identify the ways in

which care recipients are deferring to them, can help them assess the consequences of deference for the resident, and can explore with them ways in which to enhance other methods of reciprocity.

This study enhances our understanding of exchange relationships among care recipients in AL facilities. By focusing on deference, we illuminated some of the ways in which frail elders reciprocate for the care they receive. Our exploratory work points to some of the intricate pathways by which efforts to reciprocate can lead to positive—as well as negative—consequences for older adults. We encourage others to build on this research by exploring deference in different contexts to shed further light on the nature of reciprocity within social relationships.

References

Baltes, M. M. 1996. *The Many Faces of Dependency in Old Age.* Melbourne, Australia: Cambridge University Press.

Baltes, M. M., H. W. Wahl, and M. Reichert. 1991. "Successful Aging in Long-term Care Institution." Pp. 311–37 in *Annual Review of Gerontology and Geriatrics*, vol. 11, edited by W. Schaie and M. P. Lawton. New York: Springer.

Blau, P. M. 1986. *Exchange and Power in Social Life.* New Brunswick, NJ: Transaction Books.

Dey, I. 1999. *Grounding Grounded Theory: Guidelines for Qualitative Inquiry.* New York: Academic Press.

Dunkle, R., B. Roberts, and M. Haug. 2001. *The Oldest Old in Everyday Life.* New York: Springer.

Ingersoll-Dayton, B. and T. Antonucci. 1988. "Reciprocal and Nonreciprocal Social Support: Contrasting Sides of Intimate Relationships." *Journal of Gerontology* 43 (3): 565–73.

Katz, S., A. B. Ford, R. W. Moskowitz, B. A. Jackson, and M. W. Jaffe. 1963. "Studies of Illness and the Aged: The Index of ADL." *Journal of the American Medical Association* 185:914–19.

Lawrence, A. R. and A. R. S. Schigelone. 2002. "Reciprocity Beyond the Dyadic Relationship." *Research on Aging* 24 (6): 684–704.

Lidz, C. W., L. Fischer, and R. M. Arnold. 1992. *The Erosion of Autonomy in Long-Term Care.* New York: Oxford University Press.

Lustbader, W. 1991. *Counting on Kindness: The Dilemmas of Dependency.* New York: Free Press.

Matthews, S. H. 1979. *The Social World of Old Women.* Beverly Hills, CA: Sage.

McCracken, G. D. 1988. *The Long Interview.* Newbury Park, CA: Sage.

Meyer, H. 1998. "The Bottom Line on Assisted Living." *Hospitals and Health Networks* 72 (14): 22–26.

Nelson, H. W. 2000. "Injustice and Conflict in Nursing Homes: Toward Advocacy and Exchange." *Journal of Aging Studies* 14 (1): 39–61.

Pyke, K. 1999. "The Micropolitics of Care in Relationships Between Aging Parents and Adult Children: Individualism, Collectivism, and Power." *Journal of Marriage and the Family* 61 (3): 661–72.

Rakowski, W., M. A. Clark, S. C. Miller, and K. M. Berg. 2003. "Successful Aging and Reciprocity Among Older Adults in Assisted Living Setting. Pp. 25–54 in *Successful Aging and Adaptation with Chronic Diseases*, edited by L. W. Poon, S. H. Gueldner, and B. M. Sprouse. New York: Springer.

Shield, R. R. 1988. *Uneasy Endings: Daily Life in an American Nursing Home.* Ithaca, NY: Cornell University Press.

Teitelman, J. L. and J. M. Priddy. 1988. "From Psychological Theory to Practice: Improving Frail Elder's Quality of Life Through Control-Enhancing Interventions." *Journal of Applied Gerontology* 7 (3): 298–315.

Walker, A. J., C. C. Pratt, and N. C. Oppy. 1992. "Perceived Reciprocity in Family Caregiving." *Family Relations* 41:82–85.

Wentowski, G. 1981. "Reciprocity and the Coping Strategies of Older People: Cultural Dimensions of Network Building." *The Gerontologist* 21:600–609.

Yesavage, J. A. and T. L. Brink. 1983. "Development and Validation of a Geriatric Depression Screening Scale: A Preliminary Report." *Journal of Psychiatric Research* 17:37–49.

Zimmerman, S., A. C. Scott, N. N. Park, S. A. Hall, M. M. Wetherby, A. L. Gruber-Baldini, and L. A. Morgan. 2003. "Social Engagement and Its Relationship to Service Provision in Residential Care and Assisted Living." *Social Work Research* 27 (1): 6–18.

Zimmerman, S., P. D. Sloan, J. K. Eckert, A. L. Gruger-Baldini, L. A. Morgan, J. R. Hebel, J. Magaziner, S. C. Stearns, and C. K. Chen. 2005. "How Good Is Assisted Living? Findings and Implications from an Outcomes Study." *Journal of Gerontology: Social Sciences* 60B (4): S195–S204.

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