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COLLEGE OF SOCIAL SCIENCES

MAKING ASSISTED LIVING A HOME: RELOCATION, SOCIAL SUPPORT, AND  
THE MENTAL WELL-BEING OF RESIDENTS IN ASSISTED LIVING

By

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To my Mama, who brings light to my life,  
And to my Pops, who adds a healthy dose of laughter.

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## ABSTRACT

Depression is the most common mental health problem faced by people aged 65 and older. Residents in long term care facilities are among those at the greatest risk of suffering from depression. While past research indicates that a substantial proportion of nursing home residents suffer from depression, few studies have examined the rates of depression among assisted living residents. My dissertation examines the relative significance of various factors on resident well-being. I specifically focus on the impact of residents' social support networks as well as their level of control over the move to assisted living as important factors in determining resident well-being. Since the link between social support and depression has been well documented in the literature, I also examine various factors that could potentially impact residents' social support networks.

My first set of analyses examines the influence of numerous factors on the well-being of residents in assisted living. My findings indicate that, contrary to my hypothesis, resident control over the decision to move to an ALF is not the most important predictor of resident depression. Instead, residents' social support systems and their attitudes regarding their current facility are the strongest predictors of depression outcomes. In general, residents who have social ties, both within and outside of their facility, are also less likely to suffer from depression. Residents who are satisfied with their current facility tend also to be happier than their unsatisfied counterparts. These findings suggest that residents' views regarding both their current living situation as well as their level of social involvement matter more in terms of predicting resident well-being than how they came to live in an ALF.

My second set of analyses considers the factors that shape residents' social support networks. My results indicate that, on the whole, whether residents' had control over their move to assisted living predicts their social support outcomes. Residents who had control over their move are more likely to maintain satisfactory relationships with both their family and friends. This suggests that future studies would benefit from a more in-depth analysis of what can be done to ensure that elders feel they are in control of the relocation process. Such studies could provide facility administrators as well as ALF residents and their families with information that could ease the transition into assisted living.

## CHAPTER ONE INTRODUCTION AND LITERATURE REVIEW

Depression is the most common mental health problem affecting people aged 65 and older. Residents in long term care facilities are among those elderly at the greatest risk of suffering from depression. Residents in nursing homes, for example, are three to five times more likely than elders living in the community to suffer from depression (NIH 1992; Chandler and Chandler 1988). Moreover, studies suggest that up to 50% of nursing home residents suffer from minor depression (Rosen, Musant, and Pollack 2000).

Past research indicates that depression affects elders' rates of mortality and morbidity as well as their health and overall life satisfaction (Blazer et al. 2000; Cooke and Tucker 2001). Residents in nursing homes and assisted living facilities are especially at risk of suffering from the negative consequences associated with depression, given the high rates of depression among residents in long term care facilities. A study conducted by Reynolds and Kupfer (1999), for example, estimates that depression increases the likelihood of resident mortality by 59 percent, regardless of physical health status.

While a good deal of research has documented rates of depression among nursing home residents, relatively few studies have examined levels of depression among residents in assisted living facilities (ALFs). What little research that has been done on depression among ALF residents suggests that it is a serious problem (Cummings 2002). Considering the high levels of depression found among nursing home residents, as well as the negative consequences depression carries for elders' overall health, it is important that researchers gain a better understanding of depression among assisted living residents.

Depression is not the only measure used in the literature to examine mental health outcomes. Well-being is another frequently used term that refers to people's quality of life (Bryant and Marques 1986). Well-being is a multidimensional concept that encompasses individuals' overall emotional and mental health. Past research has used a variety of different measures for well-being. Some studies measure well-being subjectively, focusing on individuals' self-assessments of life satisfaction, while other studies measure well-being objectively, relying on measures of financial status and physical health as indicators of well-being (George 2006). Researchers should examine both residents' levels of depression as well as their levels of well-being in order to

develop a thorough understanding of the mental health issues facing residents of assisted living.

A substantial body of research has shown that social support systems matter in predicting well-being among the elderly. Therefore it is critical to understand what happens when these social support systems are disrupted due to relocation. A move can either enhance or reduce older people's social support systems. Some older individuals, for example, move to be near a child or other relative. Others may choose to move from their long-term home to a retirement community, assisted living facility, or nursing home. In some cases such moves are prompted by convenience factors, such as easing day-to-day responsibilities. In other cases, such moves are brought about by failing health (Johnson and Barer 1997).

Regardless of the reasons behind the relocation, the move from home to a long-term institution can potentially have both positive and negative implications for the social support systems of the elderly. The move to an institutional facility may lead to new sources of social support if the elderly move closer to kin or develop friendships with other residents and/or staff. On the other hand, the move to an institutional facility may be deleterious for the social support systems of the elderly. Some older people may have to move away from their kin and/or friendship networks in the community. Moves constitute major life changes for the elderly that can carry serious repercussions for their social support systems and potentially transform their lives in either a positive or negative direction.

Although previous research indicates that relocation and social support influence elders' quality of life, most research examines the impact of these factors independent of each other. Few studies examine the impact of relocation on social support systems. Thus little is known about what happens to older peoples' support networks when they move from one setting to another. An exploration of the relationship among relocation, social support, and depression can provide a more in-depth understanding of the impact of relocation on the lives of the elderly.

My dissertation seeks to explore this issue by examining the relationship between depression, relocation, and social support among residents in assisted living. Specifically, I am interested in examining the role social support plays in determining

resident well-being, as well as determining other factors, such as age, educational attainment, marital status, gender, health status, ALF environment, and resident control over the move, that influence residents' mental health outcomes. I also hope to gain a better understanding of the factors, such as geographic proximity, that influence residents' social support networks.

Assisted living refers to elderly housing that provides residents with personal care assistance, 24-hour supervision, health care services, and social activities. ALFs claim to provide a homelike atmosphere and assist their residents in maintaining a sense of autonomy and dignity. They are not designed to care for residents who are bedridden, who require 24-hour nursing supervision, or who have stage 3 or 4 pressure sores (Pepper Institute of Aging and Public Policy 2002).

Assisted living is currently the fastest growing form of elder housing in the United States. ALFs boasted an annual growth rate of approximately 15-20% in the 1990s (AHCA 1998). It is estimated that as many as 600,000 seniors currently live in an ALF in the United States. Florida alone housed 2,305 assisted living facilities in 2000, which accommodated approximately 75,000 residents (Pepper Institute on Aging and Public Policy 2002). Considering the rapid growth of assisted living in the U.S. today, it is crucial that researchers gain a better understanding of depression among their residents.

In this chapter, I examine previous research concerning the relationship between social support and well-being in the lives of the elderly. First, I address the theoretical background underpinning social support research. I specifically define and examine terms such as social networks, social support, and stress process. In addition, I discuss the distinction between perceived versus actual support. Second, I address the unique role that social support has in the lives of the elderly. I examine the sources from which the aged receive social support, concentrating on the different roles played by spouses, children, and friends. I also address the influence of geographic proximity on elders' social support systems. Third, I examine the prevalence of depression among the elderly as well as various factors that contribute to the mental outcomes of older adults.

## **Social Support and Depression**

A substantial body of research has shown that social support is an important predictor of depression and well-being among the elderly. Durkheim's influential study of suicide ([1897] 1951) stimulated interest among social scientists regarding the importance of social ties. He argued that the emergence of an industrialized society had resulted in a breakdown of social integration. As workers migrated to urban areas to find jobs they severed their ties with family, church, and the larger community, which resulted in a loss of social support and a lessening of social constraints. Durkheim looked at suicide rates to examine the impact of diminished social integration on psychological well-being. He found that people with few social ties were more likely to commit suicide.

Since Durkheim's influential work, a large body of research has continued to document the link between social ties and psychological well-being. Past research indicates that older adults who have supportive social support networks tend to report less loneliness, higher levels of life satisfaction, and fewer symptoms of depression than older adults who are not embedded in supportive social networks (Russell and Cutrona 1991; Oxman 1992).

## **Definitions of Social Support**

Little consensus currently exists among scholars regarding the appropriate way to conceptualize and define social support as well as related terms such as social integration and social networks. Much of the debate centers on whether to conceptualize social support in terms of the structure of such relationships or in terms of the functions that they provide. Consequently, these terms have been used interchangeably in past literature to refer to both the structural and functional aspects of social relationships (Cohen and Syme 1985).

Social integration and social networks have often been used in the literature to describe structural elements of social relationships. Social integration, for example, usually refers to the existence and quantity of social relationships. The term social network is used to refer to the structural properties of social relationships.

Social support, on the other hand, is typically used to describe the functional aspects of social support -- such as the provision of emotional, instrumental, or tangible help (Cohen and Syme 1985; House and Kahn 1985). In addition it is used to refer to the more qualitative aspects of social relationships, such as the level of satisfaction that people feel regarding the support that they receive (Antonucci, Fuhrer, and Dartigues 1997).

How scholars choose to define and conceptualize these terms carries important implications for resulting research. It is difficult for researchers to make comparisons across studies without a consensus regarding the appropriate definition of social support. Since this paper will focus greatly on the concepts of social support, social integration, and social networks, I will now briefly discuss the manner in which these terms are most commonly used.

### **Social networks**

Social networks are the vehicles through which social support is exchanged. Networks consist of a set of points (people) and the ties of support that connect them (Antonucci 1985). Social networks can be examined with regard to their structure, composition, and component relationships (Vaux 1988). The structure of a social network is determined by both its size (the number of individuals who make up the networks) as well as its density (the level of interconnectedness among network members) (Antonucci 1985; Vaux 1988).

Network composition refers to the proportion of the network that is made up of friends, family members, etc. In addition, the composition of a network is determined by the level of homogeneity among members with respect to age, race/ethnicity, gender, and social status (Vaux 1988). The relationships within a social network can be assessed according to many factors such as the frequency with which contact occurs, the geographic proximity of its members, and the strength and resiliency of the relationships. In addition, researchers often examine the context in which social support exchanges take place, the degree of reciprocity involved, as well as whether the relationship consists of one or more different types of exchange (Vaux 1988).

## **Social support**

The term social support has been defined in various ways. Some scholars, for example, base their definition of social support on individuals' perceptions regarding the level of social support that they receive (Lowenthal and Haven 1968). In a study conducted by Lowenthal and Haven, for example, the authors allowed the respondents to determine what they considered to be an intimate relationship (1968).

Other research in this area has defined social support in terms of differing types of support. In other words, such research focuses on categories of supportive behaviors and/or actions (Antonucci 1985). One commonly used typology, developed by Kahn and Antonucci, separates social support into three categories: affective, affirmative, and aid (Kahn and Antonucci 1980). Affective support, according to Kahn and Antonucci, refers to, "expressions of liking, admiration, respect, or love." Affirmative support refers to, "expressions of agreement or acknowledgement of the appropriateness or rightness of some act or statements of another person." Finally, they define aid as "transactions in which direct aid or assistance is given, including things, money, information, time and entitlements."

Still other scholars define social support according to whether it leads to positive or negative outcomes (Antonucci 1985). Until recently, the majority of research in this area focused on the positive outcomes of social support in terms of both mental and physical health. Current research, however, indicates that social support networks may not solely result in benefits for the elderly. On the contrary, some current research suggests that social support may, in fact, exert a detrimental impact on older adults' risk of mortality as well as on their physical and mental health (Silverstein, Chen, and Heller 1996).

Some studies, for example, suggest that there can be "too much of a good thing," when it comes to social support among the elderly (Silverstein, Chen, and Heller 1996; Krause 1987). Silverstein, et al examined a sample of 539 older respondents in the University of Southern California Longitudinal Study of Generations to determine whether an excessive amount of received support leads to an increase in distress levels

among the elderly. Their results indicate that moderate levels of received social support from children serve to enhance older individuals' well-being. However, an excessive amount of intergenerational support (oversupport) can lead to adverse psychological outcomes.

Krause also found that the receipt of social support may carry negative consequences for the elderly. Specifically he examined the relationship between received support, anticipated support, and mortality among elders (1997). Received support refers to measures of tangible help actually received by the individual, while anticipated support refers to the level of support that individuals feel is available to them if necessary (1997). His findings suggest that while anticipated social support is indeed associated with a decrease in mortality rates among elders, received support is actually associated with an increase in mortality.

One explanation for the possible detrimental impact of received support upon elder well-being centers around autonomy. Proponents of this explanation maintain that the elderly place a high value upon independence and self-reliance. They prefer to handle their problems on their own rather than turn to others for assistance (Lee 1985). As such, if the elderly are forced to turn to others for assistance, it can negatively impact their well-being. They may view the need to ask for help as a sign of vulnerability or as an admittance that they are unable to take care of themselves. Accordingly, elders who are forced to turn to others for help may have lower self-esteems and feel more dependent on their support providers than their counterparts who are better able to take care of themselves (Krause 1987). Of course, the negative impact of received support on mortality could also be explained by the physical condition of those elders actually receiving support. In other words, those individuals who are in poor physical health may have a greater need for actual support, and thus be more likely to receive that support, than their counterparts in better health. In this case, poor physical health rather than actual received support would explain the increase in mortality risk.

The negative impact of social support on elderly well-being, however, is not solely attributable to the loss of control or autonomy associated with received support. Instead, some researchers assert that interpersonal conflict can also lead to feelings of distress among the elderly (Krause 2001). Currently, there is little empirical research

that examines the links between conflict, social support, and elders' well-being. What research has been done in this area is mixed.

Dunham, for example, focused on the relationship between intergenerational conflict, social support, and depression among elderly parents (1995). She proposed that conflict between older parents and their adult children would exacerbate the negative impact of social support from children on their parents' well being. Her results, however, failed to substantiate this claim. Although her results did show that elderly parents who received social support from their children were more depressed than those who did not receive support, after controlling for physical health. This relationship did not vary according to the level of conflict involved with the interaction (1995).

Finally, social support has also been used to refer to the qualitative nature of social support, especially the level of satisfaction that people feel regarding the support that they receive (Antonucci, Fuhrer, and Dartigues 1997). This is a more subjective measure of social support as it takes into account individuals' perceptions of the support they receive (Doeglas et al 1996). Recently, researchers who examine social support have delved into the relative importance of actual versus perceived/anticipated support. Perceived social support is typically measured by asking people the extent to which they feel they have support available to them. Received support is usually measured by asking people about the specific acts of social support they have actually received (Helgeson 1993).

**Perceived versus Actual Support.** Some research indicates that measures of individuals' perceptions regarding social support may, in fact, be as good a predictor of health outcomes and well-being than measures of actual support received, if not superior. Wethington and Kessler, for example, found that the impact of social support on stress is more strongly linked to perceptions of social support rather than to actual supportive behaviors (1986). Helgeson (1993) examined the relative impact of perceived versus received social support on patients' adjustment to a first cardiac event. In this case, adjustment is measured as the patients' ability to adjust to life after the cardiac event in terms of their health, work and home lives, sexual relationships, relationships with extended family, social activities, and psychological distress. Her results indicate that

perceived support was, in fact, a better predictor of patient adjustment than was actual support received.

Researchers have advanced three possible explanations for the greater positive impact of perceived versus actual support on well-being. First, the knowledge that there are people available to provide support if and when necessary provides individuals with a social safety net that encourages them to try to solve problems on their own (Wethington and Kessler 1986). If the individuals are indeed able to solve their problem without seeking external help, this may increase feelings of well-being, self-worth, and personal control (Rodin 1990).

Second, anticipated support may enhance the functioning of an individual's social network. Past research has shown that social support providers can feel burdened and overwhelmed if faced with repeat requests for assistance (La Gaipa 1990). If, however, elders feel encouraged by their social networks to address their own needs, it might help to mitigate the strain placed upon social support providers as well as enhance feelings of well-being among the elderly (Krause 2001).

Finally, the realization that others are available to provide support if/when necessary may foster the belief that current stressors are temporary and can eventually be resolved. In other words, the support net provided by anticipated support may provide the elderly with a sense of hope (Krause 2001). Research has shown that individuals are able to overcome enormous difficulties if they maintain hope and believe that the situation can be overcome (Nunn 1996).

### **Social Support and the Stress Process**

Scholars have proposed the stress process model as a theoretical approach that highlights the social factors that mediate and moderate the impact of stress on health and well-being. This approach defines stress as a demanding level of environmental strain placed on a person (Wheaton 1983). The stress process model focuses on three elements: 1) the circumstances that give rise to stress (stressors); 2) the consequences or outcomes of stress (outcomes); and 3) the tactics people use and resources they have to draw upon to mediate stress (mediators) (Pearlin 1989).

Historically, researchers have concentrated on two types of stressors – life events and chronic strains. Life events refer to discrete events whose occurrence leads to stress. Life events that are undesired, unplanned, uncontrolled, and nonnormative tend to carry the most harmful consequences for individuals (Pearlin 1989). Chronic strains, on the other hand, refer to continuous, ongoing sources of stress, such as conflicts, problems, and threats that individuals face in their day to day lives (Pearlin et al 1981). Research suggests that such persistent stress results in more deleterious outcomes than acute events, particularly among the elderly (Aneshensel 1992).

Outcomes refer to the consequences of stress on the individual. Typically, past research has focused on the manifestation of stress on physical and mental health (Pearlin et al 1981). Stress has been found to impact, “the immunological and endocrine systems, the digestive and cardiovascular systems, anxiety, depression, and mental health” (Pearlin 1989 p.252).

Mediators are resources that influence how individuals react to stressors. Coping is commonly identified in the literature as one such factor that mitigates the impact of stressors. Coping refers to individuals’ behavioral, cognitive, or perceptual responses to stress that can serve to avoid, control, or lessen its impact. Evidence suggests that coping techniques can help reduce the negative impact of stress on emotional well-being (Pearlin and Schooler 1981). Social support is another factor that helps mitigate the impact of stress. Social support can limit the severity of outcomes that follow a stressor by lessening the detrimental outcomes resulting from individuals’ responses to stress, particularly in terms of mortality, as well as physical and mental health (Turner 1983; Pearlin 1989).

One common question addressed in the social support literature concerns when social support matters the most in terms of its impact on health. Does social support affect an individual’s mental health regardless of their stress level or does it serve as a buffer, mitigating the harmful impact of stress on health (Turner and Turner 1999; Kessler and McLeod 1985). In other words, does social support have a greater impact in times of high stress as compared to less stressful times? The answer to this question has important implications for determining who has the greatest need for social support and thus may benefit the most from some sort of social support program (Turner 1983).

Past research examining the main versus buffering debate has produced mixed results. Some studies have found that social support impacts health regardless of stress level. Other research, however, indicates that social support is only significant during periods of high stress (Turner 1983, Turner and Noh 1983). For the most part research findings suggest that, while social support has a clear impact on mental health status regardless of stress levels, it has a greater impact in times of high stress (Turner and Turner 1999).

There is also evidence of a relationship between an individual's social location (i.e., socioeconomic status, gender, age, marital status, etc.), social support, and stress. For example, stress is more likely to result in psychological distress among individuals with low socioeconomic status (Turner and Marino 1994; Turner and Turner 1999). Social support partially accounts for the increased susceptibility to stress found among lower-class individuals (Turner and Noh 1983). Social support has a greater impact on the responses of higher- and middle-class individuals to stress than those of their lower-class counterparts. For example, among the middle-class, social support is a significant predictor of psychological distress, regardless of stress level. Among the lower-class, however, social support only matters in times of high stress (Turner and Noh 1983). Interestingly, the level of social support that individuals have access to does not, in fact, vary by class. Available research indicates that class does not impact individuals' access to, and quality of, social support systems (Turner and Marino 1994).

Overall, research using the stress process model suggests that the social context in which an individual is located carries important implications for the stress process, including the role that social support plays in this process. An individual's class location, for example, does not impact the level of social support that they receive, but does impact the ability of their social support system to mediate the stress they encounter. My research will examine the ability of social support to mediate stress among assisted living residents.

### **Sources of Social Support**

Research that examines the impact of social support on the elderly typically focuses on the influence of family, friends, and neighbors (Cantor and Little 1985; Sauer

and Conrad 1985; Armstrong and Goldstein 1990). However, there is much debate regarding which of these sources of support has the greatest influence on the lives of the aged. The following sections give an overview of the literature that examines the impact of varying sources of social support on the elderly.

**Family.** A substantial amount of research has highlighted the importance of the support that families provide to their members. Past research suggests that family members are the primary source of instrumental support (information, assistance, and aid) for individuals throughout the life course (Longino and Lipman 1981; Adams and Blieszner 1995). Family members are also more likely than friends to provide the elderly with support when their needs are both significant and on-going (Litwak 1985; Antonucci and Akiyama 1995). The type of support the elderly receive from a family member depends upon their relationship to the provider. The elderly receive varying types and levels of support from their spouse and children.

*Spouse Support.* Research is mixed concerning the impact of a spouse on the receipt of social support among the elderly. Some studies find that married elderly people have higher “levels of morale, life satisfaction, mental and physical health, economic resources, social integration and social support, and lower rates of institutionalization” than their nonmarried counterparts (Verbrugge 1979). However, other research suggests that marital status may not be as important of a predictor of social support as previously thought. Choi (1996), for example, found that the difference in the level of social support received by never-married and divorced elderly compared to their married counterparts was not, for the most part, explained by marital status. Instead individual characteristics such as gender, race, health, and educational attainment, and family characteristics such as siblings and number of children accounted for most of the difference. Longino and Lipman (1981) also explored the impact of marital status on the nature and quality of informal support that older adults receive. Their findings indicate that marital status does not impact the number of people to whom individuals turn for support. Regardless of marital status, respondents report a support network of 10 people, on average, to whom they turn to for help. They also find that marital status does impact the number of an individual’s primary (close personal relationships) versus secondary relations. In their study elderly men without spouses reported fewer primary relations

than their married counterparts, but these results did not hold for women. Widowed women receive more support from their family members than do their male counterparts. Longino and Lipman conjecture that, historically, married women have invested more time than men in maintaining their households' family and friendship ties. Consequently, as they grow older, women benefit from the social support that stems from such ties. Men, on the other hand, benefit from such ties while their wives are alive but often suffer their loss upon the death of their wives. Longino and Lipman hypothesize, however, that the deficit in primary relations found among unmarried, particularly male, residents may be partially compensated for through their secondary relations. Residents without spouses report more secondary relations than their counterparts with spouses.

In sum, past research is inconsistent regarding the impact of having a spouse on the receipt of social support among the elderly. While some research indicates that having a spouse is a significant predictor of social support among the elderly, other research suggests that it may not be as important as other individual and family characteristics. In addition, some research shows that the support elderly individuals lose upon the death of their spouse may be partly compensated for through other relationships.

*Children.* Findings regarding the social support that children provide to their elderly parents are also mixed. Some research has shown that adult children are an important source of both instrumental and emotional support for their adult parents (Eggebeen and Hogan 1990; Litwak 1985; Rossi and Rossi 1990; Shanas 1979). Other research indicates that older persons prefer to rely on friends and other relatives rather than depend on their children for emotional and instrumental support.

Silverstein and Bengston (1991) examined the link between older parent-child relationships and mortality using a sample of 439 elderly parents from the U.S.C. Longitudinal Study of Generations. Their results indicated that while reported intimacy with adult children had no direct effect on mortality, it did have a buffering effect. In other words, elderly parents benefited from close emotional ties with their children in the context of a stressor. Specifically, elderly parents who had intimate ties with their children lived longer after the death of a loved one than those parents without intimate ties to their children. This relationship was especially strong among those parents who experienced the death of a spouse.

Dean, Kolody, and Wood (1990) studied 1,174 elderly individuals to examine the impact of varying sources of social support on symptoms of depression among the elderly. Specifically, they addressed the relative contributions of spouses, friends, and children on the well-being of their respondents. Their results indicate that, compared to spouses and friends, support from children exerted the weakest effect on overall depression. The authors caution, however, that the relative impact of children on depression may vary episodically during times of illness or stress.

Oxman, Berkman, Kasl, Freeman and Barrett (1992) studied 2,806 elderly women and men to examine the impact of social support on depression. Their results contradicted previous studies that found that support from children is the weakest predictor of depression. Their results indicate that visual contact with children, measured as face-to-face visits, is more important than visual contact with friends or other relatives in predicting depressive symptoms.

Finally, Stoller (1985) examined the impact of reciprocity in exchange patterns between elderly parents and their children on well-being. She found that, while the receipt of help from children was positively associated with depressive symptoms, the provision of help to children was negatively related to depressive symptoms, after controlling for health. She concluded that the well-being of elderly persons is undermined, not because of the need for assistance, but rather if they are unable to participate in a reciprocal relationship with their children.

As stated earlier, research focused on social support from children and its impact on the elderly is mixed. In some cases support from children is clearly beneficial, especially within the contexts of stressors, such as the loss of a loved one. The nature of the relationship also appears to be important. Elderly parents derive more benefits from their relationships with their children when the relationship is reciprocal rather than one-sided. In other circumstances, however, social support from children exerts only a weak effect on the well-being of the elderly.

**Friends.** Past literature has identified the support that individuals receive from their family as the most common source of social support among the elderly. However, it is also clear that the support provided by friends plays a unique and significant role in the lives of the elderly. As mentioned earlier, research has shown that friends tend to provide

the elderly with different types of support than do family members. Studies suggest that friends are more likely to provide elderly individuals with emotional support while family members are more likely to provide instrumental support (Crohan and Antonucci 1989; Seeman and Berkman 1988). Research also shows that the elderly are more likely to name friends, rather than family, as the people they enjoy spending time with and as the people with whom they spend most of their time (Antonucci and Akiyama 1995).

Moreover, some research has shown that the support provided by friends is a more important predictor of elderly persons' morale and well-being than that provided by certain family members (Adams and Blieszner 1989; Matthews 1986; and Peters and Kaiser 1985; Lee and Ellithorpe 1982). Dean, Kolody, and Wood (1990), for example, found that support from friends exerted a weaker impact on depressive symptoms than support from a spouse, but a stronger impact than support from children and other relatives. Similarly, Wood and Robertson found, in a sample of 257 grandparents, that friends had a stronger positive influence on the morale of the elderly than did grandchildren. Moreover, in many cases studies have shown that the elderly prefer to turn to friends rather than family for support (Griffith 1985).

The literature clearly indicates that friendship plays an important role in the lives of the elderly. The important role that friendship plays in the lives of the elderly could potentially have a positive or negative impact on their mental and physical health post-relocation. For example, relocated elders could stave off a loss of morale or even experience an increase in feelings of well-being if they are able to form friendships in their new facilities. If however, they are unsuccessful at making new friends, or if they are unable to maintain their friendships outside of the facility, this could be detrimental to both their mental and physical health.

Most research suggests that the influence of friends on the lives of the elderly varies by gender. Past research has indicated that older women tend to have a greater number of friends than their male counterparts and that friends are an important source of both emotional and instrumental help for elderly women. Women are also more likely than men to place a high value upon such relationships and to invest their time and energy into maintaining them (Roberto and Scott 1986; Roberto and Kimbo 1989). As such, the majority of research that focuses on the impact of friendships on the elderly

tends to limit its focus to women. Armstrong and Goldstein (1990), for example, examined friendships among aged women. Their findings indicated that the majority of their respondents listed friends as their primary source of emotional support.

Past research has also shown that the importance of friend support increases as people get older. Matt and Dean (1993), for example, found that people aged 71 and older are more likely to experience psychological distress upon the loss of a friend, and, for whatever reason, have lost friend support when experiencing psychological distress than their 50 to 70 year old counterparts. The authors conjecture that several factors may account for the increased importance of friend support among the older people. First, they are more likely to be widowed than their younger counterparts. Second, they are more likely to have withdrawn from the labor force, which reduces friendship networks. Finally, they are more likely to have lost friends as the result of death. All of these factors combined significantly reduce older respondents' sources of friend support, which may cause them to rely on their remaining friends more heavily.

### **Factors That Influence Residents' Social Support Networks?**

Considering the well-documented link between social support and depression it is important to examine the various factors that could potentially impact residents' social support networks. I have already identified gender and age as factors that could influence residents' social support networks. Other factors, however, such as relocation and geographic proximity could also impact the social support systems of the elderly.

#### **Relocation**

This section addresses the impact of relocation on the lives of the elderly. Specifically, I examine the linkages between relocation and social support. Prior research indicates that relocation is one of the more stressful life events that an elderly person experiences (Stokes & Gordon 1988). Relocation affects elders' rates of mortality and morbidity, their mental health, as well as their levels of health and life satisfaction. In addition, relocation can carry serious implications for elders' social support systems.

## **Social Networks and Relocation**

Although little research exists that explicitly examines the impact that relocation has on elders' social support systems, what research does exist suggests that relocation significantly impacts social support. For example, Coffman (1981) examines past research regarding nursing home relocations and proposes that the impact of relocation on elderly individuals' social support systems may be a primary predictor of mortality. He argues that all relocations entail the disruption of some aspects of social support. Some types of relocation entail a larger disruption than others. For example, large amounts of disruption occur when an institution is closed down and its residents scattered. Less disruption takes place if the population of the institution is moved as a whole. Coffman suggests that all relocations involve processes of both losing and gaining elements of social support. If, upon relocation, new elements of social support are readily available, the move can prove to be beneficial for the individuals involved. If residents lose elements of their social support systems faster than they are able to replace them, the end result could be dangerous and potentially deadly.

Wells and MacDonald (1981) investigated the impact of relocation on residents' relationships among a sample of residents from an extended-care facility who were relocated to several other facilities. Their results indicate that, on average, residents' primary relationships were reduced by around one-third eight to twelve weeks following relocation. This loss resulted from a reduction in the number of relationships with peers and staff from the original institution. However, their results indicate that pre-relocation friendships did not impact the resident's adjustment to their new facility.

Consistent with previous results, Tesch, Nehrke, and Whitbourne (1989) found that intra-institutional relocation, within a VA domiciliary, disrupted peer friendships among men, within the institution. Residents reported a reduction in both the quantity and quality of their peer friendships post-relocation. However, contrary to Wells and MacDonald, their results indicated that pre-relocation friendships were an important predictor of residents' ability to adjust after their move. In fact, those men with the largest friendship networks were the most adversely impacted by the relocation, both in

terms of morale and attitudes towards aging. These findings suggest that the men experienced feelings of distress in response to the disruption of their friendship networks.

Johnson (1996) also sought to understand the impact that intra-institutional relocation has on the elderly by examining a sample of 12 elderly religious sisters. Her results indicate that the sisters experienced feelings of loneliness and isolation post-relocation. The move disrupted the sisters' social networks and some felt physically unable to move about the building to visit with their old friends.

### **The Role of Friendships in Residents' Institutional Setting.**

It is clear that resident's relationships with family and friends often suffer after entry into a long-term care facility. However, some research suggests that the friendships formed with other residents and staff within the facility can help mitigate the negative impact of disruption of prior family and friendship ties (Bitzan & Kruzich 1990; Miller 1986; Retsinas & Garrity 1985; Miller & Beer 1977). For example, a study by Fessman and Lester indicates that whether residents have friends within the facility is a stronger predictor of well-being than whether they maintain relationships with friends and family members outside of the facility (2000). In addition, residents who develop close friendship ties within a facility are more likely to participate in facility activities, express a higher level of satisfaction with the facility, and report greater satisfaction with their lives in general (Bitzan & Kruzich 1990).

Numerous factors, including age, gender, cognizance, level of mobility, hearing and speech impairment, and length of residency influence the likelihood that residents will form friendships within the facility. Women are more likely than men to develop friendships within the facility. In addition, residents who are mentally cognizant, mobile, and able to speak and hear are more likely to develop friendships (Bitzan & Kruzich 1990).

Current evidence is mixed regarding whether the length of time a resident has lived at a facility impacts their ability to form and maintain friendship ties with other residents and staff. Retsinas and Garrity (1985), for example, found that residents' tenure in a nursing home is negatively associated with number of friends. Long-term residents reported having fewer friends, within the facility, than did other residents. Other studies,

however, have not found a significant relationship between length of residency and friendship ties (Bitzan and Kruzich 1990).

**Proximity.** The impact of relocation on social support systems may vary depending upon geographic proximity. What happens when elders move a significant distance away from their social support systems? Are elders able to maintain their relationships with family and friends from a large geographical distance or do these relationships suffer from a loss of physical proximity?

A large body of research suggests that geographic proximity plays an important role in predicting the level of social support that older adults receive. Hook, Sobal, and Oak (1982), for example, examined the factors that predicted nursing home residents' visitation with friends and family. Their results indicated that distance was the most important predictor of the occurrence of visits, with visitors living in the nearby vicinity visiting more often.

In terms of family, Dewit, Wister, and Burch (1988), found that proximity was a stronger predictor of intergenerational contact than both parent characteristics (health status, race/ethnic background, age, gender, and educational attainment) as well as child characteristics (income, gender, and marital status). Research also suggests that proximity impacts elders' levels of sibling support. White and Riedmann (1992), for example, found that the closer older adults live to their siblings the greater their belief that they could call on their siblings for help. In addition, elders who lived close to their siblings were more likely to report that they had actually received sibling support.

Little research has examined the impact of proximity on friendships. Some researchers maintain that proximity will have a stronger influence on relationships with friends rather than family members. Because friendship ties are voluntary, rather than obligatory, they may require more effort to maintain over a distance than would family ties (Litwak 1985). The ability to maintain long-distance friendships may be exacerbated by age because the elderly often lack access to modes of transportation, such as cars, that would help them continue visual and physical contact with their friends after the move.

Proximity of friends and family also plays an important role in determining the types of social support received by the elderly. Geographic proximity is particularly important in predicting instrumental support. For instance, geographic distance is

strongly negatively associated with services such as help with household duties and assistance during times of illness (Rossi and Rossi 1990). The impact of distance on emotional support (such as comforting), however, is much smaller (1990). Seeman and Berkman also found that the impact of geographic proximity on social support varies by type of support (1998). Specifically, their results show that although geographic proximity impacts both emotional and instrumental support, it was a better predictor of instrumental, rather than emotional, support (1998). Similarly, Eggebeen and Hogan found that proximity mattered more for instrumental support than for emotional support (1990).

### **Resident and Facility Characteristics and Depression**

Other than social support, a variety of factors, including both resident and facility characteristics, may influence the mental health outcomes of assisted living residents. As mentioned earlier, few studies have examined the occurrence of depression among assisted living residents. However research that examines both the community dwelling elderly and nursing home residents indicates that individual characteristics, such as age, gender, marital status, educational attainment, and health status all play an important role in predicting depressive symptoms among the elderly.

#### **Resident Characteristics**

**Age.** The majority of studies examining depression among the elderly suggest that rates of depression are highest among the oldest old. Mirowsky (1996), for example, found that, among adults over the age of 60, the likelihood of suffering from depression increases with age, with people aged 80 and older facing the greatest risk of suffering from depression. Furthermore, individuals' perceptions of well-being also decline with age. Mroczek and Spiro (2005), for instance, found that the perceived well-being of older adults declines after age 65.

It is possible, however, that the increased risk of depression, and lowered perceptions of well-being, associated with aging are not reflections of age, per se, but rather of other factors such as declining health, retirement, widowhood, and financial struggles that accompany aging. In addition, it is possible that relationship between age

and depression is really a function of educational attainment. Older cohorts tend to be less educated than their younger counterparts which, since education decreases the risk of depression, could explain the elevated risk of depression among the oldest-old (Mirowsky and Ross 1992).

**Educational Attainment.** The link between depression and education has been well documented. Adults with lower levels of education are much more likely to suffer from depression than their better educated counterparts (Adler et al. 1994, Kessler et al. 1994, Dohrenwend et al. 1992). Moreover, the education gap in depression grows wider with increasing age (Miech and Shanahan 2000). The relationship between education and depression can partly be explained by the cumulative advantages accrued by those with higher levels of education. Deteriorating health may also account for the increased association between education and depression among older adults (Miech and Shanahan 2000). In other words, highly educated older adults tend to be in better health than their less educated counterparts, which helps to reduce the risk of depression.

**Marital Status.** Past research indicates that married individuals of all ages have higher levels of well-being and lower levels of depression than their unmarried counterparts (Mirowsky and Ross 1992; Pinquart and Soerensen 2001). However, there is little consensus regarding whether men or women suffer more upon the loss of a spouse. While some research indicates that women are at greater risk of suffering from depression after the death of a spouse, other research indicates that men are more susceptible (Carey 1979; Stroebe and Stroebe 1983).

Some studies suggest that the link between widowhood and depression may matter particularly among elderly women, who tend to live longer than men and, as such, are more likely to experience the death of a spouse. Furthermore, women are more likely to suffer from financial disruption upon losing a spouse which can exacerbate the impact of widowhood on depression (Smith and Zick 1986). On the other hand, some studies suggest that men are more likely than women to suffer from emotional distress after the death of a spouse (Umberson, Wortman, and Kessler 1992).

**Gender.** In general, women of all ages are more likely than their male counterparts to suffer from both depression and low levels of perceived well-being. However, the gender differentials in depression and well-being are especially large

among the elderly (Pinquart and Sorenson 2001; Mirowsky 1996). Limited studies suggest that the gender difference in depression found among the community-dwelling elderly carries over into assisted living facilities. Cummings (2002), for example, found that women in assisted living were more likely than their male counterparts to suffer from depression.

A number of explanations have been advanced for the gender difference in rates of depression. Research, for example, indicates that, among older populations, women have significantly lower levels of educational attainment than their male counterparts (Johnson and Crystal 1999; Ross and Wu 1996). Given the role that education plays in predicting depression it is possible that the gender gap in education is also responsible for the gender gap in depression.

Past research has also noted that, among the community dwelling elderly, women report higher rates of disability than do men (Anderson et al 1999; Ross and Wu 1996; Verbrugge, Lepkowsky, and Imenaka 1989). Furthermore, research also suggests that the impact of health events, such as illness, on levels of depression is stronger among women than among men (Dean et al 1992). Since, women are more likely than men to suffer from a disability, and since the impact of a disability is greater for women than men, it is possible that the gender gap in depression may be partially explained by health status.

Finally, elderly women are more likely than their male counterparts to live either in poverty or on limited incomes. Since economic well-being helps to reduce depression, and women are more likely than men to experience financial insecurity, the gender gap in depression among the elderly may be partially accounted for by economic hardship (Mirowsky 1996; Dixon 2003).

**Health Status.** Physical health is also an important determinant of elderly people's emotional and mental well-being (Blazer 1980; Roth and Kay 1956). Older people who suffer from poor health are more likely to report emotional distress than their healthier counterparts (Arling 1987). Depression has also been linked in the literature to the loss of physical functioning and independence. Research shows that elderly people who experience difficulties performing activities of daily living (such as eating, dressing, grooming, bathing, toileting, and physical ambulation) are more likely to suffer from emotional distress (Harralson 2002; Arling 1987). The link between ADL limitations and

depression exists among both the community dwelling elderly as well as nursing home residents.

Numerous studies document the link between ADL limitations and depression among the community dwelling aged. Community dwelling elderly who encounter difficulties performing activities of daily living are more likely to suffer from depression (Arling 1987; Turner and Noh 1988; Dean, Kolody, and Wood 1990; Mirowsky and Ross 1992; Harralson et al 2002). Moreover, some scholars suggest that ADL limitation is the single most important predictor of well-being among the elderly (Arling 1987).

As for nursing home residents, several studies suggest that increased ADL limitations are associated with higher rates of depression (Arling 1987; Harralson 2002). Furthermore, Gilbert and Hirdes (2000) found that higher rates of ADL limitations were linked to an increased risk of mood problems. Although few studies have specifically examined the relationship between mental and physical health among assisted living residents, what research has been done suggests that residents' functional impairment and self-assessed health status are significantly associated with mental health outcomes (Cummings 2002).

Individual characteristics, however, are not the only factors that matter when predicting the mental health outcomes of assisted living residents. It is also likely that the factors that surround residents' move to assisted living, as well as the environment of their ALF, are likely to impact their levels of well-being.

### **Facility Characteristics**

**ALF Environment.** The environment of an ALF carries important implications for residents' mental health outcomes. Research indicates that the quality of the facility environment is a strong predictor of mental health outcomes. Lieberman, for example, found that residents who were placed in unfriendly, restrictive, environments showed the greatest declines in mental health, while patients who were placed in friendly environments that encouraged autonomy were the most likely to improve (1971). Furthermore, Martin (2002) found that residents in hostile, restrictive environments suffered from distress.

The role that an ALF's environment plays in determining resident well-being may particularly matter among residents receiving Florida State Supplementation (OSS). OSS is a cash assistance program used to help pay for costs in an assisted living facility for qualified low-income residents. While few studies have specifically examined the relationships between ALF quality and OSS residents, the majority of studies examining nursing home quality have discovered a strong negative relationship between the quality of a nursing home and its percentage of Medicaid residents (Nyman 1988). It is likely that this relationship between nursing home quality and Medicaid patients can be applied to assisted living facilities and OSS residents. What research that has been done on this area suggests that this may, in fact, be the case (Street et al 2005).

### **Control over the Decision to Move**

Research suggests that elders' perception of their level of control in the decision-making process concerning when, if, and where to move carries important implications for their levels of well-being post-relocation. Residents who were in control of their relocation report lower levels of distress and higher levels of life satisfaction than those who lacked control over their move (Ferrari 1962; Noelker and Harel 1978; Harel and Noelker 1985; Coulton et al 1988; Armer 1993; Reinardy 1995).

Coulton et al (1988), in a study of 314 elderly hospital patients, examined the impact of patient's perceptions of control over the relocation process on their discharge satisfaction. They found that patients who lack control over discharge planning, who feel rushed in the decision making process, who are anxious or uncertain of the outcome, who see few alternatives in terms of outcomes, who lack control over their decision, or who receive little support from their family in asserting their right to make their own decision have lower levels of satisfaction with their post-hospital setting. Patients who feel as if they have control over the decision regarding their post-hospital setting, on the other hand, experience higher levels of satisfaction and lower levels of distress following their discharge from the hospital (1988).

Armer (1993) used data gathered from semistructured interviews with 50 residents of congregate housing to look at, among other things, the impact of elders' perceived choice in the relocation process on their ability to adjust to their new location.

The results indicated that perceived choice is positively associated with resident adjustment. Residents who felt that they had a choice in the decision making process, both in deciding whether and where to move, were better able to adjust to their new facility. Reinardy (1995) also examined the impact of choice on residents' reactions to their new facility, using data from the Geriatric Nurse Practitioner Study. His results indicate that control over the decision to move to a nursing home positively impacts patients' initial reactions to their new facility.

### **Conclusion**

Past research indicates that depression is a common health problem afflicting the elderly. In addition, the link between well-being and social support has been well-documented in the literature. For the most part, however, research has not examined the relationship between social support and well-being among residents in assisted living. In my dissertation I plan to examine the connection between well-being and social support among a sample of elderly residents in assisted living facilities in the state of Florida.

CHAPTER TWO  
DATA AND METHODS

**Data**

To examine the relationship between social support and well-being among ALF residents, I use data from the following sources.

**2004 Assisted Living Study**

Data come from the 2004 Assisted Living Study, which is a compilation of data from four surveys: The Assisted Living Resident Survey (ALRS), the Assisted Living Facility Survey (ALFS), The Assisted Living Staff Survey (ALSS), and The Assisted Living Caregiver Survey (ALCS). I use data from the ALRS to inform my analyses. The ALRS provides demographic, health, and facility admission information on a sample of ALF residents in the state of Florida.

The ALRS sample currently includes 382 ALF residents. Florida's ALF resident population is fairly homogeneous in terms of gender, race/ethnicity, and age. Women outnumber the men 70:30. Non-Hispanic whites account for 96% of ALF residents. In terms of educational attainment, 72 percent of residents have, at a minimum, graduated from high school, while 28 percent never completed high school. The vast majority (84%) of residents are over the age of 75. Table 1. reports descriptive statistics for the resident sample.

**Table 1. Characteristics of Resident Sample**

<i>Characteristics</i>	<i>%</i>	<i>(N)</i>
<i>Gender</i>		
Women	69.6	(381)
Men	30.5	
<i>Marital Status</i>		
Married	13.2	(380)

**Table 1. Continued**

Widowed	64.7	
Divorced	14.0	
Never Married	8.2	
<i><u>Race/Ethnicity</u></i>		
White	96.3	(377)
Black	2.9	
Other	0.8	
<i><u>Education</u></i>		
Less than 8th grade	10.6	(378)
Some high school	17.2	
High school graduate	23.8	
Vocational/Tech. degree	7.7	
Some college or AA	23.3	
4-year college graduate	11.4	
Post-graduate	6.1	
<i><u>Age</u></i>		
65 to 74	16.5	(382)
75 to 84	36.9	
85 and older	46.6	

It should be noted that residents' cognitive ability presents a special challenge when dealing with an elderly sample. In order to address this issue, residents in our sample were given one of three surveys based upon their cognitive ability. Cognitively intact residents were given the complete survey, moderately impaired residents were asked fewer questions on the medium length survey, and highly impaired residents were asked fewer items still on the short survey. Cognitive screens consisting of measures for residents' orientation for place and time as well as their recall abilities were used to determine the appropriate survey instrument for each respondent. In order to minimize sample size inconsistencies, I restricted my sample size to residents who were given the long form of the survey.

Other sampling issues could also impact my findings. For example, in some instances cognitively intact residents who were very frail, hard of hearing, or who had difficulties speaking were unable to complete the full interview. The exclusion of such residents from my sample could impact my findings. Frail residents, in all likelihood, would likely report lower levels of well-being than their healthier counterparts.

Along the same lines, it is possible that the healthiest and most independent residents (who are often absent during the day from facilities or absorbed in other activities) may be underrepresented in the resident sample. Residents who are healthy and active would likely report higher levels of well-being than their less healthy, less active counterparts.

### Dependent Variables

Table 2. reports descriptive statistics for my dependent variables.

<b>Table 2. Descriptives for Dependent Variables</b>		
	<b>%</b>	<b>(N)</b>
<i><u>Depression</u></i>		
Not Suffering from Life Dissatisfaction	71.7	(290)
Suffering from Slight Life Dissatisfaction	10.3	
Suffering from Moderate Life Dissatisfaction	9.0	
Suffering from Severe Life Dissatisfaction	9.0	
<i><u>Control over Life</u></i>		
Always/Mostly in Control	93.4	(289)
Seldom/Never in Control	6.6	
<i><u>Isolation</u></i>		
Not at all Isolated	46.5	(301)
Sometimes feels Isolated	26.3	
Often feels Isolated	17.6	
Always feels Isolated	9.6	
<i><u>Contact with Family</u></i>		
Yes	76.4	(382)
No	23.6	
<i><u>Satisfied with Family Contact</u></i>		
Satisfied	81.4	(312)
Not satisfied	18.6	
<i><u>Family Support</u></i>		
Count on family most of the time	85.9	(311)
Count on family some of the time	9.0	
Count on family hardly ever	5.1	
<i><u>Contact with Friends Outside of the ALF</u></i>		
Yes	47.9	(382)
No	52.1	

**Table 2. Continued**

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<i>Satisfied with Outside Friends</i>		
Yes	81.3	(192)
No	18.8	
<i>Friends in the Facility</i>		
Yes	77.3	(352)
No	22.7	
<i>Satisfied with Facility Friends</i>		
Yes	98.4	(255)
No	1.6	

### **Resident Well-Being**

The dependent variables for resident well-being consist of three scales, each measuring one of three aspects of well-being: 1) life dissatisfaction, 2) control over life, and 3) isolation. The questions used to construct each scale are derived from the Geriatric Depression Scale (GDS), a scale developed as a basic screening measure for depression in the elderly (Brink, Yesavage, Lum Heersema, Adey, and Rose, 1982). I used exploratory factor analysis to identify items from the GDS that reflect similar constructs and, as such, could be combined together.

**Life Dissatisfaction.** The variable for life dissatisfaction is the sum of three items from the Geriatric Depression Scale: 1) Are you basically satisfied with your life? 2) Are you in good spirits most of the time? and 3) Do you feel happy most of the time? Respondents are ranked on a scale of 0 to 3. A low score indicates low levels of life dissatisfaction while a high score indicates high levels of life dissatisfaction. The overwhelming majority of residents indicate that they do not suffer from life dissatisfaction (71%). Roughly 29 percent of respondents report suffering from slight to severe life dissatisfaction.

**Control over Life.** The measure for control over life is constructed from the following three GDS items: 1) Are you afraid something bad is going to happen to you? 2) Do you often feel helpless? and 3) Do you feel that your situation is hopeless? Possible responses range from 0 (respondent reports being in complete control) to 3 (respondent feels they have no control over their situation). The majority of the residents

indicate that they are in complete control of their lives. Twenty-nine percent of respondents, on the other hand, report feeling out of control at least some of the time.

**Isolation.** The variable for isolation is composed of the following four items from the Geriatric Depression Scale: 1) Do you feel that your life is empty? 2) Do you often get bored? and 3) Do you often feel lonely? A score of three indicates that the respondent suffers from high feelings of isolation while a score of 0 indicates that the respondent does feel isolated. More residents report suffering from feelings of isolation than from either feelings of life dissatisfaction or loss of control. A slight majority of residents (55%) report that they suffer from feelings of isolation at least some of the time.

### **Social Support**

**Family Contact.** This variable measures whether residents have had any contact, either face to face or over the phone, with their family members during the past month. Approximately 76 percent of the sample reported that they had been in contact with their family members over the past month.

**Family Satisfaction.** The item for family support measures whether or not residents are satisfied with their family relationships. This variable contrasts residents who report that they have about the right amount of contact with their family (1), with residents who report that they do not have enough contact with their family (0). Eighty-one percent of the sample reported that they had enough contact with their family members.

**Perceived Family Support.** The third variable measures how residents perceive the level of social support they receive from their family. This variable compares residents who feel that they can count on their family in times of trouble most of the time (1), sometimes (2) or hardly ever (3). The vast majority of the sample (86%) reported that they could count on their family for help most of the time. Only 5 percent stated that they could hardly ever count on their family.

**Contact with friends outside of the facility.** Resident contact with friends is measured by a variable that indicates whether residents have had recent contact with their friends outside of the facility. This variable contrasts residents who have made contact over the past month, either in person or over the phone, with their friends outside the

facility (1) with those residents who have not (0). Almost half of the sample (48%) reported that they had some sort of contact with their friends who live outside of their facility during the previous month.

**Satisfaction with friends outside of the facility.** This variable measures residents’ feelings of satisfaction regarding their relationships with friends outside of the facility. This variable compares residents who report that they had about the right amount of contact with their friends who live outside of the facility (1), to residents who report that they do not have enough with their friends outside of the facility (0). Eight-one percent of the sample reported that they were satisfied with their level of contact with friends outside of the facility.

**Friends within the facility.** Resident contact with friends is measured by a variable that indicates whether residents have formed friendships in their current facility. This variable contrasts residents who have made friends in their new facility (1) with those residents who have not (0). The overwhelming majority of the sample (77%) reported that they had formed friendships with other residents in their facility.

### Independent variables

Table 3. reports descriptive statistics for my independent variables.

<b>Table 3. Descriptives for Independent Variables</b>		
	%	(N)
<i><u>Control over the Decision to Move</u></i>		
Little or no control	27.4	(372)
Complete or some control	75.6	
<i><u>Length of Residency at ALF</u></i>		
One Year or Less	36.7	(376)
More that one year	63.3	
<i><u>Hearing Impaired</u></i>		
Yes	33.8	(382)
No	66.2	
<i><u>Self-Assessed Health</u></i>		
Good to Excellent	68.2	(368)
Fair to Poor	31.8	

**Table 3. Continued**

<u>Facility OSS Status</u>		
Non-OSS	74.4	(382)
OSS	25.7	
<u>Facility Size</u>		
Small	6.5	(382)
Medium	20.9	
Large	72.5	
<u>Satisfied With Living Space</u>		
Yes	92.2	(361)
No	7.8	
<u>Do You Feel Safe In Your Facility</u>		
Yes	96.73	(382)
No	3.27	
<u>Facility Feels Like Home</u>		
Yes	63.7	(366)
No	36.3	
<u>Feels Like A Member Of The Family At ALF</u>		
Yes	55.5	(292)
No	44.5	
<u>Have Enough Privacy</u>		
Yes	73.1	(353)
No	26.9	
<u>Time Spent Alone</u>		
Not much of the time	25.8	(369)
Some of the time	34.7	
Most of the time	39.6	
<u>Attend Most Facility Activities</u>		
Yes	58.1	(339)
No	41.9	
<u>Participate In Outside Activities</u>		
Have enough opportunities	69.8	(305)
Do not have enough opportunities	30.2	
<u>Moved Because Needed More Help</u>		
Yes	34.0	(382)
No	66.0	
<u>Moved Because Health Worsened</u>		
Yes	27.8	(382)
No	72.3	

**Table 3. Continued**

<u>Moved Because It Was What Kids Wanted</u>		
Yes	27.8	(382)
No	72.3	
<u>Moved Because Of Specific Event</u>		
Yes	17.5	(382)
No	82.5	
<u>Able To Lock Door</u>		
Yes	87.0	(354)
No	13.0	
<u>Able To Sleep Late</u>		
Yes	76.1	(285)
No	23.9	
<u>Encouraged To Do As Much As You Can</u>		
Yes	96.5	(288)
No	3.5	
<u>Able To Come And Go As You Please</u>		
Yes	97.1	(345)
No	2.9	
<u>Have Family Members That Live Less Than One Hour From The Facility?</u>		
Yes	44.6	(352)
No	55.4	

### Control over the Decision to Move

The level of control residents had over the decision to move to their current ALF is measured as a dummy variable that contrasts residents who felt as if they had at least some control (1) with residents who felt as if they had little or no control (0). The majority of respondents (76%) reported that they had at least some control over the decision to move to their current facility.

### Resident Demographics

**Length of Stay.** In the ASLRS the respondents are asked how long they have lived in their current facility and are offered a series of discrete response categories, “less than 6 months,” “6 months to 1 year,” “over 1 year but less than 2 years,” between 2 and

5 years,” and longer 5 than years.” For my analyses I contrast residents who have lived in their current facility for less than one year (1) with all others (0). This enables me to compare recently relocated residents who are more than likely still adjusting to the move with residents who have had more time to settle into their facility. Many of the residents (63%) have lived in their current facility for at least one year, while 37% have lived there for less than one year.

**Female.** Gender is measured by a dummy variable where 1= female; 0 = male.

**Age.** Although my sample excludes respondents under the age of 65 it is still necessary to control for age differences considering that the experiences of a 65-year-old resident likely vary from those of an 80-year-old resident. For the purpose of these analyses, residents aged 65-74 (young-old) are coded 1, residents aged 75-84 (middle-old) are coded 2, and residents older than 85 (oldest-old) are coded 3.

**Married.** Marital status is measured by a dummy variable where 1 = currently married; 0 = not currently married.

**Educational Attainment.** Educational attainment, used as a proxy for social class, is measured as a variable that ranges from residents who received less than eighth grade education to those possessing a post-graduate degree. Residents are coded: 1) if they completed 8<sup>th</sup> grade or less; 2) if they completed some high school; 3) if they completed high school or received their GED; 4) if they completed vocational/technical/trade School; 5) if they completed some college or are a community college graduate; 5) if they are a 4-year college graduate; and 5) if they completed post-graduate work.

## **Resident Health**

**Level of Mobility.** The scale measuring residents’ mobility is calculated by summing the responses to the following questions: 1) How hard is it for you to get out of bed or a chair by yourself, without using special equipment? 2) How hard is it for you to get around indoors by yourself without using special equipment? 3) How hard is it for you to climb a flight of stairs? and 4) How hard is it for you to walk to the end of the room and back? The scale ranges from 1 (no problems performing each activity) to 4 (experience difficulties performing each of these actions).

**Hearing Impediments.** Hearing ability is measured as a dummy variable that contrasts residents who have hearing impediments (1) with all others (0). Approximately 34% of the residents in my sample suffer from some sort of hearing impediment.

**Activities of Daily Living (ADLs).** Resident needs are calculated by summing whether residents need assistance with dressing, eating, transferring, bathing, and toileting. The scale of resident needs ranges from 0 to 5, where low scores indicate needing less assistance with ADLs and high scores indicates a greater need for assistance with ADLs.

**Self-Assessed Health.** Residents' self-assessed health status is measured as a dummy variable (1= resident report being in excellent or good health) (0= resident reports being in fair to poor health). Almost 70 percent of the sample reported being in good to excellent health.

### **Facility Characteristics**

**Facility OSS status.** OSS is a cash assistance program used to help pay for costs in an assisted living facility for qualified low-income residents. Facility OSS status is measured as a dichotomous variable coded 1 if the resident lives in a facility that accepts OSS. Only 26 percent of respondents live in a facility that accepts OSS.

**Size.** Residents' facility size is measured by a series of dummy variables. Small facilities are measured with a dummy variable coded 1 if the respondent lives in a small facility. Medium facilities are measured with a dummy variable coded 1 if the respondent lives in a medium facility. Large facilities are measured with a dummy variable coded 1 if the respondent lives in a large facility. The majority of respondents (73%) live in large facilities.

### **Residents' Perceptions of Current ALF**

**Staff Satisfaction.** The measure of residents' satisfaction with the staff at their facility is a scale calculated by summing responses to the following questions: 1) Are the staff members who care for you usually dependable? 2) Are you satisfied with personal assistance you are getting here? 3) Do you feel that the staff show affection and caring for you, 4) Are your complaints or concerns usually taken seriously. The scale of staff

satisfaction ranges from 0 to 4, where 0 indicates that residents are not at all satisfied with the staff at their facility and 4 indicates that residents are very satisfied.

**Resident Satisfaction their ALF.** Originally I planned to construct a scale to measure residents' level of satisfaction with their current facility composed of the following items: 1) Are you satisfied with the personal assistance you are getting here? 2) Are you generally satisfied with your living space? 3) Do you feel safe and secure here? and 4) Does this place feel like home to you? Because exploratory factor analysis indicated that these variables were not sufficiently correlated, I then considered only using the measure of whether or not residents viewed their facility as home, eliminating the other measures from my analyses. However, a series of Wald tests indicated that the remaining variables contributed significantly to my ability to explain the variation in resident depression. As it stands, I included the variables as dummies where, for each of the items, a score of 1 indicates an affirmative response.

I also included two additional dummy variables that measure residents' satisfaction with their facility. The first variable measures whether residents feel they have enough privacy in their facility (1=yes) and the second indicates if they feel like a member of a family at their facility (1=yes).

The overwhelming majority of residents (92%) report being satisfied with their living space. Ninety-seven percent of residents state that they feel safe in their facility. A little over half of the respondents (64%) report that their facility feels like home. Fifty-five percent of residents state that they feel like a member of a family at their ALF. Finally, seventy-three percent of respondents report that they have enough privacy.

### **Resident Involvement**

Included in my analyses are a series of variables that measure the level of interaction residents have with individuals both in their facility as well as in the greater community. For example, the amount of time residents spend alone is measured by a variable where, 1 = not much of the time, 2 = some of the time, and 3 = most of the time. Forty percent of residents report that most of their time is spent alone, while 26 percent of residents state that they do not spend much time alone. Residents' participation in facility activities is measured as a dummy variable coded 1 if the resident attends most of

the activities offered at their facility. A little over half of the respondents (58%) report that they attend most of the activities offered by their facility. Residents' participation in outside activities is also measured with a dichotomous variable coded 1 if the respondent reports having enough chances to participate in outside activities. Roughly 70 percent of the respondents report that they have enough opportunities to participate in activities outside of their facility.

### **Reasons Precipitating Residents' Move to an ALF**

I include five dummy variables that address the different circumstances that can potentially result in a residents' move to an ALF. The ASLRS lists 10 specific reasons why residents may have moved to their current ALF and allows them to pick as many responses as are applicable to their situation. For my analyses I chose the five most common reasons that precipitated residents' move to their current ALF: 1) I needed more help (34%); 2) My health got worse (28%); 3) My children wanted me to move (28%); 4) I moved because of a specific event (18%); and 5) I couldn't live alone any longer (18%).

### **Facility Restrictions**

My analyses include a series of variables that measure restrictions placed upon residents by their facility. These include: 1) Can you lock your bedroom door (0=yes); 2) Can you sleep late if you want to (1=yes); 3) Can you come and go as you please (1=yes); 3) Are you encouraged to do as much for yourself as you can (1 = yes). Eighty-seven percent of respondents report that they can lock their bathroom door, 76% report that they can sleep late if they want to, almost all of the respondents (97%) report that they are encouraged to do as much for themselves as they can, and 97 percent state that they can come and go as they please.

### **Geographic Proximity**

I include a dummy variable that measures residents' proximity to their family members. Residents who live within one hour driving distance of a family member are coded 1, residents whose closest family members is further than 1 hour away are coded 0.

Almost half of the respondents (45%) report having a family member that lives within one hour of their facility.

<b>Table 4. Key Variable Definitions</b>	
<u>Variable</u>	<u>Definition</u>
<b>Dependent Variables</b>	
<b>Resident Well-Being</b>	
Life Dissatisfaction	Scale calculated by the summing responses to the following items from the Geriatric Depression Scale: 1) Are you basically satisfied with your life? 2) Are you in good spirits most of the time? and 3) Do you feel happy most of the time? The responses range from 0 to 3 with low scores indicating low levels of depression and high scores indicating higher levels of depression.
Loss of Control	The measure for loss of control is constructed from the following three GDS items: 1) Are you afraid something bad is going to happen to you? 2) Do you often feel helpless? and 3) Do you feel that your situation is hopeless? Possible responses range from 0 (respondent reports being in complete control) to 3 (respondent feels they have no control over their situation).
Isolation	The variable for isolation is composed of the following four items from the Geriatric Depression Scale: 1) Do you feel that your life is empty? 2) Do you often get bored? and 3) Do you often feel lonely? The responses range from 0 to 3 with low scores indicating low levels of isolation and high scores indicating greater levels of isolation.
<b>Resident Social Support</b>	
Family Contact	Dummy variable coded 1 if residents have any contact, either face to face or over the phone, with their family members.
Family Satisfaction	Dummy variable that contrasts residents who report that they had about the right amount of contact with their family (1), with residents who report that they do not have enough contact with their family (0).
Perceived Family Support	This variable contrasts residents who feel that they can count on their family in times of trouble most of the time (1), sometimes (2) or hardly ever (3).
Contact with Friends Outside of the Facility	Dichotomous variable that contrasts residents who have made contact over the past month, either in person or over the phone, with their friends outside the facility (1) with those residents who have not (0).
Satisfaction with Friends Outside of the Facility	Dummy variable that contrasts residents who report that they had about the right amount of contact with their friends who live outside of the facility (1), with residents who report that they do not have enough with their friends outside of the facility (0).

<b>Table 4. Continued</b>	
Friends within the Facility	Dichotomous variable that compares residents who have made friends in their new facility (1) with those residents who have not (0).
<b>Independent Variables</b>	
Control over the Decision to Move	Dummy variable that contrasts residents who felt as if they had at least some control over their move (1) with residents who felt as if they had little or no control (0).
Length of Stay	Dummy variable that is coded 1 if residents who have lived in their current facility for less than one year.
Female	Dummy variable coded 1 if respondent is a woman.
Age	Residents aged 65-74 (young-old) are coded 1, residents aged 75-84 (middle-old) are coded 2, and residents older than 85 (oldest-old) are coded 3.
Married	Dichotomous variable coded 1 if the respondent is married.
Educational Attainment	Variable coded: 1) 8 <sup>th</sup> grade or less 2) Some high school 3) High school graduate/GED 4) Vocational/Technical/Trade School 5) Some college or community college graduate 6) 4-year college graduate 7) Post-graduate
<b>Resident Health</b>	
Level of Mobility	Scale calculated by summing responses to the following questions: 1) How hard is it for you to get out of bed or a chair by yourself, without using special equipment? 2) How hard is it for you to get around indoors by yourself without using special equipment? 3) How hard is it for you to climb a flight of stairs? and 4) How hard is it for you to walk to the end of the room and back? The scale ranges from 1 to 4 with low scores indicating little difficulty with mobility and high scores indicating great difficulty with mobility.
Hearing Impediments	Dummy variable that is coded 1 if the resident suffers from some sort of hearing impediment.
Activities of Daily Living (ADLs)	Resident needs are calculated by summing whether residents need assistance with dressing, eating, transferring, bathing, and toileting. The scale of resident needs ranges from 0 to 5, where low scores indicate needing less assistance with ADLs and high scores indicates needing greater assistance with ADLs.

<b>Table 4. Continued</b>	
Self-Assessed Health	Binary variable that contrasts residents who perceive themselves to be in excellent or good health (1) with residents who report being in fair to poor health (0).
<b>Facility Characteristics</b>	
Facility OSS Status	Dichotomous variable that is coded 1 if respondent lives in a facility that accepts OSS.
Small	Dummy variable coded 1 if respondent lives in a small facility.
Medium	Dummy variable coded 1 if respondent lives in a medium facility.
Large	Dummy variable coded 1 if respondent lives in a large facility.
<b>Residents' Perceptions of Current ALF</b>	
Staff Satisfaction	Scale composed by summing the responses to the following questions: 1) Are the staff members who care for you usually dependable? 2) Are you satisfied with personal assistance you are getting here? 3) Do you feel that the staff show affection and caring for you, and 4) Are your complaints or concerns usually taken seriously. The scale ranges from 0 to 4, where 0 indicates that residents are not at all satisfied with the staff at their facility and 4 indicates that residents are very satisfied with their facility.
<b>Resident Satisfaction with their ALF</b>	
Satisfied with Living Space	Dummy variable coded 1 for yes.
Do You Feel Safe Here	Dummy variable coded 1 for yes.
Does this Place Feel Like Home to You	Dummy variable coded 1 for yes.
Do You feel Like a Member of a Family in Your Facility	Dummy variable coded 1 for yes.
Do You Have Enough Privacy	Dummy variable coded 1 for yes.
<b>Resident Involvement</b>	
Time Spent Alone	Variable coded 1 if resident reports that they don't spend much time alone, 2 if they spend some of the time alone, and 3 if they are alone most of the time.
Do You Attend Most of the Activities Offered by Your Facility	Dichotomous variable coded 1 for yes.
Do You Have Enough Chances to Participate in Activities Outside of Your Facility	Dichotomous variable coded 1 for yes.
<b>Reasons Precipitating Residents' Move to an ALF</b>	
Need More Help	Dichotomous variable coded 1 for yes.
Health Worsened	Dummy variable coded 1 for yes.
Children Wanted the Move	Dichotomous variable coded 1 for yes.
Specific Event	Dummy variable coded 1 for yes.
Couldn't Live Alone Any Longer	Dichotomous variable coded 1 for yes.
<b>Facility Restrictions</b>	
Can You Lock Your Bedroom Door	Binary variable coded 1 for yes.
Can You Sleep Late	Dichotomous variable coded 1 for yes.

<b>Table 4. Continued</b>	
Can you Come and Go From Your Facility as You Please	Binary variable coded 1 for yes.
Are you Encouraged to do as Much for Yourself as You Can	Dummy variable coded 1 for yes.
<b>Geographic Proximity</b>	
Family Member Lives Within One Hour Of The Facility	Dichotomous variable coded 1 for yes.

## CHAPTER THREE RESIDENT WELL-BEING

As discussed earlier resident well-being consists of three different components: 1) life dissatisfaction, 2) control, and 3) isolation. I will examine the unique factors that predict each of these aspects in hypothesis 1a, hypothesis 1b, and hypothesis 1c, respectively.

### **Life Dissatisfaction**

Hypothesis 1a examines the factors that impact the level of life dissatisfaction among elderly residents in assisted living facilities.

Prior research suggests that elderly people, especially those in long term care facilities, are at a high risk of suffering from life dissatisfaction. Accordingly, I propose that older residents will be more likely than their younger counterparts to suffer from life dissatisfaction.

In keeping with past research, I propose that whether residents had control over the decision to move may be a determining factor in relocation outcomes. Individuals who willingly make the decision to move may adjust more readily, and thus less likely to suffer from life dissatisfaction, than residents who relocate involuntarily.

Numerous factors other than control, however, potentially play a role in predicting resident life dissatisfaction. Residents' health status, for example, could account for some of the variation in reported life dissatisfaction levels. More specifically, healthy residents may be less likely than those in poor health to suffer from life dissatisfaction. To test this I will consider several factors that measure resident health including residents': 1) level of mobility; 2) hearing ability; 3) self-assessed health status; and 4) the level of assistance they need to perform activities of daily living.

Facility characteristics, such as OSS status and facility size, may also play an important role in predicting resident life dissatisfaction. Past research utilizing the ALRS suggests that residents who live OSS facilities report higher levels of life dissatisfaction than their counterparts in private facilities. The higher occurrence of life dissatisfaction among residents in OSS facilities may, in part, be explained by the higher prevalence of

mentally ill residents in such facilities. In addition, residents who reside in medium facilities report the highest levels of life dissatisfaction, while residents in small facilities report the lowest levels (Street et al 2005). Perhaps residents in small facilities are able to form closer relationships with their fellow residents which help to ward off life dissatisfaction. I predict that these findings will hold true in my analyses.

Residents' feelings about their current assisted living facility are also likely to impact their level of life dissatisfaction. Previous studies indicate that residents who view their facility as their home are more likely to be well adjusted than those who do not (Cutchin et al 2003). In keeping with such research, I propose that residents who feel positively about life in their current ALF will report the lowest levels of life dissatisfaction. In order to test this I will examine several dimensions of residents' satisfaction with their facility including: 1) their level of satisfaction with the staff at their facility, 2) whether or not they regard their facility as their home, 3) Whether they have enough privacy at their facility, and 4) whether they feel like a member of the family at their current ALF.

Finally, I propose that residents' relationships with their friends and family as well as their level of involvement in their ALF and greater community will have a negative impact on life dissatisfaction. As mentioned in the literature review, older adults who have supportive social networks tend to enjoy better mental health than those who are not embedded in supportive social networks (Krause, 1997).

## **Results**

I initially planned to use ordered logit to test my hypothesis that the level of control residents had over the decision to move to an ALF is associated with their level of life dissatisfaction. Ordered logit appeared to be the logical choice since my independent variable (life dissatisfaction) has more than two categories which can be ranked from low to high but the intervals between which are unknown. The ordered logit model estimates the effects of the independent variable on the log odds of having higher rather than lower scores on the dependent variable i.e., higher versus lower levels of life dissatisfaction. In ordered logistic regression, Stata normalizes one of the predicted categories, in this case,

not at all depressed, to zero and estimates the cut points for separating the various levels of the response variables.

In order to use ordered logit, however, my models must satisfy the parallel regression assumption, otherwise known as the proportional odds assumption. Ordered logit assumes that the coefficients for the variables in the equations would not vary significantly if they were estimated separately – the intercepts differ but the slopes would essentially be the same. I used the Brant test to determine if my models met this criterion. The results indicated that my model for life dissatisfaction violated the parallel regression/proportional odds assumption.

Since my model violated the assumption of parallel regression necessary for ordered logit I turned to multinomial logit to test my hypothesis. The results of multinomial logit provide three sets of coefficients: the first set indicates the predicted odds of beings slightly depressed versus not at all depressed, the second set contrasts the odds of suffering from moderate life dissatisfaction with the likelihood of not being depressed and the third set provides the odds of being very depressed as opposed to not at all depressed.<sup>1</sup>

Problems with my sample size<sup>2</sup> prevented the inclusion of all possible explanatory variables in each of my analyses. In order to determine which variables should be included in my analyses I used the Wald statistic to analyze the significance of my independent variables. The Wald statistic is the chi-square statistic for the change in the model when a particular independent variable is removed. With a few notable exceptions, variables that were not significantly related to the dependent variable were excluded from my analyses. First, non-significant demographic variables were included in all analyses for control purposes. Second, nonsignificant variables that are crucial to testing my hypotheses, or that can reasonably be expected to influence my dependent variables are also kept in my analyses. Table 5. reports multinomial regression results of residents' likelihood of suffering from life dissatisfaction.

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<sup>1</sup> In conducting my analyses I was concerned about the possibility of multicollinearity degrading my results. To determine whether or not multicollinearity was, in fact, impacting my analyses, I computed the variation inflation factors (VIF) and tolerance levels for my independent variables. The results indicated that I did not have a near linear dependency between any of my two variables.

<sup>2</sup> A more in-depth discussion of the problems with my sample can be found in Chapter Five.

**Table 5. Multinomial Logistic Regression Results of Resident Life Dissatisfaction**

Life dissatisfaction	<u>Model One (n=277)</u>			<u>Model Two (n=253)</u>		
	Slight	Moderate	Severe	Slight	Moderate	Severe
<i>Variables</i>						
Control Over the Move	-.550 (.448)	-.216 (.523)	-1.450** (.464)	-.453 (.474)	-.086 (.543)	-1.53** (.520)
<u>Demographics</u>						
Age	-.223 (.279)	-.549† (.302)	-.667 (.300)	-.165 (.292)	-.278 (.315)	-.677* (.328)
Gender	.181 (.463)	.315 (.510)	.281 (.517)	.047 (.474)	.444 (.534)	.105 (.567)
Married	-.171 (.670)	.644 (.638)	-7.34 (1.076)	-.307 (.682)	.825 (.676)	-.515 (1.11)
Education	-.008 (.117)	-.207 (.138)	-.052 (.132)	-.005 (.121)	-.180 (.144)	-.145 (.148)
<u>Resident Health</u>						
Mobility				.398 (.374)	-.697 (.480)	.997* (.437)
Health-Status				-.241 (.462)	-.973† (.509)	-.756 (.515)
More Help				-.071 (.458)	-1.702* (.783)	-.440 (.635)
<u>Attitudes towards ALF</u>						
Staff Satisfaction						
ALF as Home						
Privacy						
Satisfied with Living Space						
Member of the Family						
<u>Social Support</u>						
Facility Activities						
Outside Activities						
Contact with Family						
Friends in Facility						

**Table 5. Continued**

## Time Spent Alone

Life dissatisfaction	<u>Model Three</u> (n=253)			<u>Model Four</u> (n=168)		
	Slight	Moderate	Severe	Slight	Moderate	Severe
<i>Variables</i>						
Control Over the Move	-.152 (.677)	.131 (.805)	.523 (.820)	.084 (.809)	-1.558 (1.269)	-.322 (2.161)
<u>Demographics</u>						
Age	.206 (.466)	-.353 (.458)	-.585 (.529)	.523 (.524)	-1.405† (.786)	1.303 (1.464)
Gender	-.396 (.696)	-.160 (.737)	-.254 (.824)	-.707 (.756)	.041 (1.122)	.317 (1.524)
Married	-.973 (.942)	.920 (.958)	-.362 (1.44)	-.928 (1.324)	1.531 (2.378)	.505 (2.503)
Education	-.143 (.180)	-.355 (.227)	-.445† (.248)	-.135 (.209)	-.506 (.386)	-1.790* (.850)
<u>Resident Health</u>						
Mobility	.669 (.597)	-.510 (.704)	1.49* (.736)	.797 (.662)	-1.201 (1.232)	5.536† (2.878)
Health-Status	.633 (.773)	-1.44* (.709)	-.958 (.761)	.720 (.828)	-2.359† (1.363)	-2.338† (1.336)
More Help	.053	-2.218†	-.288	.404 (.753)	-39.05 (6.410)	.299 (1.971)
<u>Attitudes towards ALF</u>						
Staff Satisfaction	-.450 (.476)	-.370 (.496)	-.478 (.399)	-.005 (.556)	-.433 (.851)	-.633 (.771)
ALF as Home	.537 (.907)	-1.095 (.804)	-2.798** (1.057)	.415 (.981)	-1.09 (1.322)	-6.416* (3.207)
Privacy	-2.45* (1.247)	-1.689 (1.194)	.347 (.826)	-3.874* (1.930)	-2.343 (1.750)	1.150 (1.440)
Satisfied with Living Space	-2.437† (.966)	-.288 (1.389)	-.615 (1.076)	-3.466** (.008)	20.225** (6.923)	-.698 (1.999)
Member of the Family	-.503 (.683)	-.218 (.718)	.728 (.914)	-.354 (.785)	-2.482† (1.341)	2.369 (1.901)
<u>Social Support</u>						
Facility Activities				.644 (.885)	-2.931* (1.371)	-2.376 (1.740)
Outside Activities				-.722 (.992)	-1.160 (1.597)	-1.715 (1.522)
Contact with Family				-1.229 (.875)	-1.445 (1.855)	1.968 (2.072)
Friends in Facility				-1.613 (.989)	3.315† (1.953)	-4.498† (2.317)
Time Spent Alone				.186 (-.279)	-.328 (.950)	.351 (1.136)

Notes: †p&lt;.10; \*p&lt;.05; \*\*p&lt;.01

The first model for resident life dissatisfaction includes the variable for resident control over the move as well as conventional demographic indicators. With a few notable exceptions, my independent variables do not significantly impact life dissatisfaction. As predicted, resident control over the decision to move only matters when predicting the likelihood that a resident suffers from severe life dissatisfaction. More specifically, residents who felt in control of their move were approximately one-fourth as likely ( $e^b=.235$ ) to suffer from severe life dissatisfaction than to not suffer from life satisfaction at all.<sup>3</sup>

Model 2 adds a set of explanatory variables that measure resident health. Such variables include residents' level of mobility, their self-assessed health status, and whether or not they moved to their current facility because they needed more help. This model still leaves unexplained much of the variation in residents' likelihood of suffering from slight or moderate life dissatisfaction. Residents' self-assessed health status and whether or not they are in their current ALF because they need help are the only variables that significantly impact residents' likelihood of suffering from moderate life dissatisfaction rather than not. Residents who feel they are in good health are a third as likely ( $e^b=.378$ ) to suffer from moderate life dissatisfaction. Surprisingly, residents who moved because they needed more help are also slightly less likely ( $e^b=.182$ ) to suffer from moderate life dissatisfaction. One possible explanation for this unexpected finding is that residents who understand they need assistance are more likely to recognize the benefits of living in an ALF and, accordingly, are less likely to suffer from life dissatisfaction.

In support of my hypothesis, residents who felt they had at least some level of control over the move were less likely to suffer from severe life dissatisfaction. Interestingly, older residents were less likely than younger residents to indicate feelings of severe life dissatisfaction. Again, a possible explanation for this somewhat surprising result is that older residents are more likely than their younger counterparts to accept that they need the help associated with residency at an ALF and thus more willing to trade their independence in exchange for such assistance. In terms of the impact of residents'

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<sup>3</sup> To simplify discussion in the text coefficients have been converted into odds ratio by taking  $e^b$  (exponentiating the slope coefficient).

health status, residents with limited mobility were more likely to be very rather than not at all depressed.

Model 3 adds a group of variables that address residents' attitudes towards their current ALF. This set of variables includes residents' level of satisfaction regarding the staff that works at their facility, whether or not they view their ALF as their home, whether they have enough privacy in their facility, whether they are satisfied with their living space, and whether they feel like a member of the family in their facility. This suggests that how happy a resident is with their ALF matters more in predicting life dissatisfaction than the circumstances that led them to their current facility.

In terms of the relationship between residents' views regarding their facility and life dissatisfaction, residents who indicate that they have enough privacy at their ALF ( $e^b=.086$ ), who are satisfied with their living space ( $e^b=.087$ ), and who call their facility home ( $e^b=.061$ ) are all less likely to suffer from some level of life dissatisfaction. Other predictor variables were also significant in model three. Residents who feel they are in good health, for example, are roughly one-fourth as likely ( $e^b=.237$ ) to suffer from moderate life dissatisfaction. Residents who moved to their current facility because they needed more help are approximately one-tenth less likely ( $e^b=.109$ ) to suffer from moderate life dissatisfaction. This finding lends support to my argument that residents who recognize they need help are more likely to be satisfied with their living arrangements. Not surprisingly, less mobile residents are almost four times more likely ( $e^b=.4.437$ ) to suffer from severe life dissatisfaction.

Model 4 adds a set of variables that measure residents' level of involvement with other individuals both in and outside of their facility. The variables in this group include whether they attend activities offered at their facility, whether they have enough chances to participate in activities outside of their facility, whether they have contact with their family, whether they have friends within their facility, how much time they spend alone, and whether or not they have a roommate.

Residents who report having enough privacy ( $e^b=.021$ ) as well as those who are satisfied with their living space ( $e^b=.32.008$ ) are less likely to be slightly depressed. Resident age, health status, satisfaction with facility, and resident involvement all play a role in predicting the likelihood of suffering from moderate life dissatisfaction. Older

residents are a fourth as likely ( $e^b=.245$ ) to suffer from moderate life dissatisfaction. Residents who are in good health are a tenth as likely ( $e^b=.0945$ ) to suffer from moderate life dissatisfaction. Residents who feel like a member of the family at their facility are slightly less likely ( $e^b=.084$ ) to suffer from moderate life dissatisfaction. Interestingly, residents who are satisfied with their living space are far more likely to suffer from moderate life dissatisfaction. Residents who participate in the activities offered by their facility are five times less likely ( $e^b=.053$ ) to report being moderately dissatisfied.

One somewhat unexpected finding is that residents who report having friends at their facility are approximately 28 times more likely ( $e^b=27.522$ ) to be moderately dissatisfied. Although this seems surprising, while I was in the field conducting interviews, residents frequently stated to me that one of the hardest part of living in an ALF is watching your friends grow ill and possibly die. This process of watching your friends deteriorate may partially explain this result.

Residents with high levels of educational attainment are approximately 17 times less likely ( $e^b=.167$ ) than their counterparts with lower levels of education to suffer from severe life dissatisfaction. Residents who are in good health are approximately 10 times less likely ( $e^b=.097$ ) to be severely depressed, while residents with limited mobility are more than 200 times more likely ( $e^b=253.661$ ) to suffer from severe life dissatisfaction. Residents who view their facility as their home are slightly less likely ( $e^b=.002$ ) to suffer from severe life dissatisfaction, although the size of the effect is quite small. Residents who have friends within their facility are 10 times less likely ( $e^b=.011$ ) to suffer from severe life dissatisfaction.

Overall, my analyses suggest that resident control over the decision to move to an ALF does not matter when predicting residents' levels of life dissatisfaction, once you control for whether or not residents consider their facility to be home. Instead, resident attitudes towards their ALF as well as their level of involvement in both their ALF and greater community are better predictors of resident life dissatisfaction. Residents who are satisfied with their current facility tend to be happier than those who are not. In general, residents who have social ties, both within and outside of their facility, are also less likely to suffer from life dissatisfaction. As mentioned earlier, these findings suggests that residents' views regarding both their current living situation as well as their level of

social involvement matter more in terms of their well-being than how they came to live in an ALF.

### **Control**

Aside from life dissatisfaction, control is another important aspect of resident well-being. Hypothesis 1b examines the relative significance of factors that predict whether or not residents feel they are in control of their lives. Research suggests that elders' perceptions of control over the relocation process carry important implications for the manner in which they react to the move. As such, I propose that residents who felt as if they had at least some control over their move to an ALF will be more likely than those who had little or no control over the move to report that they are in control of their lives. On the other hand, individuals who felt that the decision to move to an ALF was out of their hands will be less likely to report that they are in control of their lives.

Clearly, other factors may serve as important predictors of whether residents feel in control of their lives. Health status, for example, could account for some of the variation in residents' feelings of control. I propose that residents who: 1) feel healthy, 2) are able to take care of their daily needs, and 3) can communicate easily with those around them will report greater feelings of control than those residents with limited health.

Facility characteristics, such as OSS status, may also influence residents' perception of having control over their lives. Past research suggests that residents who live in OSS facilities are more likely to report that they lack control over their lives than those residents who live in private facilities (Street et al 2005). Since residents in OSS facilities tend to have less economic resources available to them than residents in private facilities it is possible that OSS residents were unable to move to their facility of their choice which could impact their feelings of control. Or, it is also possible that the lack of control reported by residents in OSS facilities is a reflection of the higher incidence of mental illness in such facilities.

Residents' perceptions regarding their current ALF are also likely to influence their feelings of control. I propose that residents who feel positively about their current

ALF will be more likely to report having control over their lives. Furthermore, residents who feel that the staff and other residents at their facility treat them respectfully will also be more likely to indicate that they are in charge of their lives. Finally, residents who report having enough privacy at their facility will be more likely than those who feel they lack privacy to report being in control of their lives.

Residents' social relationships with their friends and family as well as their involvement in activities both inside their facility as well as in the greater community could potentially have a positive or a negative impact on their feelings of control. On the one hand, some research suggests that social support systems exert a detrimental impact on older adults' feelings of autonomy. More specifically, ALF residents may view the need to ask the members of their social support systems for help as a sign of vulnerability or as an admittance that they are unable to care of themselves (Krause 1987). On the other hand, however, residents who have social support systems that they rely on to help them in times of need or even just to get them out of their ALF and into the community for awhile may feel less trapped in their facility and therefore in greater control of their lives.

Finally, restrictions placed upon residents by their facility could also influence residents' feelings of control. For example, residents who live in facilities that maintain strict control of their residents' daily activities may be more likely to feel that they lack control over their lives than residents who live in more lenient facilities.

## **Results**

Logistic regression is used to test the relative significance of my predictor variables on the level of control residents feel they have over their lives. Table 6. reports logistic regression results for impact of control over the move on residents' perceptions of whether they are in control of their lives.

**Table 6. Logistic Regression Results of Resident Lack of Control**

	<u>Model One</u> (n=279)	<u>Model Two</u> (n=254)	<u>Model Three</u> (n=234)	<u>Model Four</u> (n=183)	<u>Model Five</u> (n=157)
<i>Variables</i>					
Control Over the Move	-1.032* (.517)	-1.124* (.546)	-.691 (.639)	.763 (1.126)	.032 (2.131)
<u>Demographics</u>					
Age	-.786* (.339)	-.801* (.359)	-.527 (.415)	.083 (.640)	-1.259 (1.107)
Gender	.466 (.596)	.606 (.640)	.623 (.745)	1.890 (1.358)	5.256 (3.595)
Married	-.181 (1.103)	-.234 (1.14)	.0152 (1.167)	-.432 (1.466)	2.502 (2.380)
Education	-.196 (.161)	-.263 (.173)	-.176 (.178)	-.101 (.262)	.083 (.403)
<u>Resident Health</u>					
Mobility		.259 (1.126)	.254 (1.290)	-1.004 (1.666)	.567 (3.634)
Health-Status		-.550 (.544)	-.639 (.592)	-.163 (.864)	.264 (1.412)
MADLS		.726 (1.14)	.952 (1.280)	3.301† (1.741)	2.260 (3.281)
<u>Attitudes towards ALF</u>					
Privacy			1.033 (.630)	.373 (1.742)	2.470 (2.266)
Satisfied with Living Space			-.499 (.790)	.592 (1.433)	.760 (2.020)
<u>Social Support</u>					
Outside Activities				.095 (1.047)	3.450 (2.933)
Contact with Family				-2.778* (1.185)	-6.416† (3.681)
Satisfied with Family Contact				-.392 (1.078)	.281 (1.789)
Roommate				1.673 (1.045)	-.012 (1.893)
<u>Facility Restrictions</u>					
Lock Bedroom Door					2.477 (2.295)
Sleep Late					-2.917 (1.881)
Facility Encourages Self-Sufficiency					-4.040 (3.351)

Notes: †p<.10; \*p<.05; \*\*p<.01

The first model examines the impact of residents' control over the decision to move on the level of control they feel they have over their lives, controlling for demographic factors. Residents who reported at least some control over the decision to move are approximately one-third less likely ( $e^b=.356$ ) to report that they often or always feel out of control. Older residents are almost half as likely ( $e^b=.456$ ) as their younger counterparts to feel always or often out of control.

Model 2 incorporates a set of explanatory variables that take into account resident health. Such variables include residents' level of mobility, their self-assessed health status, as well as the level of assistance they need to perform activities of daily living. Residents' age ( $e^b=.449$ ) and whether or not they had control over their move ( $e^b=.325$ ) remain the only significant explanatory variables in this model and the size of these effects is similar to those for the first model.

The third model adds a set of explanatory variables that measure residents' satisfaction with their facility. Such variables include whether residents feel that they have enough privacy in their facility as well as whether they express satisfaction with their living space. The explanatory variables in this model are not statistically significant.

Model 4 includes a set of control variables that measure residents' level of involvement with other individuals both in and outside of their facility. The variables in this group include whether they have adequate opportunities to participate in activities outside of their facility, whether they have contact with their family, and whether they are satisfied with their level of familial contact. Only two variables are statistically significant in this model. The first significant variable is the level of assistance that residents need performing their activities of daily living. Not unexpectedly, residents who require more assistance are 27 times more likely ( $e^b=.27.140$ ) to report that they lack control over their lives. The second significant predictor variable in this model is whether or not residents have contact with their family members. Residents who maintain contact with their family members six times less likely ( $e^b=.062$ ) to feel that they often or always lack control.

The final model includes a series of variables that measure facility restrictions regarding residents' behavior. Whether or not residents are in contact with their family

members is the only significant predictor in this model. Again, residents who maintain contact with their family members are slightly more likely ( $e^b=.001$ ) to report that they are in control of their lives, although the size of the effect is very small.

My results provide little support for my hypotheses. None of my predictor variables has a consistently significant impact on residents' feelings of control.

### **Isolation**

Isolation is yet another important aspect of resident well-being. Hypothesis 1c examines what roles certain factors play in predicting whether or not residents feel suffer from feelings of isolation.

Prior research suggests that elderly people, especially those in long term care facilities, are at a high risk of suffering from isolation. In keeping with such research, I propose that older residents are more likely than their younger counterparts to suffer from isolation.

I hypothesize that residents who felt in control over the decision to move will be less likely to feel isolated. I believe this to be true for several reasons. First, as mentioned earlier, resident' perceptions of control over their move to an ALF carries important implications for whether or not they are able to adjust to their new facility. Residents who are able to adjust to their move may be more likely to form new friendships with those working and living in their facility and thus less likely to suffer from feelings of isolation. On the other hand, residents who relocated involuntarily may be too upset with their current living situation to try to form new relationships. Furthermore, residents who felt that they lacked control over the move may, in part, blame their current situation on their family members. If this is the case, residents could experience feelings of isolation due to those strained relationships.

I predict that health status is also a significant predictor of resident isolation. The ability to form social ties in an ALF requires residents to have the energy to socialize, the ability to move freely about the facility, and the capacity to communicate with others. Those residents who are able to perform such activities may have an easier time forming new friendships in their facility and, as such, could be less likely to feel isolated.

Facility OSS status may also influence residents' likelihood of suffering from isolation. For example, residents suffering from mental illness tend to be clustered in facilities that accept OSS (Street et al 2005); this could lead OSS residents who are not mentally ill to feel isolated.

Residents' views regarding their current ALF are also likely to influence whether or not they feel isolated. I propose that residents who are satisfied with their current facility are less likely to feel isolated. More specifically, residents who feel positively about their facility and its inhabitants may be more likely to form new relationships and less likely to feel isolated.

Finally, residents' relationships with their family, friends, and community are likely to be important predictor of resident isolation for obvious reasons. I propose that those residents who are able to form and maintain ties with their friends and family, as well as with their greater community, will be less likely to suffer from feelings of isolation than those residents who lack such social support ties.

## Results

Table 7. reports multinomial logistic regression results of residents' likelihood of suffering from feelings of isolation.

**Table 7. Multinomial Logistic Regression Results of Resident Isolation**

Isolation	Model One (n=287)			Model Two(n=282)		
	Slight	Moderate	Severe	Slight	Moderate	Severe
<i>Variables</i>						
Control Over the Move	-.141 (.362)	-.441 (.396)	-1.129† (.471)	-.147 (.371)	-.529 (.409)	-1.216† (.481)
<u>Demographics</u>						
Age	.226 (.213)	-.283 (.237)	-.168 (.471)	.299 (.219)	-.124 (.246)	-.036 (.315)
Female	.549† (.332)	.704† (.407)	1.307* (.612)	.506 (.336)	.558 (.419)	1.226* (.618)
Married	-.026 (.422)	-1.23 (.776)	-.960 (1.07)	-.096 (.426)	-1.35† (.786)	-1.02 (1.081)
Education	-.258** (.089)	-.255† (.104)	-.306* (.140)	-.274** (.091)	-.279* (.107)	-.324* (.141)

**Table 7. Continued**Resident Health

Health-Status	- .514 (.344)	-1.120* (.383)	- .888† (.068)
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Facility Characteristics

OSS Status

Attitudes towards ALF

Staff Satisfaction

ALF as Home

Privacy

Member of the Family

Social Support

Facility Activities

Outside Activities

Contact with Family

Satisfaction with  
Family Contact

Friends in Facility

Time Spent Alone

Notes: †p&lt;.10; \*p&lt;.05; \*\*p&lt;.01

Isolation	<u>Model Three</u> (n=190)			<u>Model Four</u> (n=154)		
	Slight	Moderate	Severe	Slight	Moderate	Severe
<i>Variables</i>						
Control Over the Move	-.332 (.494)	-.596 (.617)	-1.418† (.805)	-.548 (.593)	-1.379 (.892)	-1.01 (1.390)
<u>Demographics</u>						
Age	.347 (.310)	-.290 (.376)	.339 (.612)	.502 (.360)	-.097 (.510)	1.633 (1.370)
Female	.812† (.434)	.501 (.621)	1.039 (1.055)	.913† (.510)	1.271 (.915)	4.623 (3.354)
Married	.118 (.507)	-37.524 (4.800)	-36.43 (6.500)	-.037 (.650)	-43.79 (.650)	-44.295 (2.460)
Education	-.359* (.119)	-.395* (.1667)	-.382 (.244)	-.390* (.145)	-.717* (.255)	-1.075† (.447)

**Table 7. Continued**

<u>Resident Health</u>						
Health-Status	-.280 (.444)	-1.266* (.550)	-1.632* (.761)	-.032 (.546)	-1.158 (.745)	-1.924 (1.178)
<u>Facility Characteristics</u>						
OSS Status	-.281 (.515)	.279 (.620)	.688 (.854)	-.306 (.595)	.785 (.852)	.653 (1.340)
<u>Attitudes towards ALF</u>						
Staff Satisfaction	.181 (.408)	-.566 (.347)	-.809† (.413)	.173 (.540)	-.584 (.626)	-1.196† (.704)
ALF as Home	-.611 (.481)	-1.46* (.678)	-1.120 (1.055)	-.726 (.554)	-1.84* (.927)	-1.890 (1.607)
Privacy	-.336 (.469)	-1.460* (.702)	-.366 (.849)	-.726 (.585)	-3.265** (1.203)	-1.036 (1.233)
Member of the Family	-.542 (.424)	-.340 (.631)	-.296 (.994)	-.882† (.518)	-.291 (.829)	-1.422 (1.754)
<u>Social Support</u>						
Facility Activities				.111 (.543)	-.278 (.856)	-1.350 (1.640)
Outside Activities				-.631 (.615)	-.944 (.808)	-1.352 (1.476)
Contact with Family				.681 (.978)	20.462** (3.499)	-1.343 (2.649)
Satisfaction with Family Contact				.681 (.979)	-.178 (.824)	-1.684 (1.494)
Friends in Facility				-.750 (.721)	-.964 (.991)	-2.945 (2.056)
Time Spent Alone				-.232 (.327)	1.26 (.591)	-1.567 (1.087)

Notes: †p<.10; \*p<.05; \*\*p<.01

The first model tests the impact of control over the move on residents' feelings of isolation, controlling for gender. In general, this model suggests that women are more likely than men to feel isolated. Women are approximately twice as likely as men to suffer from slight ( $e^b=1.731$ ) and moderate ( $e^b= 2.022$ ) feelings of isolation and almost four times more likely ( $e^b=3.700$ ) to suffer from severe feelings of isolation. Residents who had control over their move to an ALF are a third less likely ( $e^b=.323$ ) than those who lacked control to suffer from feelings of isolation most of the time. In addition, residents with high levels of education are less likely than their less educated counterparts to suffer from feelings of isolation.

Model two incorporates residents' self-assessed health status. Similar to the first model, women remain three times more likely than men ( $e^b = 3.400$ ) to suffer from severe isolation, while residents who had control over their move are 1/3 less likely ( $e^b = .296$ ) to report feelings of severe isolation than their counterparts who lacked control. This supports my hypothesis that involuntarily relocated residents may be too upset to form new relationships or, perhaps are harboring resentment toward their family members for allowing or even encouraging the move. The results for model two also support my prediction that health has a negative impact on residents' likelihood of suffering from isolation. Specifically, residents who report good health are a third less likely ( $e^b = .326$ ) suffer from moderate feelings of isolation and almost half as likely ( $e^b = .400$ ) to suffer from feelings of severe isolation. Educational attainment remains a significant predictor of residents' feelings of isolation.

Model three takes into account residents' level of satisfaction with their current ALF as well as facility characteristics such as OSS status. As to be expected, residents who are satisfied with the staff at their facility are almost half as likely ( $e^b = .445$ ) to feel isolated than those who are unhappy with their facility's staff. In addition, residents who view their facility as their home and those who feel they have enough privacy are almost one-fourth less likely ( $e^b = .232$ ) to suffer from feelings of isolation. Residents' gender, educational attainment, health status, and control over the move continue to contribute to our ability to predict isolation.

Model four incorporates variables that measure residents' level of involvement with others. Residents who maintain contact with their family members are less likely to report that they often suffer from feelings of isolation. Residents who regard their facility positively continue to be less likely to suffer from feelings of isolation. Not surprisingly, residents who spend a good deal of time alone are more likely to often suffer from feelings of isolation than those who spend less time by themselves.

My results provide evidence to support my hypothesis that resident control over the decision to move to an ALF helps predict of residents feelings of isolation. In fact, control over the decision to move has a significant, negative impact on resident isolation. My results further indicate that other explanatory variables also play important roles in predicting the likelihood that a resident suffers from feelings if isolation. Specifically,

residents' gender, educational attainment, health status, attitudes towards their ALF, as well as their level of social involvement all serve as key predictors of isolation. Women are more likely than their male counterparts to suffer from isolation, while healthy residents are less likely to feel isolated. Residents with high levels of educational attainment are less likely to feel isolated than their less educated counterparts. Residents who are satisfied with their current facility tend to experience less isolation than those who are not. Finally, residents who have social ties, both within and outside of their facility, are also less likely to suffer from isolation.

### **Discussion**

This chapter shows how various factors affect the well-being of residents in assisted living. Limited prior research indicates that residents' perceptions of their level of control over the move are an important predictor of well-being. My results, however, indicate that this relationship may be weaker than previously thought. While control over the move does predict one aspect of resident well-being, isolation, it fails to consistently predict other aspects, such as life dissatisfaction and control over life.

In terms of isolation, resident control over the decision to move has a significant negative impact on the likelihood of feeling isolated. Residents who report that they had at least some control over the relocation process were less likely to feel isolated. As mentioned earlier, residents who involuntarily moved to an ALF may be too upset with their current circumstances to socialize other residents, or they may still harbor feelings of resentment towards their family over the move. In addition to whether or not they had control over the move, residents' gender, educational attainment, health status, views regarding their ALF, and social involvement are all important predictors of isolation.

As for life dissatisfaction, this paper indicates that residents' attitudes towards their facility and their social support systems are more important predictors of resident depression than whether or not they had control over the move to assisted living. These findings suggest that what happens to residents after they move into assisted living is more important in terms of predicting life dissatisfaction than how they came to live in their current ALF.

One interesting aspect of the results for resident life dissatisfaction is that, contrary to previous research, older residents were consistently less likely than their younger counterparts to suffer from life dissatisfaction. As suggested earlier, older residents may be more likely to accept that they need the assistance offered by ALF residency and thus more satisfied with their living situation.

As for lack of control, not surprisingly, residents who indicated that they were in control of their move to assisted living were more likely to report being in control of their lives. In addition, residents who experienced difficulties performing activities of daily living were more likely to report that they lack control over their lives. This finding is not unexpected considering that residents who must rely on others for assistance carrying out their daily activities do, in fact, lack a certain level of control over how and when they can participate in activities of daily living. Finally, residents who report that they are in touch with their families are also more likely to indicate that they are in control of their lives. I suspect that the assistance these residents receive from their family members plays a large role in enabling them to either maintain control, or at least feel as if they have control, over their lives.

## CHAPTER FOUR RESIDENTS' SOCIAL SUPPORT NETWORKS

My second analysis chapter will provide an in-depth examination of the social support systems of residents in assisted living facilities.

### **Family Support**

Hypotheses 2a – 2c examine the influence of relocation to an ALF on the quantity and quality of residents' relationships with their family members. One factor that may influence residents' social support systems is the length of time they have lived in their current facility. I predict that the longer residents live at an ALF the less likely they are to maintain and be satisfied with their family ties.

Another factor that likely plays a role in predicting residents' levels of social support as well as their satisfaction with support is the level of control they had over their move to an assisted living facility. My results for hypothesis 1c, in fact, indicate that residents who were in control over their move to an ALF were less likely to suffer from feelings of isolation. It is possible that residents who moved involuntarily to their current ALF may hold their family members responsible for their current situation. Or, it is possible that such residents may have had strained relationships with their family members prior to the move which left them few alternatives to assisted living. In either case, such tension could be reflected in residents' relationships with their family members.

Facility characteristics, such as OSS status, could also have an impact on residents' relationships with their family members. Residents who end up in OSS facilities may, in part, be located in such facilities because they lack a familial social support system that could potentially provide financial assistance. Or, residents whose family simply couldn't or wouldn't provide them with financial support may feel abandoned by their family. Finally, a large proportion of residents in OSS facilities are mentally ill which could lead to strained family relations (Street et al 2005).

How residents feel about their current assisted living facility may also influence their family relationships. Residents who have sources of social support to whom they

can turn within their facility, whether it be staff or other residents, may feel less dependent on their family members than residents who lack such facility ties. If residents are not forced to rely solely on their family for support, it may improve family relationships, which could lead to higher levels of family contact and satisfaction.

It is also likely that the proximity of residents' facilities to their family members plays an important role in determining social support outcomes. Past research, for example, suggests that geographic proximity is a better predictor of intergenerational contact than both parent and child characteristics (Dewit, Wister, and Burch 1988). In keeping with this study, I propose that residents who have family members living nearby are more likely to maintain contact with their family than are residents who do not have family members living in the area.

Finally, I propose that the circumstances that led residents to move to an ALF will impact their relationships with their family. Earlier I hypothesized that residents who had control over the move will be more likely to have a positive relationship with their family. The same reasoning applies here, residents who feel that they made the move to assisted living for the right reasons will be more likely to keep in touch with, and be satisfied with, their family members.

My analyses of residents' familial social support systems consist of three parts. First, I examine the impact of various factors on the likelihood of residents being in contact with their family members. Second, I analyze factors that predict whether or not residents are satisfied with their level of family contact. Third, I address residents' levels of perceived familial support, or, the level of family support that residents believe is available to them.

## **Results**

### **Resident Contact with Family Members**

Logistic regression is used to examine the impact of relocation on the odds that residents are in touch with their family members. Table 8. reports logistic regression results from the impact of relocation on whether or not residents are in touch with their family.

**Table 8. Logistic Regression Results of Residents' Contact with Family Members**

	<u>Model One</u> (n=361)	<u>Model Two</u> (n=247)	<u>Model Three</u> (n=189)	<u>Model Four</u> (n=189)
<i>Variables</i>				
Been in Facility Less Than One Year	.054 (.276)	-.219 (.395)	-1.619* (.794)	-2.356* (1.031)
Control Over the Move	.712* (.280)	.570 (.403)	1.393† (.716)	1.964* (.864)
<u>Demographics</u>				
Age	.539* (.180)	-.102 (.288)	-.762 (.598)	-.891 (.658)
Female	.485† (.294)	.568 (.426)	.713 (.870)	.847 (.949)
Marital Status	1.135* (.561)	.788 (.703)	.932 (1.410)	.473 (1.458)
Education	.099 (.078)	.145 (.116)	.020 (.224)	.067 (.254)
<u>Resident Health</u>				
Health-Status		.090 (.417)	1.084 (.821)	1.217 (.923)
<u>Facility Characteristics</u>				
OSS Status		-.317 (.447)	.323 (.966)	-.319 (1.054)
<u>Attitudes towards ALF</u>				
Satisfaction with Staff		.606* (.224)	.917* (.452)	1.370* (.629)
Satisfied with Living Space		-.249 (.744)	1.355 (1.190)	1.570 (1.330)
Considers Facility to be Home		-.193 (.452)	-1.727 (1.118)	-2.55 (1.461)
<u>Social Support</u>				
Time Spent Alone			-.198 (.501)	-.194 (.535)
Outside Activities			-2.427† (1.250)	-2.924* (1.383)
Facility Activities			1.222 (.863)	1.031 (.915)
Roommate			-1.508 (.955)	-.706 (1.034)
Have Friends in Facility			.165	.444

**Table 8. Continued**

Have Friends outside of the Facility	.584 (.755)	.746 (.835)
Proximity to Family	-.021 (.805)	-.592 (.918)
<u>Reasons For Move</u>		
Need More Help		-1.916† (1.083)
Deteriorating Health		-.004 (1.016)
What Kids Wanted		1.131 (.888)

Notes: †p<.10; \*p<.05; \*\*p<.01

The first model examines the impact of two variables on the likelihood that residents are in contact with their family members, resident tenure at their current facility, and whether they had at least some control over the decision to move. Residents who had at least some control over the decision to move are twice as likely ( $e^b = 2.038$ ) to maintain contact with their family as those residents who were not in control over the move. This finding supports my hypothesis that residents' social support systems may suffer after an involuntary relocation due to the strain placed upon their familial relationships. Older residents were also slightly more likely ( $e^b = 1.714$ ) to be in contact with family members, which could possibly be explained by the greater level of assistance required by older residents.

Women residents are almost twice as likely ( $e^b = 1.624$ ) as their male counterparts to be in touch with their family members. This makes sense considering, historically, women have invested more time than men in maintaining family ties. In addition, married residents are approximately three times more likely ( $e^b = 3.111$ ) than non-married residents to be in touch with their family members.

The second model includes a group of control variables that take into account residents' self-assessed health status and facility characteristics such as facility OSS status as well as residents' attitudes towards their facility. The variables measuring residents' attitudes include: 1) whether or not residents are satisfied with the staff at their facility, 2)

whether they are satisfied with their living space, and 3) whether residents consider their facility to be their home.

Residents' level of satisfaction with the staff at their facility is the only significant predictor variable in this model. Residents who are satisfied with their facility staff are almost twice as likely ( $e^b = 1.834$ ) to be in touch with their family. One potential explanation for this finding is that residents who have sources of support at their facility place less pressure on their family members and thus maintain better relationships. Or conversely, it is possible that residents who have a family to help care for them and perhaps offer financial support may end up at better facilities, with better staff, than those who do not.

Model three incorporates a set of explanatory variables that measure residents' level of involvement with others, both within their facility as well as in the greater community. The variables in this group include: 1) whether residents feel they have enough chances to participate in activities both within and outside of their facility, 2) whether they have a roommate, 3) whether they have friends within their facility, 4) whether they have relatives who live within an hour of their facility, 5) how much time they spend alone, and 6) whether or not they have friends outside of their facility.

The length of time a resident has lived in their current facility is significant in this model. Residents who have lived in their current facility for less than one year are less likely ( $e^b = 1.98$ ) to maintain contact with their family members. This finding contradicts my hypothesis that the longer residents live in their ALF the less likely they are to maintain contact with their family. Perhaps, following relocation, residents choose to devote their energy toward forming new relationships with other residents rather than toward their family. Or, it is possible that, before their move to an ALF, residents turned to their family members to meet their needs. After their move, however, residents no longer have to rely on their family exclusively for help which may reduce their level of familial contact.

Resident control over their move remains significant in this model. Residents who reported having at least some control over the decision to move are four times more likely ( $e^b = 4.027$ ) to maintain contact with their family. Residents who are satisfied with the staff at their facility are twice as likely ( $e^b = 2.502$ ) to be in touch with their family

members. Not surprisingly, residents who report that they do not have enough chances to participate in activities outside of their facility are less likely ( $e^b = .088$ ) to maintain contact with their family.

The fourth model includes a set of variables that take into account the reasons that residents' moved to their ALF. These variables include: 1) residents who moved because they needed more help, 2) residents who moved because of deteriorating health, and 3) residents who moved because it's what their children wanted. Length of residency remains a significant, negative predictor ( $e^b = .095$ ) of residents' contact with their family in this model. Residents' level of control over their move, their satisfaction with the staff at their facility, and whether they have enough opportunities to participate in activities outside of their facility also continue to be significant predictors. In addition, residents who moved to their current facility because they needed more help ( $e^b = .147$ ) are less likely to be in contact with their family members. It is possible that individuals who move because they need more help lack the necessary family ties to provide such help in their own home.

In general my results fail to support my hypothesis that the longer residents live at an ALF the less likely they are to maintain contact with their family. In fact, my results suggest the exact opposite -- long-term residents are actually more likely than their newly relocated counterparts to be in contact with their family members. My results also indicate that residents' control over their move is an important predictor of family contact. Residents who had at least some control over their relocation to an ALF are significantly more likely to be in touch with their family.

### **Resident Satisfaction with Level of Familial Contact**

Logistic regression is used to examine residents' satisfaction with the amount of contact they have with their family members. Table 9. reports logistic regression results from the impact of residents' tenure at their current ALF on their level of satisfaction with family contact.

**Table 9. Logistic Regression Results of Residents' Satisfaction with Family Contact**

	<u>Model One</u> (n=298)	<u>Model Two</u> (n=292)	<u>Model Three</u> (n=215)	<u>Model Four</u> (n= 73)
<i>Variables</i>				
Length of Residency	-.022 (.327)	-.089 (.338)	-.408 (.412)	.291 (.979)
Control Over the Move	1.181** (.326)	1.30** (.347)	1.146* (.419)	.876 (.995)
<u>Demographics</u>				
Age	.424† (.220)	.331 (.227)	.156 (.301)	-.407 (.779)
Female	-.262 (.381)	-.066 (.399)	.154 (.489)	-.975 (1.28)
Marital Status	1.344† (.763)	1.37† (.776)	1.585† (.893)	
Education	.092 (.097)	.105 (.101)	.161 (.125)	.413 (.297)
<u>Resident Health</u>				
Health-Status		1.134** (.341)	.787† (.414)	.371 (1.14)
<u>Facility Characteristics</u>				
OSS Status			-.098 (.416)	-.854 (1.018)
Medium			.959 (.694)	-1.546 (1.436)
Large			1.201† (.615)	-.206 (1.017)
<u>Attitudes towards ALF</u>				
Satisfaction with Staff			.739* (.263)	
Feels Safe in Facility			2.564 (1.65)	
Satisfied with Living Space			.895 (.667)	
<u>Social Support</u>				
Time Spent Alone				.213 (.630)
Outside Activities				.906 (1.115)
Satisfaction with Outside Friends				1.704 (1.527)

**Table 9. Logistic Regression Results of Residents' Satisfaction with Family Contact**

Proximity to Family	2.151† (1.156)
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Notes: †p<.10; \*p<.05; \*\*p<.01

The first model examines the impact of residents' tenure at their current ALF, their level of control over the decision to move to an ALF, and their demographic characteristics on whether or not they are satisfied with their level of family contact. The results indicate that residents' tenure in their current facility is not associated with their level of satisfaction with the amount of contact they have with their family. As predicted, residents who reported that they had at least some control over the decision to move were approximately three times more likely ( $e^b = 3.258$ ) to be satisfied with amount of contact they have with their family. This lends support to the idea that involuntary relocation places a strain on residents' relationships. In addition, married residents were almost four times more likely ( $e^b = 3.834$ ) than their non-married counterparts to be satisfied with their family contact. Finally, older residents are slightly more likely ( $e^b = 1.528$ ) than their younger counterparts to be satisfied with their level of family contact.

Model two incorporates residents' self-assessed health status. Married residents and residents who reported that they were in control over the decision to move remain more likely to be satisfied with their level of family contact. In addition, residents who indicated that they are in good health were three times more likely ( $e^b = 3.108$ ) to report satisfaction with the frequency at which they see their family. It is possible that family members may be less willing to visit with an extremely ill resident. Or, residents in good health may be better able to enjoy the time they spend with their family, which could result in greater visitation.

The third model adds a group of predictor variables that take into account facility characteristics, such as OSS-status and size, as well as residents' attitudes toward their facility. Variables that measure residents' attitudes toward their facility include: 1) whether they are satisfied with the staff at their facility, 2) whether they feel safe in their facility, and 3) whether they are satisfied with their current living space. The results for this model indicate that residents who are satisfied with the staff at their facility are two

times more likely ( $e^b = 2.094$ ) to be satisfied with the amount of contact they have with their family.

In addition, residents who live in large facilities are three times more likely ( $e^b = 3.323$ ) than their counterparts in small or medium facilities to be satisfied with their family contact. Residents' control over the decision to move continues to matter in terms of predicting residents' satisfaction with their family contact. Residents' who were in control of their move are three times more likely ( $e^b = 3.146$ ) to report being satisfied with the amount of contact they have with their family. Residents' marital ( $e^b = 4.879$ ) and health status ( $e^b = 2.197$ ) also continue to be significant predictors of whether or not residents are satisfied with their level of family contact.

The fourth model incorporates variables that measure residents' level of involvement both within their facility as well as in the outside community. This set of variables includes: 1) whether residents feel they have enough chances to participate in activities outside of their facility, 2) whether they have relatives who live within an hour of their facility, 3) whether they are satisfied with the level of contact they have with their friends outside of the facility, and 4) how much time they spend alone.

The results of Model five should be interpreted cautiously due to the loss of sample size (I discuss the problems arising from sample size variation in more detail in Chapter Five). However, the results can still be viewed as a basic starting point on which future research should build. Geographic proximity is the only significant variable in this model. Residents who have family members living within one hour of their facility are approximately nine times more likely ( $e^b = 8.593$ ) to be satisfied with the amount of contact they have with their family. This finding supports my hypothesis that geographic proximity matters in terms of predicting social support outcomes.

My results provide little support for my hypothesis that the longer residents live at an ALF the less likely they are to be satisfied with their level of family contact. Instead, resident control over the decision to move seems to be a better predictor of whether or not residents are satisfied with the amount of contact they have with their family. Residents who had at least some control over their relocation are far more likely to be satisfied with their family relationships. My results further indicate that residents' proximity to their family members plays an important role in predicting resident satisfaction. Residents

who have family living nearby are more likely to be satisfied with the amount of contact they have with their family members.

### Residents' Perceived Familial Support

Ordered logit is used to test the relative significance of my predictor variables on residents' perceptions of available family support. The ordered logit model estimates the effects of my predictor variables on the log odds of having higher rather versus lower levels of perceived support. In ordered logistic regression, Stata normalizes one of the predicted categories to zero (can count on family most of the time) and estimates the cut points for separating the various levels of response variables. I used the Brant test to confirm that my models satisfied the parallel regression assumption. Table 9. reports ordered logit results for the impact of relocation on whether residents feel they can rely on their family for help in times of trouble.

**Table 10. Ordered Logistic Regression Results of Residents' Perceived Family Support**

	<u>Model One</u> (n=299)	<u>Model Two</u> (n=293)	<u>Model Three</u> (n=293)	<u>Model Four</u> (n=219)	<u>Model Five</u> (n=181)	<u>Model Six</u> (n=181)
<i>Variables</i>						
Length of Residency	-.568 (.375)	-.523 (.381)	-.513 (.383)	-.957† (.527)	-1.318* (.674)	-1.674* (.734)
Control Over the Move	-1.417** (.360)	-1.442** (.373)	-1.342** (.383)	-1.629** (.496)	-1.634* (.640)	-1.780* (.674)
<u>Demographics</u>						
Age	-.886** (.243)	-.860** (.250)	-.772* (.269)	-.660† (.351)	-.378 (.444)	-.368 (.455)
Female	.133 (.407)	.017 (.114)	.055 (.426)	.459 (.607)	-.015 (.710)	-.144 (.742)
Marital Status	.014 (.600)	.070 (.613)	.137 (.620)	1.037 (.729)	.801 (.957)	.967 (.993)
Education	-.211† (.111)	-.231* (.114)	-.239* (.117)	-.273† (.153)	-.407* (.196)	-.451* (.207)
<u>Resident Health</u>						
Health-Status		-.781* (.367)	-.696† (.373)	-1.16* (.472)	-1.510* (.623)	-1.969* (.719)
<u>Facility Characteristics</u>						
OSS Status			.470 (.405)	.564 (.519)	-.115 (.702)	-.266 (.730)
Medium			-.612 (.698)	-.663 (.757)	-.890 (.984)	-.964 (1.049)

**Table 10. Continued**

Large	-0.844 (.636)	-1.256† (.701)	-1.282 (.895)	-1.106 (.912)
<u>Attitudes towards ALF</u>				
Satisfaction with Staff		-.412 (.272)	-.300 (.300)	-.229 (.316)
Satisfied with Living Space		-1.142† (.626)	-.845 (.759)	-.908 (.785)
<u>Social Support</u>				
Time Spent Alone			-.213 (.418)	-.309 (.461)
Outside Activities			-.677 (.692)	-.711 (.722)
Facility Activities			-.960 (.658)	-.961 (.709)
Roommate			1.688* (.732)	2.037* (.847)
Proximity to Family			.020 (.594)	-.081 (.609)
<u>Reasons Behind Move</u>				
Need More Help				-.733 (.690)
What Kids Wanted				-1.162* (.697)

Notes: †p<.10; \*p<.05; \*\*p<.01

The first model for residents' perceptions of available support includes the length of time a resident has lived at their facility, their level of control over the move to an ALF, and several demographic variables. Contrary to my expectations, residents' tenure at their current facility is not significantly related to their level of perceived familial support. Residents who report that they had at least some control over their move were approximately a fourth as likely ( $e^b = .242$ ) to report that they could not count on their family in times of trouble. This supports my hypothesis that residents who lacked control over their move may harbor feelings of resentment towards their family over the move. Or, it is possible that these residents do not have a family to turn to which may partially account for how they came to live in an ALF. My results also indicate that older residents are almost half as likely as ( $e^b = .412$ ) their younger counterparts to report that they can not count on their family in times of trouble. Finally, residents' educational

attainment impacts their level of perceived support. Residents with lower levels of education ( $e^b = .810$ ) report less access to social support.

Model Two incorporates residents' self-assessed health status. Residents' control over the decision to move ( $e^b = .236$ ), age ( $e^b = .423$ ), and educational attainment ( $e^b = .794$ ) continue to be significant predictors of perceived support. Self-assessed health status is also significantly associated with residents' perceptions of available support. Healthy residents are almost half as likely ( $e^b = .458$ ) to indicate that they can rely on their family during times of trouble. Perhaps residents who are in good health have not yet had the opportunity to ask for actual support and thus are unaware of any problems they may encounter actually receiving support.

Model Three introduces facility OSS status and size into the model. Residents' age ( $e^b = .261$ ), educational attainment ( $e^b = .787$ ), self-assessed health status ( $e^b = .499$ ), and level of control over their move ( $e^b = .261$ ) remain the only significant predictors of perceived support.

Model Four adds a set of control variables that address residents' attitudes towards their current ALF. This set of variables includes whether residents are satisfied with the staff and living space at their current facility. Residents' tenure at their current facility is a significant predictor in this model. Residents who have lived in their facility for less than one year are approximately a third less likely ( $e^b = .384$ ) to report that they can not count on their family during difficult times.

The results also suggest that residents' satisfaction with their living space and facility size are important predictors of residents' perceptions of available support. Residents who live in large facilities are less likely ( $e^b = .285$ ) to report that they can not count on their family during difficult times. In addition, residents who are satisfied with their living space are almost a third less likely ( $e^b = .319$ ) to report low levels of perceived support. Several other predictor variables remain significant in this model such as control over the move ( $e^b = .196$ ), age ( $e^b = .517$ ), educational attainment ( $e^b = .761$ ), and self-assessed health status ( $e^b = .313$ ).

Model Five incorporates a set of predictor variables that measure residents' level of involvement with other individuals both in and outside of their facility. The variables in this group include: 1) whether they attend activities offered at their facility, 2) whether

they have enough chances to participate in activities outside of their facility, 3) how much time they spend alone, 4) whether they have a roommate, 5) whether they have family who live within one mile of the facility, and 6) whether or not they are in contact with friends outside of the facility.

Length of residency ( $e^b = .268$ ), control over the move ( $e^b = .195$ ), educational attainment ( $e^b = .666$ ), and self-assessed health status ( $e^b = .221$ ) all remain significant predictors of perceived support. Interestingly, residents who have a roommate are five times more likely ( $e^b = 5.409$ ) to report their family would not help them if necessary. It is possible that such residents are forced to share their rooms because their family would not or could not contribute financially to help them secure a private room.

The final model incorporates a set of variables that take into account the reasons that led residents to relocate. This includes residents who moved because they needed more help as well as those whose children wanted them to move. Residents who moved because it is what their children wanted are a third as likely ( $e^b = .313$ ) to report that they can not turn to their children in times of trouble. Length of residency ( $e^b = .187$ ), control over the move ( $e^b = .169$ ), educational attainment ( $e^b = .637$ ), self-assessed health status ( $e^b = .221$ ), and whether residents have a roommate ( $e^b = 7.668$ ) remain significantly associated with perceived support.

Overall, my results indicate that residents' level of control over their move is an important predictor of social support outcomes. Residents who had at least some level of control over their move are more likely to report that they can turn to their family for help. Again, this implies that residents' relationships with their family suffer if they feel they are not in control over their move to assisted living.

In addition, the residents' tenure at their current facility also influences their level of perceived support. Residents who have lived in their current facility for less than one year are more likely than long-term residents to report that they can count on their family for assistance. Demographic factors, such as age, educational attainment, and marital status are also important predictors of residents' perceptions of available support. Older residents, for example, are more likely than their younger counterparts to report that they can count on their family in times of trouble. More educated residents also report greater access to family support than their less educated counterparts.

## **Residents' friendships**

Hypotheses 2d – 2e examine the factors that influence the likelihood that residents maintain relationships with their friends who live outside of their facility. I propose that relocation decreases the quality and quantity of residents' relationships with their friends who do not live in their facility. Specifically, the longer residents live in an ALF the less likely they are to a) maintain friendship ties with individuals outside of the facility and b) be satisfied with such ties.

Other factors, however, should also be taken into account when examining residents' friendship networks. Most research, for example, suggests that the friendships of the elderly vary by gender. Past research has indicated that older women tend to have a greater number of friends than their male counterparts. In addition, women are more likely than men to value their friendships and to invest time and energy into maintaining them (Roberto and Scott 1986; Roberto and Kimbo 1989; Armstrong and Goldstein 1990). As such, I propose that women will be more likely than men to report that they have contact with friends who live outside of their facility.

Age is also likely to play an important role in predicting residents' friendship outcomes. Past research suggests that the elderly are often in danger of losing friendship ties due to various factors such as retirement, widowhood, declining health, and the death of friends. However, while the number of friendships among the elderly declines with age, the importance of their remaining friendships actually increases, suggesting that as the elderly lose friendship ties they depend more heavily on their remaining friendships (Brown 1981; Matt and Dean 1993). As such I propose that, on the one hand, the old-old will be less likely than their younger counterparts to maintain friendship ties, but, on the other hand, they will be more likely to be satisfied with the friendship ties that they do have.

Health is also likely to impact residents' relationships with their outside friends. For example residents who do not feel well may lack the energy necessary to socialize. In addition, residents who have problems with their mobility may have a hard time visiting with their outside friends. Furthermore, residents with hearing problems may encounter difficulties communicating with friends whether over the phone or face to face.

As such, I hypothesize that residents with health problems will be less likely to maintain their outside friendship ties, and be satisfied with such ties, than healthy residents.

Finally, I propose that residents' relationships with their family members and facility friends will likely impact whether or not they are in contact with their outside friends as well as whether they are satisfied with said friendships. Residents who are in contact with their family, or who have friends in their facility who drive, may have easier access to transportation in order to visit with their outside friends. In addition, it is possible that residents who are able to develop and maintain positive family relationships and facility friendships acquired better social skills over the course of their lives which carries over into their ability to maintain outside friendships.

My analyses of residents' friendship support systems consist of two parts. First, I examine the impact of several predictor variables on the likelihood that residents are in touch with their friends outside of their facility. Second, I explore the factors that predict whether residents are satisfied with their level of contact with outside friends.

## Results

### Resident Contact with Friends Outside of their Facility

Logistic regression is used to test the relative importance of my predictor variables on whether or not residents are in contact with friends outside of their facility. Table 11. reports logistic regression results from the impact of relocation on whether or not residents are in touch with their friends who do not live in their current ALF.

**Table 11. Logistic Regression Results of Residents' Contact with Friends Outside of Their Facility**

	<u>Model One</u> (n=361)	<u>Model Two</u> (n=307)	<u>Model Three</u> (n=207)	<u>Model Four</u> (n=171)	<u>Model Five</u> (n=171)
<i>Variables</i>					
Length of Residency	.406* (.252)	.352 (.253)	.473 (.322)	.342 (.399)	.350 (.407)
Control Over the Move	.719† (.252)	.892** (.281)	.615† (.352)	.510 (.402)	.583 (.419)
<u>Demographics</u>					
Age	.011 (.014)	.016 (.016)	.013 (.021)	.012 (.025)	.009 (.026)

**Table 11. Continued**

Female	.133 (.248)	.119 (.268)	-.079 (.339)	-.145 (.402)	-.183 (.408)
Marital Status	.016 (.334)	-.051 (.360)	-.238 (.452)	-.584 (.657)	-.716 (.672)
Education	.141* (.064)	.166* (.071)	.266* (.091)	.338* (.113)	.332* (.116)
<u>Resident Health</u>					
Health-Status		-.107 (.269)	.157 (.329)	-.017 (.393)	-.0185 (.400)
Hearing Impaired		-.469† (.265)	-.606† (.333)	-.587 (.384)	-.683† (.392)
MADLS		-.010 (.571)	.172 (.739)	-.020 (.831)	.102 (.852)
Mobility		.055 (.519)	-.018 (.655)	.199 (.750)	.058 (.765)
<u>Attitudes towards ALF</u>					
Satisfaction with Staff			.145 (.234)	-.174 (.273)	-.232 (.278)
Satisfied with Living Space			-.158 (.570)	.103 (.697)	.130 (.702)
Privacy			-.562 (.359)	-.544 (.433)	-.477 (.436)
Feel like a Member of the Family			.347 (.328)	.374 (.390)	.371 (.394)
<u>Social Support</u>					
Time Spent Alone				-.329 (.257)	-.368 (.260)
Outside Activities				(.294) (.455)	.246 (.468)
Facility Activities				.497 (.417)	.495 (.422)
Roommate				-.373 (.428)	-.454 (.441)
Facility Friends				.258 (.529)	.285 (.539)
Driver's License				.232 (.385)	.234 (.389)
<u>Reasons Behind Move</u>					
Need More Help					.302 (.391)
What Kids Wanted					.620 (.403)

Notes: †p<.10; \*p<.05; \*\*p<.01

The first model includes the variable for resident tenure at an ALF as well as conventional demographic indicators. My results indicate that the length of time

residents have lived in their current ALF is a significant predictor of their contact with friends. As expected, residents who have lived in their facility for less than one year are 50 percent more likely ( $e^b = 1.50$ ) than long-term residents to be in touch with their outside friends. In addition, resident who reported that they were in control over the decision to move were twice as likely ( $e^b = 2.052$ ) to maintain contact with their friends outside of their facility. As indicated in my first hypothesis, residents who had control over their decision to move are more likely to report that they are in control over their lives. It is possible that this autonomy enables residents to keep in touch with their friends, a luxury that less independent residents may lack. Finally, residents with higher levels of educational attainment were also more likely ( $e^b = 1.151$ ) to maintain contact with outside friends. In this instance, education is likely a proxy for social class, residents with higher levels of education more than likely possess greater financial resources which they can use to gain access to transportation.

My second model incorporates measures of residents' health. These variables include: 1) residents' level of mobility, 2) their self-assessed health status, 3) whether or not they suffer from a hearing impairment, and 4) the level of assistance they need to perform activities of daily living. Residents' level of control over their move ( $e^b = 2.440$ ) and their educational attainment ( $e^b = 1.181$ ) continue to be significant positively related to maintaining friendship ties. Whether or not residents suffer from hearing impairments is also significant in this model. Residents who experience difficulty hearing are around half as likely ( $e^b = .626$ ) to be in touch with their outside friends, likely because of the difficulties they encounter with phone communication.

Model 3 adds measures of residents attitudes towards their current facility. Such variables include: 1) whether residents are satisfied with the staff at their facility, 2) whether they are satisfied with their living space, 3) whether they have enough privacy, and 4) whether or not they feel like a member of the family at their facility. Again, residents' control over their move ( $e^b = 1.850$ ), educational attainment ( $e^b = 1.305$ ), and hearing ability ( $e^b = .546$ ) are all significantly related to the likelihood that they maintain contact with their friends outside of their facility.

Model 4 includes a set of variables that address residents' level of involvement within their facility as well as in the greater community. The variables in this group

include: 1) whether residents attend activities offered at their facility, 2) whether they have adequate opportunities to participate in activities outside of their facility, 3) whether they have a roommate, 4) whether they have formed friendships within their ALF, and 5) whether they have a driver's license. Residents' educational attainment ( $e^b = 1.402$ ) is the only significant predictor in this model.

The fifth model adds a set of variables that take into account the reasons that led to residents' relocation. This group includes residents who moved because they needed more help as well as residents who moved because it was what their children wanted. Education ( $e^b = 1.394$ ) and hearing ability ( $e^b = .505$ ) are the only significant predictors of residents' friendship outcomes in this model.

Overall, my models fail to explain much of the variation in whether or not residents are in contact with their outside friends. Educational attainment seems to be the best available predictor of residents' contact with outside friends. Residents with high levels of educational attainment were more likely to maintain their friendships outside of the facility than residents with lower levels of education. Whether residents suffer from hearing impairments is also an important predictor of residents' friendship outcomes. Residents with limited hearing are less likely to stay in touch with their friends outside of their facility.

Future research should examine other factors that could potentially matter in terms of predicting residents' likelihood of maintaining friendships outside of their facility. Residents' proximity to their previous residence, for example, could help explain residents' contact with outside friends. Residents who moved into a nearby facility may have an easier time maintaining relationships with their outside friends than those who moved from farther away from their previous residence. Unfortunately, my data do not allow me to explore this factor.

### **Resident Satisfaction with Level of Contact with Outside Friends**

Logistic regression is used to test the relative significance of my predictor variables on residents' levels of satisfaction with their friends outside of their facility. Table 12. reports logistic regression results from the impact of residents' tenure at their current ALF on their level of satisfaction with outside friend contact.

**Table 12. Logistic Regression Results of Residents' Satisfaction with Outside Friend Contact**

	<u>Model One</u> (n=361)	<u>Model Two</u> (n=307)	<u>Model Three</u> (n=207)	<u>Model Four</u> (n=171)
<i>Variables</i>				
Length of Residency	.132 (.400)	-.013 (.424)	.245 (.645)	.010 (.896)
<u>Demographics</u>				
Age	.027 (.027)	.029 (.030)	.018 (.046)	.009 (.062)
Female	-.843† (.490)	-.999† (.541)	-.979 (.742)	-.932 (.993)
Marital Status	.190 (.601)	.356 (.681)	1.577 (1.072)	1.157 (1.371)
Education	-.031 (.400)	.039 (.126)	-.010 (.176)	.005 (.239)
<u>Resident Health</u>				
Health-Status		.236 (.438)	.282 (.622)	.416 (.799)
Mobility		-.664 (.969)	-1.153 (1.405)	-1.514 (1.870)
Hearing Impaired		.214 (.473)	-.167 (.631)	.149 (.883)
MADLS		.776 (1.110)	1.623 (1.654)	3.109 (2.277)
<u>Attitudes towards ALF</u>				
Satisfaction with Staff			-.098 (.394)	.116 (.543)
Satisfied with Living Space			3.127** (1.056)	3.361* (1.308)
Feel like a Member of the Family			1.627** (.604)	1.790* (.822)
<u>Social Support</u>				
Facility Friends				.372 (.938)
Satisfaction with Family Contact				.379 (.905)
Call Outside Friends				-.941 (2.121)
Visit Outside Friends				1.110 (.821)

Notes: †p<.10; \*p<.05; \*\*p<.01

The first model examines the impact of resident tenure in their current facility on whether they are satisfied with the amount of contact they have with their outside friends, controlling for age, gender, educational attainment, and marital status. Interestingly, women are almost half as likely ( $e^b = .430$ ) as men to be satisfied with the amount of contact they have with their outside friends. It is possible that women have higher expectations of their friendships and thus are more likely to feel disappointed when such expectations are not met. None of the other explanatory variables in this model is statistically significant.

Model two incorporates a set of explanatory variables that measure residents' health. This set of variables include: 1) residents' level of mobility, 2) their self-assessed health status, 3) whether or not they suffer from a hearing impairment, and 4) the level of assistance they need to perform activities of daily living. Gender ( $e^b = .368$ ) remains the only significant predictor in this model.

My third model adds a set of explanatory variables that measure residents' satisfaction with their current facility. Such variables include: 1) whether they are satisfied with the staff at their facility, 2) whether they are happy with their living space, and 3) whether or not they feel like a member of the family at their facility. My results suggest that residents' attitudes towards their facility play a large role in predicting whether they will be satisfied with their friendships. Residents who are satisfied with their living space, for example, are over 20 times more likely ( $e^b = 22.805$ ) to report that they are satisfied with their level of contact with outside friends. Furthermore, residents who feel like a member of the family in their facility are five times more likely ( $e^b = 5.089$ ) to report being satisfied with the amount of contact they have with their friends who live outside of their facility. There are several possible explanations for the link between residents' attitudes towards their facility and their satisfaction with their friendships outside of the facility. First, it is possible that residents who are satisfied with their facility are more likely to invite their friends to visit which aids in the continuation of such relationships. Another potential explanation is that residents who are satisfied with their facility are more to be satisfied with their lives in general and this contentment carries over into their assessment of their outside friendships.

Model four includes a set of control variables that measure residents' level of involvement both within their facility as well as in the greater community. The variables in this group include: 1) whether residents have friends in their facility, 2) whether they are satisfied with their family relationships, 3) whether they have contact with their outside friends, and 4) whether this contact is over the phone or in person. Satisfaction with living space ( $e^b = 28.818$ ) and whether residents feel like a member of the family ( $e^b = 5.989$ ) in their facility continue to be the only two significant variables in the model.

Overall, my results suggest that residents' attitudes regarding their ALF are the most important predictor of their satisfaction with their outside friendships. Residents who feel like a member of the family in their facility and residents who are satisfied with their living space are more likely to report satisfaction with their friendships outside of their facility.

### **Residents' Friendships within their Facility**

Past research suggests that although residents' relationships with friends and family are typically disrupted following relocation, the negative impact of such disruption may be mitigated if residents are able to form new friendships at their facility (Coffman 1981; Miller 1986; Retsinas and Garrity 1985). Given the influence of facility friends on residents' ability to adjust to life in assisted living, it is important to gain an understanding of the factors that either facilitate or deter the formation of such friendships.

I propose that the length of time residents have spent in their current facility will impact whether they have formed friendships in their facility. Residents who have lived in their current facility over a period of time have had more time to adjust to life in their facility and to meet new friends. As such, I hypothesize that the longer residents live in an ALF the more likely they are to form friendships with other residents in their facility.

Various other factors, however, could play a role in the formation of resident friendships. For example, as mentioned earlier, elderly women tend to have more friends, and to invest more energy into their friendships, than do elderly men (Roberto and Scott 1986; Roberto and Kimbo 1989; Armstrong and Goldstein 1990). In addition, the majority of ALF residents are women which could restrict men's friendship options.

Consequently, I predict that women will be more likely than men to develop friendships within their facility.

Health is also likely to impact residents’ ability to form friendships in their new facility. For example, residents who suffer from health conditions may lack the energy or the desire to be sociable. Furthermore, limited mobility may present a barrier to friendship formation. If residents have a hard time navigating their facility it may restrict their opportunities to interact with others. Additionally, residents with hearing impairments may have a difficult time communicating with other residents. As such, I hypothesize that residents with health problems will be less likely to form friendships within their facility.

Residents’ feelings about their current assisted living facility are also likely to influence whether they are able to form new friendships in their facility. It seems logical that residents who feel welcomed and accepted in their facility will be more likely to form friendships.

Finally, I predict that residents’ relationships with their family members as well as whether or not they have friends outside of their facility will influence their friendships inside of their ALF. It is possible that residents who are able to develop and maintain friendships with their friends and family have better social skills and thus will be more likely to form friendships within their facility. Conversely, however, it is possible that residents who maintain such ties with the outside world will be less likely to focus their energy on forming new friendships within their facility.

Logistic regression is used to test the relative significance of my predictor variables on the likelihood that residents have formed friendships in their ALF. Table 13. reports logistic regression results from the impact of residents’ tenure at their current ALF on their likelihood of having friends in their current facility.

**Table 13. Logistic Regression Results of Residents’ Facility Friends**

	<u>Model One</u> (n=341)	<u>Model Two</u> (n=301)	<u>Model Three</u> (n=202)	<u>Model Four</u> (n=115)
<i>Variables</i>				
Length of Residency	-.073 (.270)	-.071 (.286)	-.423 (.424)	-.058 (.774)

**Table 13. Continued**

<u>Demographics</u>				
Age	.035 (.184)	-.047 (.201)	.217 (.332)	.448 (.630)
Female	.535† (.285)	.693* (.304)	.852† (.465)	.123 (.841)
Marital Status	-.117 (.378)	.078 (.407)	.990 (.645)	-.474 (1.166)
Education	-.035 (.075)	-.020 (.080)	.103 (.123)	.161 (.236)
<u>Resident Health</u>				
Health-Status		.254 (.302)	-.147 (.466)	-.968 (.867)
Mobility		.464 (.596)	.225 (.845)	-.591 (1.75)
Hearing Impaired		.069 (.299)	-.771† (.459)	-1.266 (.822)
MADLS		-.842 (.636)	-.494 (.901)	-.093 (1.798)
<u>Attitudes towards ALF</u>				
Satisfaction with Staff			.391 (.272)	.068 (.461)
Satisfied with Living Space			.441 (.676)	.336 (1.459)
Facility Feels Like Home			.757 (.497)	1.297 (.990)
Feel like a Member of the Family			1.639**	.909 (.902)
<u>Social Support</u>				
Time Spent Alone				-1.45† (.594)
Participate in Facility Activities				1.419† (.853)
Contact with Outside Friends				-1.070 (1.297)
Satisfied with Contact with Outside Friends				.602 (.979)

Notes: †p<.10; \*p<.05; \*\*p<.01

The first model examining facility friendships includes the variable for resident tenure at their current facility as well as conventional demographic indicators. Gender is

the only significant variables in this model. As expected, women are almost twice as likely ( $e^b = 1.707$ ) as men to be friends with other residents in their facility.

The second model includes variables that measure residents' health. Such variables include: 1) residents' level of mobility, 2) residents' self-assessed health status, 3) the level of assistance needed by residents to perform activities of daily living, and 4) whether or not they suffer from a hearing impairment. Gender ( $e^b = 2.00$ ) remains the only significant variable in this model.

Model 3 incorporates a set of explanatory variables that examine residents' attitudes regarding their current facility. The variables added include: 1) whether or not residents are satisfied with the staff at their facility, 2) whether they are satisfied with their living space, 3) whether their facility feels like home to them, and 3) whether they feel like a member of the family at their facility. Gender ( $e^b = 2.344$ ) remains a significant predictor of facility friendships in this model. Hearing ability also predicts whether residents have formed friendships in their facility. Residents who suffer from hearing impairments are half as likely ( $e^b = .463$ ) to report having friends in their facility. Residents' attitudes towards their facility also seem to matter in terms of predicting friendship outcomes. Residents who feel like a member of the family in their ALF are over five times ( $e^b = 5.150$ ) more likely to have friends in their facility than those residents who do not feel like a member of the family.

The fourth model adds a set of predictor variables that measure residents' involvement in their facility as well as in the greater community. This group includes: 1) how much time residents spend by themselves, 2) whether or not they participate in the activities offered by their facility, 3) whether they are in contact with their family, 4) whether have friends who live outside of their facility, and 5) whether they are satisfied with their outside friendships. Not surprisingly, the more time residents spend by themselves the less likely ( $e^b = .235$ ) they are to have friends in their facility. Furthermore, residents who participate in facility activities are approximately four times more likely ( $e^b = 4.133$ ) to have friends within their facility.

## **Discussion**

This chapter has examined the various factors that impact residents' relationships with their friends and family. Overall, my results failed to support my hypothesis that the longer residents have lived in their current facility the less likely they are to maintain satisfactory relationships with their friends and family. In fact, in terms of residents' likelihood of maintaining contact with their family, residents' tenure had the opposite effect. Long-term residents were actually more likely than their newly relocated counterparts to maintain contact with their family. In most cases, however, length of residency did not significantly impact residents' social support systems.

My results indicate that, in general, whether residents' had control over their move to assisted living is the single most important predictor of their social support outcomes. Residents who had at least some level of control over their move are more likely to maintain satisfactory relationships with both their friends and family. This suggests that future studies would benefit from a more in-depth analysis of what can be done to ensure that elders feel they are in control of the relocation process. Such studies could provide facility administrators, residents, and their families with information that could ease residents' transitions into assisted living.

It should be noted that my predictor variables did a better job of explaining residents' relationships with their families than their relationships with outside friends. I believe this is partly due to the lack of a variable that measures residents' proximity to their previous residence in the ALRS data. My results indicate that residents are more likely to be satisfied with their family relationships if their facility is located within an hour drive from their family members. I believe that proximity could also play a key role in predicting residents' ability to maintain their friendships outside of their facility.

## CHAPTER FIVE DISCUSSION

Depression is the most common mental health problem faced by people aged 65 and older. Residents in long term care facilities are among those at the greatest risk of suffering from depression. While past research indicates that a substantial proportion of nursing home residents suffer from depression, few studies have examined the rates of depression among assisted living residents. Considering the rapid growth of assisted living facilities in the United States, it is important that researchers better understand the factors that possibly exacerbate or mitigate depression among ALF residents. The goal of this dissertation is to contribute to a better understanding of the three dimensions of depression among residents in assisted living. In what follows, I will summarize the major findings from my analyses of assisted living residents. I will also discuss the practical implications of my research. Finally, I will discuss the limitations of my analyses as well as make suggestions for areas of future research.

### **Summary of Major Findings**

The first set of analyses in my dissertation examines the influence of various factors on the well-being of residents in assisted living. My measures of well-being came from the Geriatric Depression Scale (GDS), a scale commonly used as a screening tool for depression. My analyses are unique in that I separate well-being into three distinct components: 1) life dissatisfaction, 2) lack of control, and 3) isolation. By examining the elements of well-being separately I am able to paint a better picture of how and when social support matters in terms of predicting resident well-being. For example, my results indicate that the impact of social support on well-being varies according to who is providing said support. Residents' relationships with other residents in their facility, for example, matter the most when predicting their levels of life dissatisfaction. While residents' relationship with their family, however, matter more in terms of predicting residents' perceptions of control.

Second, by addressing the three components of resident well-being separately, I am able to determine that the relationship between residents' control over their decision to move and their level of well-being is not as straightforward as previously suggested by

the literature. Past research indicates that whether residents were in control of their move to an ALF is an important predictor of their level of well-being post-relocation. My results, however, indicate that while residents' control over the decision to move is an important predictor of their likelihood of suffering from feelings of isolation, it fails to consistently predict residents' level of life dissatisfaction. Instead, residents' social support systems and their attitudes regarding their current facility are the strongest predictors of life dissatisfaction outcomes. In general, residents who have social ties, both within and outside of their facility, are less likely to suffer from life dissatisfaction. Residents who are satisfied with their current facility tend also to be happier than their unsatisfied counterparts. These findings suggest that residents' views regarding both their current living situation as well as their level of social involvement matter more in terms of predicting resident well-being whether or not they voluntarily moved to their facility.

Third, my results provide little support for my hypothesis that older residents are more likely to suffer from depression than their younger counterparts. Instead, my findings consistently showed that younger residents were more likely than older residents to report suffering from depression. This finding contradicts previous studies. Perhaps older residents are more likely than younger ones to accept that they need the assistance offered by assisted living and are thus more accepting of their living situation.

My second set of analyses considers the factors that shape residents' social support networks. My results indicate that, on the whole, whether residents had control over their move to assisted living is the single most important predictor of their social support outcomes. Residents who had control over their move are more likely to maintain satisfactory relationships with both their family and friends. It is possible that such residents lacked sources of social support prior to the move that would have helped them maintain feelings of autonomy over the relocation process. Or, perhaps residents' relationships with their friends and family were strained after the move because residents felt pressured by their social support networks to move into assisted living. Future research should try to determine which explanation is more plausible.

Another point worth noting is the direction of the relationship between residents' tenure in their facility and their relationships with their social support networks.

Originally, I proposed that residents' tenure in their current facility would be negatively related to their social support outcomes. In other words, I suspected that the longer a resident lives in an assisted living facility the less likely they are to maintain contact with their friends and family. However, in terms of residents' relationships with their family members, my results indicate the opposite – in those circumstances where length of residency significantly impacts residents' family networks, long-term residents are actually more likely than recently relocated residents to maintain contact with their family. Future research should explore why this is the case.

Finally, it is important to mention that health matters when predicting residents' social support outcomes. Residents who are in good health are more likely to report that they are satisfied with their family relationships and that they can count on their family in times of trouble. Residents' health, specifically their hearing ability, also matters when examining their friendships. Residents who suffer from hearing ability are less likely to stay in touch with their friends outside of the facility as well as form new friendships within their facility.

### **Practical Implications**

This study highlights the importance of residents' satisfaction with their facility as well as their friendships with other residents in predicting their level of well-being. Residents' who are happy and active members of their ALF community are less likely to suffer from depression. These findings suggest that programs designed to integrate residents to their facility and encourage the formation of friendships among residents may go a long way toward preventing resident depression.

My results also indicate that control over the move to assisted living is the single most important predictor of residents' social support outcomes. Residents who lack control over the decision to move also tend to lack social support. This suggests that residents who move to an ALF involuntarily would benefit from programs that are directed at helping residents maintain their ties with friends and family after their move, form new ties with other residents and staff, and provide ALF residents with

companionship from the outside community, such as visits from grade school children or perhaps bringing animals from the local shelter in for visits.

My research also highlights the important influence that residents' hearing ability has on their friendships. Residents who suffer from hearing impairments are at a distinct disadvantage when it comes to both forming new friendships and maintaining previous friendships. This suggests that, in the interest of resident well-being, assisted living administrators and staff should devise programs that could help hearing impaired residents communicate with both other residents as well as their friends outside of the facility.

### **Limitations and Suggestions for Future Research**

One major limitation with my analyses is the inconsistencies in sample size throughout my analyses. Such variations can be partly explained by residents' cognitive ability, which presents a special challenge when dealing with an elderly sample. In order to address this issue, residents in our sample were given one of three surveys based upon their cognitive ability. Cognitively intact residents were given the complete survey, moderately impaired residents were asked fewer questions on the medium length survey, and highly impaired residents were asked fewer items still on the short survey. Cognitive screens consisting of measures for residents' orientation for place and time as well as their recall abilities were used to determine the appropriate survey instrument for each respondent.

In order to minimize sample size inconsistencies, I restricted my sample size to residents who were given the long form of the survey. However, variations in sample size are still present for a variety of reasons. First, in some instances, the resident may have an appointment or planned activity that would cut their interview time short. In other, rarer, instances, cognitively intact residents who were very frail, hard of hearing, or who had difficulties speaking would be unable to complete the full interview. In still other cases, residents who the cognitive screen identified as cognitively intact still had difficulties with recall that prevented them from completing the long form of the survey.

Many of the missing cases, however, stems from residents' refusal to answer certain questions. Resident refusal was particularly common when asking questions concerning depression. I conducted numerous interviews during which the respondent was offended by the questions on the Geriatric Depression Scale and simply refused to answer them. In addition, many residents did not want to discuss their social support systems, or lack thereof.

The large number of missing cases presented some challenges while conducting my analyses. For example, as mentioned earlier, due to the variation in sample size per question, I was unable to include all possible explanatory variables in each of my analyses. Consequently, since the number of variables as well as the number of cases varies across equations, I can not conclusively determine which model is the best fit. However, I chose to include residents who did not answer each question on the long form based on the reasoning that some data are better than no data. I believe that, despite the problematic sample, my analyses still provide a solid starting point for understanding the relationship between social support, relocation, and depression upon which future studies should build.

Another limitation to my analyses is the use of cross-sectional, rather than longitudinal, data. Without longitudinal data I was unable to examine the changes in residents' levels of well-being as well as their social support systems over time. Future research would benefit from the examination of longitudinal data. Ideally, researchers could build upon the ALRS in order to follow the same residents over time. The old age and frail health of this sample, however, would make this problematic. Research concerning the impact of relocation on residents' social support and well-being would also benefit from an examination of these factors both before and after the move to assisted living.

In addition, due to sample limitations, I was unable to examine how race shapes both residents' levels of well-being as well as their social support networks. Past research that examines racial differences in depression among the elderly has produced mixed results. Some research has found that the white elderly are more likely to suffer from depression than the black elderly, some research suggests that the black elderly are, in fact, more likely than their white counterparts to suffer from depression, and still other

research indicates that there is no racial difference in rates of depression among the elderly. Future research should examine race and ethnic differences in the experiences of assisted living residents.

Another limitation to my study is the potential underreporting of symptoms of depression by the respondents. For some residents, the interviewers were the only visitors residents had received in the recent past. It is possible that residents may have wanted to make a good impression and/or ‘please’ the interviewer in order to extend the visit. As such, some respondents may have been minimized, or simply excluded, any depressive symptoms they may experience

Another limitation of my study is the lack of a measure for residents’ proximity to their previous residence. Residents who moved into a facility close to their previous residence will likely have an easier time maintaining ties with their former community than those who moved further away from home. Future research should take the distance between residents’ ALF and their previous residence into account.

One final limitation to my analyses is the lack of qualitative data, which would provide a more in-depth analyses of depression among assisted living residents. Future research should use qualitative methods in order to better understand the lives of assisted living residents as well as to inform future quantitative work.

As mentioned earlier, my results indicate that whether residents were in control of their move to assisted living is the strongest predictor of their social support outcomes. This suggests that future studies would benefit from a more in-depth analysis of what can be done to ensure that elders feel in control of the relocation process. Some research, for example, suggests that programs designed to prepare residents for their move into assisted living could enhance their perceptions of control over their move (Schulz and Brenner 1997). It is possible that one of the reasons that preparation programs reduce the negative impact of relocation is due to the social support provided by such programs. Relocates could have formed supportive relationships with the staff who participate in these programs which may help them adjust to the move. By expanding upon these studies, researchers could provide facility administrators as well as ALF residents and their families with information that could ease the transition into assisted living.

My study provides a greater understanding of what matters in the lives of ALF residents. My research confirms that the relationship between social support and well-being found among the community-dwelling elderly applies to assisted living residents as well. In addition, my dissertation highlights the crucial role that residents' control over the move plays in predicting both residents' mental health and social support outcomes.

APPENDIX A

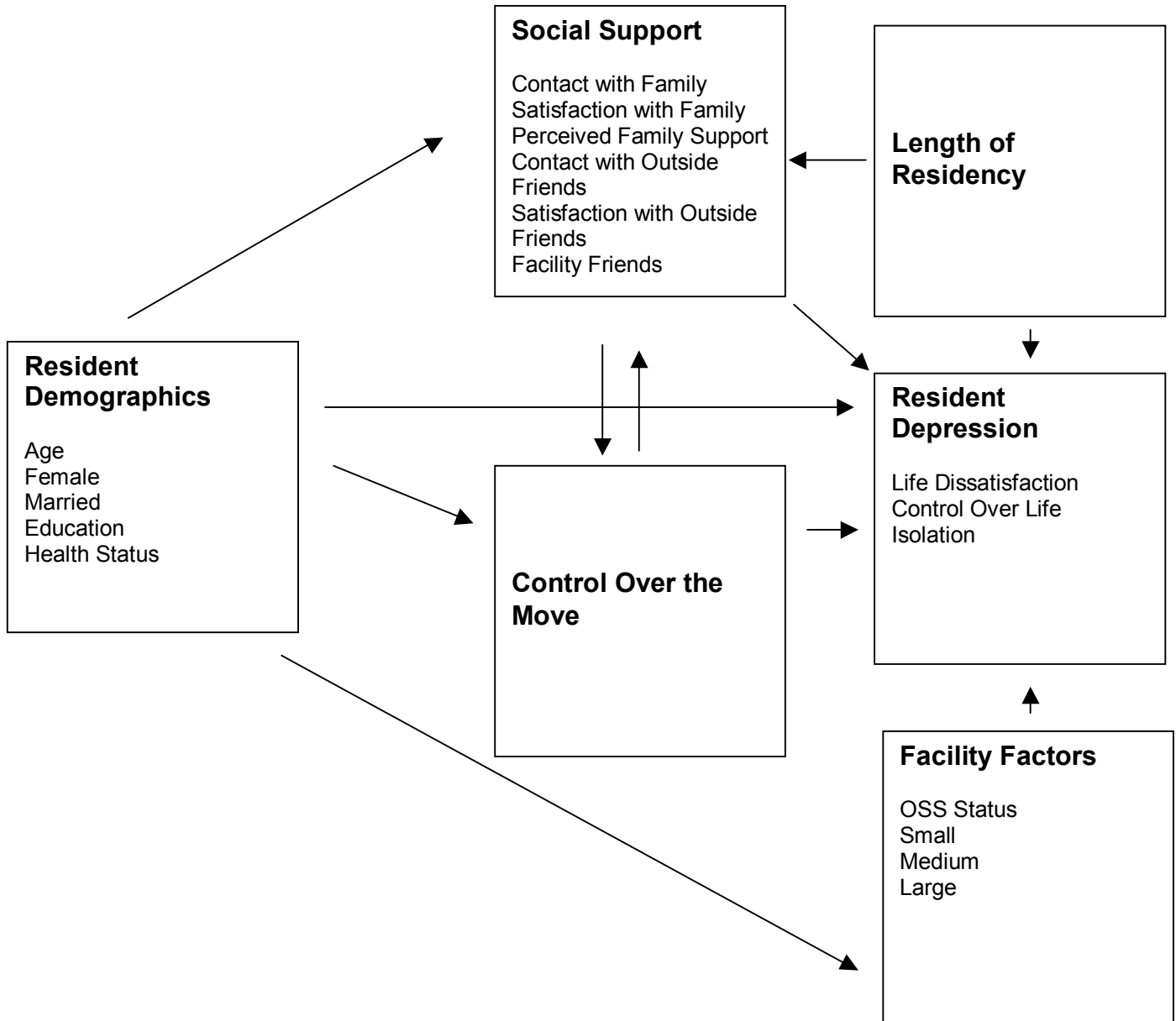


Figure 1. Conceptual Diagram of Relocation, Social Support, and the Mental Well-Being of Residents in AL.

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## BIOGRAPHICAL SKETCH

***S. ASHLEY SCHMIDT***

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### **EDUCATIONAL BACKGROUND**

PhD, Sociology, expected Summer 2006  
Florida State University  
Dissertation: “Social Support, Control over the Move, and Depression among Residents in Assisted Living”

M.S., Sociology, 2001  
Florida State University

B.A., Sociology, Magna Cum Laude, 1998  
Western Kentucky University

### **RESEARCH AND WORK EXPERIENCE**

**January 2005 – August 2005**

**AARP Florida, Intern**

Duties included conducting aging and policy research, tracking and analyzing propriety bills during the Legislative Session, representing AARP at legislative hearings and committee meetings, drafting bill summaries for priority legislation, attending pertinent AARP sponsored video and teleconferences, managing and returning volunteers’ calls to the Advocacy Line, organizing and attending AARP volunteer events, and participating in staff events

**Spring 2004-Summer 2006**

**Pepper Institute on Aging and Public Policy, Florida State University, Research Assistant to Dr. Jill Quadagno**

Worked on the Florida Medicaid Assisted Living Study, a project conducted on behalf of Florida Department of Elder Affairs (FDOE) and Florida’s Agency for Health Care Administration (AHCA) examining Medicaid populations in assisted living facilities in the state of Florida.

Duties included developing and pre-testing the survey instrument, conducting interviews with over 600 residents in more than 400 facilities across the state of Florida, entering and analyzing data using Microsoft Access and SPSS, synthesizing research for the literature review, and drafting the final report.

### **Fall 2001-Spring 2003**

#### **Department of Sociology, Florida State University, Research Assistant to Dr. Pat Martin**

Research assistant for the Taskforce on the Status of Women on The Florida State Campus. Assisted in coordination of a study designed to ensure an equitable work environment for women and men faculty at Florida State University.

Duties included drafting/creating and pilot-testing data collection instruments, conducting interviews with faculty and staff, facilitating focus groups, coding and analyzing data using Microsoft Access and SPSS, synthesizing research for literature review, performing statistical analyses, and drafting the final report.

### **Fall 1999-Fall 2004**

#### **Department of Sociology, Florida State University, Teaching Assistant**

Assisted Dr. John Reynolds in the development and implementation of an on-line Introduction to Statistics course. Duties included devising quizzes, tests, and assignments, monitoring students' weekly progress, grading assignments, and working one on one with students to ensure they understood the material.

Assisted Dr. Isacc Eberstein in the development and implementation of an on-line Introduction to Methods course. Duties included devising quizzes, tests, and assignments, monitoring students' weekly progress, grading assignments, and working one on one with students to ensure they understood the material.

Assisted Dr. Lori Reid with two Introduction to Social Problems classes. Duties included delivering guest lectures, monitoring students' weekly progress, grading assignments, and working one on one with students to ensure they understood the material.

### **RESEARCH SKILLS**

Qualitative data analysis. Methodological expertise includes:

- drafting/creating and pilot-testing data collection instruments.
- interviewing/focus group and participant observation data collection techniques.

- content analysis and qualitative data coding and analysis.

Quantitative data analysis. Methodological expertise includes experience with the following:

- statistical software programs.
- analytical techniques (e.g., means testing, regression analysis, logit, multinomial logit, ordered logit).

Hands-on experience with the following large datasets:

*Florida Assisted Living Facility Survey (2005);*  
*Florida Assisted Living Resident Survey (2005);* and  
*National Science Foundation's Scientist and Engineers Statistical Data System (1999)*

## **SOFTWARE EXPERTISE**

**SPSS** – Quantitative Analysis Program  
**STATA**– Quantitative Analysis Program  
**SAS** – Quantitative Analysis Program  
**ATLAS.ti** – Qualitative Analysis Program  
**Microsoft Office Package (Word, Excel, Works, Office, Access, Outlook)**

## **GRANTS AND AWARDS**

2001 – Attended the Inter-University Consortium for Political and Social Research (ICPSR) Summer Program in Quantitative Methods, University of Michigan.

2005 – Recipient of the Claude and Mildred Pepper Dissertation Fellowship

## **PRESENTATIONS**

2000 “The Gendered Dimension of Nonstandard Employment in Science and Engineering.” Presented at the annual meeting of the Southern Sociological Meeting, Atlanta, GA.

2003 “Learning the Rules of the Game: Race, Gender, and Academic Success.” Presented with Brandy Harris at the annual meeting of the Southern Sociological Meeting, New Orleans, LA.

2004 “Forced Relocation: The Impact of an Assisted Living Facility’s Closing on Residents and Staff.” Presented with Emily Boyd at the annual meeting of the Southern Sociological Meeting, Atlanta. GA.

## **WORK IN PROGRESS**

Schmidt, Ashley and Brandy Harris. "Learning the Rules of the Game: Race, Gender, and Academic Success."

Schmidt, Ashley and Emily Boyd. "Forced Relocation: The Impact of an Assisted Living Facility's Closing on Residents and Staff."

Reid, Lori, Stephanie Burge, Naomi Spence, Ashley Schmidt, Henry Eliassen, Melissa Barnett, Kelly Friel, and Kristin Taylor. "Soft Skill Discrimination and the Racial Gap in Employment."

Schmidt, Ashley. "Should I Stay or Should I Go: The Effect of Resident Control over the Relocation Process on the Well-Being of the Elderly."

Street, Debra, Quadagno, Jill, Burge, Stephanie, Harris, Brandy and Ashley Schmidt. "The Florida Assisted Living Survey."

## **DEPARTMENTAL SERVICE**

Sociology Graduate Student Union, Departmental Representative (2000-1), Treasurer (Spring 2001), Vice-President (Summer 2001- Spring 2002), President (Summer 2002-Spring 2003).

## **COMMUNITY SERVICE**

Resident volunteer with The Meadows, 2003

## **PROFESSIONAL MEMBERSHIPS**

Gerontological Society of America

Southern Sociological Society