Journal of Gerontology: SOCIAL SCIENCES
2007, Vol. 62B, No. 2, S129–S134

The Salience of Social Relationships for Resident Well-Being in Assisted Living

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Objectives. We examined how organizational characteristics, transition experiences, and social relationships impact three subjective measures of well-being among assisted living residents: life satisfaction, quality of life, and perception that assisted living feels like home.

Methods. Data were from 384 assisted living residents interviewed for the Florida Study of Assisted Living. Using ordinary least squares and logistic regression we estimated associations between resident well-being and organizational characteristics, transition experiences, and social relationships, controlling for gender, age, education, and physical functioning.

Results. To varying degrees depending on the measure used, higher resident well-being was associated with facility size, facility acceptance of payment from Florida's low income program, and resident perceptions of adequate privacy. Non-kin room sharing reduced life satisfaction, whereas food quality positively affected all measures of well-being. The most consistent findings concerned internal social relationships. Residents with high scores on internal social relationship measures reported more positive well-being across all measures than residents with low scores on the same measures.

Discussion. Individuals have the capacity to form new support networks following a move to assisted living, and relationships formed become more salient to their well-being than the continuation of past relationships or the physical characteristics of the immediate surroundings.

ONE of the most significant trends in long-term care for frail elders in the past decade has been the growth of assisted living (AL). A move from the community to an AL residence represents a major life transition, one often triggered by health problems or the death of a spouse (Hawes, Rose, & Phillips, 1999). Not surprisingly, some residents express dissatisfaction with their assisted living facility (ALF), but others are highly satisfied and feel that their quality of life (QOL) has improved (Fonda, Clipp, & Maddox, 2002; Phillips et al., 2003; Street & Quadagno, 2004). What explains the variation in residents' responses to the AL environment? Some of the inconsistency in findings is likely an artifact of differences in research design and populations studied (Zimmerman et al., 2003). Yet research also suggests that certain factors consistently affect well-being. For this article, we used a sample of cognitively unimpaired AL residents from the Florida Study of Assisted Living (data collected in 2004 and 2005) to analyze the effect of ALF characteristics, transition experiences, and social relationships on three measures of resident well-being: life satisfaction, QOL, and whether the ALF feels like home.

Literature Review

Organizational characteristics.—The AL industry deliberately distinguishes itself from institutional nursing home settings by emphasizing a "homelike" atmosphere that fosters resident privacy and autonomy (Chapin & Dobbs-Kepper, 2001; Frank, 2002; Hawes, Phillips, Rose, Holan, & Sherman, 2003; Mollica, 2002). Hominess may be a function of structural characteristics, like facility size or room arrangements. Some studies have found higher resident satisfaction in smaller facilities, presumably because they provide a homier, less bureaucratic environment that fosters closer personal relationships (Ball, Perkins, Whittington, Connell, et al., 2004; Chou, Bouldy, & Lee, 2003; Sikorska, 1999). Other studies have found that large ALFs with self-contained individual apartments are more homelike because they provide private rather than shared accommodations and thus are more similar to community housing (Zimmerman et al., 2003). Amenities and ambience may also contribute to ALFs being homelike, with food quality being a particularly good predictor of resident satisfaction (Frank, 2002; Kane, 2001, 2003). Satisfaction with food likely reflects an assessment of food quality as well as a complex set of resident impressions involving the ambience and the sociability of mealtimes.

Privacy in AL can involve such basic issues as being able to lock one's door as well as more fundamental ones, like having adequate privacy or sharing living space with a stranger (Kane, Baker, Salmon, & Veazie, 1998). According to a national AL study, nearly 60% of ALs offer only minimal privacy (Hawes et al., 2003), which suggests that most AL residents live in environments where privacy is scarce. The scant research on privacy in residential settings suggests that non-kin room sharing has a negative impact on resident well-being (Kane & Caplan, 1990; Lidz, Fisher, & Arnold, 1992). What is unclear is under what circumstances particular dimensions of privacy are relevant to AL residents' well-being.

Another AL objective is to encourage autonomy by allowing residents to make personal choices and decisions. Autonomy is

more than an environmental intervention; it also implies a capacity to exercise choice and preference across a number of dimensions (Rubenstein, Eckert, & Keimig, 2005). AL residents may lack a sense of autonomy when they have little control over the timing of meals, seating arrangements, choice of recreational activities, and placement of furniture (Frank, 2002). Other research has indicated that very frail AL residents often maintain a sense of independence and satisfaction through remaining activity of daily living self-care abilities (Ball, Perkins, Whittington, Hollingsworth, et al., 2004; Ball et al., 2000). According to Ball, Perkins, Whittington, Hollingsworth, King, and Combs (2005), the capacity to make even small choices—what they termed the *miniaturization of autonomy*—contributes to AL residents' well-being. Still to be explained is which dimensions of autonomy most affect resident well-being.

The AL transition.—Research has shown that relocation is among the most stressful life events for older adults (Stokes & Gordon, 1988), leading to feelings of loneliness and isolation (Johnson, 1996). Both mental and physical health may decline among elders required to move to new environs (Hays, 2002). A move to AL requires an initial adjustment that can temporarily disrupt perceived well-being. In other residential care settings, longer nursing home stays are associated with higher levels of depression (Commerford & Reznikoff, 1996). This is not necessarily the case for AL residents who may experience a period of uncertainty and adjustment immediately following a move but who eventually adapt (Brandi, Kelley-Gillespie, Liese, & Farley, 2004; Cutchin, Owen, & Chang, 2003). In fact, many AL residents who move from a nursing home experience an increase in life satisfaction (Street & Quadagno, 2004).

Forced relocation is particularly stressful, whereas voluntary moves are less likely to cause negative outcomes (Staveley, 1997). Residents who feel they have had some control over the transition to a congregate setting make better long-term adjustments and are less likely to experience a decline in health or well-being compared to individuals who feel they lack control over the transition (Heisler, Evans, & Moen, 2004). Thus, factors likely to influence resident well-being include length of stay, previous living arrangements, and involvement in decision making.

Social relationships.—Research has consistently found a positive relationship between social relationships and various aspects of well-being (Pinquart & Soerensen, 2000; Stevens, Martina, & Westerhof, 2006; Tomaka, Thompson, & Palacios, 2006). Family member and friend contacts may be particularly important to AL residents, as they represent their only links to a previous way of life (Frank, 2002). Friendship is an especially important predictor of well-being among older adults, regardless of setting (Aday, Kehoe, & Farney, 2006; Payne, Mowen, & Montoro-Rodriguez 2006; Silverstein, Chen, & Heller, 1996). Friendship may take on even greater importance when unrelated individuals live under one roof and see one another on a daily basis. Having positive relationships with AL staff is also an important factor in well-being (Cummings, 2002). Satisfaction with care staff can have a favorable effect on all other aspects of resident satisfaction (Chou, Bouldy, & Lee, 2002). The question is which social relations are salient, particularly whether social relationships within the AL setting become more significant to ALF residents than external relationships.

Hypotheses

We hypothesized that facility hominess, privacy, and autonomy would be associated with positive well-being. For homelike characteristics, we expected that smaller, more intimate facilities would contribute positively to life satisfaction and QOL, but that larger facilities would feel more like home because of their apartment-like settings. We expected that residents' perception of adequate privacy would be positively associated with all aspects of well-being. We hypothesized that residents in ALFs that offered a greater degree of autonomy would score higher on measures of well-being. Finally, we predicted that perceptions of food quality would have a positive effect on well-being.

In terms of transition experiences, we expected higher well-being among residents who had resided in AL long enough to become adjusted, who had moved from another congregate living site, and who felt they had participated in the decision about whether to move. In terms of social support, we expected higher well-being among residents who had contact with outside family and friends. Furthermore, reflecting the critical role of social relationships in bounded communities like AL, we also expected better well-being scores among residents who had friends in the facility and who had positive relationships with staff.

We used three measures of well-being to fully capture a range of residents' experiences with AL. Research suggests that AL residents may have lower life satisfaction than community dwellers (Grayson, Lubin, & Van Whitlock, 1995). We also included a measure of residents' perceptions of a change in QOL, worse as opposed to stable/improved relative to a previous living situation (Fonda et al., 2002; George, 2006; Street & Quadagno, 2004). Finally, even residents who are satisfied with their AL arrangements and feel that their QOL has improved may not feel that their ALF is home. Yet according to Cutchin and colleagues (2003), it is the sense of "at homeness" that makes an ALF a meaningful place. Thus, our third measure was whether residents felt their ALF was home.

METHODS

The Florida Study of Assisted Living, conducted from Summer 2004 to Spring 2005, included structured face-to-face interviews with AL residents ($N = 681$) across Florida and state administrative data ($N = 1{,}886$) provided by the Agency for Health Care Administration. Study organizers selected participants to approximate the proportion of residents in six facility types (both public and private small, medium, and large facilities) in each of the 11 planning and service areas across the state. Interviewers first administered the Short Portable Mental Status Questionnaire to assess cognitive function (Pfeiffer, 1975). Residents who scored low on cognitive functioning were given a short version of the survey and are not included in this analysis. Residents who answered the full survey responded to items concerning their transition to AL, environmental perceptions, cognitive and physical health, and a series of psychosocial measures. This article only reports data for

Table 1. Descriptive Statistics (Florida Study of Assisted Living)

Variable	*M*	*SD*	Range
Well-being outcomes			
Life satisfaction	81.8	21.3	0–100
Stability/improvement in quality of life (%)	74.7		0–1
Assisted living feels like home (%)	63.0		0–1
Control variables			
Female (%)	73.9		0–1
Age	84.2	7.6	65–104
Education	12.6	2.6	8–18
Physical function index (std)	0.0	1.0	−2.5–1.0
Organizational characteristics			
Small facility (fewer than 20 beds; %)	18.9		0–1
Medium facility (21 to 60 beds; %)	27.7		0–1
Large facility (more than 60 beds; %)	53.4		0–1
Optional State Supplementation facility (%)	23.6		0–1
Non-kin room sharing (%)	19.9		0–1
Other residents respect privacy (%)	92.9		0–1
Adequate privacy (%)	73.6		0–1
Autonomy index (%)	0.0	1.0	−2.0–0.9
Food quality	2.8	0.8	1–4
Social relationships			
Internal social relationships (std)	0.0	0.9	−2.6–0.8
Family contact index (std)	0.1	1.0	−2.1–1.1
Friend contact (%)	55.9		0–1
Characteristics of the transition			
Control over move (%)	73.9		0–1
Recency of transition (6 months or fewer; %)	19.3		0–1
Transitioned from home (%)	71.7		0–1
Transitioned from another assisted living facility (%)	15.5		0–1
Transitioned from another place (%)	12.8		0–1
Observations	322		

Note: *SD* = standard deviation.

a subset of Florida Study of Assisted Living residents ($N = 384$) who were cognitively intact and who were 65 or older at the time of the survey. (Analyses [not shown] revealed no significant differences between Florida Study of Assisted Living sample subset predictor variables and predictors for the smaller samples included in multivariate models.) Table 1 provides descriptive characteristics of the sample.

Women constituted 74% of the AL population in this sample. The mean age was 84. Approximately 46% of the sample had education beyond high school. The individual characteristics of elderly AL residents in the Florida Study of Assisted Living subsample were broadly similar with respect to gender, race/ethnicity, marital status, and age to those of a resident sample in a national AL study (Hawes, Phillips, & Rose, 2000).

Variables

Dependent variables.—Resident well-being had three components. The first was a life satisfaction scale (Cronbach's $\alpha = .80$) that averaged resident responses to 10 dichotomous items ("Are you satisfied with your life?" "Is your life empty?" "Are you often bored?" "Are you in good spirits most of the time?" "Are you afraid something bad is going to happen to you?" "Are you happy most of the time?" "Do you often feel helpless?" "Do you think it is wonderful to be alive now?" "Do you think your situation is hopeless?" "Do you often feel lonely?"). For ease of interpretation, we multiplied this scale by 100 so that the scale ranged from 0 to 100 (original coding ranged from 0 to 1). Second was a measure of relative QOL ("Thinking back to just before you moved here, how is your QOL now?" 1 = stable/improved, 0 = worse). The third measure was whether the ALF felt like home ("Does this place feel like home to you?" 1 = yes, 0 = no).

Control variables.—Control variables included gender (1 = female, 0 = male); age (in years); education (in years); and physical function, a standardized (*z*-score) index (Cronbach's $\alpha = .82$) that averaged residents' scores on five activities of daily living (eating, dressing, transferring, bathing, and toileting). Original coding ranged from 3 = not very hard at all, to 1 = very hard.

Independent variables.—Organizational characteristics included facility size (small $\leq$ 20 beds, medium = 21–60 beds, large $>$ 60 beds), perceptions of facility privacy ("Other residents respect my privacy," 1 = yes, 0 = no), non-kin room sharing (1 = non-kin sharing, 0 = private), and adequate privacy ("Would you like to have more privacy?" 1 = no, 0 = yes). Food quality was a four-point scale (4 = excellent, 1 = poor). Autonomy consisted of a standardized (z-score) index (Cronbach's $\alpha = .59$) averaging three dichotomous items: "Can you set your own daily schedule?" "At most meals, can you choose who to sit and eat with?" and "Can you sleep late if you want to?" Finally, we also included Optional State Supplementation status, which indicated whether the facility routinely accepts publicly subsidized, very low income residents whose hotel costs (room and food) are paid by state supplement (usually for recipients of federal Supplemental Security Income) and who depend on Medicaid for reimbursement of AL services (either under the state plan [Assistive Care] or a waiver program [such as Assisted Living for the Elderly or Aged and Disabled waivers]). To receive Medicaid services, residents must also have met age and need requirements (i.e., be eligible for nursing home level of care) and the financial requirements for Medicaid eligibility.

Measures of the transition experience included perceived control over move ("How much control did you have over the decision to move to AL?" 1 = some/complete control, 0 = little/no control), recency of transition (1 = 6 months or fewer, 0 = other), and previous living arrangement (own home, another ALF, other).

We divided social relationships into two categories. External social relationships included a measure of family contact, which was a standardized (z-score) index (Cronbach's $\alpha = .78$) averaging two items: "How often does a family member visit you?" and "How often do you speak on the phone with family?" (original coding ranged from 1 = never/almost to 5 = daily/almost daily). We also measured friend contact ("Do you have regular contact with friends that do not live here?" 1 = any contact, 0 = none). Internal social relationships were a standardized (z-score) index (Cronbach's $\alpha = .67$) that averaged responses to five items ("Do you regard any of the people who *live here* as your friends?" "Have you met residents here with similar interests to yours?" "Do you feel like a member of the

Table 2. OLS and Logistic Regression Analyses of Residents' Life Satisfaction, Stability/Improvement in Quality of Life, and Report That Assisted Living Feels Like Home

	Life Satisfaction (OLS)		Quality of Life (Logit)		Feels Like Home (Logit)	
Variable	β	95% CI	OR	95% CI	OR	95% CI
Control variables						
Female	−4.48	−9.29–0.35	1.75	0.73–4.18	0.88	0.44–1.75
Age	0.61	0.26–0.96**	1.07	1.02–1.12**	1.02	0.98–1.06
Education	1.44	0.49–2.39**	1.17	1.01–1.36*	1.04	0.94–1.16
Physical function index (std)	5.39	2.81–7.98***	1.39	0.99–1.95	1.14	0.83–1.59
Organizational characteristics						
Small facility[a]	2.34	−5.58–10.26	0.46	0.18–1.18	1.29	0.56–2.99
Large facility[a]	5.14	−0.89–11.17	1.50	0.68–3.31	2.56	1.27–5.12**
Optional State Supplementation facility	1.31	−5.11–7.73	3.27	1.36–7.90**	0.97	0.53–1.77
Non-kin room sharing	−8.01	−15.43 to −0.59*	2.70	1.04–7.00*	1.91	0.97–3.77
Other residents respect privacy	−9.15	−21.89–3.58	1.98	0.43–9.12	3.78	0.99–14.40
Adequate privacy	0.88	−4.92–6.69	2.60	1.24–5.44*	1.25	0.67–2.33
Autonomy index (std)	−0.32	−3.17–2.52	1.24	0.92–1.68	1.22	0.90–1.68
Food quality	3.48	0.66–6.30*	3.62	2.15–6.09***	1.85	1.33–2.56***
Transition experience						
Control over move	1.92	−4.23–8.07	2.12	0.88–5.09	0.82	0.43–1.56
Recency of transition	−2.75	−10.09–4.58	0.82	0.37–1.78	0.89	0.48–1.63
Transitioned from home[b]	−2.06	−9.45–5.34	0.97	0.34–2.79	0.85	0.38–1.88
Transitioned from another assisted living facility[b]	6.62	−1.66–14.89	1.18	0.40–3.50	0.88	0.33–2.34
Social relationships						
Internal social relationships (std)	6.34	3.68–9.00***	1.47	1.08–1.99*	2.79	1.96–3.98***
Family contact index (std)	1.15	−1.77–4.06	0.83	0.55–1.25	1.00	0.74–1.34
Friend contact	3.34	−1.93–8.61	0.70	0.34–1.40	0.95	0.50–1.80
−2 log likelihood				−125.26		−166.46
R^2	.29			.24		.22
Observations	267			292		322

Notes: OLS = ordinary least squares; OR = odds ratio; CI = confidence interval.

[a]Reference category is medium facility.

[b]Reference category is transitioned from another place.

*$p < .05$; **$p < .01$; ***$p < .001$.

family here?'' ''Do you feel that you have friends among the staff?'' ''Do you feel that the staff shows affection and caring for you?'').

Method of Analysis

Ordinary least squares and logistic regression models showed how resident characteristics, organizational characteristics, transition experiences, and social relationships were associated with well-being, as measured by life satisfaction, QOL, and perception that the ALF feels like home. Because AL facilities were the primary sampling unit and residents' responses within facilities may have been correlated, we report standard errors that we adjusted for clustering of cases within facilities using STATA's cluster subcommand.

Results

Controls

Older and higher functioning residents (as measured by activities of daily living) had higher life satisfaction (see Table 2). Older, better educated residents were more likely to report stability/improvement in their QOL compared to younger and frailer residents. Younger residents may have been more dissatisfied than older residents because younger residents' expectations may have been higher, particularly if they compared themselves to age peers still living independently in the community. None of the control variables had an effect on whether the ALF felt like home.

Life Satisfaction

The only organizational characteristics with significant effects on life satisfaction were the negative impact of non-kin room sharing and the positive effect of food quality. On average, residents who rated the food as excellent scored 10.5 points higher on life satisfaction compared to those who felt the food was poor. Transition experiences had no significant effects on life satisfaction. Contact with family and friends outside the facility did not significantly impact life satisfaction, but positive internal social relationships were associated with significantly higher life satisfaction.

QOL

Several organizational characteristics had a positive effect on QOL. Whether the facility accepted state payments for low-income residents (Optional State Supplementation status) had a positive effect on QOL. Residents reporting adequate privacy were more than twice as likely to report stable/improved QOL

compared to residents who wanted more, yet non-kin room sharing also had a positive effect on QOL, as did liking the food. Transition experiences had no effect on QOL. Of the social relationship variables, only internal social relationships was significantly associated with residents' stability/improvement in QOL. Residents who perceived that they had friends within the facility and positive relationships with staff were more likely to report stable/improved QOL than residents without such relationships.

ALF Feels Like Home

Residents of large ALFs were more than twice as likely to say they felt at home compared to residents of smaller facilities. Perceptions of food quality also contributed systematically to higher likelihoods that residents regarded their ALF as home. Neither the transition experience nor contact with family and friends outside the facility had significant effects on whether the ALF felt like home. Again, what mattered most were social relationships within the facility.

Discussion

The most interesting and consistent result, aside from the robust effects of food quality on all measures of well-being, concerned the impact of internal social relationships. Contact with family and friends outside the ALF had no significant effect on any of the measures of well-being. Rather, internal social relationships, as measured by friendships within the facility and positive feelings toward staff, was the most consistently important predictor of resident well-being in all the models. Socially integrated residents were significantly more likely than residents with fewer internal social relationships to report life satisfaction, stable or improved QOL, and a sense of feeling at home in AL. These results suggest that people have the capacity to form new relationships following a move to AL and that these relationships become more salient to their well-being than continuation of past relationships. We should inject a note of caution, however, about the lack of significant effects for external relationships with friends and family. It is possible that many AL residents had previously lived alone and were somewhat isolated, especially from friends. Furthermore, given the extent of retiree migration to Florida, the fact that the sample comprised mostly individuals who lived in Florida prior to AL transition may mean that they were already isolated from family members who lived in distant states. One interpretation, then, is that the lack of effect of family contact may represent an ongoing situation rather than have any association with AL residency. Furthermore, studies suggest that older people try not to burden family members and that family members typically visit on a weekly basis and rarely provide activity of daily living care. All these factors likely magnify the salience of internal social interactions.

Organizational characteristics influenced resident well-being, but no single characteristic affected well-being across all three dimensions. Although facility size had no effect on life satisfaction or QOL, residents of large ALFs were more likely than residents of smaller facilities to report that the facility felt like home. This result is consistent with other studies that have found that large ALFs provide apartment-style living experiences similar to the residential experiences of formerly community-dwelling elders (Zimmerman et al., 2003).

Non-kin room sharing significantly reduced life satisfaction but, counter intuitively, also appeared to improve QOL. A likely explanation for these seemingly contradictory findings is that elderly people who share rooms are often low income and may have previously resided in poor-quality housing. The fact that residents in Optional State Supplementation facilities scored higher on stable/improved QOL suggests that this may be the case. For these residents, the move to an ALF often represents an improvement in quality of daily life, even if it includes a roommate. However, only 20% of residents in this study shared a room, so these findings need to be interpreted cautiously and replicated within a larger sample of residents in shared rooms.

Consistent with the results of other studies, perceptions of food quality profoundly affected well-being. Beyond the actual food quality, which is necessarily a subjective assessment, mealtimes represent an opportunity for social interaction. Thus, residents who rated food quality high may have also been considering the sociality of mealtimes in their evaluations.

The transition variables proved to be unimportant across all dimensions of well-being. Prior residence and amount of control over the move had no effect on any well-being measure, nor did length of stay. This latter result may be because the initially disruptive effects are more fleeting than the "6 months or fewer since moving" measure captured. Alternatively, this variable may be unimportant relative to other more salient factors.

Some caveats apply. It is important to keep in mind that the findings can only be generalized to AL residents who are cognitively intact and not to those who are very frail or cognitively impaired. Furthermore, elderly Floridians differ from older adults in other states because they are somewhat more affluent and are more likely to reside in an apartment complex, condo, or retirement community (Quadagno, 2003). Thus, they may adjust better to an ALF than people unused to congregate living.

The results of this study have important policy implications for this fastest growing segment of the long-term care continuum. Given the clear connection between residents' well-being and their daily social relationships, AL providers should strive to engage in practices that generate positive interaction relationships among residents and between residents and staff. These could include manageable workloads for staff, staff retention initiatives, and social activities that provide meaningful resident interaction. When affordability of AL for individuals who need it makes non-kin room sharing unavoidable, well-being will be higher when administrators very carefully match room partners. Ultimately, practices that improve social relationships are as important for AL residents' well-being as the provision of homelike, private, and autonomous settings.

Acknowledgments

Support for this study was provided by Grant 1R03AG021770-01 from the National Institute on Aging, Contract M0330 from the State of Florida Agency for Health Care Administration, and a Florida State University Research Foundation Program Enhancement Grant. We appreciate

helpful comments from Jeralynn Cossman, John Reynolds, Robert Wagmiller, Patricia Yancey Martin, Kenneth Ferraro, and four anonymous reviewers.

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Received March 13, 2006
Accepted November 3, 2006
Decision Editor: Kenneth F. Ferraro, PhD