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Tri-level assisted living for the elderly and its correlation with depression and quality of life

Stephanie Jean Berberich

TRI-LEVEL ASSISTED LIVING FOR THE ELDERLY AND ITS CORRELATION WITH DEPRESSION AND QUALITY OF LIFE

A Project

Presented to the

Faculty of

California State University,

San Bernardino

In Partial Fulfillment

of the Requirements for the Degree

Master of Social Work

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Approved by:

[redacted]

Dr. Rosemary McCaslin, Faculty Supervisor
Social Work

5/6/12
Date

[redacted]

Dr. Rosemary McCaslin,
M.S.W. Research Coordinator

ABSTRACT

Elderly residing in assisted living homes are suffering from undiagnosed depression and diminished quality of life. This study tried to see if there is a correlation with the level of care an elderly person receives in a tri-level assisted living home and the quality of life they perceive and the level of depression they experience. Quantitative and qualitative methods were used. 18 participants were individually interviewed and were verbally administered the tests and questionnaire. The Geriatric Depression Scale, the Life Satisfaction Scale and an assisted living questionnaire were administered. The study consisted of 13 females, and five male participants. The significant findings were that there was a significant correlation between the Geriatric Depression Scale and the Life Satisfaction Scale and a significant correlation between age and the need for assistance with ADL'S. In independent samples t-test the mean depression score for married participants was significantly lower than that of unmarried participants and the mean depression score for individuals with positive attitudes was lower than that of negative individuals. In another independent samples

t-test the life satisfaction score for positive people was higher than for negative individuals. In the qualitative findings the main reason for having to come to an assisted living community was medical necessity and family being unable to care for them. Areas of concern were slow staff response time, problems regarding meals, lack of variety activities, and financial problems. Further research needs to be done on differences between the experiences of elders who choose to be placed in the assisted living homes as opposed to those whose family place them there without choice.

ACKNOWLEDGMENTS

With gratitude I would like to thank Dr.Rosemary McCaslin, PhD for her unwavering support and guidance on my research project. I also would like to extend a thank you to Lori Spencer the Executive Director of the assisted living community and Linda Stowell the Life Enrichment Director for allowing me to come and interview their residents. Lastly, but not least I would like to thank the participants at the assisted living community for sharing their lives with me and allowing me to learn how to better assist them.

DEDICATION

To my two beautiful children, Claire and Katie may you both accomplish what you set out to do in life.

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CHAPTER ONE

INTRODUCTION

Introduction

In this chapter depression will be discussed as it is related to the elderly population and as a connection to tri-level assisted living homes. Quality of life and dementia will be defined and the significance of doing this research for gerontological social work is discussed.

Problem Statement

"Depression in the elderly is becoming an increasing problem in the United States. According to the National Institute of Health, of the 35 million Americans age 65 or older, five million suffer from varied forms of depression. Of those, at least two million have severe depression" (2007,p.1). In California alone the aging population is rapidly growing. Currently the State has 3.5 million residents aged 65 and older which is the largest older adult population in the nation (as cited from http://www.census.gov).

The "DSM IV-TR describes Major Depressive Episode as a period of at least two weeks during which there is

either depressed mood or loss of interest or pleasure in nearly all activities. The individual also must experience at least four other symptoms from a list such as lack of sleep, loss of appetite, decreased energy, thoughts of death or suicidal tendencies, difficulties concentrating or making decisions" (2000, p. 369). Many seniors may not suffer from a Major Depression but may experience a mild depression called a Dysthymic Disorder. Dysthymic Disorder is described in the "DSM IV-TR as a depressed mood for most of the day, for more days than not, as indicated either by subjective account or observation by others, for at least two years. While depressed, two or more of the following are experienced: poor appetite or overeating, insomnia, low energy, low self-esteem, feeling hopeless, and no Major Depression Episode has been present" (2000, p. 376).

Depression in the later years is often a result of dependency and disability. Many depressed individuals do not recognize the symptoms of depression partly due to denial, and lack of coping skills. Many older individuals are misdiagnosed with dementia, when in fact they are depressed. Depression in this population is often characterized by confusion, social withdrawals, memory

problems, loss of appetite, irritability, sleep disturbances, sadness and sometimes can include hallucinations or delusions (NAMI, 2009). Despite popular belief, depression is not a normal part of the aging process.

In the California Health and Human Services Agency report "Improving Access to Mental Health Services for Persons with Alzheimer's Disease and Related Disorders" Dementia is defined as a "neurological syndrome involving progressive decline in memory and other intellectual abilities" (p. 6). Dementia is a syndrome and not a specific disease. It is a pattern of symptoms that can be caused by many different illnesses. The American Psychiatric Association's (APA) Diagnostic and Statistical Manual of Mental Disorders has "Three criteria for a dementia diagnosis which are memory impairment, cognitive disturbances in at least one other area of functioning (e.g., aphasia, apraxia, agnosia, or a disturbance in executive functions) and these impairments must be severe enough to interfere with social or occupational functioning" (2000, p. 148-149). The two types of dementia that will be discussed in this

study will be dementia caused by vascular disease and dementia of the Alzheimer's type.

Dementia is increasing in the elder population. "In 2000 an estimated 500,000 Californians had Alzheimer's type Dementia (AD). By 2040, one million older Californians will likely have the disease which is the most prevalent form of dementia. The prevalence rate for elders having dementia caused by vascular disease has been estimated to be five percent to 20% based on postmortem studies" (Long Term Care Council, 2003, p. 4).

While this study looked at elders and depression, the prevalence rate for elders to have co-occurring dementia and mental illness is extremely high. Elders with Alzheimer's dementia have a 50% rate of having major depression or dysthymia (California Health and Human Services Agency, 2003).

With modern medicine, we are prolonging life many years longer than centuries ago. Aging today means the mind declining and the body living longer. Depression in the elderly is said to be affected by internal factors of physical function and external function. This can be tied to quality of life (QOL). If the elderly feel that they do not have a good quality of life, being able to do

things for themselves, then they do not have much to live for and depression sets in. To maintain a high level of quality of life (QOL) in the elderly, physical and mental health management are very important (Shinichi et al., 2003). Depression in the elderly has profound negative effects on their physical health, social function, and comorbidity. Depression is a serious issue plaguing the elderly population who are aging in place at a tri-level assisted living facility.

Purpose of the Study

This study examined if there is a correlation in a tri-level assisted living home between the quality of life those perceive and the level of depression they experience.

The clients for this study were elderly individuals aged 65 years and older that are were not experiencing Alzheimer's dementia, or cerebrovascular disease (which is also known as "mixed" dementia) living in a tri-level assisted living facility in the San Bernardino county.

The best research design that met the needs of the study was a quantitative. This was done by administering the Geriatric Depression Scale and the Life Satisfaction

Index A. The study also benefited from a qualitative section with interviews of the elderly asking questions such as What is good about living at this facility?, What is not so good about living here? The best data source was the clients themselves, and by looking in their for some background information that helped with the study. Research assistance was provided for reading and clarity of the questions being asked, since elderly adults experience vision and hearing problems.

The dependent variable in this study was depression. The Geriatric Depression Scale was used to measure the level of depression the participants were experiencing. The independent variables were age, race, sex, disabilities, social support, and life satisfaction. The Life Satisfaction Index A was used (LSIA; Neugarten, Havighurst, & Tobin, 1961) to measure subjective feelings of well-being and life satisfaction.

Significance of the Project for Social Work

This study was needed because in California alone in the year 2010 as many as 4.5 million will be elderly and the elderly population is continuing to grow significantly (as cited from http://www.census.gov).

This study benefited social work practice and the assisted living agencies to better understand the elderly's needs so that they can feel they have a good quality of life until they die and experience little or no depression. It also gave information so that services can be provided to the elderly to enhance their quality of life and or decrease depression.

People that were interested in this study were the assisted living residence's administration, so that they can better understand their clients' depression as related to the quality of life. They can use the study to do a quality care review of their agency and look at what the clients may need to help deal with their depression.

Another group that was interested in this study is the Department of Adult and Aging Services (DAAS) because they oversee funding for the elderly and are also involved in the change of laws that govern assisted living institutions. The County may look at how Medicaid or Medical funds could be better used to pay for mental health services in assisted living facilities.

Finally, families and friends of the elderly will use this study to better know the mental health needs of their loved one when placed in an assisted living home,

especially when there is the possibility they may suffer from depression related to the lack of quality of life.

By 2020, 17% of the United States population will be 65 years or older (National Institute on Aging, 2009). The study was concerned about the high rate of depression among the elderly placed in assisted living facilities. This research was able to provoke a conversation on change with all people involved with the elderly who want to better their last days here.

If social workers understand why elderly people get different degrees of depression in assisted living homes then the clinicians will be better able to treat them medically and psychosocially. This research's results better helped families interact with the elderly in the assisted living home. The research helped to change social practice in the assisted living residences by seeing that the elderly get counseling and get a psychiatric evaluation for medication. It also increased the knowledge base of social workers and other clinicians who treat and work with the elderly population.

Looking at the Generalist Intervention Process the two areas that were informed by the study were evaluation because it assessed the elderly for their emotional

health and life satisfaction and how it correlates with level of care. The second area that was informed by the study was follow-up. This is where the researcher brought back the findings to the agencies that were used. In this follow-up data it was shared and any questions that the administration had were answered.

The thesis question is, does assisted living placement affect the degree of depression in the elderly sixty five years and older?

CHAPTER TWO

LITERATURE REVIEW

Introduction

In this chapter a critical review of the literature related to elderly and the assisted living community will be discussed. Topics that will be covered in this chapter will be assisted living communities, depression, dementia, and quality of life. Theories that guide conceptualization such as disengagement theory, activity theory and social constructivist theory will also be discussed.

Assisted Living Facilities

Assisted Living communities have emerged over decades of time trying to meet the needs of the aging population. Residential settings that housed elderly people, often called homes for the aged predated the 1965 enactment of Medicaid, and Medicare which shaped the modern nursing facility (Cohen, 1974). From 1979 to 1985 residential care for older people with health problems changed to assisted living largely as a residential facility with extra amenities which were for the rich, but eventually emerged in reaction to nursing facilities

having a vision of a different way of bringing physical environments, and care and service to offer a more desirable environment to the elderly (Wilson, 2007).

After the mid 80's early assisted living, an Eastern version was created which was founded by Paul and Terry Klaassen, who are the founders of what is now Sunrise Senior Living. The first residential setting was a Victorian home, with small sleeping rooms, most private but some shared and a variety of common spaces such as the living room, dining room and sitting rooms. Originally they called their places retirement homes, which is a direct translation of the Dutch terminology (Wilson, 2007).

While the East was creating their facility the West under the leadership of Richard Ladd, administrator of Oregon's newly formed Senior Services Division also was treading water to embark on bringing nursing homes into more of a long term care option. Oregon's long-term care policy and its authorizing legislation SB1955 called for older individuals to be able to live in the least restrictive environment. This legislation allowed them to call their facility living center for assistance from which the term assisted living came to be used.

In the 90's AARP commissioned a national study of assisted living; out of this came a working definition of the term assisted living: a group residential setting not licensed as a nursing facility that provides or arranges personal care that meets functional requirements and routine nursing services (as cited in Kane & Wilson, 1993). During this evolution there were four broad types of assisted living that came to light. These were the Hybrid model where emphasis was placed on residential style setting, a variable service capacity, and a philosophy of consumer autonomy. The next model was the Hospitality Model which was very popular in metropolitan centers. This model typically focused on concierge-type services such as housekeeping and laundry and meals, activities, and transportation. The third model that came to be in the 90's was the Housing model and the most important construct that came from this model is that seniors were given private living space and that it contributed to the development of assisted living and set high standards. The fourth model was the Health Care Model where assisted living evolved from nursing facilities and licensed board and cares. To some degree this was in reaction to market demand.

The Assisted Living Model has many strengths one being nursing care in a social environment. A state to state regulatory system allows for individualization of the model and consumer driven quality (Mitty & Flores, 2007). On the other hand assisted living facilities (ALF's) are defined as non-medical residential settings grounded in a philosophy of providing residents with choice, privacy, independence and dignity in a homelike setting. The nonmedical part prevents the facility from providing a Medicare level of care or receiving Medicare reimbursement (Wallace, 2003). The lack of being able to use Medicare for reimbursement makes assisted living facilities expensive for many seniors.

Depression and the Elderly

With the increase in elderly more demands will be placed on long-term care facilities (LTC) to meet their physical and emotional needs. The elder population looks for autonomy and a better quality of life when looking for a LTC. Long Term Care facilities provide medical and social services. Studies across the board show that the elderly who are making a transition from the community to

a long term care facility such as an assisted living facility are vulnerable to depression.

Pope, Watkins, Evans, and Hess (2006) did a study using twenty-four residents in six assisted living facilities across three counties in South Carolina. They used the Geriatric Depression Scale, the Meaning Survey, a journal, and follow-up interviews. Their study indicated that depression is associated with the individual's environment, physical health, and quality of social interaction. Particularly in this study they found that the elderly reported that they often did not share their feelings, but when they did they did so with immediate family or close friends they made at the facility. The meaningful activities that the facility provided encourage friendships and communication (Pope et al., 2006).

Cummings (2002) also looked at "Assisted living facilities as a growing resource of supportive housing for frail elderly people. Her study examined the psychological well-being of frail elderly people residing in an assisted living community, investigating the factors predictive of well-being, and the effect of functional impairment and social support on their well-

being "(p. 295). Fifty-seven elders participated in her questionnaire which consisted of depression and life satisfaction scales, and also social support and health status scales. Her study found that the elderly who were residing in assisted living facilities suffered from depression and low levels of life satisfaction. Especially apparent was that females suffered from significantly higher levels of depression and lower levels of life satisfaction. Cummings's study also found "That degree of functional impairment was significantly associated with levels of depressive symptoms" (2002, p. 299).

Another study was done on depression in the elderly who were living in assisted living facilities. Jang, Bergman, Schonfeld, and Molinari (2006) also found "Higher levels of depressive symptoms among older residents with a greater level of functional disability, poorer self-rated health, lower sense of mastery, less religiosity, and less positive attitude toward aging. For the older residents with more positive beliefs and attitudes, depression symptoms were less" (p. 309).

There have been many studies done on the correlates of depression in nursing homes. Parmelee, Katz, and

Lawton (1992) examined "Incidence and persistence of depression among nursing home and congregant apartment residents in a one year longitudinal and found an increase in major depression when they did the second round of testing. This study concluded that persistence of depression was associated with greater decline which includes cognitive status, functional disability, and physical disability" (p. 194).

A study done across four states (Florida, Maryland, New Jersey, and North Carolina) looked at the prevalence of depression in assisted living residences. This study worked with 2,078 residents aged 65 an older enrolled in one of 193 assisted living facilities in one of the four states. The researchers used the Cornell Scale for Depression in Dementia (CSDD) and classified participants as depressed if their score was greater than seven. This study found 13% of the population was depressed and 25% had symptoms of depression such as tearfulness, sad expression, worrying, and sad voice. This study found depression to have significant association with medical comorbidity, social withdrawal, psychosis, agitation, and length of stay at the residence (Watson, Garrett, Sloane, Gruber-Baldini, & Zimmerman, 2003).

Adams, Sanders, and Auth (2004) found in their study of 440 residents in two different independent living apartments giving them the Geriatric Depression Scale and the UCLA loneliness scale version 3, that depression in elderly residing in assisted living retirement communities exists. They also state that loneliness may contribute to depression.

Depression in assisted living communities is prevalent problem.

Dementia

Dementia is an illness that plagues elderly individuals as they advance in age. It is an illness that affects their mind and body. Before Assisted Living facilities came about most elderly people with dementia were placed in hospitals or nursing homes because they needed higher level of care. Now assisted living facilities have levels of care and have special units for individuals that have different forms of dementia.

Elderly people that suffer from dementia have been found to have good quality of life in assisted living facilities. One study done in a Midwestern state used ten facilities and used an observational method known as

Dementia Care Mapping, where they collected detailed information on the types of interactions and activities the residents and staff had. They found in their study that the elders that were not in a dementia-specific unit had better quality of life than the group that was in a dementia specific unit and were a smaller group (Kuhn, Kasayka, & Lechner, 2002).

Another study was done regarding quality of life in dementia patients in long term care. This study was done by using a cross-sectional, case control design. Thirty-two facility staff were interviewed to assess quality of life of 120 patients meeting the DSM-IV dementia criteria residing in long term care. They found that quality of life was significantly higher in assisted living residents compared to residents in a skilled nursing facility (González-Salvador, Lyketsos, Baker, Hovanec, Roque, Brandt, et al., 2000). Their study did show that there is a high correlation between quality of life and depression.

Individuals with dementia still can have a good quality of life even though they have a disorder that is causing them severe impairment.

Quality of Life

Quality of life has been defined by Lawton as a "Multifaceted framework that includes components of behavioral competence, such as health, functional and social involvement; psychological well-being; subjective impression of quality of life, such as life satisfaction and environmental factors" (as cited in Michell & Kemp, 2000, p. 118)

Other terms that will be important to understand that gerontologists and researchers use when talking about quality of life are ADL's (activities of daily living) which refers to bathing, grooming, eating, and IADL'S (instrumental activities of daily living) which refers to housekeeping, bill paying, and transportation.

Quality of life (QOL) has been an important factor in assisted living and the elderly for many reasons. One reason is that it helps when designing health care and social activities for residents. Another is that Quality of Life (QOL) may influence the mental and physical health of seniors who are experiencing diminished control over their lives and the loss of functions. Last, research has suggested there may be a correlation between lower QOL with seniors living in a structured living

setting compared and seniors in the community who are living with relatives or in their own homes.

Kelleygillespie and Farley (2007) found that families perceived "quality of life more positively once moved from a nursing home to assisted living facility using Medicaid funds" (p. 221). They found that quality of life was hard to measure, but it was important because it was a part of the person's sense of being.

Newsom and Schulz (1996) looking at "The relationship between physical impairment and quality of life (QOL) found after doing a regression analysis of a national sample of 4,734 adults age 65 and older that physical impairment is associated with fewer family contacts, fewer friendship contacts, a reduction in both belonging and tangible support and a tendency to provide less material support to others"(p. 40). They also found "That family contact was no longer an important predictor of quality of life. They did find that physical function was a predictor of social support and in turn predicated depressive symptoms and life satisfaction"(Newson & Schulz, 1996, p. 40). They concluded by suggesting that "loss of emotional and informational support may have

fewer consequences for psychological health and perceived quality of life" (Newsom & Schulz, 1996, p. 41).

A study looking at the factors that affect assisted living facility residents' ability to remain successfully in an assisted living facility environment, included residents of a moderate size residence in a large suburban setting in the southeastern United States (Cummings, 2002). The staff at the facility helped the residents with ADL's and IADL'S. Fifty-seven individuals completed the questionnaire who did not suffer from Alzheimer's or cognitive impairments or communication problems. Cummings used a modification (10-item), of the Center of Epidemiological Study Depression (CESD) Scale to identify depressive symptoms, and the Life satisfaction Scale Z, a shorter version of the Scale A, which is designed to measure subjective feelings of well-being and satisfaction among older adults (2002).

Cummings (2002) found that "social support is a key in bolstering resident's psychological wellbeing; while, strong social support was present, the effect of functional impairment and poor health was no longer significant" (p. 300).

Kane (2003) has found that residents' perceived quality of life is partly a product of health, social support and personalities, but that the assisted living facilities can influence the elders' quality of life through their policies, practices and environments, and indirectly through the approaches to their families.

Meaning in life was found to be connected to the emotional support from families and friends (Krause, 2007). Older adults reported that emotional support gave them a better meaning of life than tangible support. Krause also found that anticipated support was very significant in having a positive meaning in life or quality of life (2007). Older adults who believed that there were others there to help in the future were more likely to have a better quality of life.

The elderly's view or perception of quality of life has an effect on their psychological well-being and their stay in the assisted living facility.

Theories Guiding Conceptualization

Theories that guided this study were the Disengagement Theory, Activity Theory, Social

Constructivist Theory and a Life-Course Theory such as Erickson's developmental stages.

Disengagement Theory evolved from an article published in the 1960's later was developed by Cummings and Henry in *Growing Old*. Cummings and Henry state this theory is that growing old involves a gradual and "inevitable mutual withdrawal or disengagement, resulting in decreased interaction between an aging person and others in the social systems he belongs to" (as cited in Hochschild, 1975, p. 553). The elderly then lack social contact, and social support which makes aging harder. This theory has been the first formal theory that attempted to explain the social process of growing older. This theory states that the elderly must accept a decline in status and must relinquish a leadership role in order to keep balance in aging..

A theory that argues the opposite is the theory of Activity from Havinghurst. This theory states that in order to age properly people should be encouraged to stay active, be involved, encourage expanding and developing own-age friends. Chang and Dodder looked and activity theory and psychological well-being of the aging and

found that there was no correlation between activity and psychological well-being (1984).

Another theory is Social Constructivist Theory. In this theory if the elder feels they are a burden to society then they will withdraw and possibly get depressed and feel they are an inconvenience.

Erickson's final life stage, *Integrity vs. Despair,* reviews life accomplishments, deals with loss and preparation for death.

Summary

The aging population is a growing population that we need to take a deeper look at. In this chapter Assisted Living Facilities and the history of their formation was discussed. Depression and Dementia which are disorders that affect the elderly were explained and clarified and the topic of quality of life was addressed. Finally the theories that will guide this study were concentrated on.

CHAPTER THREE

METHODS

Introduction

In this chapter the study design and sampling method will be discussed along with the way that the data was collected and instruments and tests that were used. The procedures on how the data were collected will be covered. The procedures that were used to protect human subjects' confidentiality and anonymity also will be addressed in this chapter. Finally the process of data analysis will be discussed.

Study Design

The purpose of this study was to evaluate if the level of care a senior needs in an assisted living facility has an effect on the quality of life they have and the level of depression they experience.

This was a quantitative study along with qualitative data. Previous research done in this area used the Geriatric Depression Scale (see Appendix A) and the Quality of Life Index Form A (see Appendix B) and they were very reliable. These two tests were used in this study plus a questionnaire (see Appendix C) was included

to get demographic information such as age, sex, nationality, and how long they have resided at the assisted facility and to get answers to questions the assisted living facility would like to have researched.

Methodological implications and limitations that came up in doing this study was that there were not a large enough sample, and it was only a cross sectional analysis rather than a longitudinal study done over a period of time.

The real Question was does the level of care in assisted living facilities affect the quality of life and depression in the aging?

Sampling

The researcher obtained the sample from a local tri-level assisted living facility in San Bernardino County which has 103 residents. The facility has provided a letter (see Appendix D) stating they would allow the research to take place at their facility. The researcher used purposive sampling after eliminating residents that have Alzheimer's dementia and late stage dementia. The Staff at the assisted living community assisted the research by identifying the Alzheimer's and late stage

dementia patients. The researcher used visitation to the facility and getting the elderly comfortable with having a social worker around and talking to them about participating in the study. A letter of introduction (see Appendix E) and a copy of the informed consent were sent to the families of the elderly to inform them of the research study and to give them an opportunity to eliminate their elderly relative from the study if they chose to do so. Then a recruitment flyer (see Appendix F) was handed out and posted on their activities board along with a sign-up sheet (see Appendix G) for those who would like to participate.

Data Collection and Instruments

The independent variable in this study was level of care being received. The dependent variables were quality of life and depression.

The two existing measurements that were used in this study were the Geriatric Depression Scale, (see Appendix A) and the Quality of Life Index A (see Appendix B).

The Geriatric Depression Scale (see Appendix A) has 92% sensitivity and 89% specificity when evaluated against diagnostic criteria (Kurlowicz, 1999). The

Geriatric Depression Scale (see Appendix A) is not to be used as a substitute for a diagnostic interview by a medical health professional, but it is a good tool to get a base line screening to facilitate assessment of depression in the ageing adults.

The Quality of Life Index A (see Appendix B) is a 20-item scale that is design to measure feelings of well-being and satisfaction among older adults. "Validity studies compared the LSIA scale to the Philadelphia Geriatric Center Moral Sale and life satisfaction ratings by clinical psychologists with correlations of .76 and .64 respectively" (as cited in Mitchell & Kemp, 2000, p. 120).

A questionnaire was created and used (see Appendix C) to ask questions such as age, race, sex and questions of satisfaction with the facility that the elders reside at such as Do you participate in the activities provided here?, Over all how satisfied are you with the services that you receive at this assisted living community? The facility requested that some questions about their facility were asked while doing this study. This questionnaire was pre-tested by asking a senior not participating in the study to review the questionnaire.

Procedures

Prior to any data collection an introduction letter (see Appendix D) with a copy of the informed consent (see Appendix H) was sent home to the families of the elderly residing at the assisted living community. The families were given an opportunity to call and exclude their elderly relative from this study if they would like. The data were collected during quiet times at the assisted living facility. The participants were approached and asked if they would like to participate in a study related to aging and that it would only take 20 minutes of their time and they would receive a ten dollar gift card to the food connection for participating. The interviews were conducted in a private unoccupied office to protect client's confidentiality and privacy. The researcher visited the sight several times to let the seniors get to know her and to help them sign up to participate. The researcher was the one collecting the data that was needed for this study. The number of participants that this research study achieved is 18 participants.

Protection of Human Subjects

The confidentiality and anonymity of the aging individuals that participated were protected by not having any names. The participants were given an informed consent (see Appendix H) where they dated and marked an X on it to say they had read it and understood what they were participating in. After the seniors participated in the study they were given a debriefing form (see Appendix I) that explained the study and information for whom to contact if they needed further information. There were no foreseeable risks in this study but contact numbers were provided.

Data Analysis

This study was a cross sectional analysis looking at the correlation between the levels of care, the quality of life, and the degree of depression. Nominal measurement was used to study ethnicity, gender. The next form of measurement that was used was Ordinal which is the form of measurement that measured life satisfaction. Interval scales were created to look at age and life satisfaction.

The demographic questionnaire (see Appendix C) that was included in this study was measured as quantitative for seven of the fourteen questions. The remaining seven questions were qualitative data where common themes and sub themes were looked for.

The Geriatric Depression Scale (see Appendix A) used nominal measurement and created interval scales to look at different correlations between the questions answered.

In this research analysis the researcher used statistics that determine associations such as Chi-square and correlation. For example there might be a casual association between male or females being more affected than the other. The research might find a correlation between race and degree of depression and quality of life. Age range might play a factor in this study meaning the older or younger you are the more affected you are.

Summary

This chapter discussed the study design and how the participants were going to be chosen. The data collection and the instruments that were used during this study were discussed. The procedures for during data collection were

explained. Including how the human subjects were protected and unharmed during this study. This chapter concluded by explaining the data that was collected and how it was analyzed.

CHAPTER FOUR

RESULTS

Introduction

In this chapter the findings of this study will be discussed. The qualitative and quantitative findings will be discussed. First the relevant frequencies and descriptive statistics of the entire sample population will be described and findings will be discussed. Next, the bivariate findings will be discussed. Last, the quantitative data will be analyzed and discussed.

Presentation of the Findings

The study had 13 female and five male participants. The mean age was 79.78 years with a standard deviation 0f 8.875. The mean education level of the participants was 11.5000 years with a standard deviation of 1.09813. The marital status of the participants was that fourteen of the participants were divorced or widowed, two were married. The mean years lived at the assisted living facility was 1.9953 with a standard deviation of 2.77746. Seven of the eighteen participants needed help with their ADL's. (See Table 1.)

Table 1. Descriptive Chart

	Mean	Std. Deviation
Age	79.78	8.875
Sex	1.7222	.46089
Require Assistance	1.6111	.50163
Highest Grade	11.5000	1.09813
Years Lived There	1.9953	2.77746

All Possible correlations and t-tests among variables were examined. Only the following were significant. The Pearson two tailed correlations found that there was a correlation of - 0.740 between the Geriatric Depression Scale and the Life Satisfaction Scale. The correlation is significant at the 0.01 level. This means that the less depressed you are the more satisfied you are with life.

This study also found a correlation between the age and the need for assistance with ADL's. The correlation was significant at the 0.05 level. The correlation was .548 which means that the older the elderly were the more assistance they needed with their ADL's. (See Table 2.)

Table 2. Correlation Chart

	LS Sum	Age
GDS Sum Pearson Correlation	-740**	
Sig (2 tailed)	.004	
N	13	
Require Assistance Pearson Correlation		.548*
Sig(2 tailed)		.019
N		18

** Correlation is significant at the 0.01 level(2 tailed)
*Correlation is significant at the 0.05 level(2 tailed)

In independent samples t-test the mean depression score for married participants (7.4667) was significantly lower than that of unmarried participants (17.0), (t= -2.902, df =15, p=.011). This means married individuals are less depressed than individuals that are unmarried.

In the independent samples t-test the mean depression score for positive individuals was (5.2500) was lower than the that of the negative individuals (9.6154),(t= -1.502, df= 15, p=.154). This means individuals that had negative things to say about living in an assisted living community suffered from depression.

In the independent t-test the life satisfaction for Positive people was (14.2500) which was higher than the negative individuals (10.6429) (t= 1.724, df =16, p=.104). This means that the elderly that had a positive view on living in an assisted living community were much more satisfied with life.

Qualitative Findings

In this study the eighteen participants were asked questions pertaining to what prompted them to come to stay at an assisted living community and what activities they like to take part in. This section discusses the common themes that were found among the participants. It is broken down by questions and the prominent themes that were talked about are discussed.

The first question that was asked was what prompted you to live in an assisted living community? The number one theme that was spoken about was the ability not to be able to care for themselves anymore and that they did not want to be alone. Participant one stated "I couldn't take care of myself and I had no one to take care of me in my family"(Participant 1, personal communication, November 2011) Another prominent reason for coming to an

assisted living home was the need for help with medication management and medical necessity. One of the participants' shared that she had a stroke and was doubling up on her medication at home when she was not being watched. She was unaware of what she was doing. Her daughter came to visit from another state and caught her mother doubling up on her medication and they decided it was best to place her in an assisted living home.

The next question that was asked was what kind of family or friends do you have outside of the assisted living community? The number one response to this question was daughters and sons that come and visit. Many have grandchildren that also visit weekly or, at least call once a week. Some of the participants stated that that they had friends that would come by if they did not have family. Most of the participants have family that live locally and are able to visit. One participant said "My daughter picks me up and takes me to church on Sunday" (Participant 2, personal communication, November 2011).

What is good about living at this assisted living community? Was the next question that was asked? The number one reason was the people. The participants felt

that everyone was pleasant and nice. One participant likes that they have a rule that you can't come to diner in your PJ'S. Another participant feels that "Everyone is pleasant to be around and they are so sweet and friendly to you" (Participant 3, personal communication, November 2011). Another thing that was good about the assisted living was that your food and laundry were done for you.

The next question was concerning, what are some of the challenges that you face living at the assisted living community? This question had a few areas of concern. The number one was that they felt they were not busy enough and that there were not enough activities to participate in. A few participants expressed their concern of not liking to do arts and crafts and wanting different activities.

A second area that was brought up was the meals. Participants felt that they were not in line with a diabetic's needs. They felt they were too salty and were too high in starch.

Third, the time that staff takes to respond to calls was brought up as an issue. This was a concern especially for those bound to wheelchairs and beds and

needing to use the restroom. The feeling of being trapped and at their mercy is very disconcerting and they feel mistreated.

The last area that was a large concern was finances. A few participants were very concerned about making the bills every month. Participant four shared that "It takes my whole disability check to pay for my residence and I have no extra to do anything" (Participant 4, personal communication, November 2011).

The last question that was addressed was, do you feel that your quality of life is enhanced by living at this assisted living community and by the services that they provide? Ten of the participants stated that they felt that their quality of life has been enhanced living at this assisted living community. Four were males and six were females. They felt that it was good being around people, and their worries were lifted off their shoulders. The worries were laundry, cooking, medication, money and help with ADL's. The eight that felt that their life was not enhanced by living here felt that they lost independence, they didn't have a choice about coming to an assisted living community, their family just placed them here, and they feel confined.

One person shared that they lived in a completely different region and didn't even know this area of California.

Summary

In this chapter the results of the qualitative and quantitative study were discussed. The descriptive statistics were described and the correlations with the Geriatric Depression scale and Life Satisfaction Scale were described along with the correlation between the age of the participants and the need for assistance with ADL's. The bivariate statistical findings were also explained. Last, the quantitative data were written about discussing the major themes that were apparent.

CHAPTER FIVE

DISCUSSION

Introduction

In this chapter the statistical findings will be discussed related to what research says. The limitations of this study will be addressed. Last, recommendations for Social Work Practice, Policy and research will be discussed.

Discussion

This study found that the level of care an elderly individual needs has a direct effect on the level of depression they experience and their quality of life. It was found that the less depressed you were the more satisfied you were with life. This was consistent with the findings of previous research regarding depression and assisted living homes. Those that were more depressed were less satisfied with life and felt a sense of role lose and incompetence. This is in line with the symptoms of depression, lack of interest in activities, loss of identity, sadness, hopelessness, helplessness.

Another area that this study found that was similar to previous research was that the older the elderly

person became the more need for help with their ADL's and their IADL's. This finding is true because the aging process causes the body and the mind to become physically and emotionally frail, which leads to the loss of motor coordination, and lack of eye sight, and hygiene becomes an obstacle.

In the qualitative research areas of concern to the residents of the assisted living community were in the area of nutrition, activities, staff, and finances. The underlying theme that arose from all of these areas was that the elderly residents felt they as a person were not respected and their opinions were not valued. They complained about the food, but what they wanted was to have input on what was going to be served. As for the activities they felt that there were not enough choices for people that didn't do crafts. As for the staff, the residents felt the staff were friendly but took a long time to respond to bathroom calls and other buzzer calls. The slow response gave the elderly individuals a feeling of not being valued or cared about. Finances was a big concern for the residents because they stated it took their whole check to pay for their room and board which

left them no extra money for the month to do any of the outings that the assisted living facility had planned.

These are very large concerns for elderly individuals who through most of their life had complete control over what they ate, when they got to shower and get dressed, and how they spent their money.

Limitations

The limitations of this study are first the size of the sample population. There were only eighteen participants and an unequal number of male and female participants. This study also looked at the aging that needed assistance with ADL's and the study did not have a large number of participants needing assistance.

The second area that limited this study was that only one assisted living community was used in this research. This gave a narrow view of the problems and concerns facing the aging population residing in assisted living communities.

Third, some of the questions that were asked from the Assisted Living Questionnaire during the interview were poorly written so they didn't acquire the answers

that were desired. They acquired short yes no answers or one to two word answers at times.

Recommendations for Social Work Practice, Policy and Research

The aging population is a growing population that will need more and more services in the future. As found in this study the elderly have experienced what Kuypers and Bengston (1973) describe as the Social Breakdown Syndrome. Elderly see that society sees them as incompetent, and obsolete, they have a role loss, have an atrophy of skills, and spiral into a self-labeling as incompetent and negative self-talk. Social workers need to help the elderly not fall into this spiral and empower them to find their sense of internal locus of control. Social workers can do this by improving their maintenance of coping skills which then helps the elderly internalize self-view as effective, which in turn reduces susceptibility of external roles and dependence and they are more self-reliant. By improving the following areas; housing, health, economics, nutrition, and service range it in turn provides power and money which reduces the external control that keeps the elderly in the Social Breakdown Syndrome.

In Practice social workers need to help the aging come to terms with the acceptance of deterioration. "Havighurst (as cited in Robbins, Chatterjee, and Canda, 1989) defined six developmental tasks of later maturity: 1) Adjusting to decreasing physical strength and health, 2) Adjusting to retirement and reduced income, 3) Adjusting to the death of a spouse, 4) Establishing an explicit affiliation with one's age group, 5) Adopting and adapting social roles in a flexible way and 6) Establishing satisfactory physical living arrangements" (p.208).

In regards to policy there is no state mandate in California that requires assisted living facilities to hire a licensed Social Worker (LCSW) or Social Worker (MSW) to be on staff at the local assisted living communities. These communities are required by law to have Case Managers, but they are of a paraprofessional level and deal only with financial and medical issues regarding the residents. If there was a policy stating that all assisted living facilities had to hire a Social Worker for a certain amount of hours per number of residents whose job would entail providing Advanced Case Management, Crisis intervention, group therapy, and

Individual therapy, there would be a great reduction in the level of depression in the residents and an improvement in the quality of life.

Further research needs to be done in the area of aging and assisted living communities. One area this study was unable to look at was if ethnicity played a factor in the quality of life and depression of the residents.

An additional area that was brought up in interviews was placement process. Does the issue of the family deciding or the elderly individual deciding to reside at the assisted living community affect the depression and quality of life of the elderly?

We know that depression is a disorder that affects the elderly; we need to continue to research what contributes to the depression and how can we help elevate the symptoms.

Conclusions

Aging is a difficult process that all must go through. In the 20th century the aging population is being offered the option of assisted living communities. As much as they try to advertise that they are like home

they are a far cry from what the aging had in their own private homes. As we face the baby boomers as the next generation of elderly we need to keep in mind what we can do as a society and as social workers to empower elderly to be in control of their lives as much as they can. For It is the feeling of being in control and having choices that gives them a sense of quality of life.

APPENDIX A

GERIATRIC DEPRESSION SCALE

Geriatric Depression Scale

Directions: Please choose the best answer for how you have felt over the past week.

1. Are you basically satisfied with your life? ..... Yes ***NO***
2. Have you dropped many of your activities and interests ..... ***Yes*** NO
3. Do you feel that your life is empty? ..... ***Yes*** NO
4. Do you often get bored? ..... ***Yes*** NO
5. Are you hopeful about the future? ..... Yes ***NO***
6. Are you bothered by thoughts you can't get out of your head? ..... ***Yes*** NO
7. Are you in good spirits most of the time? ..... Yes ***NO***
8. Are you afraid that something bad is going to happen to you? ..... ***Yes*** NO
9. Do you feel happy most of the time? ..... Yes ***NO***
10. Do you often feel helpless? ..... ***Yes*** NO
11. Do you often get restless an fidgety? ..... ***Yes*** NO
12. Do you prefer to stay at home rather than go out and do things? ..... ***Yes*** NO
13. Do you frequently worry about the future? ..... ***Yes*** NO
14. Do you feel that you have more problems with memory than most? ..... ***Yes*** NO
15. Do you think it is wonderful to be alive now? ..... Yes ***NO***
16. Do you feel downhearted and blue? ..... ***Yes*** NO
17. Do you feel pretty worthless the way you are now? ..... ***Yes*** NO
18. Do you worry a lot about the past? ..... ***Yes*** NO
19. Do you find life very exciting? ..... Yes ***NO***
20. Is it hard for you to get started on new projects? ..... ***Yes*** NO
21. Do you feel full of energy? ..... Yes ***NO***

22. Do you feel that your situation is hopeless? ..... ***Yes*** NO

23. Do you think that most people are better off that you are? ... ***Yes*** NO

24. Do you frequently get upset over little things? ..... ***Yes*** NO

25. Do you frequently feel like crying? ..... ***Yes*** NO

26. Do you have trouble concentrating? ..... ***Yes*** NO

27. Do you enjoy getting up in the morning? ..... Yes ***NO***

28. Do you prefer to avoid social occasions? ..... ***Yes*** No

29. Is it easy for you to make decisions? ..... Yes ***NO***

30. Is your mind as clear as it used to be? ..... Yes ***NO***

Total: Please sum up all the bold answers (worth one point) for a total score. _____

Developed by: Neugarten,B.L.PhD., Havighurst,R.J. PhD, & Tobin S.S.,M.A.(1961). *The Measurnment of Life Satisfaction*. Journal of Gerentology. April,16 134-43.

APPENDIX B

LIFE SATISFACTION INDEX-A

LIFE SATISFACTION INDEX-A

Here are some statements about life in general that people feel differently about. Would you read each statement on the list, and if you agree with it please put a check in the box under "AGREE" if you do not agree with a statement, put a check in the box under "DISAGREE" If you are not sure one way or another please put a check in the box marked with a "?"

	AGREE	DISAGREE	?
1) As I grow older, things seem better than I thought they would be.			
2) I have gotten more of the breaks in life than most of the people I know.			
3) This life is the dreariest time of my life.			
4) I am just as happy as when I was younger.			
5) My life could be happier than it is now.			
6) These are the best years of my life.			
7) Most of the things I do are boring and monotonous.			
8) I expect some interesting and pleasant things to happen to me in the future.			
9) The things I do are as interesting to me as they ever were.			
10) I feel old and somewhat tired.			
11) I feel my age, but it does not bother me.			
12) As I look back on my life, I am fairly well satisfied.			
13) I would not change my past life even if I could.			
14) Compared to other people my age, I've made a lot of foolish decisions in my life.			
15) Compared to other people my age, I make a good appearance.			
16) I have made plans for things I'll be doing a month or year from now.			
17) When I think back over my life, I didn't get most of the important things I wanted.			
18) Compared to other people, I get down in the dumps too often.			
19) I've gotten pretty much what I expected out of life.			
20) In spite of what people say, the lot of the average man is getting worse, not better			

Developed by: Kurlowicz, L,PhD,RN,CS (1999) *The Geriatric Depression Scale(GDS) Try this: Best Practice in Nursing Care to Older Adults* from the Hartford Institute for Geriatric Nursing,Division of Nursing, New York University

APPENDIX C

DEMOGRAPHICS QUESTIONNAIRE

Assisted Living Questionnaire

1) How old are you?_____

2) Circle the sex that you are. Male Female

3) What is your marital status? Married Divorced Widowed

4) What was the highest grade in school you completed? _____

5) Circle the nationality that best fits you:
   A) White/Caucasia
   B) Black/African America
   C) Asian
   D) Hispanic
   E) Native American

6) How many years have you lived here? _____

7) What prompted you to live in an assisted living community?

_____
_____
_____
_____

8) Do you have any disabilities that require assistance? What are they?

_____
_____
_____
_____

9) Do you require assistance with getting dressed and other activities of daily living such as medication, bathing, and toileting?
   1) Yes 2) No

10) What kind of family and friends do you have outside of the assisted living community?

_____
_____
_____
_____

11) Are you involved in the activities provided by the assisted living community?

12) What is good about living at this assisted living community?

13) What are some challenges that you face living at this assisted living community?

14) Are you overall satisfied with the services you receive at this assisted living community?

15) Do you feel that your quality of life is enhanced by living at this assisted living community and the services that they provide?

Developed by: Stephanie Berberich

APPENDIX D

ACCEPTANCE LETTER FROM FACILITY

EMERITUS
at Grand Terrace

Our Family is Committed to Yours.

Friday, December 03, 2010

To whom it may concern:

Stephanie Berberich has permission to do research at our community. If you have and questions please feel free to contact our Activities Director Linda Stowell.

Thank-you,
Lori Spencer- Executive Director

22325 Barton Road | Grand Terrace, CA 92313 | Tel: 909-420-0153 | Fax: 909-420-0156 | www.Emeritus.com | License # 366409607

APPENDIX E

LETTER OF INTRODUCTION TO FAMILIES

OF ASSISTED LIVING RESIDENCE

EMERITUS
at Grand Terrace

Our Family is Committed to Yours.

January 10, 2010

To Whom It May Concern,

My name is Stephanie Berberich and I am a graduate student in the School of Social Work at California State University San Bernardino. My concentration of study while completing my masters is gerontology. In order to complete my degree I need to accomplish a research project in the area of my concentration, therefore I have chosen to research the aging process in assisted living communities. Emeritus at Grand Terrace has allowed me to contact the families and the seniors that live in there community to see if they would be willing to participate in the research study that I am conducting on the aging process.

The elderly that participate will be given a survey and asked a few questions about living at Emeritus. I have enclosed a copy of the informed consent that each person will receive before participating and they will only put an "X" on the paper that they acknowledge that they are willing to participate in the study. If you do not want your senior relative to participate in this research study please contact Lori Spencer, Executive Director of Emeritus at Grand Terrace at (909) 420-0153. If we do not hear from you your senior relative may take part in this study.

If you have any questions about this study you may contact Dr. Rosemary McCaslin PhD, who is overseeing this project at (909) 537-5507. The results of the study will be available at Emeritus after the summer of 2012. I appreciate your cooperation and support in this project and look forward to working with your senior relative.

Sincerely,

Stephanie Berberich

Stephanie Berberich
MSW Intern

22325 Barton Road | Grand Terrace, CA 92313 | Tel: 909-420-0153 | Fax: 909-420-0156 | www.Emeritus.com | License # 366409607

APPENDIX F

RECRUITMENT FLYER

Graduate Student Looking for Participants for Research Project

1. The study is being done by Stephanie Berberich a MSW Graduate student at California State University San Bernardino under the supervision of Professor Rosemary McCaslin, PhD.
2. You will be asked to fill out a couple of brief surveys that will help us look at what is important in the aging process.
3. It should not take more than 20 minutes
4. The survey is anonymous and no record will be made or kept of your name or any identifying information.
5. Your opinion will help the Department of Ageing and Adults plan for future programs that better fit the aging and improve quality at Emeritus.
6. If you have any questions about this study please feel free to contact Dr. Rosemary McCaslin PhD, at 909-537-5507
7. A small gift will be given to those who take part in this study.

Please Sign up on the Sign-up Sheet on the activities board if you would like to help!!

Developed by: Stephanie Berberich

APPENDIX G

SIGN UP SHEET

Sign-up Sheet for Research Study

Date: _____

Time	Name	For Researcher: Were Tests Completed?

Developed by: Stephanie Berberich

APPENDIX H

INFORMED CONSENT

CALIFORNIA STATE UNIVERSITY
SAN BERNARDINO

College of Social and Behavioral Sciences
School of Social Work

INFORMED CONSENT

You are invited to participate in a study of assisted living facilities and ageing (people 65 years and older). This study is being conducted by a graduate social work student from CSUSB under the supervision of Professor Rosemary McCaslin, PhD. The results will be conveyed to the San Bernardino County Department of Aging and Adult Services (DAAS), and the Assisted Living community that you reside in to aid in their future planning.

Aging in place is an important part of getting old. In this study you will be asked to fill out a couple of brief surveys that will help us look at what is important in the ageing process. It should not take any more than 20 minutes.

The survey is anonymous and no record will be made or kept of your name or any identifying information. You are free to skip any questions you do not want to answer. The anonymous data from these surveys will only be seen by the researcher; the results will be conveyed to DAAS and other groups in form only.

There are no foreseeable risks to taking part and no personal benefits involved. Your opinions will help DAAS to plan for the future programs that better fit the aging.

If you have any questions regarding this study you can contact Dr. McCaslin, PhD (909)537-5507. The results will be available after the summer of 2012.
By marking below, you agree that you have been fully informed about this survey and are volunteering to take part.

Mark _____ Date _____

909.537.5501 •
5500 UNIVERSITY PARKWAY, SAN BERNARDINO, CA 92407-2393

APPENDIX I

DEBRIEFING STATEMENT

DEBRIEFING STATEMENT

Thank you very much for taking a few minutes to let us know your opinions. The surveys that you just completed were for a study on the aging population, and their quality of life in an assisted living facility. It was conducted by a graduate student of the School of Social work at CSUSB under the supervision of Rosemary McCaslin to provide information for future planning for facility.

If you have any questions or concerns about this study you may contact Rosemary McCaslin at (909) 537-5507. The results of the study will be available after the summer of 2012 and a copy will be placed in the facility that you reside in.

Thank you for your time you have provided me a wealth of knowledge.

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