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Homelike Variables and Rates of Depression among Assisted Living Facility Residents

by

Courtney J. Wright, B.A.

MSW Clinical Research Paper

Presented to the Faculty of the
School of Social Work
St. Catherine University and the University of St. Thomas
St. Paul, Minnesota
In Partial fulfillment of the Requirements for the Degree of

Master of Social Work

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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

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Abstract

There is an undeniable increase in the number of aging adults who are utilizing assisted living facilities to delay transitioning into nursing homes in order to receive care in their older years. There has also been in recent years a growing interest in the importance of recognizing and preventing depression and depressive-like symptoms in the aging population. A transition from a home environment where one has potentially spent the majority of their life brings about its own set of emotions and stressors. This may undoubtedly create a variety of concerns to become apparent by current and future facility residents and the communities to which they belong. This qualitative research study sought to delve into current facility residents perceptions of facility living and whether the inclusion, or lack thereof, of homelike qualities was in any way related to their emotional wellbeing. Individual interviews were conducted face-to-face with eight persons residing in an assisted living facility. These interviews focused on several themes that were suggested through literature review: (1) the importance of feeling protected within the facility; (2) the perception of the size and scale of the facility and the impact that has on emotional wellbeing; and (3) the importance that a person places on the facility having a natural (homelike) feeling versus an institutional setting. Implications for social work and recommendations fo future research are discussed in relation to these findings.

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Introduction

Assisted Living Facilities (ALFs) have grown to become a familiar feature of the aging landscape of American society. Providing their residents with the perception of increased autonomy and freedoms, AFLs are often celebrated as the last frontier for the independent before a transition into a skilled nursing home facility. For most ALFs, the standard resident is a woman in her mid-to-late eighties who requires assistance in at least four of the eight major activities of daily living (Resnick, Galik, Gruber-Baldini, & Zimmerman, 2011) – otherwise known as ADLs (Resident Profile, 2013). More than 81% of residents require assistance with at least one ADL (Stefanacci & Podrazik, 2005). Currently, the Minnesota Department of Human Services defines activities of daily living (ADLs) to include "grooming, dressing, bathing, transferring, mobility, positioning, eating and toileting" (2013). It was approximated there were over 6.8 million adults over the age of 85 within the U.S. in 2010 (Johnson et al., 1997), many of whom we can expect will need assistance.

The seemingly rapid shift from what was once the preferred medical model of care for the aged, the nursing home, has changed dramatically within the United States (Hrybyk et al., 2012). Presently, many residents are making the decision to transition into assisted living facilities versus nursing homes, where they are granted more independent lifestyles (Adams, Sanders & Auth, 2004). As of 2010 the National Center for Assisted Living stated that there were greater than 735,000 persons across the United States who resided in an assisted living facility (2013).

A greater emphasis is now placed on facilities to offer homelike environments providing person-centered care as residents seek to avoid nursing home placement (Imamoğlu & Imamoğlu, 2006). With greater emphasis being placed on what older adults are requesting in

their living environments – often based on publicized research – there is now more than ever a spotlight on the care that assisted living facilities are able to offer to residents. There still remains the question of how to match an individual with the correct assisted living facility.

Oftentimes, an individual who is ready to transition into an assisted living facility will receive assistance from family, friends, or even a social worker involved with their impending decision (Krueger, 2005). While research indicates the importance of a transition into an environment which closely replicates a home, Marsden points out that there are scant research studies which investigate what the idea of home means to the elder population (2001). The importance of this lack of research becomes evident when discussing the transition into an assisted living facility. These facilities remain relatively new among options. Assisted living facilities are often larger than nursing homes, and typically offer congregate style living and dining to their residents – atypical of a homelike environment for many (Marsden, 2001).

There is contentious debate as to whether the homelike environment is best simulated in larger-style assisted living facilities or smaller facilities (Sikorska-Simmons, 2005). Currently, there is research to support that the quality of care received in assisted living facilities is positively correlated with facility size (among other variables). What is not addressed is whether the size of the facility is in any way correlated with the emotional well-being of the residents. A study completed in 2004 stressed this finding with research showing that although many facilities garner the appropriate appearance of a home-like environment, residents continue to lack any emotional attachments to the facility (as cited in Williams & Warren, 2008).

The detachment cited by Dobbs (2004) is important to note due to its implications on residents well-being, specifically as a predictor for loneliness and depression among occupants. Experiencing loneliness is a prime indicator of what is commonly known as subclinical

depression, or "low-level" depression (Adams, Sanders & Auth, 2004). While depression is often the most diagnosed disorder among older adults, it is not a common part of the aging process. Many older adults do meet the criteria for what clinicians refer to as sub-threshold depression: depression which has the signs and symptoms present but does not meet criteria for any other depressive disorder (Adams & Moon, 2008). Adams and Moon further specify that sub-threshold depression is known to be related to significant impairment in functioning, and a high risk for the development of later major depressive episodes.

While actual diagnostic definitions vary regarding sub-threshold depression, it is critical that it is addressed in the aging population as its potential for diagnosing remains high among congregate living facilities (Adams & Moon, 2008). As more elders transition into assisted living facilities, it becomes essential that researchers further investigate the environments they are transitioning into, and whether these environments are contributing factors based on size alone for depressive signs and symptoms. As stated previously, there is little research published which investigates the link between the size of an assisted living facility and residents emotional well-being. As research informs us, emotional well-being is related to levels of depression and loneliness. Consequently, this research paper will attempt to explore whether there is a relationship between the size of an assisted living facility, degree of emotional attachment, and the rate of depressive symptoms in its residents.

Literature Review

The aging population continues to be bombarded with differing options for their care and services as they enter assisted living facilities (ALFs), furthering the importance of formal facilities being available. While many seniors before had limited options for placement, older adults today are facing a myriad of choices that may determine not only their quality of care, but

also their source of payment for them (Hedrick, Sullivan, Sales, & Gray, 2009). The important thing to note regarding assisted living facilities are their focus on maintaining independence and preserving the quality of life that residents can enjoy. The facilities themselves are often noticeably more "homelike," providing residents with their own apartment, secured entry to their private unit, and a functioning kitchen area.

Assisted Living Facilities

Older adults and their families often experience stigma surrounding the transition into a nursing home, where, among other things, their need for privacy may not be adequately met (Imamoğlu & Imamoğlu, 2006). The push for maintaining the privacy and quality of life amongst residents is a relatively new concept as previous facilities tend to house two persons to a room – or several persons to a small home to share. The demand for the assisted living environment has been constant as many are being asked by the state to shoulder a portion of the costly monthly payment for nursing home care (Hrybyk et al. 2012). The delay of a transition into a nursing home has serious economic incentives for states as well as residents, with the typical nursing home admittance comprising 45% of all federal Medicaid expenses annually (Cummings, 2002). Pricing of an assisted living private room in 1998 according to the Assisted Living Federation of America (ALFA) was at a daily rate of $107, compared to $226 for nursing home care (Assisted Living Federation of America, 2013).

The demand for assisted living facilities continues to grow as it remains more cost-effective than traditional nursing homes and is expected to reflect an increase in residents at an annual rate of growth between 15 to 20% (Cummings, 2002). Although the market continues to demand assisted living facilities, the confusion remains as to what distinguishes their level of care from those of a nursing home. The confusion about level of care has some professions, and

family members, concerned that ALFs are slowly transforming into the medical modeled care that nursing homes provide (Imamoğlu & Imamoğlu, 2006). Furthermore, due to the rapid growth of assisted living since its inception in the late 1980's, most states do not have unanimity regarding how to define the type of living environment they provide (Cummings, 2002). Currently, assisted living residents are those persons who do not yet meet the Department of Health and Human Services level of nursing home care criteria, yet are unable to remain living independently in a community setting (Martin, Fiorentino, Jouldjian, Josephson, & Alessi, 2010). States also agree that in addition to requiring special housing (which is not licensed as a nursing home) individuals in these environments need both scheduled and as needed assistance in supportive services (Cummings, 2002).

With the continuation of ALFs growth, the government continues to become more involved with the monitoring and facilitation of licensure to these facilities, not only to ensure that residents have minimal experiences of a negative nature, but also to delay the costly and lengthy stay of nursing home admittance (Morgan, Eckert, Gruber-Baldini, & Zimmerman, 2004). Morgan and her colleagues address that as state governments continue to fund placement into more cost-effective options such as assisted living facilities, there is more concern related to enhancing a resident's quality of care – requiring an increase in federal regulations and oversight (2004). Presently the government requires at the federal level all nursing homes with a population over 120 residents to staff one full time social worker to meet psychosocial needs amongst residents (Bern-Klug, Kramer, Sharr, & Cruz, 2010). There are no current government standards, however, surrounding assisted living facilities and staffing of social workers. Consequently, the task of enhancing residents' quality of care involves understanding the

residents' preferences and desires for their living environment and ensuring their psychosocial needs are being met.

Stigma of facility care. There is a stigma for many older adults regarding facility living. As the aging population continues to grow more and more diverse, it becomes apparent that the seniors of today are not only healthier than many before, but also more in-tune with their wants and desires for end-of-life living (Perks & Haan, 2010). Currently the trend for aging adults is toward community environments allowing for an independent lifestyle, yet also allow for shared activities, security, and companionship (Adams, Sanders & Auth, 2004). This purposeful transition into community living somewhat negates previous stereotypes suggesting the elderly withdrawal and isolate as they continue to age.

Stigma has been defined in previous research as the manner in which an individual uses an interpretation of a group or individual set of characteristics to assign a level of distance and negative worth (Hrybyk et al. 2012). While many individuals who prepare for the transition into assisted living expect it to be a final move in their life, there are many who delay this transition due to fears that it will bring about a decline in physical and/or mental health. Consequently, research by Martin, Fiorentino, Jouldjian, Josephson and Alessi corroborate that 24% to 40% of persons who transition into an assisted living facility will discharge to a higher level of care each year (2010). There also tends to be a strong preference toward familial support in lieu of formal supports, especially amongst groups of ethnic minorities, who are often expected to care for their elders and disregard severe deteriorations in health (Johnson, Schwiebert, Alvarado-Rosenmann, Pecka, & Shirk, 1997). Several of the respondents in research performed by Imamoğlu and Imamoğlu noted that while assisted living facilities were preferential to nursing home

placements, the association between having a positive impression and a desire to transition into this type of placement was not very strong (2006).

Fear of Transitions. In a compelling qualitative research study performed by Hrybyk et al. (2012), residents that were residing in assisted living and independent living facilities were interviewed on their attitudes regarding the transition into assisted living facilities. It is well researched that when it comes to a choice in where to live, older adults consistently prefer to age in their longtime homes (Perks & Haan, 2010). Knowing this preference among older adults, a decision to transition to a facility become a selection against the odds. While we know that many adults do eventually transition into a facility, the triggering event that leads to this decision may not come easily.

Perks and Haan note that in the United States the strongest trigger for transition is whether the marital partner or the adult children have the ability to provide the needed personal care for the aged parent (2010). In research that has been conducted over larger geographical areas, the majority of assisted living residents within the United States tend to fit the typography of being Caucasian, widowed and typically with post-high school educational experiences (Sikorska-Simmons, 2005). This consistency is in part due to the fact that most assisted living facilities cater to the private-pay (middle class) sector of American society. Thus, with the majority of assisted living residents being older women leaving their long-term homes and desiring to remain in their homes, the push for homelike qualities and environments with formal services is growing. Sikorska notes that the increase in comfortable environments and characteristics continues to be noticed as being positively correlated with resident's satisfaction among formal services (1999).

The Homelike Quality

There has been very little research to date on what it means to have a homelike quality within congregate housing, specifically assisted living. Most of the research available on elders and their housing preferences assess their opinions for individual housing – as in a person living in a private residence (Marsden, 2001). Most elderly individuals identified similar, if not identical, characteristics that they perceived to represent a meaning of home in research performed by Pastalan and Scwarz (1993), which upheld Despres' (1991) study of traditional home characteristics. The characteristics included things such as being able to remain in control, the need for privacy, the need for one's own space or territory, a sense of security and a sense of ownership.

The only noted differences that Pastalan and Schwarz were able to tease out from Despres' original 1991 study were that the elderly interviewed in 1993 had a stronger emphasis on the importance of a home having familiarity, choice, and the reality of eventual passing. Marsden goes on to explain that in regards to homelike familiarity, many elders use this as a coping tool when suffering from cognitive and sensory impairments. The predictability of the environment allows for them to cope with impairments and remain in their homes longer than perhaps advisable. In terms of realizing that death is an eventual aspect of their existence, Marsden hypothesizes that this daily reality impacts many persons decision to transition to a new home earlier rather than later, preferring instead to die in a place that is familiar and comfortable (2001).

Although prior studies give us an understanding into the emotional meaning that the home has for many, they do not provide information as to the physical properties that are inherently necessary (Marsden, 2001). Despres noted in a 1991 study that a person can have

differing perceptions, experiences and judgments relating to home based on the physical makeup of the environment alone (Marsden, 2001). This information has historically been neglected in research in terms of its application into theories affecting resident behaviors and psychological well-being (Marsden, 2001).

Most of the information that is available to us in regards to the emotional connection a resident may have with the environment comes from work performed by the anthropologist McCracken in 1989. McCracken studied 40 individuals and through his study, comprised seven different categories meant to symbolize the definitive characteristics of the homelike quality (1989). Each of McCracken's following symbolic properties is correlated with a definitive physical characteristic for relational comparison.

Properties of a homelike environment. McCracken's work on the necessary properties of a homelike environment are discussed in-depth by Marsden, who coins the term "homeyness" (2001). When an environment may be defined as having manageable proportions, such as "average" sized windows and doors, the environment is said to feel more comprehensible – making for *The Diminutive Property*. The aspects of a home that make it stand out from others is referred to as *The Variable Property*. This would be noticeable in homes that break the mold in appearance, using alternative building materials, etc. *The Embracing Property* is best described as the way in which a person's home provides a sense of enveloped security. The nature of how the neighborhood is arranged, the steps leading to the front door, the entrance into the home – all provide a gradual process toward the transition from the large outside world to the small and safe inner workings of the home. *The Engaging Property* is all that which is visually available to the eye in order to engage a person in the home's environment. Items such as outdoor decorations to welcome a person inside, personal pictures lining the home's interior – all

are placed to create a certain emotional feeling. In relation to the previously mentioned property, there is *The Mnemonic Property*, which is how each object within the home's environment is able to create a personalized meaning within an individual. For example, trophies that are displayed in a family's common area may evoke a strong sense of achievement within the family group – but not to a stranger visiting. This stranger would not be evoked by the mnemonic properties of the trophies. *The Authentic Property* is that which makes a home seem lived-in, rather than merely a showroom. These are the items within the home that evoke a feeling of comfort and naturalness, rather than coldness and distance. The final property that McCracken speaks to out of his research is that of *The Informal Property*, which is merely the home's use of warm and inviting color palettes to draw the individual toward its door (Marsden, 2001).

Properties of Homelike Environment within ALFs

It is important to note that the above mentioned properties are meant to work in harmony with one another, not compete against each other. McCracken noted that as multiple properties work together within an environment, the stronger the homeyness factor becomes. His research provides the first real glimpse into how such properties may be related to residents living in assisted living facilities. The themes presented by McCracken's work were collapsed by Marsden down to three main categories which provide us with the main tenets of a person's desire for a homelike environment. These three main tenets include the need to: (1) feel protected, (2) the need to have a living environment appropriately sized in terms of scale, (3) and the need for surroundings to appear natural (McCracken, 1989).

Need for protection. Beginning with the initial property presented by Marsden, the need for a person's environment to offer a sense of protection is directly related to McCracken's proposed tenet of the mnemonic property. It speaks to both the need for the person to be able to

have an emotional connection to their space, and cognitively arrange the layout for potential future deterioration. This property is often found to be difficult to create within assisted living facilities due to the congregate design of group living in general. Pastalan and Schwarz also spoke to the importance of one's home being filled with familiar items in their research, as a means of reassurance during cognitive decline and a sense of safety (1993). Purcell and Nasar mention in their research the importance of familiar surroundings; when a person is unable to categorize a room or situation as being familiar, it more often than not creates a negative emotional response to that setting – and vice versa (1992).

Need for enclosure. The concept of enclosure is used to support the notion of a protective environment being needed for homeyness. The need for enclosure is embraced through a person's desire to be sheltered and protected within a shell – either real or symbolic. Marsden mentions that previous researchers have noted the home as a symbol of protection and refuge among American society (2001). There continues to remain scant research available on how the home as a symbol of protection and refuge pertains to congregate housing environments. Brummett (1997) found in his case study that assisted living environments which provide transitions and layers within the building itself create a feeling of protection among those inside (Marsden, 2001). Marsden also notes that Regnier's (1994) case study also found familiar associations, such as a porch or a fireplace, are able to create the connotation of homeyness among residents (2001).

Need for care. The final aspect that relates to the need for protection is that which involves a feeling of being cared for – either directly or indirectly. This can be seen through the maintenance of the property or within the design of the environment. What residents notice most tends to be the care of the property in general (Moore, Allen & Lyndon, 1974). They surmised

that when a property has well-manicured lawns, was nicely painted and had attention to details such as curtains and blinds, there was a feeling of relatedness (Marsden, 2001). The need for a building to feel well cared for and relatable is crucial for an aged person undergoing a transition as a means for assurance that they too, will be cared for and "looked after".

Appropriate Size. The second tenet on the theory of homeyness relates to the proportion of the living environment in relation to the person – or the scale. This pertains to Marsden's property of diminutiveness, which is how a person is best able to understand a setting in regards to manageability. This property is quite important when we take into consideration the sensory impairments that many of the aging residents are facing during transition into assisted living environments. A setting that feels manageable is better suited for someone who is facing a physical, cognitive or sensory challenge – and provides a better sense of competency among the resident for independence. This is also relatable to the engaging property, as an environment which a person feels is manageable and maneuverable is apt to appear more emotionally engaging than one that is not.

The term "scale" is used relatively, and Marsden's theory speaks not merely of the relative size of an object in space but the size of that object in relation to a human. Many things within a typical single family home are built in relation to an average human scale, items such as the height of the countertop, the width of a hallway, or even the size of an entrance. Naturally, the scaling of things within an assisted living environment in relation to the human body is not as congruent as items which would be found within a typical single family dwelling. A study performed by Robinson (1989) pointed out that there are many noticeable differences in scale when comparing family homes to assisted living environments, most prominently the size of the building and the entryway (Marsden, 2001). While it is difficult to change the obvious fact that

assisted living environments are naturally larger in size, it is equally important to evoke the sense of a smaller scaled environment once inside the building.

Importance of a Natural Appearance. According to Marsden (2001), the tenet of naturalness within an assisted living environment deals directly with properties of a space being informal, authentic, and variable – in essence, a feeling of realness about a space, something which McCracken suggested (1989). This may be projected through the physical aspect of the building's materials, use of natural colors, and landscaping. Many would argue that the use of only natural materials when building a home creates the sense of a connection to the outside environment, and nature as a whole. This becomes a challenge with the change in construction methods and architecture. There tends to be less wood, stone, and handmade aspects incorporated into buildings in lieu of cement, steel, and artificial lighting. Without this connection to the natural environment, there is the chance – among other homelike variables mentioned previously – for a resident to develop signs and symptoms of depression inside an assisted living environment.

Mental Health in Older Adults

Issues concerning the effect of an older person's environment are important in understanding factors which affect their mental health. The rate of depression among the aging adult population is on the rise and remains a well-documented concern amongst the research community. Research provides us with the knowledge that of older adults residing in a non-facility, or community type dwelling, rates of depression over the age of 65 are estimated at 15%. When assessing that same age group who reside in care facilities, the rate of depression is closer to 20% (Adams, Sanders & Auth, 2003). These individuals are likely to have experienced the loss of familiar routines and home environments, which can contribute to an eventual

functional decline and diagnosis of depression. Knowing this information, Williams and Warren (2008) state that more efforts need to be made to prevent depression, which is an abnormal aspect of aging. The social roles that the majority of the women who had transitioned into assisted living facilities had were domestic housework and childcare – things not applicable to congregate living in ALFs.

Loneliness. While there continues to be growing interest in differing concepts of depression in older adults, the literature on a theory of loneliness and its effect on the elderly population's mental health is less developed. The research we do have on mental health and the effects of loneliness define it as a negative and subjective emotional state between what is and what one wishes there was in regards to emotional support or companionship (Adams, Sanders, & Auth, 2004). However, this does not imply that it is the same as being alone or isolated – which is a different concept in mental health literature. The concept of loneliness can be divided into two separate categories: loneliness in a social context and loneliness in an emotional context through loss for example (Weiss, 1984).

Although research is still lagging in this noteworthy area of elder mental health, there are three fundamental concepts that have begun to emerge in regards to loneliness and geriatric studies. Research has indicated that as adults continue to age, they typically spend an increased time alone rather than with others – and yet they do not report a correlative increase in their levels of loneliness on an emotional scale (Revenson & Johnson, 1984). In addition to spending more time alone than their younger counterparts, adults between the ages of 65-75 reported in a 2002 study lower levels of loneliness than the middle and young adult participants (Nolen-Hoeksema & Ahrens, 2002). This information seems to uphold that as the aging trajectory

continues, adults who navigate normal life changes successfully have less of an issue with loneliness than those who do not navigate successfully.

However, although an individual may be attempting to navigate normal life changes successfully, there are still many life events which may occur that can develop into predictors for loneliness later on. Real concerns such as being hospitalized or being diagnosed with a terminal illness are traumatic life events that a person cannot plan to prevent or avoid. Adams, Saunders, and Auth pointed out that conditions which create isolation and debilitation were strong indicators for loneliness in older adults – particularly when the individual was a female over age 80 (2004). Contrary to popular belief it is not the amount of social contact a person has that decreases loneliness. It is the quality of the relationships which research has found to be a significant factor for protecting against loneliness (Pinquart & Sorenson, 2001). This study by Pinquart and Sorenson backed up the findings by Mullins and Dugan (1990), when they reported that their participants did not feel the number of relationships was important in fending of symptoms of loneliness but rather losing contact with those relationships that were most important.

A final aspect of loneliness that must be addressed incorporates the link between levels of loneliness within the aging trajectory in relation to other health and wellness diagnoses. There is scant research on the correlation between a diagnosis of health or mental health and how loneliness interacts with those diagnoses and treatment. One such study did attempt to investigate this link and showed a positive correlation between loneliness and its ability to control the negative symptoms of an actualized health condition- albeit not a mental health condition (Fees, Martin, & Poon, 1999). In a slightly different vein, researchers examined how mental health symptoms, particularly depressive symptoms, and loneliness were correlated and

found a positive association with loneliness being a predictor for a depressive diagnosis in adults aged 75-98 (Holman, Ericsson, & Winblad, 1999).

Sub-threshold depression. The transition of many aging adults into a state of depression has captured the attention for several years of researchers and social workers as it continues to become the most diagnosed disorder in this age category (Adams & Moon, 2008). A recent finding by the National Institute of Mental Health estimated that five million elderly adults could be diagnosed with signs and symptoms of depression (2007), with the symptoms increasing in correlation with a person's increase in age. Adams, Sanders and Auth note in their article on loneliness and depression that for aged adults who are transitioning out of neighborhoods and communities where they have spent their lives, the ability to form new social connections decreases, thus making their natural life disruptions increase the likelihood for the development of loneliness and depressive symptoms (2004). Loneliness in itself may be a prime indicator for what researchers are now labeling as subclinical depression. This state of "almost depression" is closely linked to somatic symptoms rather than emotional symptoms and is different qualitatively from what we typically diagnose as a major depressive episode (Adams & Moon, 2009).

It is important to note that although sub-threshold depression is clinically different from a depressive diagnosis, its level of functional impairment can still be quite severe in an aged adult. The research on depression and older adults comes from studies concerning major depressive disorder and its symptoms; there continues to be a slow growth for research on sub-threshold depression and its effects on the aged population. The research that is available on sub-threshold depression and older adults indicates that it is largely impacted by an individual's functional abilities and previous negative life experiences (Adams & Moon, 2009).

While research is still gaining a collective understanding of what it means to recognize signs and symptoms of sub-threshold depression, several authors have attempted to operationalize the term in order to better reach consensus within literature. Horowitz, Reinhardt & Kennedy define sub-threshold depression by the signs and symptoms an individual endorses which do not meet the full criteria for a diagnosis using DSM-IV depression guidelines (2005). Meeks, Vahia, Lavrotsky, Kulkarni and Jeste point out in their research on older adults that subthreshold depression was rated at a level two to three times higher in prevalence that a diagnosis of depression per DSM-IV standards (2011). Also of note in their study, the rates of these subsyndromal depressive symptoms were highest among persons residing in long-term care settings (2011). Scholars and researchers seem to remain divided on exactly where to draw the line between sub-threshold depression and a diagnosis of depression per DSM-IV standards. Several researchers would agree however, that the importance lies within the clinical significant of the symptoms, not the number presenting, and that depression may best be understood as a continuum (Lewinsoh, Solomon, Seeley & Zeiss, 2000).

Research Question

In order to explore the relationship between an assisted living facility's ability to connect on an emotional level with residents and the resulting level of depression, the current study seeks to answer two questions: one, "What are the specific variables identified by residents as characteristics of a homelike quality?", and two, "How do ratings of homelike characteristics correlate with residents' level of depression?"

Conceptual Framework

Ecological Model

The principles embedded within the ecological model allow us to better understand the relationship between people and their surrounding environments; specifically how a relationship continues to evolve and influence individuals, groups, communities, and policies at large (Gitterman & Germain, 2008). The ecological model's backbone lies within the person-in-environment theory. According to the ecological model's perspective, throughout the life course, individuals continue the struggle toward refining a "good fit" versus a "bad fit" in regards to their environment (Barker, 1991). The term "goodness of fit" may better be understood in using the term adaptability. According to Germain (1985), poor fit between a person and their environment results in an increased level of stress and a changed perspective of the environment. The level of stress in combination with the change in environmental perspective can affect levels of functioning in regard to health and social wellbeing. The perception of one's ability to "fit" into their environment may be adjusted through changes made to the surrounding environment.

One significant addition that has been made in recent years to the concept of the ecological model has been the introduction of the term resilience as it pertains to people within environments. Resilience is cited often within the literature among social work research as attention continues to grow on its importance among understanding and treating mental health symptoms (Social Work Policy Institute, 2013). The National Association of Social Work (NASW) has adopted in its publications a definition cited often by Greene, which states, "Resilience is the act of rebounding or springing back after being stretched or pressed, or recovering strength, spirit, and good humor." (Webster's New Twentieth Century Dictionary as

cited on Social Work Policy Institute, 2013 website. According to Smith and Carlson (1997), resilience exists between person and environment and the relationship rather than specific, individual attributes related to a person. Resilience takes into account the myriad of protective variables such as biological, psychological, or environmental factors that may act as a barrier to life stressors for many (Thomlison, 1997). Perhaps the best way to define resilience is the manner in which people cope when under actual or perceived threat to their status quo (Smith & Carlson, 1997). It is important to note that these are not comprehensive definitions, yet they all speak not only to merely surviving an event but also thriving after the stressful experience (Social Work Policy Institute, 2013).

Place Attachment

A popular definition which this research study will be using states that the theory place attachment theory is best understood as the intensely deep connection and emotional bond that an individual creates in relation to a very specific place based on time and multiple interactions of a positive nature (Dallago, L. et al., 2009). Although there has been much interest throughout the years on the theory behind place attachment as it pertains to differing fields, studies have yet to find which variables or characteristics are most likely to uncover an attachment (Hidalgo & Hernandez, 2001). In addition to the difficulty the theory has had in pinning down variables of importance in relation to attachment, the various fields supporting place attachment have wavering explanations behind the operational definition of the term. Researchers have previously used the term *place attachment* synonymously with: sense of place, identity, dependence, belonging, satisfaction, commitment, etc. – which further speaks to the vague nature of the term *place attachment* (Giuliani, 2003).

Although the relationship between place attachment and satisfaction are often cited as being correlates of each other, there remains within the research community indecision regarding whether the two concepts need to be separate or remain in tandem (Giuliani, 2003). While the term "satisfaction" is often included as an indicator of place attachment, it does not adequately account for the many differing aspects of social and behavioral nuances within individuals. Pretty, Chipuer, and Bramston (2003) state that it is important to keep in mind when using the place attachment theory that a location in and of itself is not the determining factor behind a person's emotional sense of place. Rather, it is something that is dynamic between the people and the space. The synonymous use of satisfaction and attachment speaks more toward feelings related to places in a vague manner. Hidalgo and Hernandez (2001) prefer to limit the definition of place attachment to focus less on the satisfaction and more on the main tenant of attachment theory. They propose the following definition, "…a positive affective bond between an individual and a specific place, the main characteristic of which is the tendency of the individual to maintain closeness to such a place." (pg. 274). They argue that including other variations into the definition such as the concept of identity are not critical or indicative of attachment at its core, but the desire to remain close to the object of attachment is
critical (2001).

Methodology

Research Design

This study attempted to ascertain the degree to which assisted living facilities were able to connect on an emotional level with their residents. Specifically, the study sought to answer which homelike variables assisted living facility residents deemed as critical to establishing a

homelike quality; and secondly, how homelike qualities correlated with residents' levels of depression.

Sample

This researcher constructed a list of assisted living facilities within the Twin Cities Metropolitan area, limiting the results to facilities which offered an option on their website for providing personal care assistance in addition to housekeeping and meal services. The facilities were located with a basic internet search of "Assisted Living Facilities in Minneapolis." This in turn provided a targeted convenience sample, with only eight of the many facilities within the region being contacted for study participation. These eight facilities were obtained after limiting the targeted convenience sample to a twenty mile radius surrounding the pre-defined Metro area. They were then further defined (in order to obtain the eight) by facilities which provided on their website contact information (phone and/or email) for communication by the researcher. Targeted convenience sampling is when researchers sample participants which are drawn from a population which is easily accessible. This particular population was selected through availability of being within the metropolitan area and also through convenience. The criteria to participate in this study were that the resident had been living in their current facility on or before October 1, 2013. Participants were notified during the informed consent that the researcher may make a judgment call to end participation if cognitive ability, or other issues, became a concern. This was approved the University of St. Thomas Institutional Review Board (Appendix A). This researcher approximated six to eight participants to be involved in this research sample from the various facilities contacted. In total, nine persons responded to the inquiry and eight successfully completed a face-to-face interview for this research study.

Protection of Human Subjects

All potential participants were provided with information about this study, including the background information, procedure, risks, benefits, confidentiality/anonymity, and contact information of the researcher and research chair. The University of St. Thomas' Institutional Review Board approved the proposal at the level of a full board review. This type of review was pursued because of the potential risk this research posed to a population deemed potentially vulnerable, and the inclusion of recorded interviews. An application was sent to the Institutional Review Board (IRB) at the University of St. Thomas for approval of the research study and the involvement of human subjects as participants, with approval granted to begin research on January 25, 2014. The collection of data and participant recruitment did not begin until after this date.

Recruitment Process. This researcher contacted eight assisted living facilities which offer personal care assistance to their residents as an option of their stay within the specified search area and had easily identifiable contact information for their facility (telephone and email contact information for the facility administrator). Emails were then sent to the identified administrators at each facility requesting permission to post informational flyers to recruit research participants, and seek permission to perform interviews with residents on the facility's grounds. Two facilities of the eight contacted responded and agreed to be research sites for the study, submitting permission letters. Once permission was received, informational flyers were posted around the facility and on resident's room door. The flyer included information on the intent of the research study and the contact information of the researcher in order for each interested resident to directly contact via phone.

Confidentiality and Safety. Both the facility and the research participant were informed of any and all attempts at ensuring security during the research study. The names of the research participants were not recorded, and although interviews and a depression scale were utilized for the research study, no identifiable information was included which could link the participant to the research data. All information which was utilized for the study was to be destroyed after research publication, or by May 31, 2014. All research participants were also informed of the potential risk inherent in participation, which included the possibility that other residents and/or staff members of the facility may see a resident speaking with the researcher, or that difficult issues and/or feelings would arise during the interview. Both the facility and participants were also informed prior to beginning the study of the mandated reporting requirements. This included the responsibility of the researcher to inform facility staff and/or appropriate persons of abuse, or suspected abuse, to or from an individual residing within the facility. This included threats to hurt oneself or another person, or thoughts about hurting oneself or another person.

Informed Consent. Participants were notified both on the informational flyer and also in person once meeting with the researcher that there was no incentive to participate in the research study. The participants were also informed that there were minimal risks and no benefits to their well-being by participating. The potential participants were informed that the likely minimal risks would include the uncovering of potentially negative emotions relating to: placement in a facility, memories of previous home environments, discussions on depressive signs and symptoms, and the potential of being seen interacting with the researcher. These minimal risks were discussed prior to engagement in the study and as a debriefing after the study (Appendix B). All participants were provided with information on agencies to contact should they have unresolved concerns.

Instrument

The qualitative portion of this research study consisted of a semi-structured interview comprised of 13 questions; five demographic questions and eight questions which examined the key themes relating to the theory on homeyness based on Marsden (2001). The demographic information consisted of: gender, race, age of the participant, number of months spent at current assisted living facility, and current level of physical need as it relates to receiving personal care. Three questions were asked to identify what participants believed were the variables within the facility which addressed feeling protected: feeling cared for (either care for self or care of facility), the variables which evoked a sense of familiarity within the facility, and variables which elicited an emotional connection to the facility. Three questions were asked which pertained to the theme of size/scale: variables which evoked a response relating to the participant's personal room, variables which addressed the size of the facility (including outside property), and variables which related to congregate areas within the facility. One open-ended question was asked in order for participants to explain variables which make the facility feel more natural and homelike, versus hospital-like. These survey questions were created in order to elicit responses which would link to Marsden's (2001) theory on homeyness, and also to better understand important themes which promote the homelike quality. These survey questions were reviewed by committee members to increase their validity (Appendix C).

The second portion of the study used the quantitative aspect of the Geriatric Depression Scale (Appendix D). This scale offers two versions, one to be administered to the participant, and the other to be a self-survey – both with the same scoring. The scale asks participants to rate their feelings through the use of 15 questions using a "yes" or "no" response. A score of five or more "yes" answers indicates a possibility for depression. In studies on the validation and

reliability of the Geriatric Depression Scale for self-reporting signs and symptoms of depression, both the long and short version of the scale successfully differentiate depressed versus non-depressed older adults (Greenberg, 2012). The Scale itself has been found to have a 92% sensitivity and 89% specificity when compared against the diagnostic criteria for depression – and both long and short versions of the scale have a high correlation when evaluated against each other ($r = .84$, $p < .001$) (Greenberg, 2012). This researcher provided the option of having each participant be given the scale verbally or to complete the scale independently. Also, prior to completion of the interview, each participant was given a debriefing, where they were asked "how are you doing?" and "are there any issues you feel need to be addressed?" Prior to leaving participants, they were also given a resource list. The use of the Geriatric Depression Scale, the debriefing questions, and the resource list were approved by the University of St. Thomas Institutional Review Board prior to use.

Data Collection

The data for this study was obtained through participant responses in a face-to-face semi-standardized interview and also through the administration of a structured scale. Interview questions were developed by the researcher and reviewed by committee members and the University of St. Thomas Institutional Review Board. The questions developed were based upon the three major themes (need for protection, size/scale, and naturalness of the environment) as presented by Marsden (2001). Questions were also based upon the ecological model and place attachment theory as outlined in the conceptual framework section. The semi-standardized interview questions were aimed toward discovering the specific variables through the resident's perspective, and how those specific variables impact resident's in regards to levels of depression. The benefit of using a semi-standardized approach to this portion of the study allowed for

adjustments to be made based on participant's responses. As the questions relating to homelike variables were created by the researcher for this particular study, reliability or validity is not known.

Participation in the study was voluntary. The researcher did not record any identifiable information of the participants in correlation to their responses.

Data Analysis

With this study, an attempt was made to collect information on the variables which best constituted a homelike quality within assisted living facilities in order to better understand which variables residents felt were of the utmost importance. This study also sought to understand how those variables of importance were related to the levels of depression amongst residents of the facility. These aforementioned variables included:

1. The importance of a natural appearance in and around the facility;
2. The size and scale of the facility;
3. The perceived level of protection that the facility provides;
4. The level of care one perceives or receives as administered by the facility.

As previously mentioned, the study also collected a minimal amount of demographic information to understand if there was a relation between the findings and the amount of time each resident had spent within the facility, the nature of their level of dependency, and the age of the facility.

This researcher hypothesized that the majority of the participants would state that there were certain homelike variables which were more important than others, and that these would correlate with their levels of depression. Specifically, this researcher hypothesized that the more variables a resident was able to identify as being present within a facility that are deemed

important, the lower their scores on the Geriatric Depression Scale. This researcher also hypothesized that there would be some degree of influence on the length of time and level of need of the resident as it relates to their results. Data were analyzed using grounded theory for the qualitative portion, and potential for a correlation behind Geriatric Depression Scale scores and statements made would be explored.

Findings

This research was performed in order to better understand and verify the theories supporting place attachment within an individual, and whether an assisted living facility's use of homelike variables was in any way related to a resident's level of depression. There were three significant themes which were extrapolated and explored from previous research and supported via conceptual theories. These themes were: feeling safe and/or protected, the importance of the size/space of a facility, and the importance of naturalness – or homelike qualities – of a facility. The feelings of *safety* referred to any way in which the participants' perceived that the facility staff or structure promoted an environment of protection. *Size and space* was inclusive of not only the facility as a whole, but also the individual participants' personal room, as well as the common areas within the facility where residents were able to congregate. Lastly, *naturalness*, or homelike qualities, referred to any aspect of the assisted living environment which the participants' recognized as critical to reducing the feeling of institutionalism and increasing feelings of being "at home". The importance of each of these themes, and the importance of feeling at home, are discussed further in regards to their impact on the residents' mental wellbeing.

Demographics

Of the nine responses received for participation in this research study, a total of eight interviews were successfully completed. Of the completed responses, seven of the eight participants were women – one male. One interview was conducted which involved a married couple – one male and one female – although they were interviewed separately and each completed their own Geriatric Depression Scale. The mean age of the participants was 89.25, the mean number of months spent by a participant in their current facility was 34.375 (2 years and 8 months approximately). Five of the eight participants received a form of assistance in regards to personal care (bathing, grooming, dressing, eating, mobility, transferring, and/or toileting). All of the participants in the research study identified as White/Caucasian – and two of the participant's identified as being Sisters of the Catholic Church. All of the interviews were conducted on the assisted living facility site; in the participants own private apartments. Two facilities were utilized in this study, the researcher completing interviews with individuals separately at both locations.

Themes

This research study sought to answer the questions "What are the specific variables identified by residents as characteristics of a homelike quality?" and "How do ratings of homelike characteristics correlate with residents' level of depression?" The research questions which were posed to participants were created based on literature surrounding homeyness and its impact on the wellbeing of persons living in community settings. The questions which were posed to the participants were designed by the researcher based on available literature to elicit themes which addressed potential variables of interest and were related to literature reviewed. The data was transcribed and coded using grounded theory.

Safety. There were three questions in the semi-structured interview which were designed with the goal of initiating conversation amongst participants regarding the variables the facility utilized to create a feeling of protection. The responses received to these questions were typically short and concise, and yet many reiterated of key aspects that this researcher felt were therefore pertinent. Of the eight participants in this study, and between two different assisted living facilities, many felt that a key factor in feeling safe and secure was staff involvement. Only two of the participants had lived in a different assisted living facility than their current facility prior to the research study, and yet all respondents felt that staff involvement was in some way directly related to simultaneously feeling cared for and being in a safe environment. There were three subthemes that emerged from within the safety inquiry: respect, accommodations, and connections.

Respect. Although the responses and statements stemmed from the original question sought to seek out *how* the facility promoted a notion of being cared for, many of the respondents without prompting included assertions about the significance of having a relationship with staff, a sense of respect between staff and them, and the importance placed on facility activities. As this researcher anticipated, the majority of respondents (seven of the eight) felt that staff behavior and mannerisms were crucial to the way in which they perceived their safety and care within the facility. Most statements reflected common themes surrounding being respected. For example, more than one participant echoed:

> "*…they call us by name. That's really important to me… they respect our privacy…"*
> *"…they're not patronizing…"*
> *"…we respect one another…"*
> *"…they call everybody by their names, all the time…"*

Accommodations. Other participants described the importance that staff and facility accommodations had on their perception of feeling protected and cared for. In particular, one

resident spoke about the difficulty she felt once she transitioned into assisted living from a transitional care unit following heart surgery. She discussed her depressive state and lack of desire to leave her new, one bedroom unit within the facility:

> *"…there is one of the women* [facility staff] *who came in with me when I didn't go out to eat… she would come in the room…she would sit down…and she'd say, 'do you wanna tell me what's bothering you?' and so we talked and then she said, 'well you haven't been here very long' and she said, 'a lot of people have these very similar feelings'… the staff here, they are very good."*

Another participant, also speaking to the importance of accommodations having an impact on their perception of feeling safe and comfortable within the facility stated:

> *"…The waitresses in the dining room have learned that I want a glass of skim milk with my meals. And a couple of them have caught on that I want a bigger one, not just a juice glass but a bigger one… things like that, the little things, but…they, they count."*

Connections. In addition to providing practical support regarding ensuring the participants' basic needs were being met, the emotional connection and bond that developed between several of the participants and staff were also highly valued as a means in which to foster a perception of protection and safety:

> *"…They act as though they really care about everybody. And I, I assume that they pretty much do… because there are some people that are really hard to get along with – real ornery. And they always treat them nicely… they really do give an idea that they're sincere…"*

In reviewing just these few, brief statements that the participants provided in regards to how their facility promotes a perception of safety and feeling cared for, we can see that there is great importance placed not merely on the staff, but on the day to day interactions with staff. It is of note however, that one of the eight participants did not reflect on the same or similar feelings in regards to her assisted living experience, and reported:

> *"I don't feel that the staff is that interested in me… first, it's taking a whirlpool. It's 'do it at ten o'clock' so I do it at ten o'clock… some of the staff is more interested in doing what accommodates them than what accommodates me."*

When asked to further elaborate on her experience, this participant highlighted the following sentiment:

> *"…it's the negative approach by the… not the entire staff… the people that take care of the patients… you never know who is going to come through that door…"*

This statement is an interesting contradiction to the other seven responses that participants gave regarding their feeling cared for and respected by facility staff. For this respondent, it affected her thoughts and feelings regarding the entirety of the assisted living facility – which she went on to explain throughout the interview. Many of the conversations surrounding experiences of sensed protection and feelings of being appreciated were also discussed in terms of the physical size and space of the facility itself.

Size and Space. There were three specific questions asked during the interview with participants that sought to explore residents' attitudes and beliefs regarding how – if at all – the size and space of a facility was related to their feelings about said facility. Surprisingly to this researcher, there were few participants who endorsed a correlation between the size of their facility and negative emotions relating to size and/or space of facility areas. While several of the participants did have comments on size and space, there were no unanimous declarations nor were there many corroborating sentiments.

Many participants did however report a generally positive outlook on the size of their facility:

> "*…I like the big open space and I never feel crowded anyplace – and that is really a blessing…"*
> *"…I have more space here…"*
> *"…this is very comfortable…"*
> *"…you never really feel restricted to one building…"*

The participants who reflected upon the above sentiments, also endorsed seemingly simultaneously feelings in regards to expansion and enlargement that was either presently occurring or was scheduled to occur in the near future:

> *"…well ya' know, if there's anything that has bugged me it has been that big building. Because they've used up all our green space… and I suppose it's- it's a zone. So they could pretty much do what they wanted to… we used to have a lovely little park out there… and we don't have that anymore…"*

One participant, when asked about preference between a smaller versus a larger facility, uttered the following statement:

> "*…well, I think something smaller would be… I think…more homey…more intimate…"*

The importance granted to perceptions of intimacy and closeness was not lost throughout the course of the interviews with the participants. Many related statements that reflected upon their feelings regarding ways in which the facility was or was not able to recreate a homelike sentiment for them. For most, this came across in a variety of ways which were weaved throughout their interview time.

Naturalness. The last questions which were asked during each of the interviews with participants for the semi-structured portion, focused on the variables that their corresponding assisted living facility were or were not incorporating which reinforced a feeling of familiarity. More specifically, the familiarity with being in a safe, homelike environment versus an institutional setting such as an assisted living facility. Within the scope of discussing the importance of naturalness, there were four themes which emerged: welcoming, activities, community, and mementos.

Welcoming. Many of the respondents spoke to the welcoming they received upon entering their current facility, and the importance this had on their overall perception of the facility's homelike factor. All of the eight participants reported having a welcoming party and/or

committee which greeted them upon their move in and assisted them in navigating their "first day" difficulties. These welcoming parties were routinely indicated as a positive interaction for the eight respondents. For many, this included first-day introductions to other residents, and learning the routine of mealtime seating:

> *"…at first they place you at tables…where you – well, especially at breakfast, where you might be congenial with other people…"*

> *"…oh they had all kinds of welcoming party…"*

In addition to the seemingly required welcoming party that all residents reported and/or acknowledged receiving, all eight of the research participants also discussed the influence of the activities sponsored by the facility as being important to their feeling of being in a more natural and less institutional setting.

Activities. All eight of the participants discussed the ways in which their facility's daily activities was influencing their perception of feeling welcome in their environment, and perhaps more importantly, the ability to decide upon participation in activities offered:

> *"…they do all kinds of things, they just do a lot of things… but it's my choice. Nobody uh…gets on you for not doing something. They ask you and if you wanna do it – fine, and if you don't wanna do it that's fine too…"*

> *"…And basically, what I like about it is our own responsibility for the day to day stuff. Somebody else isn't (in charge)…"*

This time to engage in getting together was reiterated amongst many of the research participants. And, upon further inquiry it seemed that the activities and involvement in them was more directly related to the participants' ability to connect and establish a stronger sense of community by interacting on a regular basis. The importance of being able to congregate in order to establish this sense of community was often presented:

> *"…areas to be set aside for, just getting together in the evenings. And…like a parlor. With a TV… So people could gather and they could group and… plan parties for instance…"*

> *"…they have a lot of activities… and then, and then they're visiting with each other. So there's a lot of visiting going on… which is good. And I like to visit…"*

This underlying theme of the importance of community was especially relevant to the participants who had come to assisted living as Sisters of the Church or from other highly religious backgrounds. For them, the sense of community and togetherness was pivotal in their understanding of feeling 'at home'.

***Community*.** There were three notable references to the difference between community relationships versus assisted living relationships, and how these differences impacted having a sense of community in a facility environment. For several of the research participants, although there was ample encouragement to engage in activities and initiate conversations with others, there remained a definitive distinction between "friends" and "neighbors" so to speak. One participant explained it as:

> *"…well, it's like in your neighborhood (at home)… you know some of your neighbors and… you 'howdy' over the fence with them. And others, you are a little closer to… three of us enjoy each other's company and kept tabs on each other…"*

Two other resident participants, a married couple within the facility, explained this phenomenon by describing the difference between having 'good friends' versus the types of relationships had since moving into an assisted living facility:

> *"… I don't feel that I do (have good friendships)… 'cause most people don't wanna talk. And those that wanna talk, only wanna talk about themselves. So… I'm friendly with them but all of the friendships we had when we were younger – it's a different thing because we all know why we're here…"*

> *"…Well, you don't have life history with anybody here. And that of course is what we developed…when we first married and grew old and… and there's none of that… none of that here and I'm not really interested in having a large group of friends here…"*

This general sentiment, although seemingly contradicting the importance of community, was generally shared throughout the eight research participants. One participant identified the *"time and energy"* required to initiate and create new and meaningful friendships later in life as being something not worth engaging in. While this general sentiment regarding not wanting to exhaust energy in creating new friendship bonds was shared amongst the eight participants, many also reiterated the importance of feeling like they were in a community through engaging activities and also communication between residents and staff.

For several of the research participants, the transition into their current – larger – residence brought about a feeling of loss in regards to the community feeling they had prior to moving. Two women separately described their transition into their larger facility as particularly difficult:

> *"…We lost a lot of what we had… you know, in the way of community. Being Sisters, community is so important ya' know. And now for instance…we (only) see each other eating… A loss of community living…"*

> *"…To move into a huge place like this is…quite a change. It's umm… more impersonal. And… you have more rules and regulations…"*

Mementos. Research has indicated previously that the use of personal mementos and objects by individuals is used often to create a sense of belonging and attachment to place. A sense of familiarity is often important to feeling safe and comfortable in an environment. However, contrary to this research, many of the participants did not endorse or engage in the use or displaying of many personal objects of significance in their assisted living environment. This was of surprise to the researcher, and warranted discussion amongst the participants about their emotional connection toward the objects that were placed about their new home environment.

When asked about the personal touches that were visible to the researcher, and how it was utilized in order to make the participant "feel more at home", a variety of statements and responses were recorded:

> *"…It doesn't remind me of my home very much…"*
>
> *"…Well, neither place is like home…"*
>
> *"…(All this stuff) is really nice to have. As I stay here longer, and I'd walk in the door… it was nice. It was like thinking, 'oh home, I'm home'…"*
>
> *"Well I think in here (in apartment) that we feel that it's a homelike setting… but not out there. No, I don't think they strive to do that…"*

Although all eight of the participants had personal pictures and mementos displayed around their individual units – some more so than others – there seemed to be a general consensus amongst the eight that these personal effects did little to nothing in regards to enhancing their positive emotions surrounding their living environment. Although only a small number of participant's felt any negative emotions regarding their transition into assisted living (none expressed or displayed anger or resentment), there was a mutual feeling of acceptance surrounding their new environment.

Acceptance. Perhaps most importantly, many of the research participants discussed the apparent *lack* of personal touches around their new home environment, and the reasoning followed a common theme of acceptance regarding the temporariness of their surroundings:

> *"…this is not a home. You know? It's a facility… if I had a choice, I would be in my home – I would not be here…"*
>
> *"…A home is a home… this is just a facility… I have to adjust to facility living… if I were in my home, I could do what I want…"*
>
> *"…Our eyes were open when we came here and we knew what it was going to be like. We didn't have any emotions invested in any one piece of furniture…"*

As this researcher sought to explore deeper the acceptance amongst research participants surrounding an apparent lack of attachment to their facility environment, a shared theme emerged from the participants regarding how they understood their transition in general:

> *"…I mean, why shouldn't they think they're in a facility? They're never going to be in a home again. They might as well… well, be realistic about it…"*

> *"…I mean, I guess that's one way that you get when you get a little older. You complain about it, but you accept what is – because what can you do?"*

These statements repeated throughout the eight independent interviews seems to contradict the literature which publicizes the importance assigned to personal objects and relationships among older adults as they transition out of their communities and into facilities. The lack of importance these eight individuals placed on forming and maintaining deep relationships sheds light potentially on what it means to have a 'soft' versus a 'deep' friendship later in life.

For the eight participants sampled in this research study, there were no identifiable statements or themes to indicate any of them had unresolved grief or loss attributed to their seeming lack of personal attachment in their new environment. Also, contrary to research on depression in older adults, there were no findings reportable in this research sample to indicate that any of the general sentiments regarding loss were in any way indicative of scores obtained on the Geriatric Depression Scale.

Depression

All eight of the research participants were given a short-form Geriatric Depression Scale which was performed by the researcher and allowed for verbal self-response by the participants. As there is no diagnostic tool for measuring sub-threshold depression, the Geriatric Depression Scale (GDS) was utilized to identify any responses which may or may not indicate symptomology of depression within the participants. Per the scoring methods validated by

previous researchers, a score of zero to five is normal, a score greater than five suggests clinical screening for depression. For our interest in sub-threshold depression, scores ranging within the one to five range were of interest. Of the eight research participants, zero scored higher than a five – with the highest score of the eight being a three. The mean score on the GDS for the eight participants resulted in a 1.62. Therefore, none of the participants in this study indicated a score suggesting depression according to the Geriatric Depression Scale (short form).

While the Geriatric Depression Scale (short form) is comprised of a standardized 15 statements, there were identifiable commonalities among the eight participants regarding the individual breakdown of answers. As the table below reflects, only seven of the fifteen statements identifying possible signs and symptoms of depression were met with complete agreement amongst respondents, the scoring was based on “yes/no” responses:

Table 1. GDS Statements and Scoring

Specific Item	% Indicating Depression
Satisfied	0
Activities	0
Empty	12.5
Bored	25
Positive	0
Afraid	0
Happy	25
Helpless	0
Stay Home	37.5
Memory	0
Wonderful	12.5
Worthless	0
Energy	50
Hopeless	12.5
Better off	12.5

(Note: score of 0 representative of complete agreement among participants)

The statements which were met with complete agreement were (in order): “Are you basically satisfied with your life?”, “Have you dropped many of your activities and interests?”, “Are you

in good spirits most of the time?", "Are you afraid that something bad is going to happen to you?", "Do you often feel helpless?", "Do you feel you have more problems with memory than most people?", and, "Do you feel pretty worthless the way you are now?" These universally agreed upon statements were answered in yes/no form by the participants to reflect scoring that did not indicate depression per GDS guidelines.

For the statements where there was not complete agreement, there remain no scores totaling higher than a five on the GDS which would create cause for concern of depressive symptoms. For the four statements which resulted in a percentage of 12.5 (one respondent) indicating depression, these statements on the GDS were (in order): "Do you think your life is empty?", "Do you think it is wonderful to be alive?", "Do you feel that your situation is hopeless?", and, "Do you think that most people are better off than you are?"

Two participants in the study (25%) responded in the affirmative, an indication toward possible depression, to the statement "Do you often get bored?" Three participants responded to the affirmative, indicating potential depression, to the statement "Do you prefer to stay at home, rather than going out and doing new things?" And four of the eight participants responded in the negative, a sign for potential depression, to the statement "Do you feel full of energy?"

As none of the eight respondents in this study demonstrated a potential risk in regards to a display of depressive signs and symptoms, a correlation was not performed in regards to their GDS scores and demographical information. This decision was made by the researcher due to the lack of statistical significance any analysis results would provide. While none of the eight respondents met criterion for depression, this does allow us the opportunity to evaluate their responses on the GDS in terms of potential sub-threshold classification.

As research has informed us, sub-threshold or minor depression, presents as signs and symptoms of depression without meeting DSM-IV classification. In keeping this information in mind, the GDS scored were reviewed and grouped into categories of “minimal symptoms”, “average symptoms” and “sub-threshold symptoms”. The first group, “minimal symptoms” was arranged based on scores on the GDS ranging in zero to one. There were four participants who rated within the zero to one range on the GDS, or “minimal symptoms” category. The second group was labeled “average symptoms”, and was arranged based on a score of two on the GDS. Three of the participants in the study rated a two on the GDS. The last group, “sub-threshold symptoms” was arranged based on a GDS score of three, and there was one participant who met this criterion.

Differences between participants grouped within the “minimal symptoms” and the participant who fell within “sub-threshold symptoms” were identified after careful review of the interview transcripts. The participant who fell within the “sub-threshold symptoms” category was noted as having an increased level of negative responses in regards to questions concerning staff attentiveness and care. Statements such as:

“I don’t feel that the staff are that interested in me…”

“[staff should] do it the way it should be done”

were noted in connection with her overall sentiment that staff had a negative approach to caring for facility residents. In contrast, statements made by the four participants who scored on the opposite end within the “minimal symptoms” category endorsed comments which indicated a higher level of satisfaction with their facility staffers. One participant within this group recounted feeling a “special connection” to staff persons in the eight years she had been residing

at the facility. Other participants reiterated positive feelings regarding their staff interactions by stating:

"…they don't have preconceived opinions about us. What we outta like…"

"…they're friendly, but friendly in a professional way…I think that's very good"

It is also perhaps worth noting that of the statements which resulted in a score varying between a one and a three on the Geriatric Depression Scale, there were no noticeable commonalities between which statements produced a symptomatic indication and which did not. All participants grouped into the three previously mentioned categories rated differing statements indicating potential degrees of sub-threshold depression.

Discussion

This research project sought to explore the questions "What are the specific variables identified by residents as characteristics of a homelike quality?" and "How do ratings of homelike characteristics correlate with residents' level of depression?" The research questions which were posed to participants were created based on literature surrounding homeyness and its impact on the wellbeing of persons living in community settings. In particular, questions were formulated to discover the different variables which may affect the emotional wellbeing of residents. These questions were then compared to the participants answers to a short-form of the Geriatric Depression Scale. All of the participants in the study were identified as elderly, with the mean age of the respondent being 89. Out of the eight participants, there were none who identified enough signs or symptoms to indicate a possibility for depression.

Interpretation of Findings

Overall, the results of the research study support that there seem to be more important factors surrounding the emotional impact that a transition into an assisted living facility may

have on an individual other than the inclusion or lack thereof of homelike qualities. The participants of this research study provided invaluable life experiences and sharing of their life stories in order to aide in the understanding of how homelike qualities had an impact on their emotional wellbeing. The themes which were reviewed as being of importance included: the residents' perception of safety within the facility; these questions allowed the researcher to uncover several subthemes surrounding this concept such as respect, accommodation of needs, and connections between resident and staff. Secondly, questions were asked which honed in on the size and space of the facility itself and the manner in which this affected a resident's perception of homelike qualities. The last category of questions asked of residents sought to examine the perception of the facility's naturalness; this category uncovered several subthemes as well: welcoming environment, activities offered, sense of community, and use of mementos in personal spaces.

Undoubtedly the two most frequent and discussed themes presented by the eight participants of the study consisted of their perception of safety within the facility, which was uncovered within the subthemes of feeling respected and accommodated. While not all of the participants agreed that they had a special connection with any one particular staff person, they all reflected on the importance they placed on feeling not only cared for but cared about by staff. This was expressed most often through examples of genuineness and friendliness by staff persons. The use of an individual's first name by staff cannot be understated, as it was reiterated by all eight of the respondents as being a prime example of genuine caring. The eight interviews which were collected provided information from two separate facility care staff, all of whom seemed to be employed through shift work, yet all remained highly influential to the research respondents. In reiterating the literature mentioned previously, Marsden's (2001) themes on

homelike environments were based on the need for one, to feel protected. It is perhaps possible to relate the feelings stated by the participants to Marsden's characteristic theme. While the original thematic quality of feeling protected was explained by Marsden has having an emotional connection to a space, it is perhaps plausible that an emotional connection with the staff and the feeling of connection with the staff serves that purpose with the participants involved.

In understanding this study as it pertains to the concepts gathered within the conceptual framework, we see a strong confirmation to the workings of the Ecological Model in the responses of our eight participants. Within the Ecological Model, there is great importance placed upon the quality of relationships between *environment* and *person*. Per the theory, which is based heavily out of the person-in-environment model of understanding, the quality of relationships is continuously in flux in order to obtain a proper "*goodness of fit*". This ability to "fit" within one's environment is also understood in terms of adaptability; being able to adapt leads to less stress and therefore less emotional upset (Barker, 1991). We see this embodied perhaps no more poignantly than in the importance placed upon assisted living facility staff persons and the facility participants. The facility residents who participated in the study all seemed to have adapted in their own ways to the mode of facility living, and in doing so also expected a certain level of adaptability (accommodation) to their needs. The accommodations that most participants referred to enhanced their goodness of fit, and thus their emotional wellbeing.

Regarding the conceptual framework pertaining to Place Attachment, here we see an obvious disconnect from the research on the framework and its applicability to the participants involved within this study. None of the participants within the study adhered strongly, if at all, to the concept of Place Attachment. The theory behind this framework ascertains that the

emotional connection an individual has, based upon repeated positive encounters with a particular environmental stimuli, will create a sense of attachment (Dallago, L. et al., 2009). However, during the individual interviews for this study, none of the respondents endorsed having had the type of attachment suggested by this framework. Many of the participants had sparse decorations within their facility apartments, and did not state an interest in decorating or transporting personal effects to their new living situation. While some persons did state that they enjoyed having effects from their previous community home with them at the facility, there were no statements that supported a strong desire or need for such artifacts.

Despite the theory of Place Attachment having contributed to the field of both sociology and social work, there does not seem to be enough support through this research study to confirm the relation between personal mementos and emotional wellbeing. In fact, for participants who did have personal effects in their facility apartment, they endorsed having had such items transported and arranged by family members on their behalf. This suggests that perhaps the idea of bringing such items was not a part of their thought process for the transition to facility living at all, in contradiction again to the understandings of Place Attachment. Many of the participants did endorse that facility living neither could imitate nor would ever replicate the home living they experienced in the community. This desire to stay away from “soft” imitations has potential for future research understandings as well.

The data which was collected through these face-to-face interviews provided fascinating insight into what types of variables influenced the research participants into having a greater or lesser degree of emotional wellness in regards to their facility placement. As stated previously, within the study, participants either confirmed or denied several variables of interest to the researcher has having an influence on their emotional wellness. Of particular note, none of the

participants scored high enough on the Geriatric Depression Scale to warrant a screening for depression.

Utilizing a qualitative research design for this study may help explain some of the differences found in the literature versus the study findings presented here. The utilization of qualitative research projects, while invaluable for hearing the personal stories of many different individuals, does not allow for a standardized assessment of variables which may or may not have an impact on a rate of depression. However, a standardized manner for gathering information on the homelike variables and their potential relation to depression would likely not reveal to researchers the myriad of differing aspects which go into understanding what a homelike quality entails. Additionally, the use of semi-structured, face-to-face interviews provided an avenue for the participants to share not only their stories but also enhance their stories with their emotions and invaluable life experience. This undeniably resulted in a more detailed and rich response than one which would have been gathered using strictly quantitative measures.

Strengths and Limitations

The information disclosed during the process of this study is difficult to generalize to the population of aging adults living within the assisted living community. This is due to the sheer nature of qualitative research being unable to produce a large and diverse sample size. The sample was comprised entirely of individuals who identified as Caucasian/White, and seven of the eight participants were female. The small and homogenous sample size combined with the qualitative nature of the study make it difficult to generalize to the community. A larger sample which utilized quantitative methods may overcome many of these limitations. As the use of

electronics continues to rise within society, inclusion of an online survey may be a realistic option for assisted living residents in order to obtain a larger amount of data to analyze.

This study also was limited by the number of the facilities which were contacted for potential participants, again making the results difficult to generalize. The two facilities where respondents were located were both within the Twin Cities Metro – limiting to urban participants and excluding rural facility residents. A study which evaluated responses from not only urban but also rural, or a combination of urban and rural, would provide a more authentic look into the responses from this community.

This research study was also prone to selection bias, as the participants were all willing and receptive to be included in the face-to-face interview and were asked to contact the researcher directly on their own volition. A future research study may look into the possibility for anonymity being maintained by participants, which would likely increase the response rate and provide an added incentive to possible participants who are otherwise less receptive to research involvement.

Implications for Research

Research surrounding the theory behind the importance of homelike qualities and their effect on emotions and attachment needs to be revisited by researchers in regards to adults living in congregate settings. Research on the meaning behind homelike characteristics, dating back to McCracken (1989), is dated and difficult to use in today's society. Although literature surrounding the importance and significance that homelike variables have on individuals remains important, there continues to be little research done on facility living or congregate living – and the differences and implications this may or may not have on an individuals' affective responses.

The information derived from this research study would benefit from an operationalized tool in which variables are defined and ranked by residents as affecting homeyness, and to what degree homelike variables impact their emotional outlook. With no current tool in use, generalization to the greater population remains difficult.

Also, as mentioned within the limitations of this study, a larger sample would include more diversity between subjects' race, socioeconomic class, and gender and would benefit research greatly in uncovering differing opinions regarding homelike qualities and their importance. Notably, all of the eight participants were significantly older in age, and this may have a drastic impact on future studies using participants who are younger and able to utilize more or less a la carte services within facilities. It may be likely that the respondents in this study, due to their advanced age, had reached a stage of acceptance within their life cycle of development that would look very different from an individual aged 65 for example.

Lastly, the reported stance of acceptance which was noted in many of the interviews could be explored in future research to determine if there are any underlying concerns. Particularly, individuals who state they are not interested or have no desire to socialize or befriend other facility residents may be experiencing social difficulties or impairments such as memory loss, which require staff assistance or guidance.

Implications for Social Work Practice

This study provides us with implications for future social work practice and the social work profession as a whole. It should not be understated the importance that many participants placed on avoiding "soft" relationships in lieu of their "real" relationships. For example, many participants did not find interest in creating or maintaining a "deep" friendship with any of their facility comrades, and had a similar feeling in regards to not wanting to attempt to recreate a

homelike environment within their facility apartment. This speaks volumes in regards to current understandings of what does remain important to aging adults in facilities and what strikes them as less important. More research is needed to enhance understanding and confirm the importance – and type- of relationships older facility residents are interested in.

Limitations on the understanding of minor, or sub-threshold, depression continue to result in confusion and disagreement regarding severity of symptoms within the aging population. Future work in promoting an understanding of depression on a spectrum or continuum may assist in focusing attention toward later-life depressive symptoms that do not meet classification for a clinical diagnosis. Attention to this group of low-level depressed individuals would do much to prevent the negative health and wellness effects depressive symptoms can have on an older individual.

Conclusion

The purpose of this study was to understand the role that homelike characteristics play in the emotional wellbeing of older adults, specifically older adults residing in assisted living facilities. While previous studies have examined the importance of homelike qualities in relation to emotional satisfaction amongst community dwellers, little focus has been made on persons residing in facility communities. There also remains a gap in literature regarding the importance of homelike variables within all community contexts. This research sought to address this gap and also explore further the current literature on depression among older adults, and a potential link between environment and mental health.

The strongest themes to emerge based on this research study centered on the overwhelming importance the respondents placed upon feeling respected and feeling as though their needs were met through accommodations. The simple act of calling an individual by their

first name resonated throughout the eight individual interviews. Overall, all participants seemed pleased with their current living environment and none of the participants scored high enough on the Geriatric Depression Scale (Short form) to warrant a deeper look into possible signs and symptoms of depression.

The assisted living facility respondents all indicated the importance that connection, or lack thereof, to facility staff persons played on their perception of feeling safe and secure within their environment. Many of the research respondents also cited a lack of interest or priority for recreating a homelike quality within their facility living – and reiterated this through their lack of mementos and personal effects decorating their living quarters. This sentiment was stated with an understanding by most that their new environment would never be like their previous home(s) and there was no need “sugarcoat” this.

Currently, the push toward educating the community on the importance of recognizing and addressing depression in older adults continues to be a preventative health measure taken on by many organizations. However, there remains a continued sense of urgency in finding solutions to improve the emotional wellness and understanding of depression among many community persons and older adults. Social workers may assist in these efforts by initiating relationships between older adults, their families, facility staff persons, and mental health practitioners. With collaboration in place between all persons, all will benefit.

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Appendix A

Letter of research project approval from University of St. Thomas' Institutional Review Board.

Institutional Review Board

UNIVERSITY of ST. THOMAS

Institutional Review Board - University of St. Thomas
2115 Summit Ave. - Mail #AQU319
St. Paul, MN 55105-1078
Phone: 651-962-5341 - Email: irb@stthomas.edu

DATE:	February 18, 2014
TO:	Courtney Wright
FROM:	University of St. Thomas Institutional Review Board
PROJECT TITLE:	[546856-1] Homelike Variables and Depression among Assisted Living Facility Residents
REFERENCE #:	
SUBMISSION TYPE:	New Project
ACTION:	APPROVED
APPROVAL DATE:	January 19, 2014
EXPIRATION DATE:	January 14, 2015
REVIEW TYPE:	Full Committee Review
REVIEW CATEGORY:	Expedited review category This is the second copy.

Thank you for your submission of New Project materials for this project. The University of St. Thomas Institutional Review Board has APPROVED your submission. This approval is based on an appropriate risk/benefit ratio and a project design wherein the risks have been minimized. All research must be conducted in accordance with this approved submission.

This submission has received Full Committee Review based on applicable federal regulations.

Please remember that informed consent is a process beginning with a description of the project and insurance of participant understanding followed by a signed consent form. Informed consent must continue throughout the project via a dialogue between the researcher and research participant. Federal regulations require that each participant receives a copy of the consent document.

Please note that any revision to previously approved materials must be approved by this committee prior to initiation. Please use the appropriate revision forms for this procedure.

All UNANTICIPATED PROBLEMS involving risks to subjects or others (UPIRSOs) and SERIOUS and UNEXPECTED adverse events must be reported promptly to this office. Please use the appropriate reporting forms for this procedure. All FDA and sponsor reporting requirements should also be followed.

All NON-COMPLIANCE issues or COMPLAINTS regarding this project must be reported promptly to this office.

This project has been determined to be a Minimal Risk project. Based on the risks, this project requires continuing review by this committee on an annual basis. Please use the appropriate forms for this procedure. Your documentation for continuing review must be received with sufficient time for review and continued approval before the expiration date of January 14, 2015.

Please note that all research records must be retained for a minimum of three years after the completion of the project.

If you have any questions, please contact Eleni Roulis at 651-962-5341 or e9roulis@stthomas.edu. Please include your project title and reference number in all correspondence with this committee.

- 1 -

Generated on IRBNet

Appendix B
Unsigned copy of consent form used in research study.

CONSENT FORM
UNIVERSITY OF ST. THOMAS

Homelike Variables and Depression Among Assisted Living Facility Residents
546856-1

I am conducting a study about how assisted living facilities create a feeling of home, and how this relates to the emotional wellbeing among residents. I invite you to participate in this research. You were selected as a possible participant because you have been identified as a resident in an assisted living facility. Please read this form and ask any questions you may have before agreeing to be in the study.

This study is being conducted by: Courtney Wright, in fulfillment for the Degree of Master of Social Work with the University of St. Thomas / St. Catherine's University. This study is in no way affiliated with X.

Background Information:

The purpose of this study is: to look at how assisted living facilities are able to affect the emotional wellbeing of their residents by how much (or how little) they resemble a home.

I will be looking at things differences such as: how they make you feel like you belong, the size of different areas at X, and the different ways X reminds you of your previous home.

By asking these questions, I hope to better understand the way X relates to how you feel emotionally.

Procedures:

If you agree to be in this study, I will ask you to do the following things:

-To meet with me in a private room (or area) of your choice;

-To read this consent form and answer three questions that show me you understand this study and what I am asking you to do;

-To confirm that you understand that your participation in this study is voluntary and you can stop the interview at any time;

-To answer seven interview questions, all of which will be audio recorded;

-After our interview, I will ask you a series of questions that relate to your emotional wellbeing;

-At the end of our 30-45 minute time together, I will ask you questions on how you are doing and provide you a list of resources that relate to things we may have discussed.

Risks and Benefits of Being in the Study:

The study has several potential risks. First: You may experience negative emotions relating to placement at X. Second: memories of previous home environments may stir up difficult emotions. Third: discussions on your feelings and thoughts may be difficult. Fourth: you may be seen with me by staff or other residents and this may be uncomfortable for you.

We will discuss these potential risks before we begin the interview and before we finish our time together during a debriefing session.

You and X will be informed of my mandated reporting requirements, which include my duty to inform X staff and/or Adult Protection.

If during our interview you demonstrate that you are unable to complete the interview, for cognitive or psychiatric reasons, the interview will be stopped by me and I will not use your data.

If you inform me during our interview that you feel you are a “bad fit” for X, I will refer you to utilize the list of resources that will be given to you at the end of our interview.

You will be provided with information on follow-up care and information on resources at the end of the interview. Payment for any such treatment must be provided by you or your third party payer if any (such as health insurance, Medicare, etc.).

If you have a legal guardian, I will need their signature before you participate in this study.

There are no direct benefits to participating in this research study.

Confidentiality:

The records of this study will be kept confidential. In any sort of report I publish, I will not include information that will make it possible to identify you in any way. The types of records I will create include audio recordings, transcripts, written notes, and surveys. All of these will be kept in a secure, locked location and destroyed on or before May 31, 2014. Access to these materials will be granted only to myself, X will not have access to information, and will have access only to the final data results – which does not including any identifiable information.

Voluntary Nature of the Study:

Your participation in this study is entirely voluntary. Your decision whether or not to participate will not affect your current or future relations with X or the University of St. Thomas. If you decide to participate, you are free to withdraw at any time. Should you decide to withdraw, data collected about

you may still be used for the purpose of the research study. You are also free to skip any questions I may ask.

Contacts and Questions

My name is Courtney Wright. You may ask any questions you have now. If you have questions later, you may contact me at X. If you would like to contact my research advisor, you may contact Jessica Toft, Ph.D. at office phone X. You may also contact the University of St. Thomas Institutional Review Board at 651-962-5341 with any questions or concerns.

You will be given a copy of this form to keep for your records.

Statement of Consent:

I have read the above information. My questions have been answered to my satisfaction. I consent to participate in the study. I am at least 18 years of age. I consent to having my interview audio recorded, and later transcribed, for the purpose of this research study.

________________________________ _________________

Signature of Study Participant **Date**

____

Print Name of Study Participant

________________________________ _________________

Signature of Guardian **Date**
(If applicable)

____

Print Name of Guardian
(If Applicable)

________________________________ _________________

Signature of Researcher **Date**

Appendix C
Copy of research questions asked to participants

You will be asked to answer the following open-ended questions prior to participation in this research study:
1) Please tell me what I am going to ask you to do for interview?
2) Please tell me what this interview is about?
3) How can you stop this interview?

Demographical Information

Months in facility: ____________________

Age of participant: _________________

Gender of participant: ____________________

Race of participant: ______________________-

Does this participant require assistance with personal cares: Yes or No

Feelings of Protection

1. Describe the ways in which you feel this facility does or does not make people feel cared for.
2. Describe what this facility does or does not do to make it feel familiar and welcoming.
3. Describe the ways this facility is or is not creating connections (ie: friendships, relationships) with residents.

Feelings of Size and Scale

1. Discuss your thoughts on the size of your personal / private space (ie: your room).
2. What are the positives and negatives about the size of this facility?
3. Discuss your thoughts on the size and spacing of common areas within the facility.

Feelings on Naturalness

How does this facility create / not create a feeling of home versus a facility for you?

After the interview and Geriatric Depression Scale, the participant will be asked two debriefing questions: "How are you doing", "Are there any issues you feel need to be addressed?" and will be automatically provided with a list of referral resources.

Appendix D
Geriatric Depression Scale (short form) used in research study.

Geriatric Depression Scale (Short Form)

Patient's Name: ______________________________ Date: ________________

Instructions: Choose the best answer for how you felt over the past week. Note: when asking the patient to complete the form, provide the self-rated form (included on the following page).

No.	Question	Answer	Score
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 in good spirits most of the time?	YES / ***NO***	
6.	Are you afraid that something bad is going to happen to you?	***YES*** / NO	
7.	Do you feel happy most of the time?	YES / ***NO***	
8.	Do you often feel helpless?	***YES*** / NO	
9.	Do you prefer to stay at home, rather than going out and doing new things?	***YES*** / NO	
10.	Do you feel you have more problems with memory than most people?	***YES*** / NO	
11.	Do you think it is wonderful to be alive?	YES / ***NO***	
12.	Do you feel pretty worthless the way you are now?	***YES*** / NO	
13.	Do you feel full of energy?	YES / ***NO***	
14.	Do you feel that your situation is hopeless?	***YES*** / NO	
15.	Do you think that most people are better off than you are?	***YES*** / NO	
		TOTAL	

(Sheikh & Yesavage, 1986)

Scoring:

Answers indicating depression are in bold and italicized; score one point for each one selected. A score of 0 to 5 is normal. A score greater than 5 suggests depression.

Sources:

- Sheikh JI, Yesavage JA. Geriatric Depression Scale (GDS): recent evidence and development of a shorter version. *Clin Gerontol*. 1986 June;5(1/2):165-173.
- Yesavage JA. Geriatric Depression Scale. *Psychopharmacol Bull*. 1988;24(4):709-711.
- Yesavage JA, Brink TL, Rose TL, et al. Development and validation of a geriatric depression screening scale: a preliminary report. *J Psychiatr Res*. 1982-83;17(1):37-49.