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Social support for the frail elderly at two kinds of retirement communities

Qiaoming Liu
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AN ABSTRACT OF THE THESIS OF Qiaoming Liu for the Master of Science in Sociology presented July 9, 1990.

Title: Social Support for the Frail Elderly at Two Kinds of Retirement Communities.

APPROVED BY THE MEMBERS OF THE THESIS COMMITTEE:

David Morgan, Chair

Leonard D. Cain, Jr.

Grant M. Farr

Nancy Chapman

As few studies focus explicitly on social support for residents by residents in retirement communities which have staff, this thesis is designed to explore the nature of informal social support among residents at planned, non-subsidized retirement care facilities: the types, the amount, the impact, the limitation and the appropriateness of such support. Our focus is to explore whether different organization of a retirement community affects social support among residents, so we compare

two retirement care facilities. One provides single-level care for its residents and the other provides multiple-level care. We chose our two sites from retirement care facilities in the City of Portland, Oregon. We generated our data by interviewing residents who live independently in the two retirement communities.

The data analysis shows that residents in both facilities are an important source of support. Residents provide frail residents with personal services, social and emotional support, transportation and meals. Analysis also shows that the organization of a retirement community affects the amount and the kind of support residents provide for each other. Residents in Multi-Care are much more likely to provide support for each other than residents in Single-Care. Residents in Multi-Care are much more likely to provide social and emotional support, to help with errands inside the complex, and to help with meals. Residents in Single-Care are more likely to provide help with transportation and with errands outside the complex. However, residents' help to other residents is beneficial only to a certain point, because the help-givers are old too. Because of their age and ability, giving too much help may make well-elderly frail or even sick. When residents who become frail stay too long in the apartments, neither the help-receivers nor the help-givers are beneficiaries.

Our study has clear implications for housing for old people and for the support theory. Our study indicates that residents in Multi-Care are more supportive than residents in Single-Care. Our study also indicates that we should make the best use of the three parts of a support system: kin, friends and neighbors, and formal support. We find a new source of

support for residents in the retirement community in our study, residents' committees. Further study of the functions and the roles of these committees in helping residents will give us a better understanding of the overall support system.

SOCIAL SUPPORT FOR THE FRAIL ELDERLY
AT TWO KINDS OF RETIREMENT COMMUNITIES

by

QIAOMING LIU

A thesis submitted in partial fulfillment of the
requirements for the degree of

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CHAPTER I

INTRODUCTION

This chapter includes two sections: 1. introduction, and 2. study questions and hypotheses.

STATEMENT OF PROBLEM

The social support system of an old person is usually comprised of three subsystems: 1) the formal support subsystem; 2) the informal support subsystem from the kin; and 3) the informal support subsystem from significant others besides kin, especially friends and neighbors (Cantor, 1979). Many kinds of organizations, both governmental and voluntary, provide formal support for the old people in the United States. The kin, friends and neighbors who have the most frequent interaction with the old people provide them with social and emotional support.

Few studies focus on social support for residents by residents in planned, non-subsidized, retirement care facilities which have staff, and even fewer studies focus on the comparison of social support among residents between planned retirement care facilities with different levels of care.

The developing trend of care facilities or congregate housing has profound implications for the future. Carlin and Mansberg (1984) reported on one study that estimated 3 million elderly in the United States were in need of some form of assisted-living arrangement. As the proportion of

old-old increases in the United States, and with fewer children available as caregivers, it will be increasingly more difficult to provide the requisite institutional care. However, planned retirement care facilities can provide independent or marginally independent old people with a variety of supportive services to maintain their independence. Thus, the availability of congregate facilities is essential for the growing number of elderly without a family support system capable of providing these services.

Not only is the older population growing faster in the United States than the younger but the old population itself is aging since the old-old segment is growing faster than the young-old segment. Between 1975 and 2000, the 55-64 age group will increase by 16%, and the 65-74 by 23%, and the most vulnerable, the 75+ by 60% (Brotman, 1977). Moreover, the direction of health change in this old-old segment over a period of years is regrettably downhill. Although chronological aging by no means necessarily implies poor health, the probability that one will develop chronic illness increases with age.

There is normally a state of balance between personal competence and environmental demand and resources. Diminished competence leads to increased sensitivity to environment. Thus, old people in marginal physical or mental health have been shown to respond proportionally more strongly to environmental variation (Lawton, 1989). But if such old people move into an environment where there are more environmental resources and lower environmental pressure, such as various planned retirement communities, most of them can cope with their environment well.

Among the advantages of a planned retirement community are more

services available, or the possible emergence of mutual assistance networks among residents in the retirement community, or both. Even though most old people's first preference is to remain in their own houses or in their own apartments, many old people decide to relocate to non-subsidized, planned care facilities, where they can get more support, especially medical protection from the facilities, because they are afraid of their increasing frailty. Most of these people have lost their spouse or have no children, or their children are too far away. Other well-elderly or young-old people, especially those from middle-class or upper-middle class, move into the non-subsidized, planned retirement communities to take advantage of many of the recreational facilities and leisure pursuits provided by such communities. Some of the working class or low income old people move into the publicly subsidized apartment complexes for old people, because the rent is low, or because they worry about their safety. Because of the concentration and the interaction of old people in these age-segregated settings, mutual assistance networks among residents may emerge.

Along the continuum of living for the old Americans, non-subsidized planned retirement care facilities are especially planned to meet the set of needs that arise because of the increasing frailty of the old people. These facilities have all the claimed advantages of various retirement communities. On the one hand, in such a planned retirement community, residents can maintain their own independent living and on the other hand, the community provides many services for the residents, such as meals, house-keeping, and transportation. Some facilities provide nurses for emergency. They also provide many kinds of recreational facilities.

Residents are relieved from the burden of daily life and can concentrate their time on recreational activities and leisure pursuits. At the same time, in such facilities, because residents eat and play together, they have more chances to know each other and therefore more chances to make friends.

Life care facilities and single-level care facilities are two kinds of retirement housing. Facing the incurable nature of health problems of old people, and their desire to maintain an independent living for as long as possible, life care facilities have made accommodations that enable more intensive services to be delivered so that the frail elderly can continue to maintain independent living. Residents are relocated within the facility from independent living to intermediate care, then finally to nursing homes, according to the health of residents. However, single-level care facilities attempt to maintain the character of the original population. If residents can not take care of themselves, they have to move out of the community.

So eventually, old Americans living independently, including those residents who live in the independent apartments in care facilities, have to make a decision to relocate as their frailty continues. However, relocation in multiple care facilities is not made only according to physical health or other simple criteria of need. So, the organization of the housing environment itself and the social relations among residents both may exercise influences on the timing of moving (Morgan, 1982; Fisher, 1988). My goal in this thesis is to explore how different level of care of planned non-subsidized retirement complexes affects social relations among residents and how residents provide social support to the

growing number of frail elderly within the communities. My focus is on a comparison between two apartment complexes. One provides only a single level of care for its residents. This facility insists that residents should be able to live independently in their apartments, otherwise they have to move out of the complex. The other facility provides life care for its residents. No matter how bad their health becomes, residents will stay in the community. If residents can not take care of themselves, they will move into the Intermediate Care. If they continue to get worse and need 24-hour nursing care, they will move into the Convalescent Center. The independent living section, the intermediate living section, and the Convalescent Center are all on the same campus.

STUDY QUESTIONS AND HYPOTHESES

This thesis is mainly an exploratory study with its focus on the comparison of informal social support between two retirement care facilities: one is single-level care, and the other is multiple-level care. It explores the following questions: 1. what forms of social support do residents provide for frail residents; 2. whether different amounts of informal social support are available from residents in the two kinds of retirement residences; 3. what is the impact of social support on residents, both frail or well; 4. what is the limitation of such support among residents; 5. whether it is appropriate for frail residents to depend on other residents for long-term care.

Because of the exploratory nature of this thesis, my hypotheses in this study are tentative ones, based partly on the above literature, and partly on my observations. My hypotheses are: 1. the organization of a

congregate housing facility for the elderly is related to social relations among residents; 2. social relations among residents are related to the amount of support available for frail residents by other residents.

CHAPTER II

REVIEW OF LITERATURE

In this section, we will review the relevant literature. This section is divided into three parts: 1. old Americans and retirement communities, 2. the sense of community, and 3. informal social support for residents.

OLD PEOPLE AND RETIREMENT COMMUNITIES

Lawton (1982 and 1989) argued that there was a relationship between personal competence and environmental pressure and resources. Moreover, environmental pressure would affect the outcome disproportionately more for less competent people than for more competent people, because the former got higher environmental pressure and fewer environmental resources, such as frail health or few family members or few friends. Environmental pressure included both its social and physical dimensions.

Generally speaking, as old people continue to age, they get fewer sources of support to deal with their environment. Health declines necessitate increasing support. The loss of kin is a serious threat to the support system. Parents, uncles, and aunts, die, then older siblings and one's spouse, then friends and more distant relatives, and finally, perhaps even younger siblings and older children. All these result in increased resources deficits at the very time when increasing support is needed.

Family is a fertile recruiting ground for primary resources. If a person starts with fewer family members, as does one with no siblings, or one who never married or married but had no children, the loss of additional primary resources can be very painful, reducing options and increasing demands, which may strain remaining resources (Longino, 1981).

Wiseman (1981) discussed various strategies for improving the person-environmental fit. The first was to change an individual's level of competence or personal resources, such as providing greater economic security or improving such services as medical delivery, counseling opportunities, and educational programs. The second strategy was to change the person's environment. This may include relocating the low competent old people to age-homogeneous setting oriented towards the needs of the elderly. The third strategy was to facilitate environmental interactions for the low competent people.

So the set of needs accompanying increasing frailty can be met by either formal or informal social support, or both in various kinds of planned retirement communities (Lawton and Simon, 1968; Wiseman, 1981; Lawton, 1989). In such communities, all or most residents are old people, who share the same background. They understand their common problems. They are not expected to be as active or competent as younger people. In such way, the social pressure is lowered for the old people. The housing is designed specifically for different segments of old people: well- or frail elderly so as to lower their physical environmental pressure. Besides, in such an age-concentrated housing, more services for old people are available, and networks of mutual assistance among neighbors may ensue. With all these additional or potential resources, new balance between

personal competence and environmental pressure and resources may be achieved. Then residents can cope with their environment more easily and stay independent longer.

A retirement community is an environment in which most or all residents are retired people. Such communities encompass a broad range of living arrangements from small, self-contained apartment complexes to big neighborhoods in metropolitan areas. It refers

not only to the physical disposition of the environment but also the available community resources, such as social services and entertainment opportunities, and the interpersonal relations characteristic of the setting (Silverman, 1987:234).

There are a variety of living arrangements for older Americans, typically conceived of as a continuum of living or care that begins with independent living in one's own home or apartment and ends with residence in a nursing home or other formal care facility. Natural communities and planned communities are two kinds of retirement communities. A natural retirement community is an ordinary community where all age groups live. It has no difference with other kind of communities, except that most of the residents happen to be old people. It emerges naturally. It can be a neighborhood or an apartment complex. Single room occupancy hotel is one kind of such natural retirement community. It usually does not have as many services, especially recreational facilities, as planned retirement communities. It is usually for lower-class old people or those old people who want to maintain total independence (Silverman, 1987).

There are a variety of planned housing and community settings in which the elderly can segregate themselves to various degrees from other age cohorts. Planned retirement communities refer to those communities

that are built with the intention to meet the specific needs of different age segments of old people: well elderly or frail elderly, or of different social economic status: lower-class, middle-class or upper-class, or of those with different levels of care: single-level care or multiple-level care.

One kind is apartment complexes for old people. Many of them are federally or publicly subsidized. They are ordinary apartment complexes for working-class old people. The rent is usually very low. Some are non-subsidized apartment complexes for the middle or upper-middle class.

Another kind is retirement communities. In such communities, the housing is not only restricted to those of a given age level, but a whole community is designed to cater in varying degrees to the needs of the elderly. They provide relatively low cost, low density housing in a highly planned community context in which recreational facilities and leisure pursuits are extensively provided. The architecture of the housing tends to be modified only minimally to accommodate a population with increasing physical deficits, thus they tend to be inappropriate for those with severe disabilities. This kind of retirement community is typically found in the sun belt states (Silverman, 1987).

Another kind is congregate housing or care facilities, where residents can live with some degree of protection and support. Typically, a complex has self-contained apartments that are able to communicate with a central office in case of emergency. A medical clinic with full time nursing staff is usually available. Various support services are provided, such as meals, housing cleaning, and shopping. Some recreational facilities and leisure pursuits are provided. There are two types of care

in this kind of facility: single-level care and multiple-level care. Single-level care facility can not accommodate the bedfast and severely handicapped. Those who can not maintain an independent living have to move out of the care facility. Some of the multiple-level care facilities provide three levels of care: independent living, intermediate care, and nursing home. Others provide two levels of care: intermediate and nursing home. Regardless of their physical and mental conditions, residents with mental and health problems in multiple-level care do not have to move out of the care facility, but have to relocate to a higher level of care in another section within the same facility (Silverman, 1987).

The processes by which, on the one hand, retired people choose to migrate to new residential locations, and by which, on the other hand, planned retirement communities recruit new members usually result in compatibility between the person and his or her new environment (Longino, 1981). On the one hand, individuals who make the decision to move select the community. Based on personal needs and resources, some old people choose to buy or to rent a house in the planned retirement communities, while others move into retirement apartment complexes. Some old people choose to live in a facility that allows only independent living, and others move to a multiple-level facility that combines independent apartments and a nursing home. On the other hand, retirement communities selectively search for new residents to meet their perceived needs. Retirement communities are different in both their attractions and their built-in features, such as more recreationally oriented, or more medically oriented, or more economically oriented. The selection from among the potential migrants is based on these characteristics, thus increases the

homogeneity of the resident population.

Retirement communities will age as people who first moved into these living arrangements grow old and often frail. Lawton et al. (1985) found an overall change in tenant characteristics over 12 years. Average age had increased from 72.8 in 1966 to 77.7 in 1980. Whereas 25.2% were married among the original populations, only 7.9% were married in 1980. Similarly the mean number of living children per tenant decreased very significantly from 2.1 to 1.6. So even though old Americans are eager to maintain their independent living for as long as possible, and even though residents in retirement communities may help each other out, old people, even those who live independently in planned retirement care facilities, are likely to continue to age and to grow frail. Thus they finally reach a point when they can no longer maintain their independence, even with the support of their friends and neighbors, but without sacrificing the health or the interest of those help-givers (Morgan, 1982; Silverman, 1987; Fisher 1988). Then they have to relocate again.

Non-subsidized, planned retirement care facilities all claim that they are built to meet the increasing needs of old people. How such facilities affect the social relations and the social support among their residents, and what is the impact and appropriateness of such support, especially with regard to residents' relocation, are the questions that are not addressed very much by previous research. We focus on the exploration of two care facilities with different levels of care to find out which facility provides better support for its residents: a single-level care facility or a multiple-level care facility.

THE SENSE OF COMMUNITY

Rose (1962) hypothesized that a subculture of the aging might emerge due to the frequent interaction of old people with each other in the retirement facilities.

This occurs under two possible sets of circumstances: (1) The members have a positive affinity for each other on some basis (for example, gains to be had from each other, longstanding friendship, common background and interests, common problems and concerns). (2) The members are excluded from interaction with other groups in the population to some significant extent (Rose, 1962:95).

Many studies done in the apartment complexes for the elderly in the 1960s and 1970s found that the move into apartment complexes for the old people was associated with improved social and psychological well-being as well as a lower rate of mortality and institutionalization (Carp, 1966, Lawton and Cohen, 1974). What is more important, age could provide a foundation for community or subculture (Rosow, 1967; Messer, 1967; Hochschild, 1973; Ross, 1977).

Rosow (1967) studied 1200 middle-class and working class old people in several apartment buildings and retirement hotels in Cleveland. The apartment complexes were not age-segregated, but housed varying proportions of older people. His major finding was that living near younger age cohorts did not encourage friendships; rather, the number of friends an elderly person had increased with the proportion of older neighbors.

Messer (1967) studied two public housing projects. One was limited to elderly residents, and the other age-integrated. He found that in the integrated settings, the standards of younger people prevailed, so the

high levels of social involvement expected of all people were difficult for some of the elderly to meet, while in the age-segregated-project the norms recognized that some older people preferred less social involvement. Thus, Messer's research suggested the potential emergence of distinctive and exclusive norms relevant to old people in such age-homogeneous settings.

Hochschild (1973) found an "unexpected community" which was composed of forty-three working-class residents, most of whom were widows. Because they lived only among their peers, a subculture had emerged distinctive to the occupants. They kept track of birthdays and celebrated together. They shared information and the cost of various products. They went shopping together. They looked in on one another. They communicated frequently with each other, especially by telephone. In this community, new roles emerged to replace the old ones that were lost since they became old.

Ross (1977) studied a fourteen-story retirement home near Paris. Most of the 127 retirees and their spouses came from working class backgrounds in the construction industry. They were socialized to a distinct social organization, with status structure and norms relevant only within the community, and a sense of "we-feeling". Their political differences brought with them from outside took on a new meaning relevant to the concerns and conflicts within the residence. Previous social status was unrelated to positions occupied within the residence. Morale was not related to either their outside contacts or the amount of social activities they engaged in. A distinct community with its own norms was created.

In a word, in such age-segregated retirement setting, friends and neighbors are closest to the daily life of the old people. It is precisely these significant others with whom old people have the most frequent interaction both instrumentally and affectively. It is because of this interaction and a shared background, interest, problems, and other identities that a subculture among residents emerges. This subculture is a very important factor that affects the social support among residents.

SOCIAL SUPPORT FOR RESIDENTS IN RETIREMENT COMMUNITIES

Two models describe the informal support system, task-specific and hierarchical-compensatory. The two models mainly explain the different relationship between family and non-family as sources of support, but do not explore explicitly the forms of support residents provide to other residents in retirement communities.

There are several studies which explicitly focus on informal support by residents for residents in retirement communities. Some of them compare social support among residents in retirement communities with their peers who do not live in the retirement communities. Some of them test the above two models of informal social support. Few studies deal with the types of support among residents in retirement communities and the impact of such support for frail residents, not to mention a comparison of social support between different retirement communities.

The Task-Specific Model

Litwak and Szelenyi (1969) argued that primary groups, such as family, friends, and neighbors, had different functions and the nature of

task was different. Primary groups could be classified in term of their basic dimensions--proximity, long-term commitment, cohort, size, physical resources, and degree of affectivity, and tasks could also be divided on these dimensions. A primary group could most effectively perform those tasks that match it in structure. The kinship system was seen as most appropriate for carrying out the traditional kin-associated tasks involving long-term history and intimacy. But given the geographic dispersion of many children, only those tasks not requiring proximity or immediacy would be appropriate for kin. Neighbors, in contrast, could be expected to assist with tasks requiring speed of response, knowledge of presence in the territorial unit. Friends were uniquely able to deal with problems involving peer group status and similarities of experience and history. For example, proximity made neighbors ideally suited to provide emergency first aid services. However, neighbors usually did not have the degree of commitment and affection required to assume the responsibility of long-term health care.

The Hierarchical-Compensatory Model

Cantor, Morris, Sherwood, and Goodman argued that the function of support giving was generally ranked according to primacy of the relationship of the support givers to the elderly recipients rather than to the nature of the task. This model postulated an order of preference in the choice of the support givers. Kin was generally seen as the most appropriate source of support givers followed by significant others and lastly by formal organizations. In cases in which the initially preferred support givers were absent, other groups acted in a complementary manner

as replacement (Cantor, 1979; Morris and Sherwood, 1983-1984; Goodman, 1984).

Studies of Social Support among Residents in Retirement Communities

Sherman (1975) compared networks of mutual assistance reported by 600 residents of six facilities for the well elderly with such assistance reported by matched controls living in dispersed housing. The sites include a life-care home, three retirement villages, an urban high rise, and a retirement hotel. Compared with controls, site residents were found to have less frequent contact with children but more frequent contact with neighbors, but there was little test-control difference in help received from children. Compared with controls, more mutual assistance with neighbors in sites was found at two sites: the Life-care Home and the Rental Village, less mutual assistance at two sites: the Purchase and Manor Villages, and no difference at two: the Apartment Tower and Retirement Hotel. The data indicated that the Apartment Tower and Retirement hotel were perceived by their residents as "just housing" and little sense of community prevailed.

The kind of retirement settings in which old people choose to live -- a natural community or a planned community, a publicly subsidized apartment complex or a middle-class or upper-class self-supported planned apartment complex, a planned neighborhood or a planned care facility, a single-level care facility or a multiple-level care facility-- affects the nature of the living situations, especially in terms of social support, and has great impact on the elderly (Sherman, 1975; Silverman, 1987). The key factor that affects whether mutual assistance among residents will

emerge is not mere concentration of old people, but the interaction and the shared sense of community among residents. The above studies of creation of community in the age-segregated retirement communities directly show that residents are an important source of help. For example, Hochschild's study of the forty-three old people at one federally assisted apartment complex shows that residents help each other out in such an "unexpected community".

Sherman (1975) also argued that involvement with kin was not necessarily competitive with involvement with non-kin. Sherman reported that the more involved a resident was in kin roles, the more likely the resident was to have friends, and to have friends in the building. Those residents who were more active in communities were also active outside communities, thus had more friends and supporting ties both inside and outside of communities (Hochschild, 1973; Sherman, 1975; Jonas, 1979; Chappell, 1983).

Sullivan (1986) compared the informal support system of residents in a planned, sunbelt retirement community with their national peers. The focus was on the availability of friends and family to provide personal assistance in the event of a specified health problem, their proximity, the extent to which respondents express a willingness to utilize these support systems on a short-term and long-term basis. Sullivan's data indicated that residents formed mutual assistance networks for short term help in lieu of, or in addition to, distant or nonexistent children and other kin. As hypothesized by the task-specific model, only a minority expected long-term care from local friends. Contrary to both the task-specific and the hierarchical-compensatory models, few relied on any

primary group for long-term care (Sullivan, 1986).

Stephens and Bernstein (1984) studied social support networks of 44 residents at two federally assisted apartment complexes. They found out that other residents were often regarded as sources of support. Residents' interpersonal relations most often centered on social and psychological resources such as conversation and advice, and were less frequently involved in material or direct assistance such as financial loans and doing errands.

Goodman (1984) studied 67 elderly in two age-segregated housing facilities within a single middle-income community. She found three neighborhood exchange types in the retirement communities.

She pointed out that:

Undisputedly, families help the most, but family care may wane in the coming decades as a lower birth rate (fewer care-giving children) and more working women make elder care a greater burden. On the other hand, neighbors offer nearby help and ensure the presence of an ongoing people-pool from which friendship may be formed (Goodman, 1984:138).

Goodman even argued that this hierarchical-compensatory model of social support forms

a massive unregulated social welfare system which provides more services, security, and hope for the future than all our agency help together (Goodman, 1984:138).

All the above studies point out one fact that in retirement communities, friends and neighbors can be an important source of help, especially when family is less available. Are there limitations and appropriateness of support among residents in retirement communities?

LIMITATION AND APPROPRIATENESS OF SOCIAL SUPPORT

The above studies suggest that there is a limitation on social support among residents, especially the limitation on willingness to give support in some retirement communities, such as natural retirement communities, federally-assisted planned retirement apartment complexes, and planned non-subsidized retirement communities. So far, little research has been done on appropriateness of residents' caregiving, and the limitation of residents' ability to give support in retirement communities, and the need to integrate informal and formal support, not to mention the research specifically on social support, its limitation and appropriateness in all kinds of care facilities.

Morgan's study (1982) and Fisher's study (1988) of the illness careers of residents and their relocation in planned non-subsidized multiple-level care facilities only indirectly suggest the limitation and appropriateness of informal social support among residents in retirement communities. They found a negative effect of relocating residents to a higher level of care and/or to a nursing institution. To avoid stigma, the frail residents living independently tried to slow down the pace of their illness career by resisting relocation to a higher level of care. There were usually tension-filled negotiations between staff and residents over when the move occurred. To avoid the nursing home look, healthier dwellers in independent apartments tried to keep up appearances so that the home would be filled with outwardly healthy and competent members.

They also found that in such facilities, age and health became very important factors that affected how much support residents could give.

Most of the residents suffered from chronic illness, and expected to experience further declines in health. Because of the help-givers' age and ability, even staff and management discouraged residents from providing some help.

Morgan (1982) studied the residents and staff in a multiple-level care facility containing both semi-independent apartments and a supervised nursing area. Morgan pointed out that medical staff were well aware of the incurable nature of health problems of the old residents and the availability and reliability of social support among residents. They warned frail residents that the health of the potential source of support was in fact no more certain than the health of the intended recipients, and the use of another residents as a source of support was dangerous to the recipients as well as to the help-givers.

Although little research has been done on the limitation and appropriateness of residents' caregiving in the retirement communities, and the need to integrate informal and formal support, there is a growing recognition of both the limitation and appropriateness of family caregiving and of the need to integrate informal and formal support (Little, 1983). The physical, emotional, and financial strains suffered by family caregivers have been graphically depicted in the research literature (O'Brien and Wagner, 1980; Cantor, 1983; Little, 1983; Snyder and Keefe, 1985; Ward, 1985).

Cantor (1983) noted that there was the possibility of physical, emotional, and financial strains associated with caregiving. Such burden and costs might entail changes in the characteristics of the support network because they implied limitations in willingness and/or ability to

help.

Snyder and Keefe (1985) found out that many caregivers reported physical and emotional problems ranging from hypertension and back problems to depression and mental exhaustion because of caregiving. Their study also showed that almost 70% of the caregivers reported that their health had been negatively affected due to caregiving. Furthermore the longer persons had been caregiving the more likely they would report health problems.

What was worse, many elderly caregivers were more likely to be old and infirm themselves. They needed care themselves as well as guidance. Fengler and Goodrich (1979) regarded wives of elderly disabled men as the hidden patient.

Ward (1985) suggested that social ties might be broken when their limitations were exceeded, and social support might entail burdens for those who provided it. So it must be recognized that the contributions of informal social support to well-being could not be divorced from the possible benefits of more formal services. Because of this, Ward came to the conclusion that social networks were not necessarily beneficial to well-being when the efforts of caregivers exceeded their abilities.

O'Brien and Wagner concluded

informal social ties blocked proper access to useful services rather than lead to more humane and cheap alternatives" (O'Brien and Wagner, 1980:78).

CONCLUSION

Overall, little research has been done systematically on either informal social support among residents in non-subsidized planned

retirement care facilities, or the limitation, impact and appropriateness of such support for residents as a whole, not to mention the comparison of informal social support between care facilities that have different levels of care in such planned retirement care facilities.

Planned care facilities are a type of retirement community that provide the best opportunities for residents to pursue their later life together and to develop peer-type bonds together. They segregate the old people from other age groups. Residents have many chance to know each other and interact with each other. They have meals every day together. They can go out in the transportation provided by the facility and they can have many recreational activities together. Primacy of time, energy, interest, and emotional support which are important to develop kinship bonds are also important and available for residents to develop peer-type bonds, especially when older people are loosened from family ties sufficiently in such care facilities (Rose, 1962, Hochschild, 1973; Chappell, 1983). Theoretically, non-subsidized, planned care facilities are just like an extended family. Do residents hope that other residents will take the place of their spouse or other family members or even nurses? These facilities provide an opportunity to study these questions.

Support for frail old people from other residents and from the housing facility, the impact and appropriateness of such support, and the timing of relocation of frail residents have important implications for residents, managers and owners of retirement housing. This study therefore also offers opportunity to expand support system theory.

CHAPTER III

METHODOLOGY

In this chapter, we seek to explain the methods used in this study: data collection, sampling, description of the settings, measurement of variables, and coding and analysis.

DATA COLLECTION

Data were collected through interviews with residents who lived independently in two retirement complexes. The interview questions were originally structured around the topic of neighboring, social support, and moving by Morgan and Chapman, who are professors at the Institute on Aging, Portland State University. I added some ideas and several questions to the interview. Two professors and four graduate students, myself included, interviewed 30 residents, 15 from each site. To ensure that the same basic topics were covered in each interview, a pre-planned interview guide was developed. (See Appendix A.)

All interview questions were open-ended. Our intention was to ask residents to tell us what they did for each other and what they thought about such help, not what we researchers thought they would do and would think. Based on residents' responses, we tried to probe as much as possible. In this way, we had a better chance to understand why residents did this or that for each other and what was the impact, the limitation and the appropriateness of such support. Such a qualitative method is very

appropriate for our exploratory study.

Each interview was tape-recorded. Then these tapes were transcribed to provide the actual data base for our analysis. By using a word-processing package on a micro-computer, the transcripts were input directly into the coding and analysis phase of the project.

We collected some background information from the advertising materials of the two residences and from the regulations or laws of the two sites. We visited the two sites and knew the design of the facilities and the on-site services of the two organizations. We asked the staff for some background information about the community of the elderly that we could not get from our interviews, our observation and the above materials. In this way we understood better the organization of the two sites and their residents.

SAMPLING

When we chose our two sites, we tried to control those factors that we thought might affect our study. First, we tried to make the two sites compatible in terms of their residents' socioeconomic status, their size, and when they began to operate. Residents' socioeconomic status, especially their income, may affect the availability of support for frail elderly. Usually the more money one has, the more sources of help one might get. Also, socioeconomic status affects which retirement community the old people may move into. Generally speaking, lower-class old people can not afford to move into a retirement community which accommodates people from middle-class or upper-middle class.

Previous researches showed that the size of a given retirement

community affected the possible emergence of mutual support networks. In a smaller community residents had a better chance to get to know each other and to interact with each other than residents in a bigger one (Jacobs, 1975).

"Aging in place" is very important for our study. When residents first move into the retirement community, they are comparatively healthy and active. As they continue to age and to become frail, and can not maintain their independence any more, they may have to relocate. If the retirement facilities we chose had been recently built, they may not have as many frail old residents who have experienced frailty in the community and subsequent relocation as an older retirement communities.

Second, we thought that both sites should have common dining rooms. On the one hand, they are a very important place for residents to know and to interact with each other. Residents often see each other daily on their way to, or from, or in the dining rooms. They are also important for residents to find out whether a resident is sick or not, when he or she has not shown up in the dining room for a day or even for days. On the other hand, eating in the common dining room may indicate a similar level of independence, as residents do not need to be able to shop or cook. In some places going down to the dining room is an indicator of independence.

To control these factors, the two places we chose are non-subsidized planned retirement apartment complexes. They have common dinning-rooms. They are at least ten years old so that their residents see a lot of frail residents relocate to a higher-level of care. Residents have the same social background too: middle and upper-middle class. For our research purposes, the largest difference between the two study sites is the level

of care. To protect residents' anonymity, I call the first place Multi-Care and the second place Single-Care.

Residents were randomly chosen from those who lived in independent apartments and at the same time were willing to be interviewed in these two homes. With the help from the staff at both retirement communities, we purposely excluded those residents who might be expected to relocate soon, because we were afraid that for them to talk about support and relocation might be emotionally painful. We also purposely excluded those who have been in the communities for less than 9 months, because they might not be familiar with the situations in the communities.

DESCRIPTION OF THE SETTINGS

Multi-Care is a modern retirement complex. It was opened in 1955. It is situated in the suburb of a major metropolitan area. Old people have to pay a high entrance fee and monthly care fees so as to buy into it. However, once they are admitted into Multi-Care, they don't have to worry about their future. Residents move from a lower level of care to a higher one as their health declines. Even if they run out of money, a foundation in Multi-Care will pay for them.

There are three distinct types of residency: Independent Living, for those who can live an independent life; Intermediate Care, for those who can maintain their independent living with some assistance from the staff, and 24 hour nursing services are available; and a Convalescent Center, for those people who need skilled nursing care. All are within the same campus. There are 360 apartments in the independent living sections, 96 units for semi-independent residents, and 120 beds in the Convalescent

Center. The various residency classifications are separated spatially. This formal segregation of residency classifications is further reinforced by separate dining facilities and activities.

For those who live in the independent living apartments, the monthly fee covers three meals a day, bi-monthly cleaning of apartment, heat, water, electricity, telephone, property tax, flat work laundry, use of all facilities in Multi-Care and limited infirmary care.

Within the campus, there are a grocery store, clothing store, bank, furniture store, beauty shop, auditorium and two libraries. Residents do not have to go out. They can get almost anything within the campus. It has two facility provided buses for shopping, entertainment, and churches. It has many kinds of recreational facilities, and leisure pursuits.

Single-Care is a modern retirement complex. It was built in 1967. It is located within the metropolitan area's Northeast Section. Old people do not have to pay an entrance fee. They can rent their apartments. If they can not maintain their independence, they have to move out of the facility.

It offers only one level of care: residents have to live independently. (This previously was a life care facility; there are approximately 12 life care people remaining in the complex. None of them were interviewed.) The monthly rent covers two meals a day: breakfast and dinner, or lunch and dinner, weekly maid service, heat, water, electricity, telephone, free laundry facilities.

There are a bank, an auditorium, a library, and some recreational facilities and leisure pursuits. It provides two buses for shopping and entertainment, even though a hospital and a shopping center are within

walking distance. It has nurses on duty for emergency.

MEASUREMENT OF VARIABLES

In this section, I will explain the measure of the dependent variable: social support, and the independent variable: social organization of the retirement complex. I will also explain how we measure the impact, the limit and the appropriateness of social support among residents.

Social Support

In this study, informal social support among residents is measured by forms, amount and sources of help available among residents. The following questions were constructed to measure the availability of informal social support for frail residents from other residents. From answers to these questions we could construct forms of support available among residents. The amount of help was calculated according to the frequency of mention of each support which occurred mainly in these questions. At times, mentions of support appeared in other questions in the interview, and these were counted as well.

Our interview began with four questions about the background of residents. (See Appendix A for the full text of the interview guide.) Then we told residents the purpose of our interview in a brief introduction.

Over the years, many of the people who live in any retirement community have developed health problems that keep them from doing some of the things they once were able to do for themselves. Sometimes these problems last for just a short time, other times they are so serious that residents may have difficulty staying in his or her apartment. We are interested in how residents help out when some one has these kinds of

problems.

Then we asked:

5. What about when someone can not do things for him or herself, what are some of the ways that residents help out?

Probes: - Can you give me an example of that?
 - Can you think of other ways that people help out?
 - What else do people do when someone needs help?
 - Is there anything else that people do?

The strategy here was to begin doing as much non-directive probing as possible. The purpose here was to let residents tell us what help residents gave to frail residents, not to confirm what we researchers thought what residents did to help frail residents.

After the non-directive probing, we followed up with some directive probes in the areas of errands and transportation if they did not mention them or mentioned them only briefly. Usually, we asked these questions in the following way:

You mentioned _____, Are there other ways that residents help each other out with errands?

Or (if necessary) we ask: One area that we are interested in is errands. How do people here help each other out with errands?

The sources of informal social support among residents were measured in the following question:

6. What about you, are there people who could help you out if you were ill?

- (if yes) About how many people like that are there? Is it more like 1 or 2, or 3 or 4, or what?

If spouse or partner is mentioned as a source of help, then we probe: Is there anyone else who could help you out if you needed it?

The purpose of this question and its probes was to find the difference in the number of residents as sources of support between the two retirement apartment complexes.

Whether residents in the retirement communities as a whole were supportive or not was measured by the question:

12. How much you say that _____ is a place where people help each other out? How would you rate it on a scale from 1 to 10, where one means that people do not help each other out very much and 10 means that people help each other out a great deal?

Then we probe: Why do you say that?

The impact, the limitation, the appropriateness of such support were explored with the following questions:

7. some times people who need help expect too much from other residents. Can you give me an idea of what is too much to ask for or to expect from other residents ?
8. I just asked you situations where residents ask for or expect too much from other residents, but are there also times when friends and neighbors try to do too much?
9. Up until now, we have been talking about things that residents do for each other, but what about the staff? What are the kinds of things that staff should be doing, instead of have residents do them ?
- 9a. Are there some things that only staff are supposed to do and that residents are not supposed to do?
11. Overall, think about people in general, and not about anyone in particular. Are there times when people try to stay in this facility too long?

Probes: - When is it too long?

- How do you know when some one has stayed too long.

To see exactly how residents helped frail residents out, we asked each respondent to tell us two stories about their former neighbors or friends who had to move out because of health problems. We asked what residents did to help those frail residents before they moved out, and what was the impact of their help on those residents, whether those residents asked for too much help or stayed in the apartment too long.

The exact questions we asked were:

- 10.1. How long were you and the first person were friends or neighbors?
- 10.2. How long ago did the first person move?
- 10.3. Where did the first person move?
- 10,4 What kinds of problems caused the move?

- 10.5 Why did the move happen when it did?
- 10.6. Were there things that residents did that allowed the person to stay here longer than they would have if they had not had this help?
- 10.7. Could the person stay longer if more help was available?
- 10.8. Do you think this move happened too early or too late or just at the right time? Why?
- 10.9. Was there ever a problem with the person asking for too much or expecting too much?
- 10.10 (If necessary) One area that we are interested in that you have not mentioned is how the staff are involved in situations like this. Were the staff involved in any of this?
- 10.11 (If necessary) One area that we were interested in that you have not mentioned is how family members are involved in situations like this. Was this person's family involved in this?

Most of the questions in our interview are followed by a set of probes, such as "Can you give me an example of that?" or "Why do you say that?" or "What do you mean by 'staying too long' or 'asking too much help?'". These probes provide an insight in our understanding of the questions we have asked. That is the advantage of our open-ended questions, which let us explore the topic of support among residents in retirement apartment complexes: the availability of support (types, amounts, and sources of support), the impact, limitation, and appropriateness of such support in the retirement communities. That is the characteristic of this questionnaire, which provides us a chance to explore deeply into the area of support in the retirement communities. That is also the advantage of this study design.

Organization of the Retirement Community

Organization of the retirement community refers specifically to the level of care in the community. That is whether the community provides single-level care or multiple-level care for its residents. It also

includes the attitudes and norms related to the level of care of the retirement communities. We controlled for this independent variable by choosing two sites. One is a multiple-level care facility and the other is a single-level care facility. We want to explore whether the organization of the retirement community affects social support among residents, and how.

CODING AND ANALYSIS

We used the Ethnograph software package to code and analyze the content of the interview transcripts. Ethnograph is explicitly designed for the analysis of open-ended interviews. It can search, sort, and count textual data according to a researcher-designed coding system.

We have developed three coding systems to apply to the interviews at both sites. For an item to be coded, it must be about a resident. The first coding system was the coding of positive aspects of support. This coding system provided answers to the following questions: the types, amounts and sources of support available for residents. A basic code for the positive aspect of support had 3 parts: the form of the statement, the source of support, and the type of support. (See Appendix B for the full text of "Coding of Positive Aspects of Support".) The two forms of statement were general statement and examples. For something to be coded as an example, it must have been referred as some type of support which was done by an actual person for another, or source or the recipient of the support was an concrete individual, even if the type of support offered was only a broad category. For example, the following two responses will serve as illustrations: "I picked up some mail for my

neighbor when she was ill", or "Mrs. C was always doing errands for people".

The source of support referred to the category of the person who was providing the support. We had 9 sources: 1. other residents; 2. someone who shared a unit with the person received the support (usually it is a spouse); 3. family members who lived inside the complex, but not in the same unit; 4. friends who lived inside the complex; 5. committees or other formally organized sources of support among residents; 6. family and kin who lived outside the complex; 7. staff members; 8. people paid by the residents or family members etc; 9. others who were outside the categories listed above. We tried to distinguish friends in the community from other residents. Residents who were explicitly called a friend would be coded as friends, instead of residents. Friends outside of the community would be coded as others. For example, "I always help Allen pick up the mail, because we are friends" would be coded as friends as a source of support instead of just residents.

Types of support referred to the actual endeavors that people did for residents. After studying the transcripts carefully, we have developed four broad categories of endeavors that people did for residents: meals, personal services, transportation and social-emotional concerns. Residents often mention unspecifically that residents do help each other, so we created the fifth broad category called unspecific mention of support and supportiveness. Anything that did not belong to the above five categories belonged to the sixth one, other kinds of help.

Within the four kinds of help: personal services, social and emotional support, transportation, and meals, there were a number of

specific subcategories. Help with personal services included 6 parts: errands inside the complex, other kinds of personal services, mobility assistance, errands outside the complex, assistance with housekeeping, and general mention of help with personal services. Errands inside the complexes included going shopping inside the complex, picking up mail or deliveries, and sending mail out. Mobility assistance included help with wheelchairs and walkers, but did not include pushing residents to dining room or other mobility help associated with meals or dining room. Errands outside the building included shopping outside. General mention of help with personal services usually referred to the mentions that residents helped with personal services, but did not say what kinds of personal services. Other kinds of personal services referred to activities that people did for residents but that were not included in the above five categories. Such help included reading for other residents, watering plants, getting residents something to read, and helping in filling out forms.

Help with transportation for residents included five kinds: taking residents places outside the complex, such as shopping centers, entertainment and churches; general mention that residents helped other residents with transportation or some residents were very generous with their cars; accompanying residents on trips outside the complexes; helping with public transportation and taxis; and other help with transportation.

Social emotional support for residents included 5 aspects: looking out for other residents, other expression of social and emotional concern, emotional support, general mention of social or emotional support, and assistance with social activities. General mention was the

mention that people gave social emotional support but did not say what kinds of support.

Support with meals included five kinds: carrying trays to and from apartments for frail residents, helping residents get to the dining room, general mention of help with meals, helping residents get around in the dining room. Carrying trays to and from dining room included any forms of taking meals to rooms. Helping a person get around in the dining room included helping to seat, helping with trays, etc.

We tallied systematically all mentions of a type of support, with a form of statement and a source of support. For example, a positive code GR P2 (General)(Residents)(P2=Personal service, ERROUT) meant general statement about residents doing errands outside the building, or a code XS MO (Example) (Staff) (Meals, General) was referred as an example of staff supporting residents with meals.

The second coding system was the coding of the problematic aspects of support and moves. (See Appendix C for the full text.) This system of coding provided answers to the following questions: the appropriateness, limitation, and impact of support available for residents from residents. We sorted out those sections that mentioned the following aspects and studied them, and then tried to find some patterns of impact, limitation, appropriateness of such support for residents as a whole:

1. ASK TOO MUCH - Asking for or expecting too much help from other residents
2. DO TOO MUCH - Other residents trying to do too much for someone.
3. STAY TOO LONG - Residents staying too long.
4. STAFF - Situations where staff play a role in moves
5. RULES - Situations where community rules affect moves
6. WHY MOVE - Statement relating to when moves occur and why.

The third system of coding was the coding of accounts in each interview. The codes were based on the questionnaire. (See Appendix D for the full text.) We tried to code where the person moved: morgue, nursing home or other higher level of care, other retirement facility, with family, other, not mention. We coded what kinds of problems caused the person to move: gradual physical decline; gradual mental decline; or sudden decline, such as stroke or heart attack. We also tried to explore the help that residents provided that allowed the person to stay longer, or whether the person could stay longer with more help from residents. We also coded whether residents thought this move happened too early, too late or about the right time, and whether there was a problem with asking for too much help. In addition, we coded whether staff or family were involved in the move, and whether this move was voluntary or not. Then we counted the frequency of mentions of all the things in our codes, such as how many residents moved too late and what was the percentage of those late movers among those who had moved out.

The purpose of these codings was to point out exactly what residents did for those who had moved out already and why they moved, etc. From these accounts we could see more clearly the availability, appropriateness, limitation and impact of such support. The central analysis focused on comparing the two facilities on the availability of support for frail residents, and on the impact, limitation, and appropriateness of such support for residents as a whole.

CHAPTER IV

FINDINGS

In this section, we will present the results of our study. This section is divided into three parts: 1. forms of support available for residents at the two retirement communities, 2. sources and amount of support at the two retirement communities, and 3. specific forms of support by residents at the two retirement communities.

FORMS OF SUPPORT AVAILABLE FOR RESIDENTS

There was help available for frail residents at the two retirement communities. The help residents received could be divided into six categories: personal services, social and emotional concerns, transportation, meals, unspecific mention of support and supportiveness, and other kinds of support. (See Table I.)

People provided frail residents with support in 4 areas: personal services, transportation, social and emotional concerns, and meals. (See Table I.) Residents in Multi-Care were more likely to get support than residents in Single-Care. There were 446 mentions of support for residents in Multi-Care and 287 such mentions of support for residents in Single-Care.

Support for residents in the two communities mainly concentrated on these four types of support. These four types of support accounted for about three-fourths of all the support available for frail residents in

TABLE I
 MENTIONS OF FORMS OF SUPPORT FOR RESIDENTS
 AT THE TWO RETIREMENT COMPLEXES

	Multi-Care	Single-Care	Total
Personal services	34%	33%	34%
Social emotional concerns	19	15	17
Transportation	12	17	14
Meals	13	11	12
Unspecific mention of support and supportiveness	12	16	14
Other kinds of assistance	10	8	9
	N=446	N=287	N=733

the two communities, 78% in Multi-Care and 76% in Single-Care. Personal services were the kind of help that frail residents in the two communities were most likely to get. Such help accounted for almost one third of all help available for frail residents in the two retirement communities. Such help for residents in Multi-Care was 34%, and 33% in Single-Care. There was a little bit difference in the availability of the following three types of support for residents between the two communities: social and emotional support, help with transportation, and help with meals. Residents in Multi-Care were more likely to get social and emotional support than residents in Single-Care. Social emotional support accounted for 19% in Multi-Care, while 15% in Single-Care. Residents in Single-Care were more likely to get help with transportation than residents in Multi-

Care. Help with transportation was 12% in Multi-Care and 17% in Single-Care. Residents in Multi-Care were more likely to get help with meals than residents in Single-Care. Help with meals accounted for 13% in Multi-Care and 11% in Single-Care.

Residents in Single-Care were more likely to mention unspecifically that people helped frail residents out. Sixteen percent of all the support mentioned by residents in Single-Care were such general mentions, while only 12% of all help in Multi-Care were such unspecific mentions of support and supportiveness. Eight percent of all the help in Single-Care and 10% in Multi-Care were not included in these above four kinds of help and the above unspecific mention of help.

In a word, residents got the six categories of help at the two retirement communities. There was more help available for residents in Multi-Care than for residents in Single-Care. Residents at both communities were most likely to get help with personal services. Residents in Multi-Care were more likely to get social and emotional support and get help with meals. Residents in Single-Care were more likely to get help with transportation and unspecific support than residents in Single-Care.

SOURCES AND AMOUNTS OF SUPPORT

As far as the above six categories of help for frail residents in the two retirement communities were concerned, people inside the communities, residents and staff, helped most. Of the people inside the communities, residents were more likely to help frail residents with the six kinds of help than staff.

However, we should remind the reader that the questions of our study mainly addressed the topic of what residents did for other residents when they were ill or unable to do some of the things they were once able to do. Some help that was done by staff and family members would not be included in these six categories of support, such as medication. Moreover, residents were supposed to be able to live independently in their apartments at the two communities. If residents started to ask staff for help, staff would charge them money for the extra services they provided and at the same time would monitor them closely. If residents asked for too much help, staff would advise them to move out or move to the Intermediate Care. For example, residents in Single-Care could ask for trays for up to eight days. So, most of the time, residents would prefer asking residents for these four kinds of help, but if they had no neighbors or friends to help them, they would turn to staff for help.

Of all the help for residents that was mentioned by residents at the two communities, residents' help accounted for 73% in Multi-Care and 64% in Single-Care, and staff's help accounted for 23% in Multi-Care and 28% in Single-Care. The above help by residents and staff together accounted for 96% in Multi-Care and 92% in Single-Care. Other people outside the communities, such as kin, friends, and paid people, accounted for only 4% of the help mentioned for frail residents in Multi-Care and 8% in Single-Care. From now on, we will concentrate on the six categories of help for the frail residents by residents from Multi-Care and residents from Single-Care. We would also compare staff's help for residents with residents' help for each other in the two communities.

Residents in Multi-Care were more likely to help frail residents

than residents in Single-Care. (See Table II.) Residents' help in Multi-Care accounted for 76% of all help by residents and staff, while residents' help for residents accounted for 69% in Single-Care. Staff in Single-Care were more likely to help frail residents than staff in Multi-Care. Staff's help in Single-Care accounted for almost one third of all help in the community while staff's help in Multi-Care was about one fourth in the community.

TABLE II
MENTIONS OF RESIDENTS' AND STAFF'S SUPPORT FOR RESIDENTS
AT THE TWO RETIREMENT COMPLEXES

	Multi-Care	Single-Care
Residents*	76%	69%
Staff members	24	31
	N=472	N=265

*Residents include kin and friends inside the complexes, and residents' committees.

Residents' own reports of available support reinforced the above conclusion that residents in Multi-Care were more likely to help other residents than residents in Single-Care. We gave residents a scale from 1 to 10, and asked them to choose a number which could best describe their community: one meant that residents did not help each other very much, and ten meant that residents helped each other out a great deal. Most residents gave us a number. The average number for Multi-Care was 9.1 (n=13). Two residents did not give a number. One said that residents did not have to help each other a great deal, because they had staff. The

other resident made it clear that residents in Multi-Care were independent, but at the same time helped other residents out. She said:

We can, within our own apartments, we can be separated. We open the door and then we are part of the family. And we think we feel, every one of us, that this is our extended family, and we can ask for help. We can offer help. We can be supportive even with a smile or a greeting to someone (A1, 1838).

The average number for Single-Care was 6.7 (n=9). Four interviews didn't mention this question. Two residents couldn't give a number, but indicated very clearly that residents in Single-Care did not help each other a great deal. One resident said:

No, I really don't know, because they don't, they don't encourage that here, you know. And I can see because there are so many of them can hardly get around either (B40, 139).

From the above numbers and comments, we could see that residents in Multi-care were more likely to help other residents than residents in Single-Care.

TABLE III

WHETHER HELP RESIDENTS PROVIDED ALLOWED FRAIL
RESIDENTS TO STAY LONGER

	Multi-Care	Single-Care
Yes	60%	26%
No	27	53
Don't know	0	5
No mention	13	16
	N=30	N=19

We asked each resident to provide two stories about those residents who had to relocate because of health problems. We asked them whether residents helped those frail residents and in what way. Residents in Multi-Care could tell us an average of two stories ($n=30$). (See Table III.) They could answer almost all the questions we asked about the frail residents who had moved. They knew other residents well and knew what was going on with them. However, residents in Single-Care could only tell us 1.3 stories ($n=19$). Several residents in Single-Care couldn't answer some of our questions. One resident, who had been in Single-Care for two and half years, didn't know who had recently moved. The following was our conversation with her.

- I: Do you know anybody who has recently moved out of Single-Care?
 R: No. They have 25 or 30 every month.
 I: Oh really ?.... And you don't know anybody who has recently moved out.
 R: No.

From the stories that residents told us, we could see that before frail residents moved out, other residents in Multi-Care were more likely to help frail residents than residents in Single-Care. (See Table III.) Sixty percent of those frail residents in Multi-Care received help that allowed them to stay longer, while only twenty-six percent frail residents in Single-Care received help that allowed them to stay longer.

That residents in Multi-Care were more likely to help other residents than residents in Single-Care was also shown by the answers to another question: "What about you, are there people who could help you out if you were ill?". If they answered "Yes", then we asked how many residents. Most people gave us an exact number. In Multi-Care, the average

number of residents one could ask for help was 6.3 (n=8), while for Single-Care the average number was 3.1 (n=12). In Multi-Care, seven residents did not give an exact number. Two of them said that they could ask anyone in the floor for help, and they would help them. Another one said that she had many friends to help her. Another one said that based on the nature of the help, she would ask different people for different needs, and they would help her. One resident said that she had a husband, so she did not need to ask for help. But if she asked residents for help, they would help her. Only one resident said that she had no idea, anyway, her husband was going to help her. In one interview, we did not ask resident this question.

In Single-Care, five out of the fifteen residents said that they would only ask their family members or staff for help, not residents. One resident could not give a number, but said that there were residents to help her. In one interview in Single-Care, we didn't ask this question.

From the above discussion we knew that residents in the two retirement communities were more likely to provide these four types of help for frail residents than staff. Residents in Multi-Care were more likely to help other residents than residents in Single-Care. Staff in Single-Care were more likely to provide help for frail residents than staff in Multi-Care.

SPECIFIC FORMS OF SUPPORT BY RESIDENTS

Table IV gives us information about the six categories of help by residents and staff at the two retirement communities. Table V, VI, VII, and Table VIII gives us detailed information of each of the four kinds of

help by residents and staff for frail residents in the two retirement communities: personal services, social and emotional concerns, transportation and meals. From these tables, we can see more clearly the differences and similarities of the help for frail residents by residents and staff in the two communities.

TABLE IV

MENTIONS OF SUPPORT BY RESIDENTS AND STAFF FOR RESIDENTS
AT THE TWO RETIREMENT COMPLEXES

	Multi-Care		Single-Care	
	Residents	Staff	Residents	Staff
Personal services	35%	31%	35%	32%
Social emotional concerns	20	12	19	7
Transportation	10	17	16	17
Meals	15	9	9	17
Unspecific mention of support and supportiveness	11	19	15	18
Other kinds of assistance	9	12	6	9
	N=324	N=103	N=183	N=82

* Residents include friends and kin inside the complexes, and residents' committees.

Generally speaking residents in Multi-Care provided almost twice as much help for each other as residents in Single-Care. (See Table IV.) Mention of support by residents in Multi-Care was 324, while by residents in Single-Care was 183. Staff at Multi-Care provided more help for residents than Staff in Single-Care, but there was no big difference. We

can see the above differences even more clearly by looking at each of the six categories of help.

Personal Services

Residents in Multi-Care provided almost twice as much help with personal services for each other as residents in Single-Care. (See Table V.) There were 113 mentions of help with personal services by residents for each other in Multi-Care, while there were 64 mentions of such help for residents at Single-Care. There was no big difference in such help by staff for residents in the two retirement communities.

TABLE V

MENTIONS OF RESIDENTS' AND STAFF'S HELP WITH PERSONAL SERVICES IN THE TWO RETIREMENT COMPLEXES

	Multi-Care		Single-Care	
	Resident	Staff	Resident	Staff
Errands inside the complex	35%	0%	20%	0%
Mobility assistance	16	9	8	8
Errands outside the complex	12	3	27	31
Assistance with housekeeping	9	47	5	38
Unspecific mention of help with personal services	5	3	23	12
Any other kinds of personal services	23	38	17	11
	N=113	N=32	N=64	N=26

Both residents and staff at the two communities were most likely to provide personal services for residents. (See Table IV.) Help with personal services accounted for about one third of all their help with personal services. Such help was 35% at the two communities, 31% for staff in Multi-Care, and 32% for staff at Single-Care. However, there were differences in the specific type of the help with personal services that residents and staff at the two communities were more likely to provide.

Residents in Multi-Care were more likely to help frail residents with errands inside the community and to help residents with other kinds of personal services. (See Table V.) Residents' help with errands inside the complex for residents in Multi-Care was 35% of all their help with personal services, and residents' help with other kinds of personal services for each other in Multi-Care was 23%. These other kinds of personal services were things that were done by residents for each other inside the complex. These showed that there were many other things going on inside Multi-Care. Much of this help was in fact done by committee members in Multi-Care.

Residents in Multi-Care were also more likely to help each other with mobility assistance than residents in Single-Care. (See Table V.) Mobility assistance by residents in Multi-Care for other residents was 16%, while such help by residents in Single-Care was only 8%. This was because no wheelchair was allowed in Single-Care. Single-Care was a fourteen-story building. According to fire regulations, residents were supposed to be able to get downstairs in case of fire. It was very difficult for residents or staff to wheel wheelchairs downstairs in case of fire. There were wheelchairs in Multi-Care. Residents wheeled frail

residents to all kinds of activities inside the complex. Residents in wheelchairs in Multi-Care were pushed to see the entertainment, to see the view, etc. In this way, even though those frail residents in Multi-Care were temporarily unable to walk, they could still enjoy life.

Residents in Single-Care were more likely to provide errands outside the complex than residents in Multi-Care. (See Table V.) Residents' help with errands outside was 27% in Single-Care, while such help was 12% in Multi-Care. This was because Single-Care did not have a grocery store, a furniture store, and a clothing store inside the complex, but it was not far away from a shopping center. Residents in Single-Care had to go out shopping and could do it easily. There were buses for residents in Single-Care to go shopping. Residents in Multi-Care went shopping inside the complex. If they could not get things inside, they went shopping outside.

Residents in Single-Care were also more likely to provide errands inside the complex. (See Table V.) Such help was 20% in Single-Care. Residents in Single-Care were much more likely to mention unspecific statement of support that residents did help each other with personal services, but did not know or didn't mention the specific activities that residents did in Single-Care. (See Table V.) Unspecific mention of help with personal services was 23% by residents in Single-Care. It was almost one fourth of all their support with personal services. Residents in Multi-Care knew what they did to help other residents and they did many other kinds of personal services for each other which were not provided for residents in Single-Care. This indicated that there were more things going on in Multi-Care than in Single-Care, and residents in Multi-Care were more likely to know what they did for other residents than residents

in Single-Care.

For staff at Multi-Care, their help with personal services was mainly housekeeping, and other kinds of personal services. (See Table V.) For staff at Single-Care, their help was mainly housekeeping, and errands outside the complexes. This was because both facilities provided housekeeping as part of their services for their residents. Single-Care also had a staff member whose responsibility was driving the buses for residents. He mainly drove residents to shopping centers. He sometimes helped residents shopping outside. Multi-Care did not have such a staff whose responsibility was only to drive the buses.

In a word, residents in Multi-Care provided almost twice as much help with personal services for each other as residents in Single-Care. Residents in both communities were likely to help with errands inside the complexes. However, residents in Multi-Care were more likely to provide each other with errands inside the complexes than residents in Single-Care. Residents in Multi-Care were also more likely to help other residents with mobility assistance and with other kinds of personal services than residents in Single-Care. Residents in Single-Care were more likely to help with errands outside the complex and to mention residents' support unspecifically than residents in Multi-Care. Staff at both communities helped with housekeeping. Staff in Multi-Care were more likely to provide other personal services.

Social and Emotional Concerns

Residents in Multi-Care provided almost twice as much social and emotional support for each other as residents in Single-Care. (See Table

VI.) There were 66 mentions of social emotional support for frail residents by residents in Multi-Care, while there were only 35 such mentions for residents in Single-Care.

TABLE VI

MENTIONS OF RESIDENTS' AND STAFF'S SOCIAL EMOTIONAL
SUPPORT IN THE TWO RETIREMENT COMPLEXES

	Multi-Care		Single-Care	
	Resident	Staff	Resident	Staff
Looking out for other residents	32%	42%	43%	67%
Emotional support	26	50	9	0
Assistance with social activities	12	0	14	33
Unspecific expression of social emotional concerns	17	0	23	0
Any other expression of social or emotional concern	13	8	11	0
	N=66	N=12	N=35	N=6

Residents at both communities were more likely to provide social and emotional support for residents than staff at both retirement communities. (See Table IV.) Social emotional support by residents for residents in Multi-Care was 20%, by residents in Single-Care was 19%. Such support by staff in Multi-Care was 12%, and by staff in Single-Care was 7%. Although from Table IV, we could not see a big difference in the availability of social and emotional support for residents by residents and by staff between the two communities. Table VI showed us that in fact

there were big differences in the specific kind of social and emotional support that residents and staff were more likely to provide in the two retirement communities.

Looking out for other residents was a kind of social and emotional support that was most likely to be available for frail residents in the two retirement communities. Social and emotional support by residents in Single-Care and staff at both communities was concentrated on looking out for frail residents. (See Table VI.) Such help was 43% by residents in Single-Care, 67% by staff in Single-Care, and 42% by staff in Multi-Care and 32% by residents in Multi-Care.

There were two main ways for residents and staff to look out for other residents. Both in Multi-Care and in Single-Care, there was a tag for residents to put on the door. If residents and staff found some residents who didn't take the tag out by certain time, residents would call them first. If no one answered the phone, they would go to check on them or call staff to check on them. Another way was to see whether residents went down to have meals or not. If somebody had not shown up in the dining room or in the halls for some time or for days, residents or staff would call the resident first, then went to check if every thing was all right.

Residents in Multi-Care not only looked out for each other, but also provided emotional support, assisted with social activities, and gave other social and emotional support to frail residents. (See Table VI.) Looking out for other residents by residents in Multi-Care was 32%. Emotional support was 26%, assistance with social activities was 12%, and general mention of social and emotional concerns was 17%, and other

expression of social and emotional concern was 13%. Residents in multi-Care had all kinds of activities that supported residents emotionally. This was one of the big differences between Multi-Care and Single-Care.

Compared with residents in Multi-Care, residents in Single-Care were much more likely to mention that residents supported each other emotionally but did not say what kinds of support they provided. (See Table VI.) Residents' unspecific mention of social and emotional support was 23% by residents in Single-Care, while unspecific mention was 17% in Multi-Care. This indicated that residents in Multi-care were more likely to know what they did for other residents.

Staff in Multi-Care were also most likely to provide emotional support for residents. Staff in Single-Care seldom did that. Such social and emotional supports accounted for 50% of all support by staff in Multi-Care, while such support accounted for only 9% by staff in Single-Care. This was because Multi-Care had a counsellor. She always had time to listen to and talk with residents. She did a lot of things to make residents life go smoothly and to make the relation between residents and staff go smoothly. Other mentions of help were too few to make any sense.

In a word, residents were much more likely to provide social and emotional support for each other than staff at the two communities. Residents in Multi-Care were much more likely to provide social and emotional support than residents in Single-Care. Residents and staff in Single-Care mainly looked out for other residents. Residents and staff in Multi-Care not only looked out for other residents, but also provided residents with a lot of emotional support. Residents in Single-Care were more likely to mention the unspecific social and emotional support.

Transportation

Table IV showed that residents in Single-Care were more likely to provide help with transportation than residents in Multi-Care. Help with transportation was 16% of all their help for residents in Single-Care, while help with transportation was only 10% of all their support for residents in Multi-Care. However, residents at both retirement communities in fact provided almost the same amount of help with transportation. (See table VII.) The mention of help with transportation by residents in Multi-Care was 32 in Multi-Care and by residents in Single-Care was 29.

There were several reasons. The first reason was that many residents had their own cars. They did not want to give up driving. Some even thought that giving up their car meant giving up their independence. However, staff at both communities discouraged residents from taking frail residents to medical appointments outside the complexes. The second reason was that residents in Multi-Care did not have to go out shopping very often. There were a clothing store, a grocery store, a furniture store inside the complex.

The most common support with transportation was taking people to places, such as shopping centers, entertainment and churches. (See Table VII.) This accounted for 75% of all the support with transportation by residents in Multi-Care, 89% by staff in Multi-Care, 76% by residents in Single-Care, and 100% by staff in Single-Care. Sixteen percent of support by residents in Multi-Care and 17% of support by residents in Single-Care were such general mentions as residents helped other residents with transportation or some residents were very generous with their cars. So, help with transportation in the two retirement communities mainly

TABLE VII
 MENTIONS OF RESIDENTS' AND STAFF'S HELP WITH
 TRANSPORTATION IN THE TWO RETIREMENT COMPLEXES

	Multi-Care		Single-Care	
	Resident	Staff	Resident	Staff
Taking residents places outside the complex	75%	89%	76%	100%
Accompanying residents on trips outside the complex	0	0	7	0
Helping with public transportation, taxis, etc	3	0	0	0
Unspecific mention of help with transportation	16	0	17	0
Any other help with transportation	6	11	0	0
	N=32	N=18	N=29	N=14

meant helping take residents outside the complexes. Residents seldom accompanied residents on trips outside the complexes, and seldom helped in other ways with transportation. There was only one mention of residents' help with public transportation and taxis in the two retirement communities.

Meals

The biggest difference in the amount of help by residents for each other between the two retirement communities was help with meals. (See Table VIII.) Residents in Multi-Care provided almost three times as much

help with meals as residents in Single-Care. There were 48 mentions of support with meals by residents in Multi-Care, while only 17 mentions of help by residents in Single-Care.

TABLE VIII

MENTIONS OF RESIDENTS' AND STAFF'S HELP WITH MEALS
IN THE TWO RETIREMENT COMPLEXES

	Multi-Care		Single-Care	
	Resident	Staff	Resident	Staff
Carrying trays to and from rooms	75%	56%	29%	79%
Helping residents get to the dining room	13	0	29	0
Helping residents get around in the dining room	4	0	12	14
Unspecific mention of help with meals	4	22	6	0
Any other help with meals and in the dining room	4	22	24	7
	N=48	N=9	N=17	N=14

When residents could not get down to the dining room, residents in Multi-Care were much more likely to carry trays to their apartments. Residents' help with carrying trays to and from apartments in Multi-Care accounted for 75% of all their help with meals, while residents' help with trays in Single-Care accounted for only 29%. (See Table VIII.) Residents in both communities were likely to help frail residents get down to the dining room. There were 6 mentions of such help by residents in Multi-Care

and 5 mentions by residents in Single-Care.

Table VIII showed that help with meals in fact concentrated on help with carrying trays to and from rooms. Of the five kinds of help with meals, carrying trays to and from apartment accounted for 91% by staff in Single-Care, 73% by residents in Multi-Care, 56% by staff in Multi-Care, and 29% by residents in Single-Care. For all the help with meals by the four sources, carrying trays was the help residents and staff at both communities were likely to provide most.

Even though carrying trays by residents in Single-Care was only 29%, such help was the kind of help residents in Single-Care were most likely to provide. Residents in Single-Care occasionally helped with meals in other ways. There were 4 such mentions. This was because Single-Care did not require residents to have meals downstairs before, so some residents cooked in their own apartments. Some residents helped bake some cookies for other residents. Some residents helped cook a bowl of soup or something when frail residents did not feel like going down to eat in the dining room and just wanted a small bowl of soup which was not available in the dining room. Now Single-Care requires its residents to go downstairs to have two meals a day.

The number of "help with meals" in other categories of help was too few to make sense. In a word, residents and staff at both communities seldom helped frail residents get around in the dining room and seldom provided other help with meals or in the dining room. For one reason, there was a special place reserved near the hallway for frail residents at Multi-Care. For another reason, staff at both communities were in the dining room helping residents.

If we considered the role of the food committee in Multi-Care, it was much easier to understand why residents in Multi-Care were much more likely to bring trays to frail residents than residents in Single-Care. The committee members in Multi-Care carried trays to other residents, while committee members in Single-Care did nothing of this kind of help.

In a word, help with meals mainly meant help with carrying trays to the apartments for frail residents. Residents in Multi-Care were much more likely to provide such help than residents in Single-Care. In fact, residents in Multi-Care provided almost three times as much help with meals as residents in Single-Care. Residents in both communities helped residents get down to the dining-room too.

Unspecific Mention of Support and Other Kinds of Support

Residents in Single-Care were much more likely to mention unspecific support for residents than residents in Multi-Care. This meant that residents in Multi-Care were more likely to know what they did for each other than residents in Single-Care. Residents may not know exactly what staff did for frail residents except for housekeeping, transportation and meals, so residents often mentioned unspecific support by staff for residents.

Residents at the two communities seldom gave other kinds of support. As the question of our study mainly addressed the topic of what residents did for other residents when they were ill or unable to do some of the things they were once able to do, staff's help may be more than the figure in our tables actually showed. One thing we did know was that staff helped most with medication. In both homes, residents were not allowed to deal

medication and only staff were supposed to do that. We also knew that the two communities provided housekeeping, meals, and two buses for their residents.

CONCLUSION

The above data answered the first question of our study: the forms of support for residents by residents in the two retirement communities. In a word, the types of support for frail residents by residents in the two retirement communities were: 1. personal services: errands inside, errands outside, mobility assistance, and other kinds of personal help; 2. social and emotional support: looking out for other residents, emotional support, social activities; 3. transportation, mainly taking residents places outside the complex; 4. meals, mainly carrying trays to and from apartments and helping residents get to the dining-room.

The above data also answered the second question of our study: the differences in the amount of help and in the kinds of help that were more likely to be available for frail residents by residents. Residents at different retirement community provided different amounts of help for other residents. Generally speaking, residents in Multi-Care provided almost twice as much help as residents in Single-Care. Specifically speaking, the biggest difference in the amount of help between the two retirement communities was help with meals for frail residents. Residents in Multi-Care provided almost three times as much help with meals by carrying trays to and from apartments for frail residents as residents in Single-Care. Residents in Multi-Care provided almost twice as much help with personal services, and almost twice as much social and emotional

support, than residents in Single-Care. Residents in Multi-Care were more likely to provide other kinds of support. Residents in Single-Care were more likely to mention residents' support or supportiveness unspecifically. However, there was almost no difference in the amount of help with transportation by residents between the two retirement communities.

There were also differences in the kind of help which was more available for frail residents by other residents between the two retirement communities. Residents and staff were most likely to provide frail residents with personal services. Residents in Multi-Care were more likely to provide errands inside the complexes, mobility assistance and other kinds of personal services. Residents in Single-Care were more likely to do errand outside the complexes, and they were also likely to provide errands inside the complex. Staff were more likely to provide housekeeping. Residents in Multi-Care were also more likely to provide social and emotional concerns for frail residents and to help with meals by carrying trays, while residents in Single-Care were more likely to help with transportation by taking people outside the complex.

CHAPTER V

DISCUSSION

In this section, we are going to discuss the result of our study. This section is divided into two parts: 1. organization of the communities and social support among residents, and 2. the impact of social support.

ORGANIZATION OF THE COMMUNITIES AND SOCIAL SUPPORT

This part is divided into two parts: 1. organization of the retirement communities and social relations among residents, 2. social relations and social support among residents.

Organization of the Communities and Social Relations

Different organization of the retirement communities and different attitudes of the staff and management affect social relations among residents at the two retirement communities.

Level of Care and Social Relations. Multi-Care was a life care facility. Once old people got into it, residents did not have to worry about their future. If they could not live independently, they moved to the Intermediate Care. If they needed 24 hour nursing, they moved into the Convalescent Center. If they ran out of money, the foundation, established in Multi-Care, would pay for them. Multi-Care would be their home for the rest of their lives. Residents in Multi-Care recognized this fact:

You move in here when you are in reasonably good health, you can look after yourself, and you can carry on your own independent life. But if something happens, you are safe here.

Somebody can look after you, and if it is not serious, why that is fine, and you have children near, lots of people do, they can help them too. We are not going to live forever, and when it is inevitable that we are going to go gradually downhill, and when the time comes, we can go to the Intermediate Care and still live a fairly normal life and then when it gets too bad, we go to the Convalescent Home, and they take us out head first (A9, 1027).

Another resident put it in this way:

We have three steps to heaven. we are here and when we can not take care of ourselves here in independent living, then we can go to the Intermediate Care where we can get some assistance. That is step one. And step two is into the Convalescent Center where we are taken care of by the nurses and everybody, and step three is you are gone (A30, 1536).

Residents in Multi-Care recognized the common problem facing them too: the more staff they had, the more they had to pay them. So they tried to help as much as they could so as to save money. They also established a foundation. If they ran out of money, the foundation would pay for them. They invested their time and energy in their community.

Residents had many kinds of voluntary activities and did many kinds of jobs to get money for the foundation. They made all kinds of things, such as furniture, jewelry, flowers, etc. Residents did not charge money for their work, but other residents were asked to donate the money to the foundation, if they wanted to pay. One resident told us:

This foundation fund is used to help people who have outlived their income. They may just need to have a little extra each month. So no one is ever turned down for lack of money. All the money from the Carousel, the furniture store, the pantry, baked food sales, rummage sales, whatever, all of that money goes into the foundation....All this help in the Pantry, and the Carousel and all the committees are voluntary help (A9, 1854).

Residents made help easy by establishing more than a hundred committees. These committees were run by the residents who volunteered to

be in these committees. Residents could choose not to join in these committees, but as everybody else was busy in some way, few people risked not to be active. What was more, it took on an impersonal feature. Once they volunteered in the communities, they were supposed to help those residents who called for help, no matter whether they liked them or not, or whether they were friends or not.

To make good use of every resident's talents and strong points, once a new resident came into Multi-Care, they would be asked about his or her expertise. Residents were encouraged to use their expertise to serve the community. The stores inside the complex were run by residents. The money they got from the sale of all stores went to the foundation. The trails along the river bank were taken care of by residents. The flowers were taken care of by residents. One resident told us:

There are other people who take care of bulletin boards and you know. There is one lady who sends birthday cards to the people in the Convalescent Center. Many of those people do not have family either. There is always a birthday card on their birthday and always a Christmas card, and there will be an Easter card...(A9, 1899).

Because of their recognition, their exchange of services, and their activities, residents in Multi-Care had some chances to know each other. Some of these committees were organized by the same wing or floor. In this way, neighbors often interacted with each other. Because of such interaction and activities, a network of mutual help ensued. Because of such interaction and mutual help among residents, it is easy to make friends.

Gradually residents in Multi-Care lived together like a close-knit community. Neighbors usually knew pretty much about other residents. They

had birthday parties together. They discussed with other residents about their problems. Residents worried about other frail residents. One resident said:

I think we talk about it, and tell each other what is going on with so and so. and then we just say, well, 'don't you think that Mary (one staff member) ought to talk with them or don't you think that maybe they need to go to the Convalescent Center until they are able to take care of themselves (A1, 814).

Residents in Multi-Care cared about the appearance of their community too. Some of their regulations reflected this. We asked residents why they allowed wheelchairs in the halls, but not in the dining room. One resident defended:

If I came down to the dining room and there it was full of people on crutches and in wheelchairs and everything, well then I would think I am living in a nursing home. I am not, I am living in a retirement apartment. So we all like that idea.... When you passed them in the halls, it may be one or two and you do not think anything about that. But the other (wheelchairs in the dining room) gives a hospital atmosphere (A9, 777).

One part of the dining room in Multi-Care was reserved for frail residents who had difficulty in walking around, and that part was surrounded by plants so as to separate it from the rest of the dining room. In this way, well-elderly could not see the frail ones in the dining rooms.

Residents were not allowed to sleep in the main lobby. They were not allowed to appear in the dining room or in the hallways with curlers in their hair or with bedroom slippers and their robes. We asked the reason. One resident explained:

We would have a nursing home all over the place if we all dress that way. It would be comfortable, but it would not be too good for the whole institution (A17, 458).

That residents in Multi-Care knew their community well meant that they cared about their community. They were also proud of it. Residents in Multi-Care knew that they had all kinds of rules. One resident said: "See, this is 36 years old. So they have had a good many years to get rules and change them and work them over so by now things are pretty clear-cut" (A30, 827). Residents liked to show people outside around their community. When I went to interview him, one resident showed me around and his expression showed that he liked his community very much and was proud of it.

Things were different in Single-Care. Single-Care required residents to maintain their independent living. Once they could not take care of themselves, they had to move out of the complex. If they got sick and went into hospital, before they came back from the hospital, they must be evaluated by doctors whether they could live independently. If they could not, they had to move out. Once they could not pay their rent, they had to move out too. There was no foundation to cover their expenses.

Residents in Single-Care had fewer chances to interact with each other. Except for having meals and having some entertainment and going shopping together, some residents did not seem to interact with each other very much. Even though they had about ten residents' committees, few residents were eager to serve in these committees. Most residents were rather well satisfied with these committees, just because they did not want to serve in the committees.

As some residents in Single-Care did not interact very much with each other, they did not know very much about their neighbors. Some did not care about their community as much as residents in Multi-Care. We

asked residents about their neighbors or friends. In Single-Care, some residents did not know their neighbors very well, and they found excuses by saying either that they had been in the community only a short time or that even though they had been in the communities for many years, but they did not interfere with others' business.

One resident told us that she had been in the community only one year and did not know very much about such things as residents' asking too much help.

I am here only a year. Some of these people have been here for 17 years or longer. They know everybody and all the things that going on while I do not because a lot of us just come up and stay in our apartment or go down for entertainment something like that, so I really do not know expecting too much business (B47, 453).

Another resident had been in Single-Care for nine years. We asked her about other residents who had moved.

I: Do you have any friends who have to move out?

R: No friends, no.

I: How about neighbors?

R: No.

I: How about anybody you know in this building?

R: Well, it is hard for me to say because I am not usually interested in things like that and sometimes I do not hear about things. I will hear somebody say something once in a while, but I do not know who they are talking about or just what happened. But I know there have been people that have been asked to move, that is all I can say about that (B33, 759).

Then we continued to ask her question. When she was asked to rate how much residents helped each other using a 1 to 10 scale, she replied:

R: I could not say that at all because I do not pay enough attention to what other people do to really know what they do in case like that (B33, 874).

Later, she told us:

Many years after I came here I was very active in the American Association of Retired Persons committee and things, and I did

so many things outside that I was not too interested in what went on here at Single-Care (B33, 993).

Staff and Management. Staff and management in each of the two retirement communities affected social interaction and social relations among residents in different ways. Staff in Multi-Care did not want residents to help beyond their limit, but liked to see them help each other. In Multi-Care, residents were discouraged from taking other residents to medical appointments outside the complex, because they were not insured for that. Because of this rule, residents in Multi-Care seldom took frail residents to such appointments outside the complex.

However, staff and management in Single-Care told residents to report to staff or to turn to staff for help. For example, residents were told that, in time of emergency, to get to the fire tower, not to assist other residents. Residents were also quickly told not to bring trays to the apartment for other residents and not to take residents out in their cars.

When we asked what were the ways residents helped each other out when some residents got sick, one resident replied:

I have not been in that situation, but I do think they do sometimes. Like from the dining room take a little dish up. But they (staff and administration) do not like that. They do not like that because it is hard, you know sometimes a little bit hard to get around. If you fall and hurt yourself, you know, with a dish of food (B1, 357).

All these discouraged residents in Single-Care from helping each other. Residents realized this. When we asked residents in Single-Care what residents did to help each other, many of them said they had nurses here. One resident told us:

This facility is different than most because it has nurses on duty that do give assistance, so we are not required to do as

much for each other as we would be if we were just living in an apartment without nursing support. And of course, it has the food department which sends food to people, so we do not have to cook for anybody or do anything like that (B35, 69).

However, once residents called a nurse to their apartments, it cost them \$20. This discouraged frail residents from asking nurses for help. What was worse, the different treatment by nurses to residents who were life care and to those who were not life care in Single-Care made the latter feel not so good. In Single-Care, there were still about 12 people who were life-care people. Those life care residents in Single-Care did not have to pay \$20 to call the nurse for help. One resident complained:

Now when it was life care, they could call the nurse at any time. They could have meals in their room at any time if they had a bad headache and they did not feel like going down, they just call and get a tray.... The rest of us, if we have the nurse up, it is \$20 (B23, 574).

She then told us how she tried to avoid the \$20.

When I got the muscle spasm, I wanted a tray, and no way. I could not get downstairs to the nurse, so I called the doctor's office and said please have someone ask that I have trays sent up. Because if I have called the nurse, she would have come up and it would be \$20 (B23, 588).

She said she was not the only one who tried to avoid the \$20. When residents knew that they needed ambulance to go to hospital, they just called the ambulance for the same reason. If they had called the nurse to come up to survey the situation, it would have been \$20. They just called for the ambulance themselves.

Conclusion. In a word, residents in Multi-Care were more likely to interact with each other than residents in Single-care. So residents in Multi-care were much more likely to be active in their community than residents in Single-Care. They were more likely to know their neighbors

better than residents in Single-Care. Residents in Multi-Care were more involved with other residents and with their community than residents in Single-Care. The norms of Multi-Care were more likely to encourage residents to get involved than the norms in Single-Care. Compared with Multi-Care, staff and management in Single-Care were quick to tell residents to ask staff for help. All these factors affected the social relations among residents.

Social Relations and Social Support among Residents

Residents. Because residents in Multi-Care were more likely to interact with each other and knew each other better and knew which residents to call for help, and because residents in Single-Care were more isolated from each other, residents in Multi-Care were more likely to ask each other for these four kinds of help first, and staff second, while in Single-Care, residents were more likely to ask staff, their family members, sometimes even those outside the complex, for help, if they did not have friends inside the complex. We asked one resident in Single-Care:

I: What about you? Are there people here who could help you out if you were ill?

R: The only ones I would know or recommend would be the nurses, and of course, they have a charge on that. The minute they enter this door, it is \$25. So do not get sick.

I: People here specifically refer to residents who can help you out?

R: I would not know about that, I really would not. See, we stay pretty much to ourselves and if we need help, we either have to phone down to the office or to the nurses. (B47, 363).

Another resident we interviewed in Single-Care gave us almost the same answer:

I: If you are ill or something like that, is there anybody you could call on for help besides your husband?

R: My son.

- I: Is there any resident that would like to help you?
 R: We have nursing.
 I: So if you needed something and you were not able to get out.
 R: Well, we have emergency cords. One in the bedroom, the other in the bath room.
 I: Well, what if it is not really serious, just kind of ill and you maybe need some food or something and you need someone to pick something up, are there residents that would help you?
 R: We have nursing who will do it (B53, 106).

Residents In Single-Care were more likely to interact with nurses than residents in Multi-Care. As residents in Single-Care did not know each other too well, they would ask nurses to serve as go-betweens. One resident in Single-Care told the nurse to ask another resident whether she wanted her to cut her hair in her apartment for her so that she did not have to go out to have her haircut and so that she could feel better. This resident did not ask the other resident directly, which implied that the two were not in very close relations.

Residents in Single-Care did not know when, where and how other residents moved and did not like to interfere with others' business. Residents in Single-care just disappeared. Staff moved frail residents out from a freight elevator. Few residents noticed it. Staff did not say to other residents what happened to those residents who moved.

Some of them (residents) sit downstairs in the lobby, and they will sit and all they do is sleep. They want to sleep. Well, they can not do that. If they start doing that too much, they (staff) start watching them very closely. The first thing you know is they (residents) are gone (B2, 1151).

One resident complained:

I told Nancy (a staff member) that it seemed inhumane. She said: "well, I agree with you, but that is the way the family wants". I don't believe it at all. I think which makes for instead of saying that this one went so and so yesterday, and this one is gone today or yesterday and so forth, because they (residents) come and go all the time. It just makes for a

better public appearance or general appearance never to know (B23, 708).

Things were different in Multi-Care. First, residents in Multi-Care were more likely to know what was going on with their neighbors and friends, and they were more likely to care for other residents than residents in Single-Care. One resident in Multi-Care told us:

We are always, all of us on this floor, for instance, are pretty much aware of when somebody is going to be away, and if we think that they are here, and we do not see them, we go rap on the door and find out if anything is wrong (A17, 865).

Second, residents in Multi-Care were more likely to show their concerns.

One way we do help each other out is not in actually doing the actual work and things like that, but if anyone has a problem like, if there is a death or something, you would be surprised that how people rally around, and give them all the comfort they can. Make sure they are included in things. You know, people are aware of things like that (A35, 268).

In fact, there are many things that residents did for each other, just did as a service to friends in Multi-Care. One couple told us:

If you break a chair, you can always take your chair down to the hobby shop, and somebody will repair it. If you need a new plug on an extension cord or on a lamp, you can always take it down to the hobby shop or take it to one of your neighbors who knows how, and they will fix it for you. There are just literally dozens of small jobs that we do for each other....If your sewing machine is not working, you do not know how to fix it, and somebody will fix it for you....I build a lot of furniture. We charge for the material and they (residents) make a donation for our labor. We do not get any money for our labor, but they make a donation to the Foundation that covers a portion of the labor. I am not the only one, there are others that do the same kind of thing.... Well, there are about over 500 of us who live in these four buildings, so it is a big complex. It is a big family (A30, 1772).

Residents also took people for a ride in their wheelchairs, pushing their wheelchairs down the corridor where they could look out of a window,

or out on a deck where they could see the river. Once in a while they helped residents to the river bank so that they could see the river again.

In addition, the counsellor on the staff at Multi-Care played a very important role to make the life of residents go smoothly. She always had time to talk, and to listen. She made residents like each other, like the staff, and like the whole community.

Residents' Committees Are an Important Source of Help. If we divide residents into three groups-- residents, friends inside the complex, and residents' committees-- and if we take into account the role of committees in each retirement community, we can see one reason why residents in Multi-Care are more likely to help each other than residents in Single-Care. Residents in Multi-Care told us about their committees, while residents in Single-Care seldom told us about their committees. Only when we probed for committees did they talk about them. In Multi-Care, there were more than a hundred committees, while in Single-Care, there were about ten committees.

Committees in Multi-Care were more likely to help other residents than committees in Single-Care. Most of the committees in Multi-Care were organized to serve other residents, while in Single-Care, most of the committees were not organized to serve residents in need, but to communicate with staff and management. Committees in Multi-Care played a very important role in helping other residents. Let's take the food committee, for example. If they wanted their trays to be brought to their apartments, frail residents could call the members of the food committee. Then members in the food committee would bring food to residents who were not able to get down to the dining room. However, members of the food

committee in Single-Care just listened to complaints about the food. They were not responsible for bringing the trays to frail residents.

The total number of mentions of support from committees was 32 in Multi-Care, but only 9 in Single-Care. Except for help with transportation, the hundred committees in Multi-Care helped other residents with meals, with all kinds of personal services, with social and emotional support, and with various other ways of support. In Single-Care, only the safety committee, the hospitality committee, and the entertainment committee provided help. The hospitality committee showed new residents around and invited them to have dinner together. The safety committee put up some signs to warn people not to walk through the drive ways. The entertainment community brought a lot of entertainment activity into the complex.

One factor we should point out was that we coded committees only when they were specifically mentioned as committees in Multi-Care; otherwise we coded the source as residents. So sometimes help that was given by committee members in Multi-Care might be coded just as residents instead of committee members. Take the following two transcripts as examples. When we asked what were the things residents did for each other when some residents were ill, one resident replied:

Well, one of the most common ways I think is for a neighbor to get the mail for somebody who is not able to get to the mail box....Another one is to bring food if it is necessary and of course take the discards down to the garbage place (A17, 156).

Another resident answered:

By getting meals for them and bringing them to their room....Anyone who is assigned to that duty on the floor or wing goes down and picks up the food and brings it back to

them (A59, 110).

We coded these two transcripts differently. We coded the former one as residents carrying tray, and the latter one as committee members carrying trays, because the former one didn't explicitly say that it was the committee members who did the help, and the latter one indicated that explicitly. However, from all our interviews, we knew that most of the help with carrying trays in Multi-Care was in fact given by committee members. If we considered this factor, the role of residents' committees was greater than the figure actually reflected.

Friends. Residents in Multi-Care were more likely to interact with each other. The more residents interacted with each other, the more likely they had chances to make friends. The more friends one got, the more sources of help one may have. This was true not only in Multi-Care but also in Single-Care. A resident in Single-Care told the following story about a friend who had to move. One resident in Single-Care had lovely friends inside the complex, because they used to play bridge together. After she had a back problem, her friends came and did many kinds of things for her. They came and walked her to the dining room to make sure she could get there every day. She had many sorts of other help too. Even the staff came to her help. She could not carry things to the garbage room like healthy residents and get rid of things daily, so the staff came up more regularly to get rid of her garbage. She wanted to stay as long as possible and she got people to help her every day. So she lived in her apartment longer than some people who had the same problem she had. Later, with all the help, she would not walk to the dining-room any more. She had to cook in her own room. People would get her groceries so she could

do that. She stayed there much longer. (At that time residents in Single-Care did not have to go down to dining room, and now residents have to.)

The above example showed that friends did much more than ordinary neighbors to help frail residents. Friends in Single-Care gave this frail resident much more help than they usually gave to other ordinary residents. This was more important in a place where residents in general did not help each other very much.

In Multi-Care, committees usually took responsibility for about three days, for example, with meals or trays. Friends usually tended to help more than three days. In fact, close friends, just like spouses, tended to do too much for their friends. One resident told us:

The volunteer is supposed to be limited , I think , to three days, and then after that you can call personal care and have somebody come and get your meals for you, but there is a charge for that, for each meal. But if you have close friends who want to help out, sometimes they will do it much longer (A59, 134).

The above data and examples showed social relations among residents affected social support given to residents by residents. Of course, those who had a spouse or family members in the complexes got the most support. Those who had close friends inside the communities also got considerable help from their friends. Residents in Multi-Care were more likely to get support from friends than residents in Single-Care because of the networks of support: the residents' committees.

THE IMPACT OF SOCIAL SUPPORT AMONG RESIDENTS

The above data showed that residents in the two retirement communities were important sources of help for frail residents. They

helped frail residents with personal services, transportation, and meals. They showed their social and emotional concerns for other residents too.

Even though there were nurses in these facilities residents were supposed to live independently. These few nurses were only for emergency. They did not provide routine or long-term nursing. In this way, residents' help was important, especially emotional support. Residents felt good when there was social support among residents. For example, residents in the wheelchairs in Multi-Care were pushed to see the entertainment, to see the view, etc. In this way, even though they were unable to walk, they could still enjoy life. They felt they were living in a close-knit community. Besides, if residents could help each other mutually, they saved money too.

Take carrying trays as another example. Help with meals was very important for frail residents to stay independent longer in their apartments. For both retirement complexes, getting down to the dining room was an indicator of independence. As long as residents could get down to the dining room, staff usually paid little attention to them, or even if staff noticed them and monitored them closely, residents usually could argue with staff that they could maintain their independent living, because they could get down to the dining room. Even if they could not get down to the dining room, they still could argue that they had someone bring meals to their apartments. If they could not get down to the dining room or had no residents to bring meals to their apartments, they shortly would have to move. Residents could ask staff for trays, but if residents asked staff for trays too often, staff would advise them to relocate. For example, residents in Single-Care could ask for trays for only eight

consecutive days.

In both sites, keeping residents involved in the community was good for residents and for the whole community. Residents could still control their lives. They could organize all kinds of activities. They could revive some of the roles they lost when they became old. They felt they were still useful. They considered the community as their home, not an institution. In this way the retirement community could maintain current residents, and recruit new ones. However, there was some limitation on social support among residents.

The Limitation of Social Support by Residents

First, residents' support was most important for those residents who were not seriously ill. If residents were really ill, residents could not help. Residents were not allowed to deal with medication in either facility. When we asked whether they thought some residents could stay longer if more help from residents was available, one resident told us:

I think that she (a resident) needed medical attention that the neighbors couldn't give to her (A39, 377).

Second, residents tended to give help on a short-term basis. There was not only a time limit but also an ability limit on such support. From the previous discussion, we knew that residents in Multi-Care were more likely to help each other than residents in Single-Care. So when we asked whether residents asked for too much help, residents in the two communities gave different answers. Many residents in Single-Care said that they had not had that experience. Some said that asking people to get a heavy load of groceries or asking people to bring meals or to do personal laundry was asking too much. Some said that they occasionally did

take people in their cars or did this or that, but they did not make a practice of providing such services. One resident even said she had met some people who she thought would ask her for help if she got friendlier (B35, 453). However, residents in Multi-Care usually pointed out that doing something constantly or on a regular basis would be too much. If it was on a temporary basis, it was all right.

Residents in Multi-Care explained:

They want to help as much as possible, but they can not wear themselves out doing it (A9, 1235).

To bring meals up to their apartments constantly would be expecting too much. To transport them around to doctors and engagements like that would be expecting a good deal, I think (A39, 119).

We are happy to do it (help other residents) temporarily, and if they need a little more care, then they move to the Intermediate Care (A9, 103).

Because the people who are trying to give help sometimes are not in the best of health. They do not have the strength to go in and change a bed or run around on a regular basis. It limits their time for things that they might want to do (A59 282).

I think on a regular basis, day in and day out, week in and week out, it gets to be a burden. When it is all the meals all the time, and you can take just so much of that without seriously interfering with your own programs. No matter how much you want to help somebody, it does almost get to be an imposition (A59, 260).

One resident even pointed out:

It is not fair to those of us who are moving in.... You help out your neighbors next door. You do all these things, but you can not be their keeper. So if people really need help, they go to the Intermediate Care (A9, 319).

When we asked how they knew when somebody was asking too much, one resident answered:

When you can not handle it. You feel like you are burdened, and you can not take care of them (A39, 137).

So if the help was a long-term obligation, frail residents should either turn to the staff or family members, or hire people for help. One resident complained:

A resident here expects for you to bring her meals a good deal of the time. And that is a little too much for some of us. There is a service. She can have her meals bought to her if she wishes (A39, 129).

One resident told us a story. The eyesight of a resident in Multi-Care was diminished. She expected her neighbor to get her mail out of the mail box, to go over all her mail and read it to her, write her checks, and do the bookkeeping. This was wearing the neighbor down. Other residents complained that this frail resident had two daughters nearby who could do it for the mother or she could afford to have somebody else do this for her. The help-giver talked with residents and wondered why this frail resident did not ask the daughter to do it for her. The help-giver was considering withdrawing her help (A61, 294).

In fact, there was some conflict among residents. In Single-Care, healthy residents complained:

There are many people who have lived here for a long time that when they do have to go to a nursing home, they fight it terribly. They do not want to go. They are not going to go, and they just have to be taken. They have to get some family members or somebody who is in charge of their affairs, I think, and see that they get somebody to get them out (B33, 845).

The too long ones are the ones that are mentally in bad shape.... They are getting in the elevator and do not know whether they are going up or down, or they get confused as to what they want or do not want.... They bug me. They (staff and management) let some of those people stay quite a long time, depending on how full they are. If they can rent to somebody, then bye-bye! But if they have vacancies, they will tolerate them. It is money. The buy-ins are not like that. The buy-ins

are much better (B23, 78).

Healthy residents in Multi-Care did not want to help frail residents over too long a period of time. They wanted the staff members to take that responsibility, but frail residents tried to stay as long as possible. Even though residents in Multi-Care understood that they had three steps to heaven, they tried to delay the time of the first step as long as possible.

Two residents pointed out:

It is hard for people to move to the Intermediate Care. They do not want to give up their independence. They want to be waited on. And that is not the purpose of the independent living. You are supposed to be able to look after yourself (A9, 474).

If we do not have a Convalescent Center with good care, it would be different, but it is just right there (A30, 391).

There was conflict between staff and residents in Multi-Care too. Staff tried to persuade frail residents to relocate, while residents tried to stay on. However, staff in Multi-Care were very skillful in advising residents to move. One resident told us:

The administration does not hesitate to step in and tell residents that now is the time to consider moving because your neighbors can no longer help you more than a day at a time and so forth. They are very good at that, but also very firm at it, because most people say, "Well, I am not ready to move yet". He (a staff member) said: "I know you are not," but he said: "it would be a good idea for you to come over now and look over the kind of apartment that you would like for when you move". So he gets them over there to see the apartment. "This will be far better than where you are." And in a matter of weeks, they are there (A61, 519).

Residents in Multi-Care could help for a short time, because they had committees. Residents were helped for three days by other residents, and after three days residents were expected to hire somebody or to ask

the staff to help them. Of course, that did not mean that residents just quit at three days, but it gave people the idea of how long was enough and that they should get somebody else to do it. However, the rule of three days prevented residents from doing too much.

Some residents realized the limitation of such help from residents in the retirement communities. One resident told us:

I would not want them to help me indefinitely. If I had a long period of illness, and even if they were willing, I would not want them to help me over that long period. I would want to go where I would get professional help (A17, 253).

Spouses, kin, and close friends tended to do too much for each other, however, their energy and ability limited them. They had to give up at last. They could not take the place of nurses. They may get frail too.

The Appropriateness of Social Support by Residents

First, residents tended to stay in their apartments as long as they could. One resident emphasized:

Nobody wants to go to a nursing home. I do not know anybody that you interview that would say that "I want to go into a nursing home. A nursing home is for old people.... It is very sad situation to get into. There is nothing stimulating about a nursing home. A place like this things are going on, and it is a nice apartment, a nice view. Things are comfortable here. This is their home, so people like to stay in their home as long as they can (B35, 1226).

The accounts residents told us also showed that residents tended to stay as long as they could in an environment of independence. Except for one or two residents who made their own mind to relocate, most of them stayed in their apartments as long as possible. Some of them were found after falling to the floor. Some of them were found in the bed, shivering.

Some were taken by sudden diseases. Some of them waited until they could no longer wait any more. Only then did they agree to relocate.

In Single-Care, many people fought to stay as long as possible. Residents told those residents who helped them "Don't report it. If it gets reported, they make me move" (B35, 1331).

One resident told us a story:

I had a neighbor.... She fell and broke her hip and then she went downhill rapidly, and she always left her door unlocked so that I could go in and help her. I would offer to fix a meal for her because she could not get downstairs. She was especially fond of waffles, and I used to make waffles quite a bit, and I would get her a waffle meal. I went in one morning, and she was laying in bed and shivering really quite a bit. So I called the nurse. The nurse came up, and the woman had to be taken to the hospital....Later, her nephew had her taken to a nursing home (B33, 512).

Conditions were similar in Multi-Care.

One resident's legs are so swollen and it may take her 30 minutes or 45 minutes to walk to a meal or to walk back afterwards. There are benches and chairs along the way. She stops at each one and rests because the effort is so great. But still, she does not want to move (A30, 1587).

Some would rather die in their apartments than relocate. One resident resisted going to the Intermediate Care. At the end, she had nurses around the clock to take care of her because she could afford to do it. She preferred to have it that way and she died in her apartment (A59, 368).

For those who could not hire 24-hour care, they had to be forced out if they were so frail that they really could not keep their independence.... One resident could not keep her apartment clean or herself clean, and did not take her medicine. Her place got pretty messy. They (staff and management) just had to get in and moved her out and cleaned up the apartment. Since then she had deteriorated a lot. Now she was in the Convalescent Center (A59, 505).

Doing too much to keep the frail ones in the independent living usually happened among residents who became good friends. Usually, the frail ones did not want to relocate. In Multi-Care, some residents gave

help to their friends that exceeded their ability to do so. One woman took a friend to the hospital on a windy day. She got knocked down by a door that was blowing. She was so much worse than the one she was taking to the hospital (A1, 338).

It happened to family members too.

There was a case of two sisters who did not live together, but one of them could not get around herself. Walking was very difficult, and the other sister was trying to go to the dining room, get meals, take them to her sister three times a day, and see that her sister's clothes were washed (A59, 342).

Most often, doing too much was trying to keep a frail spouse from having to relocate. Either the husband was doing too much for the wife or the wife was doing too much for the husband. When we asked how they knew that somebody was doing too much, one couple in Multi-Care told us three stories about couples who were doing too much.

I think of R.S., L. J.. Their wives needed so much care. Their wives are now in the Convalescent Center, and the two men are in much better health. They are not tired, and they are jolly again.... You usually can tell when they are under stress. We have a couple next door. She had Alzheimer's disease. She will sit through part of a meal and get up. Well, he has to leave the table and walk with her. They might even walk the halls four, five or six times a day. They may even leave the dining room before the meal starts. This is wearing him out. He is tired. He does not smile any more (A30, 622).

In Multi-Care, when the caregiver became ill, the person he or she was caring for moved to the Convalescent Center. When he or she was back in the apartment again, they both came back.

Staying too long in an independent living apartment was not good for the help-givers. The help-givers in the retirement communities, no matter whether they were their family members or friends, because of their age and ability, could not do the nursing jobs all the time. In fact, doing

too much was not good for their health. They were usually under both physical and psychological stress while they gave help on a regular basis.

One resident pointed out:

Most people here are very active, but they are getting old and they get tired too. You could make them sick just by using them too much (A30, 365).

One resident in Multi-Care told us an extreme story about another resident. One woman moved out of Multi-Care, because she was helping a friend, and this friend was not well. She had to help this friend, but it got to be so bad that she was getting ill, and she could not tell her friend "I can not do it any more", so she just moved out (A9, 452).

One resident in Single-Care told us a similar story:

I was a friend of him and his wife....He moved to some place else because he was doing too much, and it was bad for his heart. You know, everybody was asking him, "Doc, would you come and fix this for me?". "Would you fix my toaster?". "Would you look at my T.V.?". He was running around to do things....He was doing too much, and he was ruining his health (B2, 426).

One resident in Multi-Care pointed out:

We have to keep ourselves well and have a happy life and all of that. That's what we are paying for. That is why we moved here (A9, 627).

Doing too much for frail residents was not always good for frail residents either. One resident told us this story.

I know a dear lady who can not remember. Everybody was trying to help her, and everybody was trying to direct her when she got lost. They will tell her "Now you must do this and you must do that". You know my feeling is that too many were trying to help her and it was causing more confusion than it was help. Finally, she went to the Intermediate Care where she got professional help. But there was quite a period when she was getting all these offers of help. They were all meant good faith, but it was not accomplishing what was needed. It is hard to make the decision to move (A17, 329).

In fact, when frail residents moved to the Intermediate Care on time, they would have all the things done for them, get all the attention they needed, and take their medicine on time. They would not be under the psychological stress, pretending that they could live independently in their apartments. They wanted residents for help but did not want to ask. The relocation on time was good for their health, both physical and psychological.

After those residents moved to the Intermediate Care, they told their friends that they should have moved earlier, because of all the extra things that were done for them and the extra attention they got from staff. One resident told us a story. One of her friends fought going over to the Intermediate Care. It took the home's director three years to convince her to move to the Intermediate Care. Even though she was not completely convinced, staff packed her things and moved her to the Intermediate Care. There she discovered all the friends she thought had lost to death were still alive there. The nurses and aides did so many things for her that she felt that she had wanted someone to do that and did not want to ask. Later She told her friend, "you know, I should have moved before because I like it so well. They do every thing for me" (A61, 794).

In fact a good thing about the Intermediate Care was that staff could monitor the medication. If frail residents took the medication regularly, usually they got much better. This plus the services provided by the staff made many frail residents in Multi-Care delight about their relocation. Some even said that they should relocate there earlier (A1, 66).

CONCLUSION

The information from our interviews, reported above, allows us to evaluate our hypotheses. Our data reveal that organization of a housing facility is, indeed, related to social relations among residents. They also indicate that social relations are related to the amount of help available for frail residents. Because of the different social organization of Multi-Care and Single-care, residents in Multi-Care are more likely to be involved in the community and more likely to interact with each other. Residents in Multi-Care are more likely to help other residents than residents in Single-Care. With this help, frail residents with gradual physical decline can stay independent longer .

The above discussion also explores the third, fourth and fifth questions in our research: the impact of social support among residents, the limitation of such support and the appropriateness of such support. With the help from other residents, residents who are ill may stay a little bit longer, or residents who are ill for a short time may get over their temporary crisis more easily. Also, social and emotional support among residents is also very important for residents. However, there is a limit on residents' support for frail residents. Those residents who give help were old too. Their declining ability and energy prevent them from giving frail residents long-term help. Also, these old people pay money to go to the retirement communities to enjoy the life in the community, not to become long-term care-takers. Long-term obligation can affect their activities and even their health. In addition, staying too long in the independent living by those frail residents also produces

negative consequences for them too. Frail residents who stay too long are under stress too, pretending that they can live independently. They try to avoid asking staff for help and try not to ask residents for help but at the same time need them for help. The lines between appropriate and inappropriate help is that on the one hand residents should help each other out but should not give help beyond their ability, and on the other hand frail residents should not stay too long in their apartments and should not depend on residents to take care of them on a long-term obligation. This shows that it is not appropriate for frail residents to stay too long in the independent living in retirement communities.

CHAPTER VI

CONCLUSION

From our study, we have found that residents in retirement communities are an important source of help for frail residents. Residents help each other with personal services, transportation, and meals, and provided social and emotional support.

The organization of the housing facility affects the social relations among residents. Social relations are linked to the amounts of support available for frail residents. Because of the different organization of the two housing facilities, residents in Multi-Care are more involved in their community than residents in Single-Care. Because of such involvement and interaction, residents in Multi-Care are more likely to be interested in things going on inside the complex than residents in Single-Care. They are more likely than residents in Single-Care to show their social and emotional concerns, to help with personal services, and with meals. However, there are a time and an ability limitation on the support among residents in both locations. Residents' mutual help is good to a certain point. Beyond this point, such help is a burden for both help-givers and help-receivers. So, it is not appropriate to ask residents to take the place of their family members or the nurses.

Our study has clear implications for housing for old people and for support theory. Our results indicate that residents in Multi-Care are more

supportive than residents in Single-Care. Social involvement for the old people is very important. The residents in both sites and the organization of the housing facilities affect such involvement. There are more social involvement and interaction in Multi-Care than in Single-Care. Social involvement increases the chances of developing mutual assistance networks. However, frail residents should be cautioned not to abuse the support from other residents in the community. To provide benefits to the frail elderly, we should make the best use of the three parts of the support system: kin, friends and neighbors, and formal support (Litwak and Szelenyi, 1969; Little, 1983).

Our study also has clear implications for future studies on housing for old people and for support theory. First, in our study, we have found a new source of support for residents in retirement communities: residents' committees. They are semi-formal. Residents volunteer to join in, but once they join in, they feel an obligation to give help. Residents' committees are important for residents in need. Further study of the functions and the roles of these committees in helping residents will give us a better understanding of the overall support system.

We have explored the types and the sources of help for residents in retirement communities, and have found the different amounts of help among residents reflect the different organization of the two retirement communities. Future studies can test the results of our study by using a larger and more diverse sample of communities of the elderly.

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APPENDIX A

INTERVIEW GUIDE

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INTERVIEW GUIDE

We're interested in talking to you about life here at (_____) and the kinds of help that residents give to each other here.

The first thing we want to do assure you are doing all of this on a voluntary basis and you are free to not answer any questions. We have worked with our university to write up a statement informing you about our research and we'd like you to read it over and sign it if you agree.

The kinds of questions we'll be asking you are fairly general, so there aren't any right or wrong answers. Instead, we want to hear from you about your experiences as a resident here at (____).

1. First of all, when did you move to (____)?

2. Where were you living before you came here?

Probes:

- Was that here in Portland? (If not, where was it?)
- Was that a house or an apartment or what?

3. Do you have any family members living here in Portland?

(NOTE: among "family members" we are most interested in children.)

Probes:

- Where do your nearest family members live?

4. Have you lived in more than one apartment since you moved here, or have you always been right here? (Probe for multiple moves within complex and reasons for any such moves and when they occurred.)

4a. (If necessary) Do you share this apartment with anyone?

Now we have some questions about ways that residents here help each other out.

Over the years, many of the people who live in any retirement community develop health problems that keep them from doing some of the things they once were able to do for themselves. Sometimes these problems

last for just a short time, other times they are so serious that a resident may have difficulty staying in his or her apartment. We're interested in how residents help out when someone has these kinds of problems.

5. What about when someone can't to do things for him or herself, what are some of the ways that residents help out? (If necessary: We're interested in what people do for each other when someone is ill or just needs more help than usual.)

NOTE: the strategy here is to begin by doing as much non-directive probing as possible.

- Probes: — Can you give me an example of that?
 — Can you think of any other ways that people help out?
 — What do else do people do when someone needs help?
 — Is there anything else that people do?

NOTE: After the non-directive probing, you should follow-up with some directed probes in the areas of errands and transportation.

Errands: You mentioned _____ (and _____), are there other ways ways that residents help each other out with errands?

OR (if necessary): One area that we're interested in is errands. How do people here help each other out with errands?

Transportation: You mentioned _____ (and _____), are there other ways that residents help each other out with transportation?

OR (if necessary): One area that we're interested in is transportation. How do people here help each other out with transportation?

6. What about you, are there people who could help out if you were ill?
 — (If yes) About how many people like that are there? Is it more like 1 or 2, or 3 or 4, or what?
 — (If spouse or partner is the source of support: Is there anyone else who could help out if you needed it?

7. Sometimes people who need help expect too much from other residents. Can you give me an idea what is too much to ask for or expect from other residents?

- Probes: — Can you give me an example of that?
 — What other kinds of things would be too much to ask for?
 — How do you know when someone is asking for too much?

8. I just asked you about situations where residents ask for or expect too much from other residents, but are there also times when friends and neighbors try to do too much? (If necessary: Are there times when people should really pull back from helping?)

- Probes: — Can you give me an example of that?
 — What are some other situations where people try to do too much?
 — How do know when someone is trying to do too much?

9. Up until now we've been talking about things that residents do for each

other, but what about the staff? What are the kinds of things that staff should be doing instead of having residents do them? (If necessary: Are there times when staff should really be doing the helping, not residents?)

Probes: — Can you give me an example of that?

— When should residents let staff do things?

— What else should staff be doing instead of having residents do it?

9a. Are there some things that only staff are supposed to do and that residents are not supposed to do?

Probes: — Can you give me an example of that?

— When there rules about things that staff are supposed to do?

10. So far we've been talking about helping out in general, now we have some questions about your former neighbors. We want to ask about specific people because it helps us get a clearer picture of how this works when we can follow one or two examples in some detail. We're particularly interested in any of your neighbors who has moved because of health problems or because he or she was no longer able to do the things that are expected of residents here at (_____). What about people who used to live on either side of you or across the hall, is there someone that used to live there but has had to move out? (If no: What about someone who wasn't necessarily a neighbor. Can you think of someone you know from elsewhere in the complex who has moved?).

10.1 How long were you and (first person) neighbors?

10.2 How long ago did (first person) move?

10.3 Where did (first person) move?

10.4 What kinds of problems caused the move?

10.5 Why did the move happen when it did?

10.6 Were there things that people did that allowed (first person) to stay here longer than they would have if they hadn't had this help?

Probes: — Could you give me an example of that?

10.7 Could (first person) have stayed longer if more help was available?

10.8 Do you think this move happened too early or too late or at just about the right time? Why?

10.9 Was there ever a problem with (first person) asking for too much or expecting too much?

10.10 (If necessary) One area that were interested in that you haven't mentioned is how the staff here are involved in situations like this. Were the staff involved in any of this?

10.11 (If necessary) One area that were interested in that you haven't mentioned is how family members are involved in situations like this. Was this person's family involved in any of this?

11. Is there another person who used to live on either side of you or across the hall who has moved to the Terrace or convalescent center? (If no: What about someone who wasn't necessarily a neighbor. Can you think of someone you know from elsewhere in the complex who has moved?).

11.1 How long were you and (second person) neighbors?

11.2 How long ago did (second person) move?

- 11.3 Where did (second person) move? Why?
- 11.4 What kinds of problems caused the move?
- 11.5 Why did the move happen when it did?
- 11.6 Were there things that people did that allowed (second person) to stay here longer than they would have if they hadn't had this help?
- Probes: — Could you give me an example of that?
- 11.7 Could (second person) have stayed longer if more help was available?
- 11.8 Do you think this move happened too early or too late or at just about the right time? Why?
- 11.9 Was there ever a problem with (second person) asking for too much or expecting too much?
- 11.10 (If necessary) One area that were interested in that you haven't mentioned is how the staff here are involved in situations like this. Were the staff involved in any of this?
- 11.11 (If necessary) One area that were interested in that you haven't mentioned is how family members are involved in situations like this. Was this person's family involved in any of this?
12. Overall, thinking about people in general, and not about anyone in particular, are there times when people try to stay here too long?
- Probes: — When is it too long?
- How do you know when someone has stayed too long?
12. Now one last question, how much you say that (_____) is a place where people help each other out? How would you rate it on a scale from 1 to 10, where 1 means that people don't help each other out very much and 10 means that people help each other out a great deal?
- Probes: Why do you say that?

That's all the questions we have for you, but is there anything else you would like to tell us or ask us?

APPENDIX B

CODING OF POSITIVE ASPECTS OF SUPPORT

APPENDIX B

CODING OF POSITIVE ASPECTS OF SUPPORT

GENERAL INSTRUCTIONS

For an item to be coded, it must be about a resident. For example, things that residents do for their family members outside the building are not coded. Nor are things that the residents experience prior to moving into the facility or after moving out. One exception is when support is offered to a resident who has had to move, but the source of support assumes that the resident will return to an apartment.

Because we are coding segments of transcripts, it is important to try to limit the line number range to the exact item being coded. In particular, if two codes are distinctly different, then you should try to keep them from overlapping, i.e., no line included in one code should be included in the line number range for the other code. This is most important when there is a difference in the form of statement or the source of support, or when positive aspects of support are being compared to negative aspects. It is less important when the only thing that varies between 2 codes is the exact type of support, e.g., when the person is giving a list like string of types of support, all from the same source.

In general, we are trying to code each "mention" of a form of support. If a person speaks at length about a particular form of support, this will generate only one code. The basic goal is not to count repetitions of the same ideas more than once, unless they are separated by a moderate amount of discussion of other issues. This later is

obviously a judgement call, but a minimum standard is that if the same point is made in response to two different questions in the interview, then 2 codes are required.

BASIC CODES

A basic code for the positive aspect of support has 3 parts: (1) the form of statement, (2) the source of support, and (3) the type of support. The form of the statement distinguishes the context in which the support is mentioned; there are 2 different categories for forms of statements. The source of the support is the category of the person or persons providing the support; there are 9 different categories for sources of support. The type of support describes the actual thing that is being done for a resident; there are 5 broad categories for types of support and these are subdivided to include several specific types of support.

Form of Statement The two forms of statement that we will be coding are: G, general statements and X, examples.

When the transcript contains a general statement about support, then the basic code will begin with G. For a code of G, there should be both a source of support and a type of support, even if the type of support is only one of the 4 broad categories, rather than one of the 18 specific types of support. If these are not present, this is most likely to be an instance of a Vague statement. The source or recipient of the support should not, however, be an identifiable resident. If an actual individual is being referenced, then this is likely to be an Example.

When the transcript contains an example of some type of support that

one actual person did for another, then the basic code will begin with an X. This code is still appropriate if only the source or the recipient of the support is a concrete individual, even if the type of support offered is only a broad category. For instance, "Mrs. Elsie was always running errands for people," as is "She needed someone to help her with meals for the last 3 months that she was here."

Source of Support The second letter in each basic code refers to the category of the person who is providing the support.

R refers to other Residents.

U refers to someone who shares a Unit with the person receiving the support. In most cases, this will be a spouse, but it can be a partner other than by marriage, as well as siblings who share a unit.

I refers to family members who live Inside the complex, but not in the same unit.

F refers to Friends who live inside the complex; these relationships should be explicitly referred to as somehow closer than relationships with other residents (friends outside the complex are "O").

C refers to Committees or other formally organized sources of support among residents.

K refers to family and Kin who live outside the complex.

S refers to Staff members, including housekeepers, dining room staff, business office personnel, nurses, and anyone else who is paid by the facility to provide routine services.

P refers to people Paid by the resident or family members etc. Costs for this category are above and beyond the services received as part of the basic payment or original buy-in. In some cases, the facility makes the service available (e.g., personal aides or beauticians), but the resident must pay extra.

O refers to Others, outside the categories listed above.

Types of Support The actual kinds of support are the last element in a basic code. The actual code consists of a letter for the broad category (M for Meals, P for Personal Services, T for Transportation, C for Concern, and O for Other) and a number for the specific activity within that category. There should be a space separating this portion of the code from the earlier elements of the basic code.

M Meals

- M0 — GENERAL, mentions of this category, no specific activity
- M1 — TRAYS, carrying trays to and from rooms.
(includes any form of taking meals to rooms)
- M2 — TODRM, helping a person get to the dining room.
- M3 — INDRM, helping a person get around in the dining room.
(includes helping to seat, helping with trays, etc.)
- M9 — OTHER, any other assistance with meals and in dining room.

P Personal Services

- P0 — GENERAL, mentions of this category, no specific activity
- P1 — ERRIN, errands in the building.
(includes picking up mail or deliveries, shopping in building)
- P2 — ERROUT, errands outside the building.
(includes shopping outside)
- P3 — MOBILE, mobility assistance (other than with meals).
(includes pushing wheelchairs, helping with walker)
- P4 — HKEEP, assistance with housekeeping.
(includes mending, laundry, cleaning, etc.)
- P9 — OTHER involves other kinds of personal services.
(reading letters, watering plants, escorting on trips inside, giving medication, party preparation, repairs, filling forms)

T Transportation

- T0 — GENERAL, mentions of this category, no specific activity
- T1 — RIDES, taking people places outside the complex.
- T2 — ESCORT, accompany people on trips outside the complex.
- T3 — PTRANS, help with public transportation, taxis, etc.
- T9 — OTHER, other assistance with transportation.

S Social Emotional Concerns

- S0 — GENERAL, mentions of this category, no specific activity
- S1 — EMOT, emotional support or assistance.
- S2 — LOOK, looking out for other people.
(reminders for meals & medications, checking up on, etc.
— should require little energy, most could be done by phone)
- S3 — SOC, assistance with social activities.
(must be a form of social support, not just an activity)
- S9 — OTHER, other expressions of social or emotion concern.

O Other

- O0 — GENERAL, vague mentions of support and supportiveness
(no specific topic or activity)
- O9 — OTHER, supports that do not fit into another category.

EXAMPLES OF BASIC CODES

GS M1 (General) (Staff) (M1=Meals, TRAY)

— General statement about staff members bringing trays to residents.

XP P2 (eXample)(Paid)(P2=Personal service, ERROUT)

— Example of paying someone to do errands outside the building.

GR P0 (General)(Residents)(P0=Personal service, General)

— General statement about residents doing personal services.

XU T1 (eXample)(Unit)(T1=Transportation, RIDES)

— Example of a spouse or equivalent giving rides outside complex.

GF S1 (General)(Friend)(S1= Social emotional, EMOT)

— General statement on friends from outside giving emotional support.

GS T0 (General)(Staff)(T0=Transportation, General)

— General statement about staff providing transportation

GR O0 (General)(Residents)(O0=Other, General)

— General statement about residents supporting each other

SUMMARY OF BASIC CODES

Form of Statement

G, general statements

X, examples

Source of Support

R refers to other Residents

U refers to someone who shares a Unit

I refers to family Inside the complex

F refers to Friends inside the complex

C refers to Committees of residents

K refers to Kin outside the complex

S refers to Staff members

P refers to people Paid by the resident or family members etc.

O refers to Others, outside the categories listed above.

Types of Support

M Meals

M0 — GENERAL, mentions of this category, no specific activity

M1 — TRAYS, carrying trays to and from rooms.

M2 — TODRM, helping a person get to the dining room.

M3 — INDRM, helping a person get around in the dining room.

M9 — OTHER, any other assistance with meals and in dining room.

P Personal Services

P0 — GENERAL, mentions of this category, no specific activity

- P1 — ERRIN, errands in the building.
- P2 — ERROUT, errands outside the building.
- P3 — MOBILE, mobility assistance (other than with meals).
- P4 — HKEEP, assistance with housekeeping.
- P9 — OTHER involves other kinds of personal services.

T Transportation

- T0 — GENERAL, mentions of this category, no specific activity
- T1 — RIDES, taking people places outside the complex.
- T2 — ESCORT, accompany people on trips outside the complex.
- T3 — PTRANS, help with public transportation, taxis, etc.
- T9 — OTHER, other assistance with transportation.

S Social Emotional Concerns

- S0 — GENERAL, mentions of this category, no specific activity
- S1 — EMOT, emotional support or assistance.
- S2 — LOOK, looking out for other people.
- S3 — SOC, assistance with social activities.
- S9 — OTHER, other expressions of social or emotion concern.

O Other

- O0 — GENERAL, vague mentions of support and supportiveness
- O9 — OTHER, supports that do not fit into another category.

APPENDIX C

CODING OF PROBLEMATIC ASPECTS OF SUPPORT AND MOVES

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CODING OF PROBLEMATIC ASPECTS OF SUPPORT & MOVES

We are currently dividing the coding of the interviews into two separate tasks: 1) the coding of support exchanges, essentially the positive aspects of support; 2) all other topics related to support and moves, essentially the problematic aspects of support. This second set of codes will be more open-ended in nature, with a goal of capturing the themes and categories that describe problematic aspects of support and moves.

The basis for our initial definition of the problematic aspects of support comes from the general themes that we asked about directly in the interview. Our goal is to use these general areas as a starting point and mark blocks material that fit into each of them. At some later point, we will probably refine and extend this coding system. For now, we simply want to be able to locate material related to the following codes:

ASK TOO	— Asking for or expecting too much from other residents;
DO TOO	— Other residents trying to do too much for someone;
STAY TOO	— Residents staying too long;
STAFF	— Situations where staff play a role in moves;
RULES	— Situations where community rules affect moves;
WHY MOVE	— Statements relating to when moves occur and why;

This material may or may not appear as a response to a direct question (e.g., we might hear about why residents "have to move" during our early questions on providing support, and we would code it there or anywhere else that it occurred in the interview). This material can also appear in the form of either general statements or specific examples; for now, we are not distinguishing between these.

The proper way to code this material is in longer segments that capture as much of the context as may be useful. Note that this is the opposite of the approach we have used with the support codes, where we try for very limited, non-overlapping segments. Given this difference, it probably makes sense to do the support codes right next to the numbers, and the problems codes further to the right, as many of our segments on problematic aspects will also include several support codes.

These codes will overlap each other when a given segment contains more than one type of material — and overlapping is preferable to "artificially" breaking the code segments. It is also permissible to generate long segments that span remarks by the interviewer, so long as the informant is providing a more or less continuous discussion of one of our problematic themes. If, however, there is a notable shift in the kind of material that is being discussed, even if it all fits within the same overall theme, it would be desirable to capture this as two (possibly overlapping) codes.

APPENDIX D

CODING OF ACCOUNTS

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CODING OF ACCOUNTS

RESPONDENT'S ID# _____ Story #1 #2 #3 #4
 Start line# _____ Stop line # _____

Where did the person move?

- ☐ Died (no other residence; if died elsewhere, code as type of place)
- ☐ Nursing Home or other higher level of care (including Mann Terrace)
- ☐ Other retirement facility
- ☐ With family
- ☐ Other

What kinds of problems caused the move?

- ☐ Gradual Physical Decline
- ☐ Gradual Mental Decline
- ☐ Sudden Decline (e.g., stroke, heart attack, fall with no warning, etc.)

Things people did that allowed to stay longer? ☐ Yes ☐ No ☐ Don't Know
 (If yes, say what)

Could the person have stayed longer With more help? ☐ Yes ☐ No ☐ Don't Know

Do you think this move happened too early

- ☐ Too early
- ☐ Too late
- ☐ About the right time

Was there a problem with asking for too much? ☐ Yes ☐ No ☐ Don't Know
 (If yes, say what)

Was staff involved? ☐ Yes ☐ No ☐ Don't Know
 (If yes, say how)

Was family involved? ☐ Yes ☐ No ☐ Don't Know
 (If yes, say how)

Was it voluntary? ☐ Yes ☐ No ☐ Don't Know
 (How?)