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Social Lives and Cliques Within Senior Housing Communities

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Abstract

A better understanding of social environments will benefit facilitation of social cultures within senior housing communities. Social cliques naturally form among groups of people, particularly those living in close proximity. Research has shown that often older adults experience stigma based upon their health status and are excluded from social groups. This study examined residents' perceptions of life in senior housing, social stigma, and cliques. Forty-eight residents from two types of senior housing communities participated in the study. Qualitative thematic coding was used to analyze responses to open-ended interview questions. Overall, residents reported satisfaction with the community and their privacy and reported difficulties with distance from family, caregiving, and bereavement. The majority were able to identify cliques, defining them based upon common interests, health status, and shared histories. The most salient finding was that while social cliques existed they were not a source of dissatisfaction or stigma.

Keywords

Senior housing; social interaction; cliques

Social Lives and Cliques Within Senior Housing Communities

Senior housing communities (e.g., independent living, assisted living, continuing care retirement communities) provide an attractive option for older people who seek a more convenient lifestyle without the burdens of home ownership, while taking advantage of an increased availability of activities and socialization (Marx, Burke, Gaines, Resnick, & Parrish, 2011). In general, new residents of senior housing communities report perceptions

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of an improved social lifestyle (Heisler, Evans, & Moen, 2004), and most senior housing residents enjoy a wide range of activities and interactions with neighbors and staff (Cutchin, Marshall, & Aldrich, 2010).

Social contact with others and development of a network of support are key to well-being (i.e., life satisfaction, perception of the senior housing community feeling like home) and quality of life (QoL) (Roberts & Adams, 2017; Street, Burge, Quadagno, & Barrett, 2007). A strong support network becomes more important with increasing age since friendships have been shown to play an important role in buffering against the negative effects of aging including general health, mood, and cognitive and physical functioning (Ewen, Emerson, Washington, Carswell, & Smith, 2017; Hatfield, Hirsch, & Lyness, 2013; Huxhold, Miche, & Schüz, 2013; Min, Ailshire, & Crimmins, 2016; Otero-Rodriguez et al., 2011; Obiesan & Gillum, 2009; Park, Jang, Haley, & Chiriboga, 2013; Potts, 1997; Samson, Bulpitt, & Fletcher, 2009).

Even though retirement communities often try to provide a sense of community, seniors may have negative social experiences and feel distanced or excluded from the community (Hrybyk et al., 2012; Hubbard et al., 2003; Roth et al., 2012). Older adults residing in senior living communities who experience negative social interactions may experience negative outcomes such as declines in physical and mental health (Croucher, Hicks, & Jackson, 2008; Silverstein & Zblotsky, 1996). One type of impetus for negative social interactions or experiences comes in the form of “othering”. “Othering” occurs when people different from oneself or one’s social group are identified and set apart (Johnson, Bottorff, Browne, Grewal, Hilton, & Clarke, 2004). “Othering” often results in hierarchies of social positions, stereotypes, and social cliques. A clique is a cohesive group of individuals that provides a sense of belonging and identity (West, Barron, Dowsett, & Newton, 1999). Being excluded from social cliques or labeled as an “outsider” or as an “other” may result in social stigma and lead to feelings of isolation (McDonald & Jensen-Campbell, 2011).

Dobbs et al. (2008) used ethnographic methods to study stigma in a senior housing community. They found that residents were subjected to stigma as a result of a variety of reasons including their age, class, race and ethnicity, disabilities, and cognitive status. Similarly, Roth and colleagues (2012) explored exclusive groups and cliques within a senior housing community and found that divisions had formed among the residents, typically hinging on health status. Those who were considered frail were “othered.” Research has shown that residents with greater functional ability will outwardly avoid those who are considered frailer (Dobbs et al., 2008; Roth et al., 2012; Sandhu, Kemp, Ball, Burgess, & Perkins, 2013). Research within senior housing environments supports findings that residents’ report disassociating from others who were perceived as older, disabled, or “different” from themselves (Ayalon & Green, 2013; Bonifas, Simons, Biel, & Kramer, 2014; Shippee, 2009; Schafer, 2011).

The process of “othering” one’s self from the stereotyped frail older adult is a critical component of stigmatizing behavior (Hrybyk et al., 2012). Intentional functional age-identity separation is exacerbated within senior housing communities because residents are experiencing age-related changes as a group, but at different rates. Hubbard and colleagues’

(2003) research of frail older adults living in senior housing communities found that individuals considered frail by others were segregated, ignored, and labeled with derogatory terms. Similar findings were reported based upon physical conditions such as cognitive dysfunction and hearing loss (Hubbard, Tester, & Downs, 2003; Kemp, Ball, Hollingsworth, & Perkins, 2012). Despite a wealth of literature on social relationships, little research has been conducted on social interactions and social cliques and the significance of cliques in transitioning into senior housing communities.

Therefore, the purpose of this study is to explore resident perceptions of the social environment and to identify what aspects of the social environment contribute to the experience of "stigma/othering" in senior living communities. A better understanding of social environments within senior housing communities would increase understanding of how social cultures and practices provide a foundation for the development of social cliques and social norms. Such information would benefit senior housing administrators and directors as they develop activities, welcome new residents, and set the overall expectations for conduct in planned social activities.

Research Questions

The primary research questions for this study are (1) "What aspects of the social environment contribute to social interactions in senior housing communities?" and (2) "How do social interactions contribute to social rules and groups in senior housing communities?" In order to answer these primary research questions, we asked the following secondary research questions explored in this study: (1) What are the best and most difficult aspects of living in senior housing communities? (2) What, if any, unwritten social rules exist within the facilities? and (3) What, if any, social cliques exist?

Methods

The project was reviewed and approved by the institutional review boards (IRB) at the University of Kentucky and Miami University.

Senior Housing Samples.

Two senior housing communities (i.e., senior apartments and a continuing care retirement community/CCRC) proximal to the researchers conducting the study were selected for participant recruitment. Information about the study was sent to the community administrators who gave consent to solicit participation of residents. Administrators posted flyers about the project throughout their facilities. Residents contacted the researchers based upon information provided throughout the communities.

Study Participants.

A total of 48 residents agreed to participate in the study (n=22 from the CCRC and n=26 from senior apartments). The residents self-selected to participate and, thus, were unlikely to be representative of each community; however, it was not possible to compare those who did and did not participate. Pre-screening with the Short Blessed Test prior to interviewing

ensured that all participants were cognitively intact (Katzman, Brown, Fuld, Peck, Schechter, & Schimmel, 1983).

Table 1 provides demographic and health characteristics of the participants. The ages of participants were comparable, but the participants differed by the range of educational attainment. The senior apartment housing group was comprised entirely of women, whereas the CCRC sample had both men and women, with higher proportions of women. The senior apartment housing group had a range of marital and partnership statuses including those who were single/never married and divorced. Participants in the CCRC group were either married or widowed. Functional health status measures were comparable with only one exception: the senior apartment housing participants had higher proportions of persons who needed assistance with eating/dressing/or toileting. These differences were not surprising given the higher socioeconomic status required for residency in the CCRC.

Procedure.

In this qualitative study, in-person interviews were conducted in the older adults' home or at another location of their choice by the study director or a graduate student researcher. The consent form was read aloud and two copies were signed by both the participant and the interviewer. The participant received a copy for their files and the other was returned to the university and stored in a locked file cabinet. The interview took approximately 40 minutes to complete. For the duration of the interview process field notes and memos were made which allowed for specific context-relevant information to interpret the participant responses. Subsequently this strategy was used to enrich the data about the participant's physical response, or body language, at certain parts of the interview or in response to certain questions. It was also used to provide additional information about the environment and the presence or absence of potential themes.

Interview Content.

Participants were interviewed regarding their housing, health, life satisfaction, social interactions, and well-being. Participation entailed completion of open-ended queries. The samples were designed to be smaller in order to gain more detailed information on participants' experiences. The interview questions to assess the social environment were: (1) "*What is the best part of living here? Please explain why"; (2) What is the most difficult part of living here? Please explain why"; (3) "What, if any, unwritten social rules exist within this community?"; and "What, if any, social cliques exist?"* Elicitation techniques, such asking probing questions after participant responses, were used to elicit tacit knowledge.

Analytic Plan

Responses were prepared for analysis by the lead author by aggregating responses according to each specific question using the sample as a whole. The responses were independently analyzed by three researchers (i.e., co-authors) in order to identify common responses and foundational themes. Despite the sociodemographic differences and community structures of the two samples, similar themes were identified. Therefore, it was determined to combine the study samples for the qualitative analyses. An examination of meaningful descriptions

based on the information shared by the participants on personal experience was analyzed through thematic coding (Braun & Clarke, 2006). The independent researchers constructed codes in order to identify patterns within the data regarding participant descriptions of their social experiences in senior housing communities.

Coded themes and memos related to making comparisons between data and codes to construct themes were compared among the independent researchers at three separate occasions to address inter-coder reliability. All analyses were conducted by hand without use of qualitative software. The researchers triangulated the socially-constructed views within participants' narratives in order to evaluate the investigators' interpretations for ensuring reliability and validity of codes, using a realist approach to thematic analysis (Roulston, 2001). Given that data were handwritten, the researchers queried the interviewers about inflection and emphases placed by the participants on responses, though much was noted during the interview. This additional clarification assisted with final thematic analyses. Many of the responses were thin, but succinct and are presented as descriptive findings and discussed as a touchstone for further inquiry.

Results

Results of the coded thematic analysis are described below.

Social Environment: Best Aspects.

Respondents were asked about the best aspects of living in a senior housing community (secondary research question #1). Themes of (1) care, (2) community, and (3) independence and privacy were identified as the best aspects of living in senior housing communities.

Care.—Within the theme of "care," residents mentioned amenities such as housekeeping and onsite healthcare or community-based healthcare services. One resident stated, *"I love not having to super clean the house, doing yard work, and having assistance to help me stay here*." Another said, *"I have a place to stay and people to watch over me and my kids won't have to worry."*

Community.—The dominant theme of community was shown using representative quotes that mentioned other residents, staff, and college student visitors. *"If I have to single out one thing, it would be the close personal relationships with neighbors and friends and the amiable and easy social atmosphere. The staff make every effort to make our lives good."* Another participant stated, *"Everything is good – the people here, both staff and residents, the ability to help with our church here at the facility."* Lastly, *"The new friendships and contact with so many college students. The exposure to younger people is wonderful."* Availability of common areas provided shared areas in which social interaction and recreation occurred, yet individual apartments served as havens of privacy and a place to feel independent.

Privacy.—Residents appreciated their privacy. While they discussed their proclivity for recreation and social interaction, most noted that the staff knew when to leave them alone. Their apartments provided privacy into which they could retreat and independence related to

the ability to bring their own personal touches to the housing environment and have perceived control over their physical environment. Privacy and independence were also a subcomponents to the unstated social rules within the senior apartment community in which socialization took place in common areas and were dependent on group activities in comparison to individual living units where socialization did not occur and activities were based personal independence, abilities, and preferences. Two representative quotes are: *"Being on my own and not dependent on others. I like being independent and alone."* and *"It is so very quiet and peaceful. I have my own personal space."*

Social Environment: Difficult Aspects.

Respondents were asked about the greatest difficulties associated with living in senior housing communities (secondary research question #2). Emergent themes included (1) adjustment, (2) troubles or conflicts within the community, and (3) outside forces.

Adjustment.—Adjusting to a new home appeared to be one of the biggest difficulties; most residents missed their old homes. *"I miss my home in the country and making a garden."* Moving into a smaller area without the familiarity of their former homes was difficult. However, some residents noted that a choice had to be made and some residents acknowledged the transitional difficulty with resolve to make the new place "home.": *"It's not living in your own home anymore, but it's a conscious choice and you have to be realistic."*

Community conflicts.—In addition to adjustments, residents expressed some issues with the community. Some residents voiced frustrations with their neighbors: *"My next-door neighbor is annoying!"* There were expressions consistent with ageism among residents and active processes of 'othering'. Death of residents was also a concern: *"Death! People are dying fast and often. We lost four people in the past two weeks."* Another stated, *"The coroner is here more than our children. It is disconcerting."*

Trouble and conflict within the community was reported with regard to the staff; issues ranged from overall sanitation with food preparation to patronizing language. One resident noted, "*The staff talk down to us saying things like 'sweetie,' 'baby,' and 'honey'.*" Further, residents expressed concern at the staff turnover, commenting on how it made the community seem unstable and residents feel insecure.

Outside Forces.—Among the themes, difficulties stemmed from the influence of outside forces, specifically issues with family members: *"They [adult children] don't come or call as often. I felt like I'd been abandoned at first. I still feel that way at times."* Another participant lamented: *"Family issues, by far. My daughters do not get along. They don't care for each other. It grieves me."* Geographic distance from family was categorized as being challenging. Some residents were caring for family members who were also in higher levels of care in both types of communities. Several of these residents reported being stressed by caregiving, and others felt isolated or abandoned. A caregiver commented, *"I lost him [spouse] a long while ago. He doesn't always recognize me, but I go daily. I was told by the*

doctors not to spend all my holidays at the nursing home. He has been near death three times. I can't not go."

Social Environment: Social Rules.

Respondents were asked about what, if any social rules exist within the senior housing community (secondary research question #3). Approximately 40 percent of participants indicated that there were unwritten social rules. Profiles emerging from the qualitative analyses were identified as: (a) manner of dress, (b) exclusion, (c) interactions with others.

Dressing/presentation.—Manner and type of dress was specifically mentioned, particularly that looking well-groomed and put together was a crucial expectation when in public spaces and common areas. "*[One] must dress decently in public, especially at meal times.*; "*[We] dress well for dinner. Men wear jackets in the evening."* Other unwritten social rules mentioned by participants were that of social interaction and participation. Attendance at events and being "seen" were expected. Discussing socializing within the senior apartment communities suggested that social interactions took place outside of resident's individual apartments, likely due to respect for these as private spaces. "*We don't socialize in apartments, only in common areas"*

Exclusion.—Additionally, social expectations and behavior was interwoven with the theme of exclusion. Residents were aware of people being excluded from groups or events and attributed this, partially, to failure to conform to the unwritten social rules or "culture." These behaviors ranged in intensity and scope. Dinnertime exclusion occurred when people were reserving specific tables at dinner and events for groups, despite the rules against it. As one participant stated, *"It isn't supposed to happen, but it does."* Similarly, another participant from the CCRC discussed the ways residents of a specific area within the community would hold gatherings and would be selective with invitations. *"They [specific floor] have a yearly picnic- other areas complain that they are not invited."*

Interactions with others.—Likewise, interactions with others reflected being left out, either from one's own experience or that of others. One participant identified the issue of health and frailty: *"The disabled are uncomfortable."* A new resident of the CCRC said, *"Don't speak unless you are spoken to."*

Social Environment: Social Cliques.

Respondents were asked about what, if any, social cliques exist (secondary research question #3). Open-ended responses on cliques yielded three significant themes: (a) acknowledgment of their existence but self-identify as an outsider, (b) groups based on shared history, and (c) sense of community.

Acknowledged outsider.—Residents in this sample, especially those who were on the "outside" were very aware of social cliques. One participant stated, *"Most are mild, very benign." While another said "[They] let you know they don't want to be infringed upon."* Likewise, another clique outsider described a popular clique this way: *"There is a*

Wednesday night booze group who meet before dinner. The old residents don't want new members."

The participants who considered themselves to be excluded addressed their non-involvement, often through avoidance. Representative quotes include: *"It's not inclusive of everyone. It's a serious situation. We're aware of it. They are 'friends', though."* and another *"I can't really describe them because I'm not in them."* A few who acknowledged the existence of cliques discussed the fact that they were not that important.

Shared History.—Established cliques were often based in groups with shared histories, such as college alums or members of the same ethnic group, and interests including games, hobbies, and activities. The most commonly identified cliques were comprised of those who shared interests. An independent living resident commented, *"We are divided by race. You can see the different groups in the lobby area."* A CCRC resident stated, *"[The cliques are] people who have known each other for years, like college alums …or groups based on common interests – they golf or drink together*."

Sense of Community.—Although there was some degree of acknowledgment of cliques, the majority spoke to the idea of community within their housing environments. In the same way residents identified their housing as place of socialization options with a sense of community, residents who were part of a clique may have added social benefits. One participant stated, *"They are amusing. My clique is like a family."*

Discussion

This study's primary research questions aimed to identify the ways in which residents experienced social interaction within senior housing as well as the ways that social environment and interactions led to the formation of cliques. Overall, the social interactions are influenced by both structural (e.g., common areas of the buildings) and interpersonal factors (e.g., unwritten social rules or expectations). Cliques were identified by residents both inside and outside of a clique, and were formed based upon similar interests or backgrounds of the residents. However, cliques were not mentioned as a source of dissatisfaction, which potentially indicates inclusive and cohesive environments. This finding is not consistent with other research on the topic where territoriality among cliques has commonly been reported (Salari, Brown, & Eaton, 2006). Possible explanations include the homogeneity of residents, friendships existing prior to relocation, efforts of the staff for inclusion and social integration, and resident ties and shared histories. Members who are part of a clique may not state it as a problem or view cliques as having negative impacts on the social environment (Krumpal, 2013).

Residents demonstrated satisfaction with sentiments of acceptance of the community as a whole, including the people, environment, security, and amenities. The residents consider themselves a part of a greater community and, while acknowledging the social norms and cliques, find social interactions to be a source of satisfaction. Companionship and availability of healthcare are known pull factors for senior housing and are linked to overall health and well-being (Ewen & Chahal, 2013; Krout, Moen, Holmes, Oggins, & Bowen,

2002). This idea of companionship among the residents extended to the administration who were described as kind, helpful, and available to put the effort forward to make living within the community satisfactory. Understanding how to facilitate more inclusive environments focused on companionship within senior housing communities may improve senior housing experiences, as well as to serve as a buffer against negative personal and environmental challenges that older adults may experience in later life.

Difficulties included adjustment, troubles or conflicts within the community, and outside forces (such as family issues). The most often discussed difficulties concerned adjusting to a new home, dealing with family issues, and troubles or conflicts with others, including neighbors and with staff. Conflicts with others in the facility were not mentioned in the context of cliques, though some residents noted that those who were frail were excluded, reinforcing existing literature related to “othering” based on age-related health declines (Dobbs et al., 2008; Roth et al., 2012; Sandhu, Kemp, Ball, Burgess, & Perkins, 2013). Respondents also experienced conflicts with their adult children. These conflicts could affect the overall social culture. In particular, patronizing speech from staff may exacerbate “othering” social dynamics for those who are frail. This finding is interesting considering the movement towards person-centered care in most senior housing communities and the importance of proper communication between staff and residents (Kitwood & Bredin, 1992; McCabe, 2004).

The person-centered care model’s primary mission is “to respect patients’ values, preferences, and expressed needs” (Morgan & Yoder, 2011, p. 2) and involves the resident in treatment planning and health care decision-making that has been shown to increase resident well-being and sense of autonomy (Ekman, et.al., 2011; Morgan & Yoder, 2011). The findings in this study are consistent with prior work on elder-speak (Balsis & Carpenter, 2006; Carpiac-Claver & Storms, 2007; Ryan, Kennaley, Pratt, & Schumovich, 2000) and suggest that even though PCC changes are being made, there is still more work to be done.

Limitations and Strengths.

There are several limitations to this study. First, there may be limitations in the self-report of experience. Self-reported data have been relied upon for both research and clinical diagnostic purposes for understanding human experience for decades (Polkinghorne, 2005). However, there are limitations within the scope of the interviewers’ research interviews and the participants’ insights into their experiences. As such, the findings of this exploratory study should be interpreted as an initial step towards understanding social interactions, social cliques, and inclusion in senior housing communities.

Another limitation is that the researchers did not specifically ask if residents who did not report social cliques were part of a social clique in the senior housing facility. In addition, because individuals self-selected to participate in the study, it is likely that the participant sample represented individuals who were healthier and not frail, therefore, making it less likely to capture the experiences of those who may have been “othered” in the community due to declining health. While the study designed for capture of in-depth insights, the roles of social cliques may not have been captured completely because negative social messages and interactions may be subtler and more indirect (Walker & Richardson, 1998). As such,

this may explain inconsistencies between this study and Salari, et al.'s (2006) study that found issues of territoriality among cliques.

Our study also lacks information on staff and family members' perspectives of social integration and stigma within the housing communities. A participant observation study design or inclusion of staff perceptions would lend a unique perspective and provide a foundation for validating research findings. Future research would benefit from other perspectives, such as frail seniors, staff, and family members, in approaching a broader and more in-depth understanding of social interactions, cliques, stigma, and social life within senior housing communities.

This study did have several strengths. First, we were able to recruit and interview a large number of senior housing residents for qualitative research study. Second, participants came from two different senior housing communities, thereby limiting selection bias and homogeneity of study findings. Lastly, to our knowledge, this is the first study to examine the role of social interactions, cliques, and stigma within senior housing communities.

Implications for Senior Housing Administration and Staff.

Senior housing residents tend to socialize with peers who have similar backgrounds or demonstrate behaviors that exemplify social bonds (Kawachi & Berkman, 2000). However, as older adults within senior housing communities, it is likely that residents will be exposed to greater diversity, including differences in age, functional status, and race and ethnicity. Thus, sustaining an inclusive social environment that values diversity amid eventual declines in physical and cognitive functioning can be a challenge. As Dobbs and colleagues (2008) suggested, one approach to a positive and inclusive living environment for all in the community is through adopting a strengths-based perspective to guide policies, procedures, and respectful day-to-day social interactions. This approach emphasizes and builds upon the strengths of individuals, rather than focusing on their dependencies or limitations.

Additional approaches to fostering positive social environments within senior housing communities may include staff members assisting residents in connecting with family members, friends, and neighbors to build a stable support network over time (Carroll & Qualls, 2014) or administrators promoting creative ways to increase social support and social interaction. Meaningful group activities within senior housing communities. Activities organized by the facility can offer an array of enriching recreational, cultural, and leisure pursuits while linking older adults with opportunities to socialize. Social interactions around shared interests can provide a rich context for making new friends.

To address common difficulties, a standard process initiated by the community to welcome new move-ins could help people transition. Welcoming new residents through a personal letter; sharing policies and procedures; a list of available services and important telephone numbers; responding promptly to questions and listening to the residents' preferences are all practical ways that staff can support the resident (Pearce, 2007). Senior housing community staff should also make efforts to reduce potential stigmatization resulting from patronizing speech ("elder speak") from staff, family members, or other residents during a transition to a more intensive level of care in order to foster a more inclusive community (Dobbs, et al.,

2008; Williams, Herman, Gajewski, & Wilson, 2009). Those subject to “elder speak” report lower well-being, specifically self-esteem and competency, decreased motivation and active coping behaviors, as well as increased mortality, anxiety, and depression due to a feeling of helplessness and additional stress associated with living in a social environment that perpetuates negative ageist stereotypes (Nussbaum, et. al., 2005; Zimmerman, et. al., 2016). In fact, residents have been found to be resistant to care when elder speak is present (Williams et al., 2009).

Implications for Staff and Social Work Practice.

Social workers understand the importance of relationships and are trained to help older adults build social support and promote a culture of inclusion in long-term care settings. For instance, nursing home social workers are often involved with assessing the social and emotional needs of residents, providing emotional support, and helping to resolve conflicts or disagreements (Bern-Klug & Kramer, 2013). Within independent living, below we discuss a variety of ways how social workers can help older adults adjust to the transition of moving to an age-segregated community and improve their emotional and social functioning through strengthening social ties.

Many senior living communities provide a warm welcome, offer a comfortable space where individuals can have private conversations, and invite family and friends to facility-sponsored special social or cultural events to encourage involvement. Staff members and social workers can facilitate continuation of important relationships and introductions of new residents. Staff are also involved with removing barriers that prevent social connectedness. In some communities, senior transportation for social activities can expand the possibilities for social interaction, continue meaningful relationships, and enable older people to have a better quality of life. For older adults who live a long distance from their families, training and support can be arranged to help seniors use social media to increase communication with tech-savvy family members and friends online. Social networking sites have been found to enhance the relationships between older adults and their children or grandchildren (Nef, Ganea, Müri, & Posimann, 2013).

Social workers can also offer support and education to residents, friends and family about how to deal with the feelings of loss that they may be experiencing. Often, family members and friends find it hard to visit due to their own emotional struggles involved with witnessing the decline of a loved one, or the desire to avoid confronting their own fears about aging and poor health (Bonifas, et. al., 2014). When relationships are strained, social workers can listen and offer emotional support, help to problem-solve complex situations, and provide information about available resources and referrals for community-based services when needed to improve relationships.

Staff can support an inclusive culture for all within the senior living community. This is another way that social workers can support relationship-building by shaping cultural values and expectations for how people should treat each other. A more personal relationship is necessary to learn about their interests and preferences (Pearce, 2007). On-site staff and administrators also provide leadership and advocate for person-first language that recognizes the strengths of the individual. In the current study, we found some instances of patronizing

speech that negatively affected the quality of relationships. Exclusionary behaviors and negative comments can add stress, perpetuate ageist views, and contribute to feelings of helplessness, anxiety, and depression (Nussbaum, et. al., 2005; Zimmerman, et. al., 2016). Attention to this issue is one step toward resolving conflict, facilitating communication among residents and staff, and developing a plan to move forward.

Residents will create and reshape the social environment and culture, yet those in charge of retirement communities have responsibility for ensuring a climate of opportunity and inclusion. The key finding of this study is that the presence of social cliques and the culture of “unwritten social rules” existed in both types of senior housing communities, yet were not identified as a source of stigma or dissatisfaction with the social environment.

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Table 1.

Demographic and Health Characteristics of the Participants

	Apartments (n=26) Percentage / Mean (sd)	**CCRC (n=24) Percentage / Mean (sd)**
Age	79 (11.1)	83 (5.1)
Gender[a]		
Male *	0%	37%
Female	100%	63%
Education[a,*]		
Grade School	8%	--
HS	31%	13%
Some College	35%	13%
College	19%	38%
Graduate	8%	38%
Marital Status[a]		
Single *	8%	--
Married *	8%	35%
Widowed	58%	65%
Divorced *	27%	--
Health Limitations (MOS)[a]		
Vigorous Activities	81%	85%
Moderate Activities	54%	25%
Climb flight stairs	58%	60%
Walk uphill/few stairs	58%	30%
Bending/life/stooping	54%	70%
Walk one block	42%	20%
Walk several blocks	50%	30%
Walk a mile	69%	85%
Eat/Dress/Toilet *	31%	0%

* $p \leq .05$

[a] A binomial test of difference in proportions was to test for differences.