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INSTITUTIONAL CONSTRAINTS ON RESIDENTS IN LONG-TERM CARE FACILITIES FOR THE ELDERLY

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ABSTRACT

For frail older persons, gaining access to care is primarily in the context of long-term care institutions. Based on hypotheses derived from the theory of the total institution (Goffman, 1961) and anticipatory socialization theory (Merton & Kitt, 1950), linkages of intra-institutional and extra-institutional social ties with quality of life outcomes were assessed based on 168 residents' self-reports of their life and problems experienced in long-term care (Kahana, Kahana, & Young, 1987). Findings reveal that lack of anticipatory socialization was a significant predictor of subsequent wellbeing, whereas the extent of social ties to the outside world did not predict subsequent wellbeing.

INTRODUCTION

With increasing numbers of older adults requiring long-term care in our aging society, understanding the impact of this form of care on wellbeing of care recipients presents an important challenge. Gerontological scholarship

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has approached the topic of long-term care delivery though diverse prisms often reflecting disciplinary orientations of researchers. Accordingly, health service researchers have focused on alternative forms of financing and regulation as key determinates of both access to care and quality of service provision (Castle, 2006; Kitchener, Hernandex, Ng, & Harrington, 2006). Political scientists have analyzed long-term care as reflecting "the worst aspects of privatization that is so championed today by new conservative forces" (Olson, 2006, p. 297). They attribute substandard care to harsh workplace environments dictated by profit motives of nursing home owners. Anthropologists, in turn, have continued to conduct ethnographic studies of nursing home care that focus on the culture of long-term care environments, particularly as they reflect negative societal attitudes towards frail residents (Kayser-Jones, Schell, Lyons, Kris, & Chan, 2003). Some see the potential for "meaning making" by residents who view long-term care facilities as their home and families who can help contribute to a social, rather than the medical model of care (Stafford, 2003).

All of these research traditions converge in lamenting dehumanizing aspects of nursing home life and consider long-term care an undesirable station of last resort for those older adults who are unable to continue to live independently in the community. Prior research has seldom considered that moving into a long-term care facility may, for some residents, actually be a preferable option of care, and may not be a last resort. Nevertheless, many older adults do confront stressful situations in diverse institutions for the elderly (Kahana, 2005). Furthermore, residential long-term care extends beyond walls of the institutional structure, to homes for the aged, assisted living facilities, adult foster care, and other congregate settings (Mollica & Johnson-Lamarche, 2005).

Prior work on the stressors posed by institutional life is well documented (Goffman, 1961; Gubrium, 1975; Kayser-Jones, 1981; Vladeck, 2003). What these studies found is that institutional living limits residents' choices and autonomy. In spite of wide spread attention to problems faced by long-term care residents, there has been relatively little empirical research applying fundamental social theories, such as the classic works of Goffman (1961), to explore the lived experience of residents in long-term care facilities.

This study seeks to bring sociological insights to understanding the experiences of institutional living by following a group of residents entering diverse long-term care facilities and following them for an eight-month period. We argue that the essence of the experience of institutionalization has been incisively defined by Goffman (1961) as related to barriers between the institution and the outside world. This research therefore examines the

impact of macro-level institutional structure for residents; specifically in their experience of institutional barriers and on the impact this has on their quality of life which reflects their satisfaction with care. Additionally, this research examines extra-institutional factors, examining experiences that occurred prior to moving into long-term care (Merton & Kit, 1950). We also place adaptations to institutional life in the context of social structural positions of patients as reflected by demographic characteristics.

Social theory speaks of the fundamental challenges for institutionalized patients. This chapter seeks to explore expectations based on major social theories, Goffman's theory of the total institution (1961), and Merton's theory of anticipatory socialization (1950) as they apply to residents living in an institutional setting. This study examines one aspect of total institution theory, specifically how much access to the outside world residents have in these long-term care facilities. Additionally, patient characteristics and their influence on quality of life were assessed, including demographic and social structure positions. Merton and Kitt concept of "anticipatory socialization" (1950), which describes the process individuals identify with a group they aim to belong to and how they socialize themselves to that groups norms. It is examined in order to contextualize and to theoretically understand the process and preparations prior to moving into long-term care. Gerontological research on relocation (Shultz & Brenner, 1977) has revealed considerable adverse affects after relocating to institutional facilities. Older adults, who move to long-term care facilities with limited involvement in decision-making, may be expected to experience greater stress even beyond the adverse affects due to lacking contact with the outside world.

Data from a National Institutes of Health (NIH) funded study will be presented on 168 elderly residents over the age of 75 (Kahana et al., 1987). Respondents resided in 14 urban long-term care facilities, with data collected during the early phase of institutionalization when critical adaptations occur.

THEORETICAL BACKGROUND

Total Institution Theory

Goffman's theory of the total institution has been universally recognized as key to understanding the impact of institutions on inmates. Goffman characterized the "total institution" as an environment where residents live in a congregate setting, with the same group of people, do the same activities

with one another, and live under the same set of rules. Typically, people living under these conditions lose their individualism and live with very little autonomy. Often actual or symbolic barriers prevent patients from entering or leaving the facilities. This causes greater difficulty in contacting and interacting with people who live outside of the facilities, including family. Over time, these institutional characteristics will lead to the mortification of the self, and one's self-concept is likely to change. While Goffman's research was conducted on mental institutions, his "total institution" theory has been applied to other institutional settings, including the nursing home (Gubrium, 1993; Savishinsky, 1991; Vladeck, 1980). His conceptualization allows us to test what definitions of self are stable over time and therefore core, and which are more transient, and consequently subject to change in different environments.

Goffman's theories have been accepted as classic explanations of institutional life. Works following Goffman's concepts include Beuf, who used the "total institution" framework to guide part of her research on children's hospitals (1989). Goffman's framework served as a prototype for anthropologists (Henry, 1963; Savishinsky, 1991) and gerontologists (Gubrium, 1993; Vladeck, 1980). These works describe the humiliation, loss of dignity, loss of freedom, and lack of choice experienced by elders placed in an institutional setting, as well as the efforts of residents to adapt to this new environment. In studies focusing on the early impact of institutionalized living, physical and psychological decline was found primarily in the first year of institutionalization (Lieberman & Tobin, 1983). In one qualitative study, Clark and Bowling tested whether the total institution theory held in a long stay hospital ward and in smaller nursing homes for the elderly (1990). They found that the theory only applied to the hospital ward. The research reported here focuses on larger facilities, thus distinguishing it from Clark and Bowling's work. Overall, while many researchers have utilized Goffman's theories in shaping their research, very few have empirically tested them in long-term care facilities for the aged. This research aims to fill this gap.

Anticipatory Socialization

One is said to have more anticipatory socialization if they voluntarily decide to move, decide to move over a longer period of time, or if the transition was scheduled, where the older person was involved in planning to move. The concept of "anticipatory socialization" originated from Merton's writings.

Merton and Kitt proposed the concept of ''anticipatory socialization'', which describes the process individuals identify with a group they aim to belong to and how they socialize themselves to that groups norms (1950).

Anticipatory socialization is a process or set of experiences in which individuals come to correctly anticipate the values, norms, and behaviors that will be encountered in a new social setting (Merton, 1957). The individuals who become more successfully integrated into a new setting and function more effectively in it are those for whom anticipatory socialization was more effective. While Merton wrote about this process for newcomers on a job, the concept of ''anticipatory socialization'' has been applied to the moving process into residential care placement (Chenitz, 1983; Nolan & Grant, 1992; Nolan, Walker, Nolan, Williams, & Poland, 1996).

When older adults move into long-term care, most do not know what to expect and how to act. Those who have visited the home and know more about what to expect will be more comfortable in that environment earlier on, while those who have little understanding of the home would have to observe and learn the new socialization patterns in the home. For this research, anticipatory socialization is measured by one's voluntary or involuntary decision to move into a nursing home and how quickly the decision to move was made, as well as how reluctant respondents were to moving into long-term care.

RATIONALE AND HYPOTHESES

This research explores one key dimension of Goffman's theory (1961), examining the barriers institutions create in interacting with others outside of the institution (1961), as well as Merton and Kitt's concept of anticipatory socialization (1950). While there are several aspects to Goffman's theory, including living in a congregate setting, doing the same activities with others, living under the same rules, etc., examining barriers to the outside world is central to conceptualizations of life in the total institution. Furthermore, residents who expect to be linked to the outside world may be particularly vulnerable. These residents face more difficulties when encountering the more totalistic features of the institution. Accordingly, in this sample, some residents have associations with people outside of the institution and others do not. This affords the possibility to examine whether more contact with the outside world impacts residents' psychological wellbeing.

Two alternative hypotheses are presented as related to the influence of extra-institutional and intra-institutional influence on residents' quality of

life. The first hypothesis examines the negative impact that institutional barriers have on residents in long-term care facilities for the elderly. Hypothesis 2 refers to the potentially positive impact of anticipatory socialization. Those residents better prepared for the move and more involved in the decision to move were expected to have better subsequent quality of life.

Institutional Barriers

Hypothesis 1 was tested by examining residents' social connectedness to the outside world, measured after eight months of living in the institution. Typologies were created from a question that asks, ''At the present time, who are you close to?'' and probes respondents with the question, ''anyone else''. Answers were coded into three typologies. First, Typology 1, ''close associations inside the institution only'', refers to residents who indicated that they were close to other residents or staff, but not with family or outside friends. Second, Typology 2, ''close associations outside the institution only'', refer to residents who indicated being close to a family member and/or friends outside of the institution, but not with staff or residents inside the institution. Spouses were included in this category whether or not they also lived in the institution. Third, Typology 3, ''close associations both inside and out of the institution'', was coded to include residents who have associations with both someone inside the institution and someone outside of it.

Residents who lack contact with someone outside of the facility (Typology 1) are expected to experience the impact of a total institution more strongly than those who have associations with someone outside of the institution (Typologies 2 and 3). This is due to the presumption that residents would like to continue their old friendships and continue to bond and interact with their family who live in the community. Therefore, it was anticipated that having no connections with people outside of the institution (Typology 1) will lead to more adverse outcomes. Typology variables were correlated with outcome measures, measured at time 3, in order to test the hypotheses.

Anticipatory Socialization

Aspects of preparedness for the move were correlated with outcomes, to determine how they impact quality of life. By examining anticipatory

socialization, we were able to determine whether the institution represented a place of last resort, or whether the institution represented a dwelling place where one chose to be. If anticipatory socialization had a greater impact on outcomes than social typologies, it would support the alternate hypothesis. Anticipatory socialization was measured by three single items including respondents' eagerness to move, the time to decide to move to the institution, and who made the decision to move. Furthermore, if residents who opted to live in long-term care, and therefore had more anticipatory socialization, resulted in better quality of life, it would mean that the institution did not represent a total institution type setting. Rather, it is one's orientation and expectations prior to entering long-term care that determined how overbearing the institutional structure was for a new resident.

Background characteristics are considered in order to describe the sample studied in this research. Additionally, bivariate correlations with quality of life measures were assessed in order to determine the impact of social structural positions on the wellbeing of residents. Interview questions assess respondents' gender, age, country of birth, number of children, and religious affiliation. Residents' cognitive impairment as reflected in memory deficits, measured through the mental status questionnaire, is assessed at the time just prior to residents moved into the facilities for the aged (Kahn, Goldfarb, Pollack, & Peck, 1960). The scale provides a brief, objective, and quantitative measurement of cognitive functioning of older adults, appropriate for patient samples (1960). Questions assessed respondents' orientation, including knowing the day's date, who the president was currently, and who the president was before him (10 items). Scores ranged from 0 to 10, with 10 representing no errors (alpha = 0.73).

The outcome measures included morale and self-rated health. Morale was measured by a subset of Lawton Morale Sale that included questions on loneliness and dissatisfaction, with scores that ranged from six to twelve, with higher scores representing higher morale (Lawton, 1975). For the sample, the alpha reliability on this scale was 0.75. Self-rated health (Liang, 1986) was measured by a two item index, composed of the questions: health compared with others your age and health compared with three to four months ago measured, with the items summed together. The self-rated health scale ranged from zero to eight, with as core of eight representing the best-reported health.

FINDINGS

Institutional Setting and Sample Characteristics

Respondents in this sample relocated to 14 different long-term care facilities in two large, urban, midwestern cities. Homes were both proprietary and non-profit charitable or religious institutions. The average size of the facilities was 203 beds, with none less than 100. Patients were admitted to self-care or intermediate care divisions. The homes were licensed, either with nursing home licensure or with board and care home licensure. Of the fourteen homes, four were non-sectarian, and eleven of the homes were religiously sponsored, with five Jewish, four Protestant, and two Catholic institutions. While religiously based, the homes did not limit residence to those who practiced that faith.

Sample characteristics reported here include those reported in Table 1 as well as additional data that are reported only in the text. Examining demographic characteristics, the majority of respondents are female (77.4%) and in their late seventies (mean age 78.5 years). Race of respondents was predominately causation (97.2%), with only 2.8% being African American. Additionally, a very large sub-population (37.6%) was born outside of the United States, reflecting the high rates of immigration that occurred in the late 19th century and early 20th century, when this population was born. This trend is further supported with the even higher percentages of respondents whose mother and father were born outside of the United States (59.4%, 60.8%, respectively) (not in tables).

Examining family characteristics, marital status, and information on children are reported here. Residents' marital status reveals that the majority was widowed (65.1%), with a small but significant portion still married (16.3%). Furthermore, 9% of the sample was divorced or separated at the time they moved into the institution, while 9.6% never married. Residents had an average of two children, with about one quarter (23.2%) having had no children (not in tables). A small sub-group had four or more children (16.8%). Most of these respondents with living children had a son or daughter living nearby (mean = 1.7, standard deviation = 1.5). Cognitive functioning of respondents when entering the long-term care institutions was fairly good with respondents having relatively few errors on the mental status questionnaire, thus representing a fairly healthy sample (mean = 8.6).

Table 1. Descriptive Results of Demographic and Sample Characteristics.

Study Measures	Mean (Standard Deviation)	Distribution	% (*N*)
Gender		Female	77.4 (130)
		Male	22.6 (38)
Age		52–65	2.6 (4)
		65–74	29.6 (45)
	78.5 (7.7)	75–84	44.1 (67)
		85–94	23.7 (36)
			(Missing = 16)
National origin		Born in the USA	62.4 (103)
		Born outside of the USA	37.6 (62)
			(Missing = 3)
Number of children who live in nearby area	1.7 (1.5)	0	20.4 (28)
		1–2	57.7 (79)
		3	8.0 (11)
		4–7	13.9 (19)
			(Missing = 31)
Religious affiliation		Protestant	45.3 (73)
		Catholic	18.0 (29)
		Jewish	31.7 (51)
		Other	5.0 (8)
Cognitive functioning	8.6 (1.9)	1–4, most errors	4.5 (7)
		5–7	19.7 (31)
		8–9	21.7 (34)
		10	54.1 (85)

Note: $N = 168$. Percentages reported based on number of non-missing cases.

Descriptive Findings

Table 2 reports descriptive results on anticipatory socialization. Anticipatory socialization was considered using several measures. A surprisingly large proportion of residents were eager to move into long-term care (39.6%). We found that for the most part, respondents had over six months lead time from the time they decided to move, to when they actually moved (49.7%), while 22% had less than a month's lead time prior to moving. The decision to relocate to the institution was generally made jointly between the current resident and others (47.8%). However, many residents did make the

Table 2. Descriptive Results on Anticipatory Socialization.

Study Variables	% (*N*)
Eagerness to move	
1: Eager to move	39.6 (63)
2: Somewhat willing to move	41.5 (66)
3: Reluctant to move	18.9 (30)
Time to decide to move to institution	
7–8: One or more years ago	34.6 (55)
6: 6 months to one year ago	15.1 (24)
4–5: 1–6 months ago	28.3 (45)
1–3: Within the last month	22.0 (35)
The decision to move was made by	
1: Yourself only	43.5 (70)
2: Jointly with others	47.8 (77)
3: Others only	8.7 (14)

Note: $N = 168$. Percentages based on total number of cases, not including missing data.

decision to move by themselves (43.5%). Finally, a small, but important group had the decision to move being made completely by others (8.7%). This pattern suggests that voluntary rather than involuntary relocation was normative for our sample.

Descriptive results on quality of life measures are reported in Table 3. Regarding morale, about one-third of respondents had the highest morale, while about 17% had the lowest scores. Finally, looking at self-rated health, 63.3% of respondents rated their health as ''good'' or ''excellent'' as compared with others their age, while about 11% rated it as ''poor'' or ''very poor'' in comparison. Furthermore, 21.5% reported their health as ''better'' or ''much better'' than three to four months prior, while 24.1% rated it as ''worse'' or ''much worse''.

Typology variables were created to test whether residents who associate with people only inside the institution impact health and quality of life outcomes (Table 4). Residents mostly fell under Typology 2 (65.6%), with most having close associations with people exclusively outside of the institution. About 16% of residents had close associations with people exclusively inside the institution and about 13% of residents had associations with people both inside and outside of the institution. This pattern represents a noteworthy departure from expectations based on Goffman's total institution theory on relocation where few residents reported being cutoff from the outside world.

Table 3. Descriptive Data on Quality of Life Measures.

Study Measures	Mean (Standard Deviation)	Distribution of Scores	% (*N*)
Lawton Morale Scale	10.3 (1.8)	6–8	16.9 (27)
		9–10	25.6 (41)
		11	25.0 (40)
		12	32.5 (52)
		(Highest morale)	(Missing = 8)
Self-rated health (SOPH)	3.4 (1.5)	7–8	29.1 (48)
		5–6	50.3 (83)
		3–4	18.1 (29)
		1–2	3.1 (5)
		(Worse health)	(Missing = 3)
SOPH item 1: Health compared to others	2.3 (1.0)	5 – Excellent	20.4 (30)
		4 – Good	42.9 (63)
		3 – Fair	25.9 (38)
		2 – Poor	7.5 (11)
		1 – Very poor	3.4 (5)
Item of SOPH: Health compared to 3–4 months ago	3.1 (0.8)	5 – Much better	2.0 (3)
		4 – Better	19.5 (29)
		3 – Same	54.4 (81)
		2 – Worse	20.1 (30)
		1 – Much worse	4.0 (6)

Note: $N = 168$. Percentages based on number of non-missing responses.
SOPH: Subjectively rated overall physical health.

Table 4. Typology of Connectedness with the Outside World.

Study Measures	Distribution	% (*N*)
Typology 1: Are association exclusively inside the institution?	No	84.5 (142)
	Yes	15.5 (26)
Typology 2: Are association exclusively outside the institution?	No	34.5 (58)
	Yes	65.6 (110)
Typology 3: Are association both inside and outside the institution?	No	87.5 (147)
	Yes	12.5 (21)

Bivariate Correlations

Anticipatory socialization, social typologies, and demographic characteristics were correlated with physical health and morale after eight months of living in the long-term care facilities (Table 5). Results show that if respondents were more reluctant to move into the long-term care facility, than they rated their health significantly more negatively after eight months in the institution ($r = -0.21$). Conversely, residents with associations exclusively inside of the institution (Typology 1) had significantly better self-rated health than either Typologies 2 or 3 ($r = -0.21$). Quality of life, as measured by morale, was not significantly related to any of the typology variables (Table 5). However, respondents who were more reluctant to move had

Table 5. Associations between Demographic, Anticipatory Socialization, and Social Connectedness and Quality of Life Outcome[1].

	Self-Rated Health[a]	Morale[a]
	r	*R*
Demographic and personal characteristics		
Gender (women = 1)	0.00	0.04
Age	−0.08	−0.31***
National origin (born outside the US = 1)	−0.22**	−0.27**
Number of children who live nearby	−0.16	0.05
Religion – Protestant	0.21**	0.22**
Religion – Jewish	−0.10	−0.25**
Religion – Catholic	−0.05	0.09
Cognitive functioning	−0.13	0.03
Anticipatory socialization		
Reluctance to move	−0.21**	−0.29***
Time to decide to move	0.01	−0.01
Decision to move made by others	−0.14	−0.13
Social connectedness		
Typology 1: Close associations exclusively inside the institution	0.21**	0.09
Typology 2: Close associations exclusively outside the institution	−0.06	−0.09
Typology 3: Close associations inside and outside the institution	−0.01	0.09

Note: $N = 168$.
*$p < 0.05$, two-tailed.
**$p < 0.01$, two-tailed.
***$p < 0.001$, two-tailed.
[a]Higher values represent better health, morale, and functioning.

significantly lower morale scores ($r = -0.29$). Finally, demographic characteristics did appear to significantly impact quality of life, with being Protestant and having been born in the United States related to better self-ratings of health ($r = 0.21$, $r = -0.22$, respectively). Furthermore, older, foreign born, and Jewish residents experienced lower morale than their counterparts ($r = -0.31$, $r = -0.27$, $r = -0.25$, respectively). Results point to the importance of extra-institutional factors as well as demographic characteristics in helping to shape residents perceptions of quality of life in long-term care facilities.

DISCUSSION

This research examined issues involving provision of care to residents in long-term care facilities for the elderly. We considered aspects of life common to all residents living in long-term care facilities for the elderly. Specifically, the factors that impact residents prior to moving to long-term care were evaluated. They include the impacts of decision-making prior to entering the institution and linkages with representitive of the outside world after entering the institution. Interviews with residents show that the long-term care facilities studied did not represent a total institutional type environment. Furthermore, stressors faced within the home did not have as great an impact on quality of life as was expected. Rather, extra-institutional factors that precipitated the move had a stronger impact on quality of life for residents, reflecting their satisfaction with care. This study found that factors relating to the older adult and to their circumstances prior to moving into long-term care had a greater impact on their quality of life than did intra-institutional factors, which included linkages with the outside world representing problems experienced in the institutional setting.

These data were collected on elderly people entering long-term care facilities in the 1970s (Kahana et al., 1987). The study was based on a sample of 168 residents entering 14 different non-profit homes in two metropolitan areas. We anticipated that universal theories about stressors of institutionalization were applicable to these elderly, particularly, as these social theories were developed in the 1950s and 1960s, close to the era when our data was collected. Descriptively, findings show limited support for the theory of the total institution, where few residents encountered the stressors, defining a totalistic environment (Goffman, 1961). This limits the opportunity to test the theory, because of insufficient variability of defining characteristics of the total institution. Our findings are important in demonstrating that

institutional environments need not diminish access to social ties with the outside world.

Residents, for the most part, were not cut off from the outside world. In these institutional settings, only a minority of residents (15.5%) lacked close associations with family or friends outside of the long-term care setting, with 66% of the sample reporting being close only to family or friends outside of the institution. Previous research (Noelker & Poulshock, 1984) found similar findings, where of the 40 respondents in one private residential home, almost 70% reported that they were close to family members or friends outside the home. The continuing maintenance of outside social ties was also reported in research by Bitzan and Kruzich (1990), who found that the vast majority of residents in 54 nursing homes (87%) had close associations with at least one person outside of the homes, with some of these residents having associations with people inside the home as well, and only 5% of their sample who had limited associations to people in the institution. Results from these studies support our findings. Our results suggest is that for the most part, residents did have access to their family and friends outside of the institutions and did not experience a total institution type environment. Therefore, contextually, Goffman's theory did not apply for this sample and adverse impacts of severed ties with the outside world (a defining feature of total institution theory), could not be adequately tested.

An interesting question is raised by our data regarding the universal nature of the totalistic institutional features, particularly in terms of absence of linkages between the social world of residents and the outside world. While this sample reflects newly institutionalized persons in an earlier era, Goffman's theory was developed around the same time frame as when the data was collected. Despite data not supporting Goffman's theories in this setting, we do not believe that data from our research assails the fundamental tenets of total institution theory. Rather, we find evidence of diversity in the degree of totalistic features among institutions.

Characteristics of this sample may be attributable to these low rates of experiencing a more total institution. This study had relatively few residents with cognitive impairments, with only 15% of the sample with some impairment, who answered four or more questions incorrectly. This compares with 51% of nursing homes residents on average were cognitively impaired and with 23–42% of residents with cognitive impairment in assisted living/residential facilities (Zimmerman, Gruber-Balidini, Sloane, Eckert, & Hebel, 2003). High rates of good cognitive functioning may have contributed to this sample being able to maintain their social connections, whereas studies that include a more cognitively impaired sample may find that residents lose

these connections. Furthermore, as the institutions in this research were non-profit, our findings do not rule out expectations that residents in for profit homes experience greater barriers in connecting with family and friends outside the institutional walls (Olson, 2006). Finally, it may be that over time, residents in present day long-term care institutions experience increased barriers and frailer residents now entering institutions since the data was collected.

We acknowledge evidence from other studies of persisting barriers between the institution and representatives of the outside world. A few studies point to the potential increase in family involvement that can occur. Specifically, Stafford found that some family members were able to interact on a closer emotional and personal basis with residents, now that they no longer had to provide physical care for them (2003). However, other empirical research found a reduction of family involvement post-institutionalization. Port, Gruber-Baldini, Burton, Baumgarten, and Hebel (2001) found that from 1,441 interviews with significant others of residents in nursing homes, contact decreased by about half after residents were admitted, as compared with contact pre-admission. In another study, Port considered 93 nursing home family caregiver-resident pairs to examine the barriers to family involvement (2004). Results show that fewer visits by family members was due to caregivers having more difficulty finding transportation, having poorer relationships with the staff, and to caregivers having a smaller supportive network of family and friends. Additionally, Yamamoto-Mitani, Aneshensel, and Levy-Storms found among the 210 relatives of nursing homes residents with dementia, those who visited the resident more often were the spouse of a resident, were less educated, had a previous close relationship with resident, had a strong sentiment against placement, and lived closer to the facility (2002). What these studies suggest is that for long-term care institutions in more recent times, families may be facing barriers to interacting with residents in these institutions. Overall, while previous research did indicate the limitations placed on families in maintaining contact with residents in long-term care, this occurrence only happened for a small proportion of this sample (16%). This does not negate the importance of understanding barriers, but does underscore that for many residents in some institutions, these barriers are not as severe.

Merton and Kitt's concept of anticipatory socialization was applied to this institutionalized sample (1950) in an effort to better understand extra institutional influences on residents' quality of life. While much of the literature assumes that older adults did not want to move to long-term care, this research found fairly high levels of anticipatory socialization where only

a small portion felt reluctant to move (10.9%), did not have input in the decision process involved prior to moving (8.7%), and/or abruptly decided to move within the last month (22.9%). Therefore, for a vast majority of residents, moving into long-term care represented a move they preferred to make.

Results from this sample show higher levels of involvement and choice on the part of residents to be in these institutions than did previous research. While this research found that 44% of this sample made the decision to move on their own, a qualitative study on 52 older adults' respondents found that only 24% of their sample made the decision to move by themselves (Nakashima, Chapin, Macmillan, & Zimmerman, 2004). Furthermore, researchers found that the transition into a nursing home is typically involuntary, with the decision to move into a long-term care facility often made by others, where many may enter one against their will (McAuley & Travis, 1997; Thorson & Davis, 2000; York & Caslyn, 1977). Our study, contrary to more recent studies found higher levels of anticipatory socialization of respondents. Differences may be due to this sample entering facilities for the elderly when they were more physically healthy and had better cognitive functioning. Future studies could expand upon the work on anticipatory socialization, in determining the role that physical frailty and cognitive impairment may have on limited anticipatory socialization.

Bivariate correlations between demographic characteristics, anticipatory socialization, and social typologies with assessment of quality of life support the second hypothesis, but not the first. Noteworthy, social structural positions did significantly affect wellbeing of respondents, as demographic and personal characteristics influenced health and quality of life. For example, after entering an institution, older people and people born outside of the United States had lower morale. This further supports the importance of sociological interpretations, where outcomes are in part based on social characteristics.

The first hypothesis was not supported by data. Results did show that residents with close associations exclusively inside the institution had the best self-rated health ($r = 0.21$). Social typologies, however, were not related to morale. Therefore, while the first hypothesis was not supported, the link between health and social connectedness did reveal an important finding. That is, families were more likely to remain connected to residents who rated their health more negatively. Families endeavored to maintain their connections with loved ones after they have moved into long-term care, which was especially true when loved one was sicker. Families worked towards keeping a linkage with loved ones despite barriers to their

involvement, which may have limited the negative experiences of morale. Future research on the role of families in minimizing stressors should examine the dyad of the caregiver and the care recipient in long-term care. This would further help us to understand the role that families play in the actual lives of residents in long-term care settings.

Anticipatory socialization had a significant impact on quality of life outcomes, supporting the second hypothesis. As bivariate correlations show, anticipatory socialization factors played a significant role in predicting a better quality of life. Findings on anticipatory socialization support prior empirical and conceptual writings. Settersten proposed that transitions into institutions that are more scheduled, where residents previously planned on moving, resulted in an easier adjustment to long-term care (Settersten, 1999). Furthermore, those who voluntarily made a decision, such as leaving a job or transitioning from retirement into a nursing home, were more likely to have a positive experience (Pearlin & Yu, 2000). This theory was empirically tested, with results supporting voluntarily retirement as leading to better adjustment and to better ratings of health than those who involuntarily retired (Shultz, Morton, & Weckerle, 1998).

Findings from our study have implications for policy and practice. Accordingly, they point to the value of involving older adults in the decision to move to long-term care. If a move to a long-term care facility is necessary, it is still important to involve a person with both physical impairments and with cognitive impairment in the actual decision process. Even for those elders more reluctant to move, it may be useful to have them visit the facilities with their family. These older adults, can, thereby help to decide *which* facility they move to. Furthermore, by socializing elders as to what they can expect once they move to these institutions, it can mentally prepare them and will hopefully make the adjustment process that much easier and lead to a better quality of life. Institutions themselves can help with the process by meeting with both the potential resident and with their family member(s) to discuss what their expectations for care are and what families and future residents can expect from the facility and from staff after the older adult has moved in. Any worries or concerns can be discussed at that point and compromises and understandings can be reached prior to the actual move. This would increase anticipatory socialization for both the families and the future resident and would therefore increase chances for a better adjustment process and lead to better satisfaction with the institutional environment.

Overall, this research points to the potential positive outcomes and experiences that can result from living in long-term care, where many residents

can hope for a good adjustment and an overall positive quality of life. This positive nature of long-term care is supported in prior literature (Chou, Boldy, & Lee, 2002; Kahana, 2005; Kruzich, Clinton, & Kelber, 1992; Mitchell & Kemp, 2000). Stafford found that many residents do find life in nursing homes meaningful, where many adapt and find new relationships with people inside the home, staying involved in activities and developing new roles (2003).

The institutions studied in this research were not found to be total institutions, but instead, many residents were able to maintain close relationships with family and friends as they did prior to moving to these facilities. Furthermore, many of the residents actually chose to move to these institutions and knew what to expect once they moved in. As a result, they were better adjusted to life after eight months in long-term care, as demonstrated with a better quality of life, and were more satisfied with their lives in long-term care facilities. This research, as well as others, support that, for a substantial portion of residents, a good and easy adjustment to life in long-term care is a distinct possibility, where the result is a good quality of life and satisfaction with their new home.

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