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INSTITUTIONALIZATION OF THE ELDERLY: AN ASSESSMENT OF COMPETING PERSPECTIVES

BY

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ABSTRACT

The purpose of the study was that of assessing a number of theoretical perspectives which have been developed in an attempt to explain the experience of institutionalization, particularly as this applies to the elderly. Examination of the major tenets of each of three perspectives revealed that all utilized institutionalization as a unidimensional concept - explaining the experience in terms of a single, primary dimension or characteristic of the environment or of the aging process. As a result, all were criticized for their failure to recognize sources of inter-institutional variation, and thus, for their inability to account for variations in the experience of institutionalization by the elderly. An alternative model which asserted the necessity of recognizing the heterogeneous (social and physical) nature of the living environment was then suggested. Exploratory analysis of the potential of this latter approach made use of the dimensions suggested by Kleemeier (1961) and refined by Pincus (1968). Included were items reflecting the availability of privacy and freedom to residents, the integration of the residence into the community, the availability of resources, and the size and service orientation of the residence.

Utilizing secondary data collected on an original sample of 4805 institutionalized and noninstitutionalized elderly in the Province of Manitoba (1971), step-wise

procedures of multiple regression analysis were instituted in order to assess the theoretical relationships specified within each framework. The dependent variable - perceived well-being - was operationalized through the Life Satisfaction Index 'A' developed by Neugarten et al (1961). Two analyses were conducted - one for the sample as a whole and one for the facility dwelling sample alone.

The analyses supported the critique made of each of the three unidimensional perspectives. No support was found for the views of institutions as mechanisms for the provision of relief (the social welfare model) or for the facilitating of withdrawal (the disengagement theory of aging). Some minor support was found for the view that institutions function as bureaucratic organizations. Although there was little indication that institutionalization resulted in identification with the 'sick role', there was some support for the notion that, in generating withdrawal, institutions may indirectly adversely affect resident well-being. The view that institutions vary on a number of dimensions which may positively or negatively affect well-being received the greatest measure of support. While there was little indication of the importance of the particular dimensions included, numerous factors were found to be important in predicting perceptions of well-being for both the sample as a whole and for the facility dwelling sample. Although some factors were important to both samples, differences also appeared. Consistent with the results of

past research, perceptions of health and economic well-being were important to both samples. Also, the degree of autonomy in choosing the place of residence was important to both. However, while contact with friends and relatives was important to facility dwelling elderly, for the total sample, church attendance was of greater importance. Nationality also appeared as an important predictor for the institutional sample. The finding that a number of factors were important to perceptions of well-being for both samples, and that some of the factors differed for the two samples, was interpreted as suggesting the necessity of assuming multi-dimensionality when attempting to explain the experience of institutionalization by the elderly.

On the basis of these findings, it was suggested that because of its potential, and because of the relative theoretical and empirical underdevelopment of the multi-dimensional approach, additional research was necessary. Of particular value appeared to be research utilizing a long-itudinal design.

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INTRODUCTION

Sociological concern with the problems of the elderly within modern industrializing societies is of relatively recent origin, and appears to be largely a response to practical concerns with the problem of integration (both physical and social) of the elderly into the larger society. It thus reflects concern over trends toward the increased social and physical segregation of the elderly from the mainstreams of modern life.

The exclusion of the elderly from active participation is widely documented (Atchley,1972; Hendricks and Hendricks, 1977; Rosow, 1967), and appears to have resulted from a number of factors rooted in society's industrial and technological innovations (Atchley, 1972). Rosow (1974) asserts that "the progressive corrosion of the status of the aged is an unintended but direct result of larger social changes" (1974:2), and that these changes have taken place in all areas which have traditionally served to govern the status of the elderly in all societies. Those 'areas' or 'institutional factors' which have experienced change include: (1) property ownership; (2) strategic knowledge; (3) productivity; (4) mutual dependence; (5) tradition and religion; (6) kinship and family systems; and (7) community life. Ownership of property is no longer concentrated in the hands of the elderly and their importance to the modern productive system has declined. The knowledge derived from experience which tended to maintain the status of the elderly in more

stable societies is no longer highly valued. Similarly, tradition and religion have become less important to the modern way of life (Rosow , 1974:5-7). The consequences of these alterations are such that "the institutional forces that typically support the position of old people in simpler societies are inimical to them in our own" (Rosow 1974:7). For the elderly, such changes are said to bring about their exclusion and devaluation, role loss and role ambiguity.

Both the absolute and relative increases in the number of elderly within industrializing societies has served the dual function of increasing the magnitude of the problems associated with the exclusion of the elderly (to the extent that such problems now apply to more individuals) and the visibility of the elderly and consequently, of their experience of social segregation. Using the Province of Manitoba as an example, available statistics indicate that in 1941, those aged 65 years of age or older accounted for 6.3 per cent of the total population. By 1971, this figure had risen to 9.6 per cent. It has been estimated that by 1981, the elderly will comprise 11.3 per cent of Manitoba's total population (Aging in Manitoba, 1973:1).

Coincident with modern trends toward the segregation of the elderly from many aspects of social life is the tendency towards physical segregation. Reflecting substantive concerns over the physical segregation of the elderly as well as with the possibility that the elderly are perhaps more susceptible to environmental conditions than are other age groups in

society (Bennett, 1970; Lawton, 1970; Rosow, 1967; Yarrow, 1963), a number of investigators have made attempts to study the effects of certain types of segregated living arrangements upon various indices of the social and psychological well-being of the elderly (Bultena and Wood, 1976; Messer, 1967 cited in Bennett, 1970; Rosow, 1967). For the most part however, systematic research on the effects of institutionalization is lacking. "In most studies the setting has tended to serve as a backdrop rather than as a significant analytic component" (Bennett, 1970:98). Yet, as Blenkner (1969) notes, because American (and also Canadian) society has had a custodial orientation toward the needy aged, the institutional facility has been one of the most accessible sources of care for this group. Also, due to the lack of alternative services (to provide for social, economic, and psychological as well as physical needs), the elderly are often forced to seek institutional care even when they require only a few of the services offered (Brody, 1969). Available research also suggests a trend towards the increased utilization of institutional facilities (Bennett, 1963). Although it is often suggested that very few of the elderly actually reside within institutional settings (approximately four to five per cent at any one time - see Atchley, 1972; Kastenbaum and Candy, 1973; Riley and Foner, 1968), there is some suggestion that there is <u>at least</u> a twenty per cent chance of any elderly individual becoming institutionalized in some form of extended care facility at some time in his/her life (Kastenbaum and

Candy, 1973).

Although there are numerous studies of the elderly in institutional settings, the research which has been done has tended to be of a descriptive nature, concentrating on the accumulation of data on factors associated with the institutionalization of the elderly. Such research has revealed that female rates of institutionalization are generally higher than those of males (Riley and Foner, 1968), that elderly individuals in institutions are less likely to have a living spouse or children and are more likely to have lived alone prior to institutionalization than are comparable aged within the community (Goldmann, 1960; Riley and Foner, 1968; Scott, 1955), and that they tend to be financially disadvantaged (Butler, 1975; Kahana, 1971; Riley and Foner, 1968).

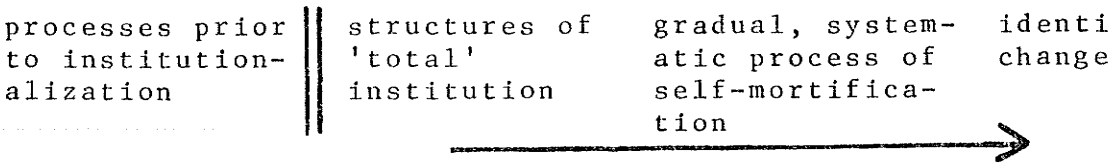
Yet, little is known of the importance of the institution as one form of social context (Bultena, 1974). The neglect of environmental factors appears to have been due to the lack of conceptual frameworks which would facilitate the systematic analysis of such environments. As Pincus (1968:207) notes:

> (t)he development of a systematic method of analyzing institutional environments is a necessary step in building a conceptual and methodological foundation for evaluating the effects of different institutional and group-living facilities on the aged. It is also a prerequisite for moving from exploratory case studies of single institutions to hypothesis testing research on large samples of institutions.

A number of views of institutionalization (both implicit and

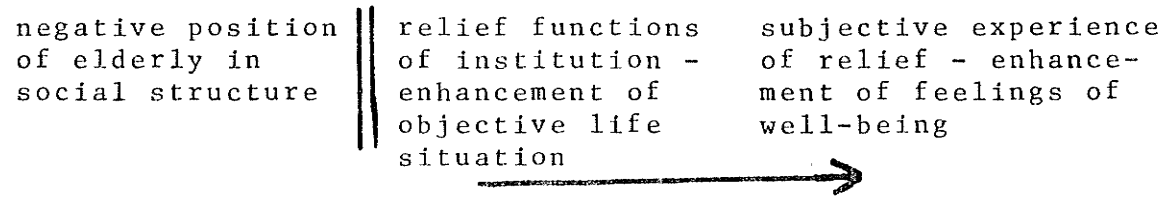
explicit) are however evident within the literature. For the most part, these represent attempts to define the institutional experience in relation to the operation of a single, primary factor or dimension of the institutional environment. Representative of such views are the 'bureaucratic', 'social welfare', and 'disengagement' perspectives.

The 'bureaucratic' perspective, emphasizing the negative implications of the institutional experience, received major support within the writings of Freidson (1970), Gustafson (1972), Scheff (1966), and others. However, the major proponent of this view remains Goffman (1961) who, within his seminal analysis of 'total institutions', classified the old age home and the nursing home as instances of this ideal type. This conception is structured around the concept of 'bureaucracy' and emphasizes the role of the institution in effecting transformations in personal identity. To the extent that, to the individual inmate, this transformation requires the alteration of prior conceptions of self in a situation where individual automomy is largely absent, the experience is visualized as a negative one. The bureaucratic conception can be represented schematically as follows:



The view that the consequences of institutional living are necessarily deleterious ones is countered by adherents of the 'social welfare' model. Whereas the prior conceptualization focused upon aspects of bureaucratic

organization as constituting the key determinants shaping the institutional experience, the latter perspective isolates the welfare (relief) component of institutionalization as most significant in shaping the institutional experience of the elderly 'inmate' (Myles, 1977a). It is suggested that, to the extent that the welfare or relief function is the central component, the experience of the institutionalization for the elderly is largely a positive one. The basic tenets of this view can be depicted in the following way:



Whereas the 'bureaucratic' and 'social welfare' perspectives deal specifically with the experience of institutionalization and generally stand in basic opposition to one another, the 'disengagement' perspective stands as a general theory of the aging process which has special implications for an understanding of the elderly within institutional settings. Opposing both of the views previously discussed, the latter initially appears to reject an association between objective life situation and the behavior and attitudes of the elderly. The elderly are regarded as participating with society in a mutually accepted process of withdrawal (disengagement). Within this process, elderly individuals gradually become increasingly self-centered and withdrawn, displaying decreased concern with aspects of their social and physical environments. Such withdrawal is, in turn, seen as being beneficial to the

well-being of the elderly. Consequently, it appears (i.e. within this perspective) that general processes of aging which influence the attitudes and behavior of the elderly are (or become) largely independent of the social context in which they occur. However, since it appears that institutions for the elderly may function as mechanisms for facilitating withdrawal (through reducing the number and complexity of the roles which the individual is required to perform), the institutional experience may, as a result, be a positive one.

As Myles (1977a) notes, the construction of such analytical tools is the beginning and not the end point of analysis. Ultimately, each must be assessed in terms of its adequacy in "depicting the true situation". It will be argued here that the actual utility of the three models proposed for an understanding and consequently, for an explanation of institutional effects, appears to be limited. Though each of the models proposed received some empirical support, each fails to consider the issues of inter-institutional differences in relation to possible differences in the relative importance of a <u>number</u> of institutional dimensions for resident consequences within alternative institutional settings. The failure to examine such variations appears to be particularly problematic for empirical research since, in choosing to isolate 'institutionalization' (whether this is primarily defined in terms of bureaucratization, relief functions, or withdrawal functions) as the lone independent or explanatory variable, inter-institutional homogeneity is

necessarily assumed (i.e. with regard to other factors which may differentiate between institutions). Potentially significant variations among institutions are therefore obscured. In addition, 'institutionalization' per se would appear to be inadequate as an explanatory variable since it does not indicate what it is about the experience which is relevant to specified resident outcomes (Anderson, 1965) and, as seen above, different theories interpret it differently. Other potentially important aspects of institutionalization could include differential control - totalism, and variations in privacy, resource potentials and access to the larger community (Pincus, 1968).

A number of investigators have argued that institutions for the elderly vary on a number of environmental dimensions including those discussed above (Kleemeier, 1961; Pincus, 1968). In addition, limited attempts have been made to examine the impact of such dimensions upon a number of social and psychological variables including activity levels and morale (Pincus, 1968; Schooler, 1969). However, much of existing research on institutional effects utilizes 'institutionalization' as the casual variable and tends to rely upon cross-sectional analyses of community and institutional samples. As a result, such research is subject to problems of selection (Kasl, 1972; Tobin and Lieberman, 1976).

Given (a) the extreme lack of consensus regarding the impact of institutionalization upon the elderly which is evident within the literature; (b) dissensus over whether

institutionalization is more properly conceived of as an unidimensional or as a multidimensional phenomenon; and (c) major methodological problems which limit the generalizeability of the findings to date; an assessment of the relative utility of those explanations which have been offered appears necessary.

This thesis then, examines three competing perspectives on institutional effects (the bureaucratic model, the social welfare model, and the disengagement theory of aging), criticizes each for its unidimensional approach, and suggests an alternative perspective which takes into account the heterogeneity of institutional environments. Empirical data from Manitoba are then analyzed to test the critique of the unidimensional models. These findings are utilized to suggest the formulation of a more adequate approach to an understanding of the effects of institutionalization on the elderly resident.

CHAPTER I

THE EXPERIENCE OF INSTITUTIONALIZATION: COMPETING PERSPECTIVES

a) The Bureaucratic Perspective

A number of investigators have centered their analyses of institutionalization around the notion of bureaucracy. The consequent focus on the centrality of power and authority and on the role of the official within such settings has resulted in a view which lays stress on the consequences of the loss of power and individual autonomy (which accompanies entrance to an institution) for the identity of the institutional resident.

The recognition that the institution may have a profound and negative effect on the elderly resident owes much to Goffman's (1961) classification of the old age home and the nursing home along with the reformatory, the concentration camp, and the orphanage, etc. as instances of an ideal type - the 'total' institution. Within his analysis, a dual focus upon both the structure of the institutional setting and the processes of self mortification which are determined by this structure is established. Although Goffman's work focuses specifically upon the experience of institutionalization as this occurs within the formal structure of the mental hospital, his objective is to understand "total institutions in general..." (1961:xiii) and the way in which such institutions affect "...the structure of the self" (1961:xiii) of the institutional inmate. Goffman defines the total institution as:

> a place of residence and work where a large number of like-situated individuals, cut off from the wider society for an appreciable

> period of time, together lead an enclosed, formally administered round of life (Goffman, 1961:xiii).

Those encompassing characteristics of the institutional environment which are ultimately responsible for the breakdown of barriers ordinarily separating statuses (the central feature of such environments) which, in turn, result in the systematic process of self mortification are outlined by Goffman (1961:6) as:

(a) the fact that all aspects of life are conducted in the same place under the same single authority;

(b) that all phases of residents' daily activity are carried out in the immediate company of others, all of whom receive similar treatment;

(c) that all aspects of this daily life are tightly scheduled and imposed from above through a system of explicit formal rulings and administered by a body of officials; and

(d) that the contents of such enforced activities are regarded as rationally planned, supposedly designed to fulfill the goals of the particular institution.

Within this conception, the fusion of distinct life activities within the confines of the institution -i.e. of sleep, work, and play - is ultimately responsible for the alteration of identity which characterizes inmates of such environments. As such:

> (t)he handling of many human needs by the bureaucratic organization of whole blocks of people - whether or not this is a necessary or effective means of social organization in the circumstances - is the key fact of total institutions (Goffman, 1961:6).

To Goffman, the result of this bureaucratically determined system of mortification lies within the alterations

it requires in the inmates' personal identity. Such alterations begin to occur largely upon entrance to the institution whereupon the new inmate faces gross changes in his/her moral career, a career which is defined by "the progressive changes that occur in the beliefs that he has concerning himself and significant others" (Goffman, 1960:454). S/he is immediately confronted by a standardized system of defacement, a stripping process which will now characterize the inmate career. This process of induction into the inmate career is visualized as a gradual one, beginning largely upon entrance[1] when the new recruit is confronted by a series of alienating and demoralizing admission procedures. Increased affronts to the maintenance of one's personal identity through enforced routinization of activity, deference requirements, and verbal and other profanations, tend to result in the inmate's adopting the definition of self preferred by the particular institution.

Implicit in this view is a particular view of the self; a view which stresses the notion of the self as being indivisible from the social context.

> The self... is not a property of the person to whom it is attributed, but dwells rather in the pattern of social control that is exerted in connection with the person by himself and those around him. This special kind of institutional arrangement does not so much support the self as constitute it (Goffman, 1961:168).

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1. Although Goffman (1961) notes that this process is set in motion prior to actual entrance to the institution, this is regarded as comprising an analytically distinct phase of the inmate career.

Garfinkel (1973) labels such systemized processes of self mortification as 'status degradation ceremonies'. In a view similar to that of Goffman, he notes that status degradation, as a transformation or essential reconstitution, is accomplished through communicative tactics, which have, as their result:

> (i)n the social calculus of reality representations and test, the former identity (comes to stand) as accidental; the new identity is the "basic reality". What he is now is what "after all" he was all along (Garfinkel, 1973:204).

Also utilizing Goffman's conception, Freidson (1970) notes that in order to render the individual amenable to the treatment process offered by the particular institution, it is necessary that s/he identify with the form of deviance to be treated - it is imperative that the individual assume "the hospital's view of himself" (Goffman, 1961:155). Therefore, once institutionalized, the inmate "can do no more than play the deviant role, choosing only to play it badly or well" (Freidson, 1970:325). S/he comes to be both rewarded for playing the now appropriate deviant role and punished when attempts are made to return to conventional roles (Scheff, 1966:84). At a social-psychological level, this process is inherently iatrogenic - the treatment becomes the cause of the "disease" (Myles, 1977a:3).

Concurring with Scheff (1966), Posner's (1974) participant observation study of a Canadian home for the aged reports that inmates were rewarded for displaying incompetence

through increased attention by staff and the receiving of private rooms. She argues that a significant structural feature of the institutional experience is that being or displaying competence can work against the inmate. Thus entrance to such an institution signifies a statement about self. One officially acknowledges one's incompetence, one's dependency, and one's withdrawal into the 'sick' role.

Given therefore, that within this view, the tendency is for the inmate to adopt the identity preferred by the institution, a problematic issue concerns whether or not this adoption serves to induce a positive or negative sense of personal well-being.[2] It is apparent that, to Goffman, the new recruit, not yet indoctrinated into the inmate role, will experience a low level of morale when faced with continuous assaults to his/her self concept. It could be argued however, that those inmates who have become indoctrinated and have, as a result, adopted the institution as a reference group, will find positive meaning within the designated role and will consequently reflect an increased level of social and psychological well-being. However, for Goffman, the consequences of the inmate's perception of incongruity between his/her view of self and that held by the institution are necessarily deleterious ones, reflected in the inmate's self concept by a sense of "failure" (1960:464), "personal inefficiency" (1961 :44), and of "life wasted" (1961:68), and often expressed through a

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2. This issue is discussed in a later section of this thesis (see Chapter III).

tendency towards "situational withdrawal" (1961:61). At this point in the inmate career, the new recruit, through such coping mechanisms as withdrawal (disengagement) is attempting to deny the new identity while coping with continual affronts made to his/her present (past?) one. To the extent that this incongruity ceases to exist once the new inmate adopts the institutional definition of self, the issues of permanency (of withdrawal reaction) and of perceived well-being accompanying prolonged institutionalization remain problematic.

Two issues are of relevance here. The first concerns the elderly within the institution as an analytically distinct group for whom the experience of confinement is a unique one. Such a view is offered by Gustafson (1972). In an application of Goffman's thesis to institutions designed specifically for the aged, Gustafson argues that due to the fact that in such an institution, there is no progressive career for the patient/inmate to enter (since recovery is not expected), the tendency towards withdrawal becomes permanent. She conceives of admission to such a home as an introduction to a regressive career which ends in death.

Implicit in Gustafson's view, and perhaps Goffman's as well, is the assumption that withdrawal is both a reflection of and a reaction to low morale and a negative sense of self worth. If this is the case, then Gustafson's conclusion that withdrawal behavior represents a permanent reaction to features of institutional life among the elderly, specifies that for

the elderly, the inmate career is characterized by a low level of morale.

A related issue therefore concerns the effect of length of institutionalization upon inmate morale. To Gustafson, the tendency towards withdrawal increases as a function of time spent within the institution. Based on the view that for the elderly, withdrawal reflects a low level of morale, one can therefore predict that as withdrawal increases, the level of morale decreases. In this instance, it would appear that the elderly residing within the formal structure of the nursing home, the home for the aged, and the mental hospital, etc. do not derive positive meaning from the inmate role.[3]

A final aspect of the bureaucratic conception which is relevant to a consideration of institutional effects concerns those factors which may serve to mediate the impact of institutionalization upon the personal identity and social-psychological well-being of the elderly inmate.

Although Goffman clearly stresses the importance of the institutional environment in "assuring an aggregate of people a common fate and eventually a common character", he does note that not all 'inmates' react similarly to the institutional experience. Variations appear to arise from a number of contingencies similar to those 'career contingencies' which

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3. Both cross-sectional and longitudinal studies on the impact of length of institutionalization upon various indices of well-being have tended to lend some support to this view - see Bennett and Weinstock (1971), Coe (1965), Dick and Freidsam (1964), and Lieberman et al (1968).

eventuated in the initial institutionalization of the individual. Though Goffman does not specify the exact nature of such contingencies, he does make reference to the importance of class status. For example, Goffman notes that the "humiliations (encountered within the institution) are likely to be most keenly felt by middle-class patients since their prior condition of life little immunizes them against such affronts" (Goffman, 1961:219). Within gerontology, those factors which have been found to differentiate those most severely affected by institutionalization include sex, social class, health status (both real and perceived), marital status, and the availability of social supports.

In conclusion, within the 'bureaucratic' conception as it applies to the elderly within institutional settings, the consequences of confinement are, in general, negative ones which result in withdrawal (disengagement) accompanied by a negative sense of self worth and low morale. This view receives support within a number of studies.

Brody (1973) coins the adjective 'procrustean' (denoting the production of uniformity through violent means) to describe the experience of the elderly inmate. Noting that a sense of power over one's own destiny is crucial to the maintenance of integrity in the human personality, she argues that a loss of control over this destiny by the elderly, predetermines poor morale.

> The institution actively participates in reducing the resident to a total lack of power... Admission is accompanied by a series of procedures that transfer the

> individual's power over his own life to the personnel of the institution... (The consequences are)... what might be called the iatrogenic diseases of institutional life; dependency; depersonalization; low self-esteem; lack of occupation or fruitful use of time... loneliness, lack of privacy, (loss of) identity ...desexualization... (Brody, 1973:433).

This assumption of total control over all aspects of the patient's life and its deleterious consequences for elderly residents is evident within studies conducted by Gottesman (1973) and Gottesman and Bourestom (1976). These studies showed that in many homes, more than half (55% and 56% respectively) of the patient's waking hours were spent doing nothing at all, about twenty per cent was occupied with such basic activities as dressing and eating; and about twenty per cent with other activities such as watching television (Gottesman, 1973 cited in Brody, 1973).

Townsend (1962), who conducted extensive research into nursing and old age homes in England reports findings supportive of those found by Brody (1973) and the arguments put forth by Goffman (1961) and Gustafson (1972). He depicts the institutional experience as constituting a gradual process of depersonalization. Selected features of the institutional environment which are central to this process include restrictions on mobility and access to the larger society, communal living characterized by a lack of privacy and of opportunities in which to exercise valued skills and abilities, and limitations on social experiences. Residents appear to be "subtly oriented toward a system in which they submit to orderly routine,

noncreative occupation, and cannot exercise... self-determination". Evidence further suggests that social contact among residents and between residents and staff is limited (Townsend, 1962:330).

Stannard (1976), in his participant observation study of a proprietary nursing home noted the dominance of the custodial ideology and the implications of this ideology for patient care.

> The nurse emphasized the hopeless conditions of the patients...and the necessity of controlling them with drugs and cloth restraints. Care, thus, was defined minimally in terms of tending to the bodily needs of the patients and keeping them and the home clean and orderly... (Stannard, 1976:448-449).

A number of investigators have focused on the impact of institutionalization in relation to more specific social and psychological variables. Results from a number of studies have shown the elderly to display a number of negative personal and social characteristics which have usually been attributed to the experience of institutionalation. Based upon a review of the literature, Lieberman (1969) characterizes the elderly institutional resident as displaying:

> poor adjustment, depression and unhappiness, intellectual ineffectiveness because of increased rigidity and low energy... feelings of personal insignificance and impotency, and a view of self as old. Residents tend to be docile, submissive, show a low range of interests and activities, and to live in the past rather than the future. They are withdrawn and unresponsive in relationships to others. There is some suggestion that they have increased anxiety which at times focuses on feelings of death (Lieberman, 1969:330-1).

Representative of this view are the studies conducted by Fink (1956), Lieberman et al (1968), Mason (1954), Pollack et al (1962), and Scott (1955).

Mason (1954) sought to determine the effects of institutionalization upon the self-conception of the elderly inmate, reasoning that one's judgement of self worth represented the major determinant of success or lack of success in adjusting to the role of the aged. Utilizing three groups for comparison - a group of elderly residing within a municipal infirmary (N=60), a group of elderly from the community(N=30), and a group of noninstitutionalized young adults (N=30) - Mason found that the group of institutionalized elderly expressed the most negative views of self worth (as measured by a battery of psychological tests yielding eighteen self-concept measures) and the group of young adults, the least negative view of the three groups. This was not however indicative of similar differences toward present state of happiness or ability to contribute. Although found to be less 'happy' than the young adults, there were no differences in the judgements of the two elderly groups on the variable of present mood. It is important to note however, that the measurement for present mood consisted of a rating by an informant and not by the individual him/herself. In contrast, the measure of self-concept was derived from a questionaire designed for the study and revealed the respondent's reactions to a number of statements considered relevant to the self-concepts of an elderly population. Based upon these findings, Mason (1954) concludes that both age and institutionalization

have a negative impact upon feelings of self worth.

Similar results were obtained by Pollack et al (1962) who, in their research, investigated patterns of orientation for self of elderly institutional and community residents. The test utilized for an indication of orientation for self consisted of the respondents' reactions to viewing themselves in a mirror. Comparison of a randomly selected group of residents of nursing homes, homes for the aged, and state hospitals, with a randomly selected sample of residents within the surrounding community revealed significant differences in the frequency of self-derogatory responses between the two groups. The institutionalized sample, in general, expressed a negative view of self more often than did the noninstitutionalized sample.

A number of other factors have been studied in relation to institutionalization and are supportive of a bureaucratic interpretation. The results of research which is based upon comparisons of institutionalized and community elderly have shown the former to be characterized by poorer adjustment (in terms of normative expectations of appropriate role behavior - see Scott, 1955), lower levels of morale (Pierce and Clark, 1973) and life satisfaction (Riley and Foner, 1968) a greater concern with the past and significantly lesser concern with the future (Fink, 1956; Lieberman et al, 1968), poorer cognitive functioning (Lieberman et al, 1968), and by a lesser concern with the importance of their roles as grandparents (Kahana and Coe,

1969 cited in Kahana, 1971) than are elderly community residents.

Although research such as this is suggestive of the possible consequences of institutionalization, much of it appears to be of limited value due to severe methodological difficulties. One such difficulty arises when homogeneity among institutions and within the community are assumed, despite findings indicating that neither category is, in actuality, a homogeneous one (see Butler, 1975; Coe, 1965; Wolk and Telleen, 1976). Kasl (1972), in reviewing the literature on the institutionalization of the elderly, notes that a large proportion of the studies conducted are cross-sectional surveys wherein the elderly residing within an institutional setting are compared to those within the community. He states that because, within such studies, it is not possible to differentiate whether negative findings are due to self-selection factors, to the consequences of institutionalization, to differential survival rates, or to the effects of relocation,[4] the findings can at best be regarded as supportive of the 'possible' impact of institutionalization.

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4. It has been suggested that the conditions associated with moving into a new setting may be responsible for the effects often attributed to living in an institution (Lieberman, 1969). Such conditions may include whether the relocation was voluntary or involuntary (Lawton and Yaffe, 1967 cited in Lieberman, 1969; Smith and Brand, 1975), the amount of preparation (Jasnau, 1967 in Lieberman, 1969) and the meaning attributed to entering an institution by the individual (Kleemeier, 1960 in Lieberman, 1969; Lieberman and Lakin, 1963), etc. It has been argued that relocation is often accompanied by feelings of grief in that it represents a disruption to the past as well as to the present and the future (Fried, 1963) and that this reaction may be temporary (Bennett and Weinstock, 1971).

The view that institutionalization generally has negative consequences for those elderly finding themselves within such a setting is prominent within social gerontology, and receives some empirical support. However, Myles (1977a) takes the bureaucratic view to task and proposes an opposing view of institutionalization based upon the notion of 'welfare'.

b) A Social Welfare Interpretation

In a sense more traditional than the bureaucratic conception is the social welfare perspective. However, although the belief in the medical, social and economic benefits to be derived from institutionalization by the elderly (the basis of the social welfare model) has largely been the guiding force behind the introduction and recent proliferation of institutional settings in Canada and the U.S., this perspective has not, until recently, been utilized extensively as a theoretical framework to guide sociological investigation into the meaning and consequences of institutionalization to the institutional resident.

Recently, Myles (1977a), in his consideration of the elderly within institutional environments, emphasizes the welfare or relief functions of such settings. Whereas the bureaucratic conception establishes an initial focus upon the structure of the institution, the social welfare perspective chooses to focus instead upon those aspects of the structure of society (including social, political, and economic elements which are similar in meaning to Goffman's

(1961) "career contingencies") which initiated the need for such institutions.

Beginning with a critique of the bureaucratic conception, Myles questions Goffman's (1961) characterization of the 'total' institution and asserts that within this framework, institutions are treated within a social vacuum. Consequently, "the institution emerges from this perspective as a particularly aberrant social structure rather than as a reflection of the position and social relationships which characterize the situation of such negatively privileged status groups as the aged... in contemporary society..." (Myles, 1977a:18-19). This neglect of social and historical forces which generated the demand for such institutions results in both analytical and methodological problems for the bureaucratic conception.

Noting that the latter framework rests upon the assumption that institutionalization involves the loss of power and autonomy by the individual, Myles argues that since the exercise of power in any social system is dependent upon one's control over valued resources and that, in a society where property ownership is highly concentrated, and mobility is high, most of the elderly are left with few resources. Added to this is the arbitrary exclusion of the elderly from the labor market. Also, the position of the elderly within the private sphere can be visualized as involving a loss of autonomy. In addition to being a negatively privileged status group, the elderly also tend to be poor.

Thus individual autonomy in their roles as consumers is severely limited. Therefore, Myles concludes that the elderly within our society have little power and autonomy to lose.

Emanating from this reappraisal of the bureaucratic framework, Myles offers an alternative - the social welfare perspective. Noting that the position of the elderly within modern society is one characterized by gradual pauperization, increased illness with age, and social isolation due to reduced opportunities for social participation, and further, that it is precisely these three conditions with which the institution is both designed and equipped to deal, Myles concludes that the experience of institutionalization (the key fact of which is the provision of relief), is beneficial rather than detrimental to the well-being of the elderly.

This provision of relief also has consequences for the morale or subjective assessments of well-being of elderly institutional residents. Myles notes that to the extent that studies which have attempted to determine the most important correlates of life satisfaction and morale among the elderly have continually found these to be related, either directly or indirectly, to poverty, illness, and social isolation, and to the extent that the institution offers a solution to these problems, it follows that life satisfaction and morale should increase when such problems are alleviated.

As a logical extension of this argument, Myles,

rather than viewing the institution as actively engaging in a process of self mortification which ultimately causes the inmate to adopt the sick role, regards it as a prosthetic environment which actively reduces the identification by inmates with the sick role. This, in turn, will be reflected in increased levels of morale for those elderly whose problems have been taken care of by the institution.

In conclusion, Myles asserts that is is the welfare component of institutionalization which is the primary determinant of the institutional experience of the elderly resident. He concludes with a prediction which is antithetical to that expounded by proponents of the bureaucratic conception - the institutionalized elderly are assumed to be positively rather than negatively affected by institutionalization. Necessarily modifying this association are the variables of income (poverty), health status (illness) and the availability of social supports (social isolation). Also important therefore are such factors as sex and marital status as these have been shown to be important correlates of income and social isolation among the elderly.

Support for Myles' critique of Goffman appears in the research conducted by Anderson (1965) and Lepkowski (1956), both of whom failed to find associations between institutionalization and negative consequences for the elderly. Anderson (1965), in her research, attempted to determine the relationship between institutionalization and self conception.

Envisioning the problem inherent in much of the

previous research on institutionalization as the failure to clarify how or why institutionalization produces negative consequences, she proposed to investigate the relationship in a three-way linkage in which institutionalization was regarded as the independent variable, self-conception as the dependent variable, and variation in interaction as an intervening variable. Variation in interaction is an important variable, argues Anderson, which accompanies a change in living arrangements and, as such, appears to be a significant condition for an alteration of self-conception whereas institutionalization does not. In commenting upon her rationale for choosing not to focus upon institutionalization per se, Anderson (1965:250) states:

> The nature of institutionalization suggests its inadequacy as an explanatory variable. It is a short-hand way of describing many changes in one's physical surroundings which does not necessarily affect self-conception, but the social-psychological meaning of the change does. Hence, accounting for more than the fact of being institutionalized is necessary if a modification in self-conception is to be explained...

In an effort to approximate a longitudinal design, Anderson compared residents of a church sponsored retirement home and a group of elderly who had applied for admission to the same home. Matching the two samples in terms of sex, education, occupation, nationality, and marital status, both samples were administered a closed-ended questionnaire.

Anderson found no significant differences between the two samples in self-concept. Neither were there differences

in the amount of social interaction engaged in by the two groups. Anderson concludes that although her findings are merely suggestive, institutionalization cannot be accredited with a decrease in an individual's self-esteem. Rather, the particular conditions associated with institutionalization must be specified and included within an explanatory framework. That this is necessary is illustrated by the fact that Anderson's institutional sample was chosen from a church sponsored retirement home, an environment which may differ significantly from other (governmentally or privately sponsored) institutions for the elderly (an issue which is discussed later).

Lepkowski (1956) compared the attitudes and adjustment of institutionalized and noninstitutionalized Catholic elderly. The institutional sample consisted of 93 residents of a Catholic home for the aged, and the non-institutional of 32 regularly attending members of a Catholic sponsored group. Utilizing a questionnaire to elicit relevant demographic data in addition to an Attitude Inventory, to reveal attitudes towards work, friends, health, religion, etc., Lepkowski found no significant differences between the two groups.

Having defined the institutional experience as one characterized by the provision of relief from the conditions of illness, poverty, and social isolation, Myles (1977a) attempted to determine empirically whether and to what extent, this provision of objective forms of relief was experienced as such by elderly residents and thereby also served as a

subjective system of relief. Utilizing data collected in the Province of Manitoba in 1971,[5] Myles compared institutionalized and noninstitutionalized elderly in terms of (a) their tendency to adopt the sick role and thus to define themselves as ill; (b) their levels of participation in social and nonsocial activities and the subjective importance attributed to these activities; and (c) their perceptions of current and future economic well-being.

In assessing the impact of institutionalization upon the tendency to view oneself as ill, Myles asserts that "assuming comparable levels of disability and disease... the institutionalized... (will be)... less likely to view their illnesses as problematic" (Myles, 1977a:89), and thus less likely to view themselves as ill. Controlling for the effects of age and objective health status and utilizing three groups for comparison - a group of institutionalized elderly, a group of elderly within the community, and a group of elderly residing within housing units - Myles found that although scoring higher on all measures of objective disability and disease, the sample of institutionalized elderly appeared less likely than either of the other two samples to view themselves as ill. Myles therefore concludes that "(r)elief from illness... constitutes one dimension of the manner in which institutionalization affects the 'structure of the self' (1977a:116). In addition, Myles, noting the

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5. This is the same date which is used in the present research.

centrality of the concepts of morale and life satisfaction within social gerontology, attempted to examine the impact of institutionalization on the association between perceived health and life satisfaction. Utilizing a measure of life satisfaction developed by Neugarten et al (1961) and controlling for the effects of marital status, economic status, and social participation, Myles found self-assessed health to be the most important determinant of life satisfaction among the elderly. Combining this with his earlier findings that both institutionalized and noninstitutionalized elderly were equally affected by their perceptions of health and that the institutionalized elderly were the least likely to view themselves as ill, Myles concluded that the institutionalized elderly were, in general, more satisfied than the noninstitutionalized elderly. However, Myles did not conduct a direct test, nor did he control for the type of setting.

Within his analysis of the impact of institutionalization upon social participation, Myles compared activity levels, preferences for social rather than nonsocial activities, and frequencies of interaction with friends, neighbours, and relatives of the institutional and community samples. As hypothesized, no association was found between institutionalization and level of activity or preference for social rather than nonsocial activities. Significantly however, both the institutional and housing unit samples displayed higher levels of interaction with friends and neighbours than did the community sample. However, the former two samples had

a significantly lower level of interaction with relatives than did the community sample. Myles notes that although this may be interpreted as providing support for Goffman's view, it is also possible that self-selection factors are operative insofar as lack of interaction with relatives may predispose one to institutionalization. From these findings, Myles concludes that it is the noninstitutionalized elderly who appear to be relatively disengaged (withdrawn) from social relationships.

Finally, in assessing the role of the institution in modifying the relationship between economic situation (perceived present and future economic well-being) and life satisfaction, Myles found all samples to be less likely to view themselves as economically deprived than their objective economic situations would seem to indicate. In addition, Myles found that institutionalized elderly had higher perceptions of economic well-being than did the noninstitutionalized. Although this appeared to be a function of their higher objective economic status, Myles asserts that it also reflects the institutionalized respondents' appreciation of the welfare function of the institution. As a result, Myles asserts that because perceptions of economic well-being are important to overall assessments of well-being, it follows that the institutional sample is, in general, more satisfied than the noninstitutional sample.

Myles, although providing a convincing argument, has overlooked a number of important issues. Central to his

thesis is the idea that the institution, because of its orientation towards the treatment and cure of disease, mitigates the tendency of individuals to identify with the sick role. Although homes for the aged have traditionally been settings wherein the elderly who are no longer able to function effectively within the community (due to social, economic, and/or other losses) can spend their remaining days in a protected environment (Kahana, 1971), evidence suggests that they are not extensively oriented towards the 'treatment and cure of disease' (Wessen, 1965). What Myles neglects to note, and a fact which has received wide documentation within the literature (see for example Kahana, 1971; Wessen, 1965), is that the rehabilitative ideal founded upon a medical model of illness - based upon the isolation of a cause derived from a series of symptoms which, in turn, prescribes a cure (i.e. the 'doctrine of specific etiology' - see Scheff, 1966) - is largely inapplicable to many (most?) of the illnesses which beset the aged, since such illnesses tend to be of a regressive (Gustafson, 1972) and chronic (Kahana, 1971) nature, requiring long-term custodial type care (Wessen, 1965). Cure is no longer a forseeable goal, and, as a consequence, long-term care has been depicted as a "regimen of limited objectives" (Wessen, 1965). Institutions for the elderly do not appear to be treatment oriented. Research conducted by Gottesman (1960) revealed that the amount of time spent by elderly patients in direct doctor-to-patient contact was so little

that it did not warrant differentiating for purposes of coding the data. Also, within most long-term care facilities, the elderly are cared for primarily by relatively untrained personnel (Wessen, 1965).

Also suggesting the opposing view that institutions are not beneficial in lessening the tendency of elderly patients to identify with the sick role is evidence suggesting that elderly individuals entering such institutions most often regard it as a prelude to death (Brody, 1973) and as the least desireable of possible living arrangements (Kahana, 1971).

Also, Wolk and Telleen's (1976) research indicates that various parameters of the institutional setting have an impact upon both the level and the correlates of life satisfaction, and that perceived social and psychological restrictions (outside of participatory and economic constraints) are important to the maintenance of life satisfaction. In their research, Wolk and Telleen found perceived health to be an important correlate of satisfaction only for those aged residing within an institution rated as highly constraining (a concept similar to Goffman's (1961) 'total' institutions). This was not the case for those within the lower constraint setting for whom the most important correlates of satisfaction appeared to be perceived autonomy and self-acceptance.

Myles' perspective appears to suffer from a similar problem as that which he attributes to the bureaucratic perspective - i.e. the "rush to generalize" (Zeitlen, 1970:

ix in Myles, 1977a:198). Whereas Myles asserts that in his attempt at developing a formal theory of institutions, Goffman has ignored the social and historical context, it appears that both Goffman and Myles have, in their "rush to generalize", failed to some extent to take into account potentially significant variations within the category of institutions for the elderly. Myles' research for example, reveals nothing of the impact of alternative institutions upon: the propensity of individuals to identify with the sick role; the number, quality, and satisfaction derived from their social relationships, etc. In treating the institutional sample as a homogeneous one, he is necessarily committing himself to an examination of average levels of activity, of satisfaction, and of perceived health status characteristic of the institutional sample in comparison with similar averages characteristic of those within the housing unit and community samples. Yet there are potentially significant differences within each setting category which possibly serve to cancel each other out and are subsequently rendered inevident when combined in this way. Myles, although aware of the potential problems resulting from this omission and therefore by the necessary assumption of homogeneity among institutional settings, asserts that this issue becomes less problematic in view of the high level of governmental control over such institutions within the Province of Manitoba. This does not however appear to be the case (see pages 47-8).

Finally, Myles' research may also be subject to the

problems discussed earlier with reference to research done supporting the bureaucratic conception. In comparing community and institutional samples, his research too is subject to problems of selection bias as is the research conducted by Anderson (1965) and Lepkowski (1956). In comparing samples such as this, it becomes difficult to distinguish between the effects of institutionalization and other factors which may differentiate the two samples. Possibly important are differences in social isolation prior to residence, differential mortality rates, etc.

In conclusion, whereas the bureaucratic conception emphasizes the iatrogenic nature of the institutional experience and suggests that institutional living has a negative effect upon the personal identity and social-psychological well-being of the inmate, the social welfare model stresses the relief characteristics of the experience and the positive implications of these characteristics for residents' identity and well-being. While, to Goffman, the institutional experience is qualitatively different from that of living in the community, to Myles, the same dimension as is assumed to be operative within institutions (i.e. the provision of relief) is regarded as operating within the community though to a lesser degree. In addition, although proponents of both the bureaucratic and social welfare perspectives acknowledge the possibility of some degree of variation along the one particular dimension which is regarded as being the major influence within institutions, both assume inter-institutional

homogeneity with regards to additional factors which may serve to differentiate institutional environments. Therefore, while both views receive some support in the literature, both can be criticized for their failure to recognize additional characteristics or dimensions of the institutional environment which could affect resident well-being.

c) The Disengagement View

Whereas both the 'bureaucratic' and 'social welfare' perspectives deal specifically with the issue of institutionalization and its impact upon the social and psychological well-being of elderly inmates, the disengagement theory does not focus upon institutionalization, but rather, upon the nature of the aging process itself. Although this theory has not been investigated in relation to the institutionalization of the elderly, it does bear special implications for such an investigation.

Perhaps the most prominent theory of aging to date, the disengagement perspective was first outlined by Cumming et al (1960) and was later formalized by Cumming and Henry (1961). As a functionally derived theoretical perspective (Gubrium, 1973; Atchley, 1972), disengagement theory views the aging process as one of withdrawal - as a process involving the gradual withdrawal of the elderly individual from society and social involvement and similarly, of society from the aging individual. Within this view:

> (a)ging within the model person is thought of... as a mutual withdrawal or disengagement which takes place between the aging

> person and others in the social systems to which he belongs... (O)ne of the early stages of disengagement occurs when the aging individual withdraws emotional investment from the environment. We have thought of the inner process as being an ego change in which object cathexis is reduced; this results in an appearance of self-centeredness, and an orientation to others which betrays less sense of mutual obligation... The fully disengaged person can be thought of as having transferred much of his cathexis to his own inner life; his memories, his fantasies, his image of himself as someone who 'was' something and 'did' accomplish things (Cumming and McCaffrey,1960 cited by Havighurst, 1963:309).

The withdrawal of the individual from society and of society from the individual is a gradual process characterized by its mutuality, its inevitability, and its universality. As a mutually accepted and eventually mutually satisfying process, it is regarded as having both responsive and developmental aspects. Society requires the withdrawal of its elderly so as to ensure its continuity and continued equilibrium, and aging individuals desire and/or accept withdrawal due to their recognition of these system requirements as well as of their decreasing capacities and impending death. The process of disengagement then, appears to constitute a preparation for death. The fundamental basis of the theory is, as Atchley (1972) and Chappell (1975) have noted, human mortality. Disengagement is inevitable because death (the final disengagement) is inevitable and "according to a basic principle of functionalism, society and the individual always accomodate themselves to the solid facts of existence"

(Rose,1968:185).

Central to the disengagement theory is the notion that disengagement has both its 'inner' and its 'outer' aspects - it has both personal and social implications. Cumming and Henry (1961) note that these changes occurring during the cyclical process of disengagement are normally of three types:

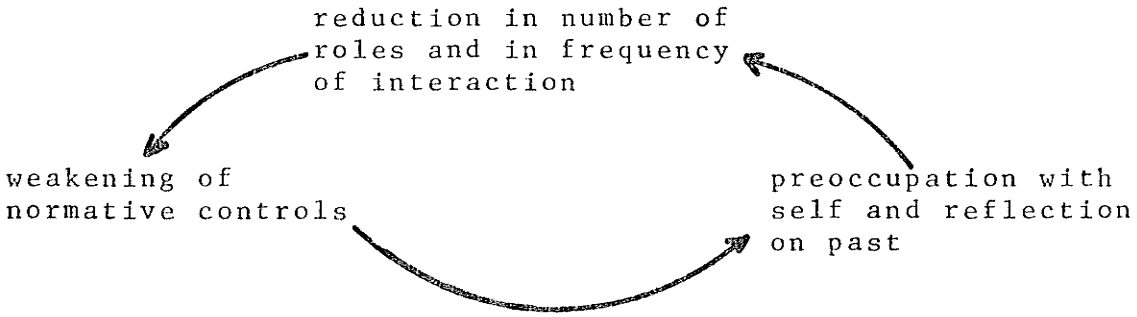
(1) changes (decreases) in the number of people with whom the individual interacts accompanied by a shift in the goals of such interactions (in the direction of short-term gratification)

(2) qualitative changes in the style of interactions (changes displaying decreased emotional investment); and

(3) changes within the personality, attitudes, and orientation of the elderly individual (in the direction of increased preoccupation with self and a hedonistic or carefree orientation) which both cause and are caused by decreased involvement with others and an increased preoccupation with self.

Such changes generally occur in the direction of gradual decreases in the number of people with whom the individual interacts, and thus in the number of roles which s/he performs. This reduction is held to result in a weakening of normative control; a freedom which, when accompanied by declining physical capacities and an awareness of the possibility of death, leaves the individual content to live with symbols of the past. This process is regarded as being one of increasing individuation resulting in increased

preoccupation with oneself, and can be represented schematically as follows:



It is, in a sense, the reversal of the socialization process:

> (S)ocialization is the encouragement of children to abandon their parochialism and individuation and to accept conformity to the demands of the major institutions of society, while disengagement is a permission to return again to individuation (Cumming, 1964:10).

Such a shift in orientation is either accompanied by, or preceded by, a changed perception of self. As noted, this change appears to involve the aging individual viewing him/herself in terms of "someone who 'was' something and 'did' accomplish things" (Cumming et al, 1960).

Although disengagement is viewed as a natural rather than an imposed process which has positive implications for the morale of the elderly, it is possible that although not prepared for disengagement, some elderly are forced to withdraw (since this is a system requirement). Cumming and Henry (1961:224) note that, in such instances, the result is ordinarily disengagement accompanied by low morale. However, since disengagement is regarded as being an inevitable process ultimately characterized by mutuality, this situation is regarded as a temporary one. Morale will increase once the

individual is prepared to disengage.

Although the proponents of this theoretical perspective do not make explicit reference to the role of the institution within the context of the disengagement process, the perspective itself would appear to be capable of generalization to such a consideration. To the extent that disengagement is a gradual process of withdrawal involving a reduction in both the number of roles played and the frequency with which these roles are acted out, and, to the extent that the individual eventually becomes desirous of such withdrawal, entrance to an institution (characterized as it appears to be, by a reduction in individual autonomy in decision-making and a drastic reduction in the number of roles available to the individual resident) may be conceived of as both a societal and individual mechanism for disengagement. Society provides mechanisms by which this withdrawal can be facilitated and through which, the consequences (including poverty and social isolation) which may upset system stability can be partially alleviated. Similarly, the individual, no longer oriented towards active involvement, may regard the institution as a mechanism by which to ease the process of withdrawal, through its reduction in the number of roles which the individual is required to perform and the lessening of the demands associated with these role(s).

Important to note as well is that within this theory, the concept of 'disengagement' does not hold negative connotations as it does within the bureaucratic and social welfare

perspectives. Rather, it is considered a normal adjunct of the aging process and one which has beneficial consequences for the morale, life satisfaction, and self-esteem of the elderly.

Since institutions for the elderly generally serve a caretaking or custodial function (Blenkner, 1969), it appears reasonable to assume that outside of certain scheduling requirements, the elderly individual is to a large extent free from a number of role constraints. Indeed Gottesman's research (see page 18) would seem to indicate that the elderly within the institution do have a great deal of opportunity to "live in their own self-centered world". Considered relative to the demands of community living (in terms of role flexibility and frequency of interaction)which most often requires that the individual service his/her own needs, this appears to be the case.

According to this view then, institutionalization, insofar as it clearly defines the transition into disengagement, does not appear to have negative effects on the well-being of the elderly resident. Rather, insofar as it represents a vehicle for withdrawal by the elderly (and by society), and withdrawal is held to have a positive effect upon the well-being of the elderly (i.e. except in those cases where the individual is not yet ready for disengagement), the experience of institutionalization appears to be a beneficial one.

Although the disengagement process is regarded as being both inevitable and universal, such factors as

sex,[6] the availability of social supports, and financial solvency are considered significant in that such factors (although they cannot significantly alter the process itself once it has begun to occur) can serve to delay or hasten the onset of disengagement.

A great deal of criticism has been levelled against the disengagement perspective. Briefly summarized, the majority of such criticisms questions the 'inevitability', the 'desireability', and the 'necessity' (and thus universality) of the trend toward disengagement by the elderly. In reviewing such criticisms, Rose (1968) cites research indicating that: (a) rather than being an inevitable process for all elderly, disengagement may simply reflect "a continuation of a 'life-long' social psychological characteristic of 'some' people" (Rose, 1968:186); (b) engagement rather than disengagement is positively related to well-being among the elderly; and (c) the theory is a "poor interpretation of the facts" since it can not account for the fact that the disengagement of the elderly is not the case elsewhere in the world. Thus it disregards the importance of social structure and ignores social trends towards the reengagement of the elderly into society.

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6. Cumming and Henry (1961:212) postulate that "(b)ecause the central role of men... is instrumental, and the central role of women is socioemotional, the process of disengagement will differ between men and women". It is argued that the process is more problematic for men and that this difference is a result of differences in major life roles. Whereas for men, disengagement symbolizes the relinquishing of all of an activity (i.e. the work role), for women, it requires giving up only the major burden of an activity.

More problematic for the present research is the fact that along with the bureaucratic and social welfare perspectives, the disengagement theory (when generalized to a consideration of institutionalization) focuses upon only one dimension - withdrawal. In isolating only the one dimension and treating it as inevitable and universal, the disengagement theory also appears to rest upon an assumption of homogeneity among institutions. Yet there is evidence suggesting that other factors or dimensions of the social and/or physical environment may be important to the well-being of the elderly (see Kleemeier, 1961; Pincus, 1968; Schooler, 1969 Townsend, 1962).

In conclusion, the disengagement view would hypothesize a positive association between institutionalization (regarded as an experience which is facilitative of withdrawal and therefore, of high morale) and perceptions of well-being among the elderly. In this way, the disengagement view would appear to be consistent with the social welfare interpretation. However, whereas the latter argues that institutionalization is beneficial through mitigating the consequences of social isolation and enforced withdrawal, the latter appears to suggest the reverse. Institutions are beneficial not because they lessen withdrawal but rather, because they promote it. Although the view that institutions promote withdrawal is consistent with the bureaucratic interpretation, its connotation differs. While within the bureaucratic model, withdrawal is regarded as being detrimental

to well-being, within the disengagement perspective, it is regarded as beneficial. Finally, whereas within the bureaucratic perspective, the institutional experience is seen as being qualitatively different from that of living within the community, both the social welfare and the disengagement perspectives view the same factors as being operative in both (i.e. either withdrawal or relief). Within these latter perspectives, institutions serve either to ease the process of withdrawal or to provide more relief than is available within the community.

Within the following section, literature on institutions for the elderly is reviewed and an attempt made to develop a perspective(relying upon a view of institutions as heterogeneous) which can be generalized to take into account significant variations within the category of institutions for the elderly.

d) In Search of an Alternative: The Institution as Heterogeneous

Each of the perspectives so far discussed has focused upon the issue of institutionalization in terms of a single defining characteristic. Whereas the 'bureaucratic' conception focuses upon the notion of bureaucratic organization, the 'social welfare' view orients itself around the notion of relief. Similarly, proponents of the 'disengagement' theory have focused on the concept of withdrawal. Extending this focus to an analysis of institutionalization, representatives of each approach generalize so as to take into account all members within the category under consideration (in this case, that

of institutions for the elderly). Consequently, each arrives at a different understanding of the phenomenon and none gives extensive consideration to variations within the general category.

The possibility of inter-institutional variation, although acknowledged by a number of proponents of a bureaucratic perspective including Goffman (1961:5), appears to be regarded as being of secondary significance. Goffman's main focus is upon the uniformities of the institutional experience - upon the similarity of the experiences encountered while in the institution and the similar consequences of these experiences for institutional inmates. This is indicated by Goffman when he states:

> Persons who become mental hospital patients vary widely in the kind and degree of illness that a psychiatrist would impute to them... But once started on the way, they are confronted by some importantly similar circumstances and respond to these in some importantly similar ways... It is thus a tribute to the power of social forces that the uniform status of mental patient can... assure an aggregate of persons a common fate and eventually... a common character... (Goffman,1961:123).

However, an important issue which requires consideration in relation to such an approach is its appropriateness in relation to the specific category being analyzed. The approaches discussed previously are necessarily founded upon the assumption that the individual components within the general category are, in some important way, comparable or homogeneous. It is possible however, that the individual

components within any given category (here special settings for the aged) differ to such an extent in significant aspects of their social structures, that their complexity and/or their diversity cannot be adequately understood through reference to any one property or characteristic (see Pincus, 1968). Consequently, a number of characteristics must be considered along with any variations occurring within them.

Such a focus is implicit in the writings of Garfinkel (1973). Within his article entitled Conditions of Successful Degradation Ceremonies, Garfinkel acknowledges the variable nature of tactics of degradation - variations which ultimately define differential consequences for inmates. However, although he acknowledges this to be the case, Garfinkel asserts that the mechanisms for effecting such degradation have been fairly well standardized within modern society. Wheeler (1966) however, within his examination of The Structure of Formally Organized Socialization Settings argues that such settings do produce differing socialization experiences. To Wheeler, it is important to differentiate between institutions.

> (T)he organizations that process people may differ widely in (a) the degree to which there is differential emphasis on a clear separation between role socialization and status socialization; (b) the extent of conflict that is felt between the needs of the recruits and the needs of the external community; (c) the development of separate organizational hierarchies... (d) the extent to which the recruits participate in the setting of goals... These differences ought to have an important effect on the total socialization process in a wide variety of situations (Wheeler, 1966:72).

It can be argued that the assumption of similarity among institutions for the elderly is more hazardous than it appears to be for numerous other types of institutional settings. Firstly, institutions for the elderly vary widely in terms of the populations which they are 'designed' to serve. Therefore, whereas Myles (1977a) views all such settings as mechanisms for the relief of poverty, illnesses, and social isolation, evidence suggests that the service orientations of the various types of settings are somewhat more specific. Kahana (1971) for example, subdivides the category of institutions for the elderly into four broad groupings: (1) personal care homes; (2) nursing homes; (3) chronic disease hospitals; and (4) psychiatric hospitals. She notes that whereas personal care homes are designed to serve the mentally and physically capable elderly who require the security of such a home due to a variety of economic and/or social problems, nursing homes and chronic disease hospitals have been designed to meet the needs of the physically ill aged, requiring long-term, routine nursing care. Finally, psychiatric hospitals exist (in part) to serve the 'mentally ill' or 'senile' aged. Within Canada, institutions for the elderly vary widely according to the type (level) of care which they provide (Table 1).

Institutional settings for the elderly can also be differentiated in terms of sponsorship and ownership. Whereas prisons and mental hospitals are largely governmentally sponsored institutions, homes for the elderly and nursing

homes are additionally administrated by religious, fraternal, and legion organizations as well as by private individuals and larger business interests. An unpublished study of institutional care in Canada, conducted in 1973 by Statistics Canada (cited in Myles, 1977a) indicates that of the elderly who were institutionalized in Manitoba, 46 per cent were in proprietary institutions. The similar figure across Canada was 45 per cent. The remainder of the homes were sponsored by religious and governmental organizations, etc.

TABLE 1

DISTRIBUTION OF RESIDENTS OF INSTITUTIONS FOR THE ELDERLY BY THE LEVEL OF CARE PROVIDED: CANADA AND MANITOBA, 1973

	Canada*	Manitoba
Room and Board	12%	8%
Personal Care[a]	33	32
Basic Nursing Care[b]	24	22
Full Nursing Care[c]	31	38
Totals	100%	100%

Source: Myles, 1977a:55 from Statistics Canada , unpublished data.
* Excluding Quebec
a. Individual receives some supervision in activities of daily living. Minimal nursing supervision.
b. On-going nursing supervision and assistance. Provision for medical care as necessary.
c. Continued medical care with qualified nursing services 24 hours per day.

The utility of assuming inter-institutional homogeneity (an assumption which underlies attempts to explain the institutional experience in relation to the operation of a single, primary factor) appears particularly problematic in light of the rather extensive number of 'primary factors' which have been identified and related to various indices of well-being among the elderly.

Bennett (1970) reports research conducted by Bennett and Nahemow (1966) in which they attempted to study relationships between socialization (defined as an awareness of social norms) and adjustment in residential settings selected to represent differing degrees of totality - a public housing development, a home for the aged, nursing homes, and a mental hospital. The results of their research indicated that socialization scores were highest in settings rated low in totality. However, socialization scores did not correlate with adjustment in settings at either extreme of the continum. Socialization was correlated positively with adjustment only within institutions representing a middle range of totality.

Later, Bennett and Nahemow (1968, cited in Bennett, 1970) studied the effects of institutionalization upon attitudinal dependency of elderly residents. They found institutionalization within nursing homes to be worse than institutionalization within housing projects or supervised apartment residences in terms of attitudinal dependency among residents.

Coe (1965) in his analysis of inter-institutional differences tested the hypothesis that "the degree of

depersonalization varies with the severity of the total characteristics of the home" (1965:228). Three institutions designed to care for the chronically ill aged were located at different points along a continuum of institutional totality. By means of a semi-structured interview schedule which included a Twenty Statements Test as a measure of self-conception data on residents of the three institutions were collected. The results led Coe to conclude that institutionalization had a profound effect on self-conception.

> Certainly, the relative isolation, the separation from kinsmen, the degradation of having to be cared for like a child, have their effects on the self-conception of these patients...(Coe,1965:242)

As expected the largest proportion of withdrawn and uncommunicative patients was found in the nursing home, the institution rated as having the most depersonalizing (total) characteristics. Although similar characteristics were found among residents of the public institution, they were present to a much lesser degree. Coe notes that they were found to be present only rarely within the special care unit (the setting considered least total).

Also utilizing a similar dimension, Wolk and Telleen (1976) compared two settings varying in terms of 'environmental constraint'. However, their findings indicated that differences between institutions also result in different factors being of importance to well-being. In settings rated as highly constraining, the best predictors of perceived well-being by residents were health and developmental task accomp-

lishment. In the lower constraint setting however, the best predictors were found to be perceived autonomy and self-acceptance.

In addition to research which focuses primarily on environmental constraint or institutional totality - both of which focus on the internal system of rules, regulations, and scheduling procedures - a few studies have been conducted which relate more objective, structural characteristics of the institutional environment to various indices of resident well-being. Rosow (1962), in reviewing the literature in order to assess the impact of the institutional setting on social integration, found that the critical factor determining morale and integration was the extent to which the setting was able to approximate a "full-fledged, self-contained community". Greenwald and Linn (1971) suggest, from the findings of their research, that as the size of homes for the aged increases, patient satisfaction, activity, and communication, decrease. Similarly, Curry and Ratliff (1976) found resident isolation to be greater within larger institutions. Finally, Scott (1955) found a tendency for elderly residents to be better adjusted within better equipped institutions (institutions having higher physical plant ratings).

Although a relatively large number of researchers have acknowledged the possibility that institutions for the elderly vary considerably on a <u>number</u> of dimensions, and further, that these dimensions must be considered in order to understand the nature and effects of institutionalization

(Kahana, 1971; Kleemeier, 1961; Pincus, 1968; Yarrow, 1963), few systematic attempts have been made to isolate these dimensions. Even less have attempted to relate one or more of these dimensions to resident characteristics.

One of the most notable attempts to outline those core features of institutional environments which have an impact upon the lives of their residents is that by Kleemeier (1961). Arguing that institutions differ in terms of the responsibility they assume for the full life patterns of their residents, Kleemeier suggests that institutions be characterized in ways that adequately describe the nature of the setting in terms of its impact on residents' lives and activities. He notes that the names typically assigned to the different types of settings (such as nursing homes) are, at best, inaccurate indicators of the functions they serve. Kleemeier isolates three dimensions which ultimately define the lifestyle of elderly institutional residents:

(1) the age segregated - nonsegregated dimension: referring to opportunities provided for interaction with all age groups in society;

(2) the institutional - noninstitutional dimension: which illustrates the extent to which residents are forced to comply with an imposed system of rules, regulations, and sanctions; and

(3) the congregate - noncongregate dimension: which refers to such group aspects of the setting as the size of the group, closeness of individuals and degree of privacy.

Research conducted by Townsend (1962) of 173 institutions and homes for the aged in England, led him to devise a standard of comparison for distinguishing between 'good' and 'bad' institutions. Combining both objective and subjective criteria, Townsend focused upon five features of the institution - physical facilities, staffing and services, means of occupation, freedom in daily life, and social provisions. Including a number of items within each of these categories, Townsend obtained a total of 48 items, each of which was given a score from 0 to 3, to total to a score of 100. Within his research, Townsend found that few institutions acquired a score above 60 - a score considered satisfactory. Townsend did not however, examine the relationship between these institutional characteristics and selected resident characteristics.

Schooler (1969) however, examined the relationships between morale, integration, and environmental characteristics. Using six factor-analytically derived environmental dimensions, Schooler constructed a measure of environmental favorableness. Among the factors found to be important were: distance from facilities, condition of dwelling units, convenience of location, opportunity for social contacts, an awareness of available supportive services, and the size of the dwelling unit. Schooler found morale to be determined by perceived environmental favorableness.

Perhaps the most systematic attempts to date to devise a framework for studying the institutional environment are those by Bennett (1963) and Pincus (1968). Bennett argues

that when elderly individuals are institutionalized, it is commonly assumed that they will remain there until they die and that any attempts on their part to participate in social interaction will be limited to such an extent as to be inconsequential. Such a view ignores the fact, asserts Bennett, that depending upon the role it plays in society, each institution develops a unique, specific way of life to which inmates are expected to adapt. Each institution develops its own set of adjustment criteria which differs considerably from that applied within other institutional settings and from those relevant to the adjustment of the elderly in the community.

In an attempt to determine those core features of the institution which were ultimately responsible for such variations, Bennett (1963) utilized the 'total institution model' proposed by Goffman (1961), and developed a framework by which to measure the degree of totality represented within any one institution (see Figure 1). Although Bennett's framework is also unidimensional insofar as it attempts to define the institutional environment in terms of a single characteristic (i.e. totality), her model is significant in that it encompasses a variety of diverse institutional characteristics.

Pincus (1968) in criticizing such attempts, argues that they fail to capture the complexity of such environments and preclude a determination of the relative importance of various aspects of the institutional setting and of the

FIGURE 1

BENNETT'S CRITERIA OF TOTALITY OF INSTITUTIONS FOR THE ELDERLY

Item	High	Medium	Low
1. Duration of residence for which intended	permanent	both	temporary
2. Orientation of activities	institution	both	community
3. Scheduling of activities	all group	some group	none
4. Provisions for dissemination of normative information	formal	informal	none
5. Provisions for allocation of staff time for observation	continual observation	infrequent observation	none
6. Type of sanction system	standardized	individual	none
7. Personal property	most removed	some removed	none removed
8. Decision making re: use of personal property	no input	some input	all
9. Pattern of recruitment	involuntary	semi-voluntary	voluntary
10. Residential Pattern	congregate	both	private

relationships between these aspects. Alternatively, based upon a definition of the institutional environment as the "psychosocial melieu in which residents live, as expressed

through and generated by such factors as physical plant characteristics, rules, policies and programs, and staff behavior" (Pincus and Wood, 1970:117), Pincus asserts that a multidimensional approach will allow a greater degree of flexibility in exploring the interaction between characteristics of the residents and of the institution.

Based upon a review of the literature and primarily upon Kleemeier's (1961) formulations, Pincus proposes four dimensions of the setting considered most relevant to a study of the aged institutionalized:

(1) the public - private dimension which refers to the extent to which the resident is able to maintain a 'personal domain' which is not subject to the scrutiny of the institution or the public;

(2) the structured - unstructured dimension, referring to the amount of freedom by the resident from institutional rules and regulations;

(3) the resource sparse - resource rich dimension, which refers to whether or not the setting contains provisions for active participation in both leisure activities and in interactions with staff and other residents; and

(4) the isolated - integrated dimension, referring to the degree to which the institution affords opportunities for residents to interact with the larger community in which it is situated.[7]

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7. For a more complete definition of these dimensions, see Appendix A.

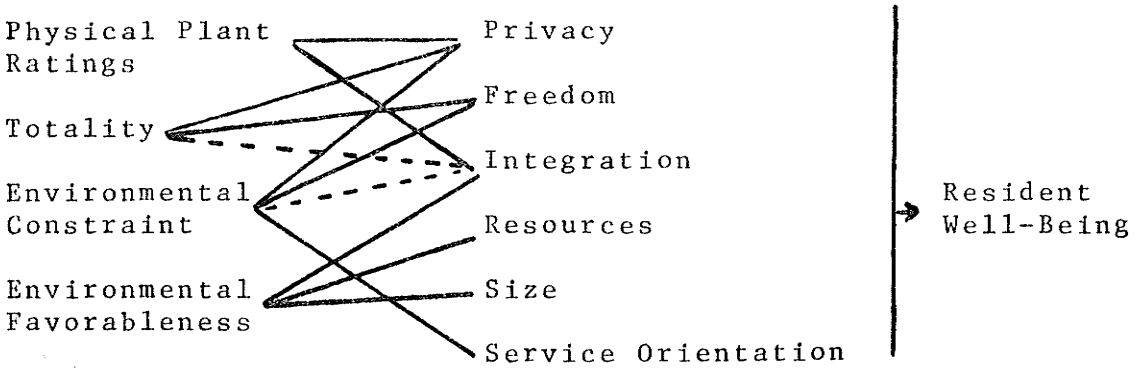
Through combining these four dimensions with three aspects of the institutional structure (with aspects of staff behavior, of the physical plant, and of the system of rules, regulations, and programs offered) and considering these aspects and dimensions in relation to each other, Pincus is able to propose a framework useful for analyzing such settings.

Utilizing this framework, Pincus and Wood (1970) report research in which they examined the relationship between the subjective and objective measures of each dimension and overall satisfaction by residents with the environment. Significant correlations were found between all the subjective measures regarding the adequacy of privacy, freedom, resources, and integration and satisfaction with the environment. However, none of the objective measures (relating to the residents' utilization of privacy, resources, etc.) displayed significant correlations with overall satisfaction with the environment. The authors note however that problems of sample size (N=72) and the administration of instruments served to limit the generalizeability of their findings.

In general, the major results of research as discussed above can be summarized within the following diagram (see Figure 2). The concepts of 'totality' (Coe, 1965; Bennett and Nahemow, 1968), 'constraint' (Wolk and Telleen, 1976), 'environmental favorableness' (Schooler, 1969), and 'physical plant ratings' (Scott, 1955) as operationalized within the various studies, all incorporate one or more of the dimensions

FIGURE 2

DIMENSIONS OF THE INSTITUTIONAL ENVIRONMENT



discussed by Kleemeier (1961) and later refined by Pincus (1968). Similarly, the research conducted by Townsend (1962) and the review by Rosow (1968) also suggest the importance of these dimensions within a consideration of institutions for the elderly.

The preceding review clearly illustrates the potential of an inter-institutional comparative approach to the study of the impact of this experience upon the well-being of elderly institutional residents. It has questioned the utility of assuming unidimensionality, and consequently, of theoretical frameworks which utilize this mode of analysis. It thus suggests the importance of differentiating those socio-environmental facors which may affect residents' behavior and attitudes. Such a stance, in turn, opens up a number of possibilities with regard to factors affecting well-being among the elderly: (1) that multiple but different dimensions are operating for both institutionalized and community elderly; (2) that multiple but the same factors are operative for both;

and; (3) that multiple factors are operative - some of which are the same and some of which are different - for institutionalized elderly and for the elderly in general.

e) Summary

In the foregoing chapter, an attempt has been made to outline the basic tenets of three competing perspectives which similarly attempt to account for the experience of institutionalization by the elderly within an unidimensional framework. Representative of such an approach were the bureaucratic, social welfare, and disengagement perspectives. It was argued that because of the assumption of inter-institutional homogeneity underlying attempts to account for the effects of institutionalization through consideration of a single, defining characteristic or dimension, each is unable to account for: (a) possible differences among institutions caring for the elderly; (b) the possibility that a number of factors are important to well-being; and therefore, for (c) the possibility that different factors are of importance to resident well-being within differing institutional environments.

A review of the literature identified additional dimensions of the institutional environment which have been suggested as being relevant to the well-being of elderly residents. Those which appeared to offer potential for developing a view capable of reflecting the heterogeneity of institutions for the elderly were: the availability of privacy, freedom, and resources; the integration of the setting into the larger community; the size of the residence; and the service orientation of the institutional facility.

The specific hypotheses used in testing the critique

of the unidemensional models are outlined in the following chapter. This is followed in Chapter III by a discussion of the research methodology utilized in assessing the relationships specified within each of the three theoretical perspectives as well as in examining the potential importance of other institutional dimensions in accounting for the experience of institutionalization by the elderly.

CHAPTER II

RESEARCH OBJECTIVES

The preceding review clearly illustrates the necessity for further research in the area of institutionalization as it applies to the elderly. Available literature indicates that a more comprehensive approach to associations between institutional living and its consequences for the elderly resident which takes into account the central features of the environment may provide some useful findings in this area. Also, the apparent dissensus over the implications of institutionalization which is evident in the area, suggests a need for an assessment of the utility of the different theoretical perspectives in accounting for the effects of institutionalization on the well-being of elderly residents.

To the extent that no research has been done which focuses upon a number of environmental characteristics within a large sample of institutions for the elderly (a sample including institutions differing in service orientations), and to the extent that the present research is directed towards a general assessment of the perspectives discussed, it is of an exploratory nature. It is directed towards obtaining a better understanding of the experience of institutionalization by the elderly, particularly as this occurs within an exclusively Canadian context.

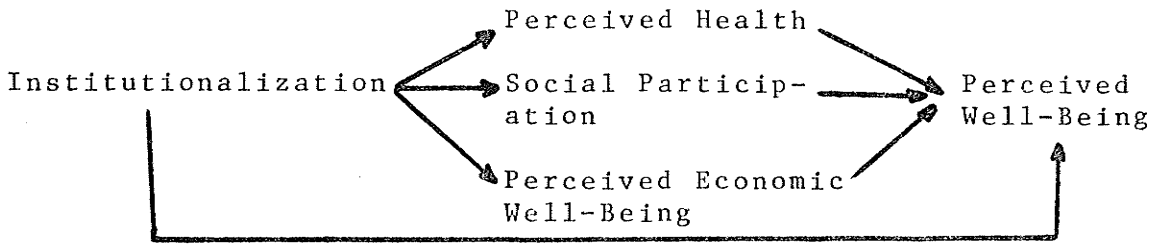
In an attempt to realize these objectives, the present study assesses the extent to which each of the three unidimensional perspectives (i.e. the 'bureaucratic', and 'social welfare'

perpectives in addition to the 'disengagement' theory of aging) is able to account for assessments of well-being within samples of institutionalized and noninstitutionalized elderly. The major claims of each of these perspectives may be summarized as depicted in the following model (see Figure 3). In the course of analysis, those aspects of this model which are of particular significance to each of the three perspectives are considered separately. As noted within the previous chapter, institutions are defined by the bureaucratic model in terms of bureaucratic organization. Inmates of such institutions are therefore perceived to gradually withdraw and adopt the sick role. As a result, those independent factors which are of particular importance to the bureaucratic perspective include: institutionalization (as defined by 'bureaucratization'); perceived health; social participation; and length of residence.

Within the social welfare model however, institutions are defined in terms of the provision of relief. As a mechanism for the relief of poverty, illness, and social isolation, institutions are also seen to function as a subjective form of relief, enhancing feelings of economic well-being and perceptions of health as well as social participation. In this way, institutions are expected to be beneficial to overall perceptions of well-being among the elderly. Reflective of the central arguments advanced by this perspective, the following independent variables are considered: objective and perceived health; income and perceived economic well-being; and the availability of social supports and social participation.

FIGURE 3

THE UNIDIMENSIONAL MODEL

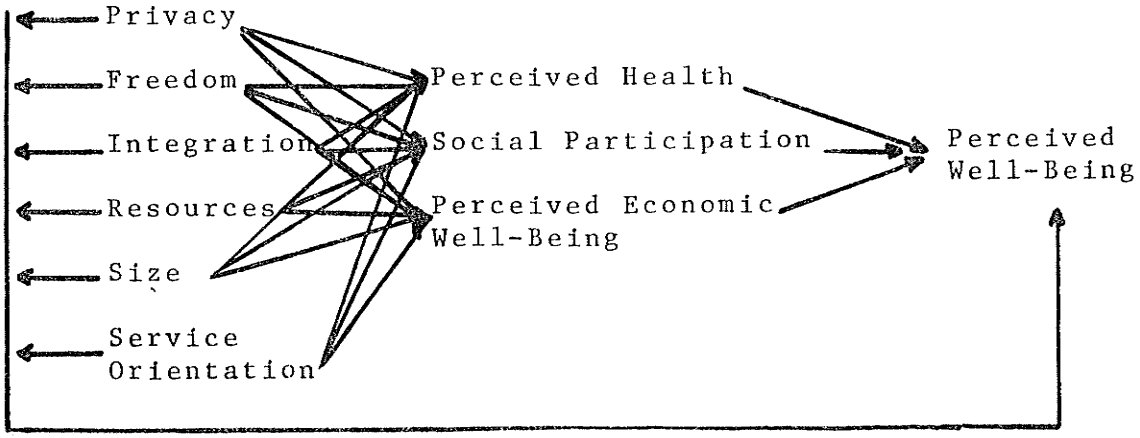


Finally, generalizing from the disengagement perspective, it appeared that institutions for the elderly, insofar as they may represent vehicles for disengagement, are also regarded as being beneficial to well-being. Because important within this process as well, are the age and sex of the resident, those variables of greatest importance within the analysis are: age, sex and social participation.

Figure 4 illustrates the structure of the analysis used in exploring the potential of a multidimensional approach to an understanding of the experience of institutionalization by the elderly. Rather than isolate 'institutionalization' as being the primary indicator of perceived well-being, this approach emphasizes the importance of distinguishing those features of the setting which may affect residents' perceptions of well-being. Those dimensions which have been chosen for inclusion in the study are those discussed by Kleemeier (1961) and Pincus (1968). Consideration is also given to the size and service orientation of the residence.

FIGURE 4

THE MULTIDIMENSIONAL MODEL



The variables of age, sex, health, education, current occupation, income, length of residence, and the availability of social supports are also considered within analysis of this latter model.

Hypotheses

The available literature gives rise to a number of conflicting propositions concerning the relationship between physical living environment and subjective assessments of well-being among the elderly. Empirical assessment of the utility of each of the theoretical perspectives in accounting for this relationship is based upon an analysis of the conflicting hypotheses which have been generated by them. These hypotheses and a brief discussion of the perspectives which they represent are outlined below.

Within the 'bureaucratic' perspective, primarily as outlined by Freidson (1970, Goffman (1961), and Gustafson

(1972), institutionalization per se is viewed as an experience which is characterized by a loss of individual autonomy and enforced submission to the requirements of bureaucratic organization. Moreover, within the category of institutions, it appears that increasing bureaucratization may result in even greater losses of individual autonomy. For the individual inmate, the consequences of this experience are said to be gradual withdrawal, identification with the 'sick role', and as a result, a low level of morale or perceived well-being. The hypothesis which has been derived from this perspective is as follows:

(1) Institutionalization (bureaucratization) will be negatively related to perceptions of well-being among elderly residents.

In direct opposition to the bureaucratic perspective is the social welfare model, which emphasizes the role of the institution in providing relief to the elderly from poverty, illness, and social isolation. Myles (1977a), the major proponent of this view, argues that through the provision of objective forms of relief, institutionalization is beneficial to subjective assessments of well-being. The social welfare model thus provides the rationale for the following hypothesis:

(2) Institutionalization (as defined by relief functions) will be positively related to perceptions of well-being among elderly residents.

Opposing both the bureaucratic and social welfare perspectives is the disengagement theory which, although stressing the increasing lack of concern by the elderly with

aspects of their social and physical environments, is consistent with a view of institutions as mechanisms for facilitating such withdrawal by the elderly. Perceptions of well-being are said to be positively related to the extent of withdrawal. Although this process is regarded as having psychological as well as social implications for the aging individual, the present analysis focuses only upon the occurance of social disengagement.[8] The hypothesis which represents this perspective is as follows:

(3) Institutionalization (as defined by withdrawal functions) will be positively related to perceptions of well-being among elderly residents.

A distinct alternative to each of the former perspectives is the multidimensional approach. Resting upon a critique of the unidimensional model of analysis, this approach emphasizes the necessity of recognizing those factors which may serve as a basis for differentiation among institutions, and consequently, factors which must be considered in an attempt to account for the impact of institutionalization on the elderly. A number of factors have been suggested as being of importance to the elderly - the degree of privacy and freedom which is available; the size of the residence; the availability of resources; and the integration of the residence into the community, etc. These are the subject of exploratory analysis in the present study. Also examined is the related issue of whether or not institutions form

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8. Suitable indicators for the prescence of psychological disengagement were unavailable in the data.

distinctive living environments differing qualitively from the community as a living environment.

Three hypotheses are therefore examined. Each reflects the central argument of one of the three perspectives being assessed and, in this way, represents a statement of the overall effects of institutionalization on perceptions of well-being according to the particular model. Necessary for support of the bureaucratic model is evidence suggesting that elderly institutional residents have lower perceptions of well-being than do the elderly in general and that such perceptions tend to decrease as the extent of bureaucratization increases. Similarly, findings indicating that the institutionalized elderly tend to have poorer evaluations of health and to participate less in social activities than do the elderly in general; and that these are also associated with increasing bureaucratization and are important to perceptions of well-being, would also be interpreted as supportive of the bureaucratic perspective.

In contrast, support for the social welfare model relies upon findings indicating that the institutionalized elderly have more positive perceptions of well-being than do the elderly in general and that they tend to increase as the amount of relief provided increases. Support is further contingent upon findings indicating that institutionalization is beneficial to perceptions of health, social participation, and perceptions of economic well-being.

Finally, if the results of the analysis indicate

that perceptions of well-being are somewhat higher for the institutionalized elderly than they are for the elderly in general, that social participation decreases as the necessity for participation decreases, and that a decrease in participation is important for positive perceptions of well-being by the elderly, this will be interpreted as consistent with a disengagement perspective.

If, however, the results of the analysis fail to indicate that bureaucratization, relief functions, or withdrawal functions are either directly or indirectly responsible for perceptions of well-being among elderly residents, but rather, that a number of factors are relevant, this will be interpreted as supporting the necessity for assuming multidimensionality.

Chapter III

Research Methodology

a) The Data

The source of data for the present study is the Aging in Manitoba study[9] carried out in 1971 by the Manitoba Department of Health and Social Development. Originally conducted in an attempt to identify and assess the needs and priorities of the elderly in Manitoba relative to both existant facilities and services and to possible changes over time in needs and priorities the study was conceived of as a response to a need for "more global, long-range planning..." (1973:7) to the pressing, yet changing needs of a heterogeneous elderly population. More specifically, the objectives of the research involved (a) the measurement of levels of need of the elderly in a number of need areas and (b) an assessment of the extent to which available resources were capable of meeting the need areas specified. Those need areas considered in the original study included psycho-social needs (including interests and activities); needs for shelter, household maintenance, food, and clothing; language, religious, ethnic, and cultural needs; physical and mental health functioning needs; and needs regarding the availability and accessability of resources (including legal, economic and other services).

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9. The study was carried out under the direction of Ms. B. Havens of the Department of Health and Social Development.

In an attempt to realize these objectives, included within the study sample were all existent facilities for the elderly (including general, mental, and extended care hospitals; nursing homes; hostels, housing units and guest homes), all governmentally and nongovernmentally sponsored services, and an area probability sample of all elderly within the Province of Manitoba.[10]

The study sample consisted of 4805 respondents (ages 65 and over) of which 3566 (representing a 5% probability sample randomly drawn from those living outside Winnipeg in addition to a 2.5% sample drawn from within Winnipeg) represented the general community population, and 1239 (a 20% sample of those outside Winnipeg and a 10% sample of those within Winnipeg) represented the facility dwelling population.

Demographic, attitudinal, and behavioral data relevant to the needs of the elderly were gathered through personal interviews. In cases where the respondent could not be interviewed, a proxy was employed (for all but the attitudinal items). Within the institutional sample, 69 per cent were interviewed independently, 4 per cent received minor assistance and 27 per cent were either interviewed with much assistance (3 per cent) or a proxy was employed (24 per cent). Within the community sample 90 per cent were interviewed independently, 4 per cent received minor assistance, and 6 per cent were either inter-

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10. Data on the resources (institutions and service agencies, etc.) were unavailable at the time of the present analysis. Thus the date base for the study is the sample of elderly.

viewed with much assistance (2 per cent) or a proxy was used (4 per cent). In total, 433 respondents (N=133 community residents plus 300 facility residents) were interviewed via proxy.

For purposes of the present research, a subsample consisting of only those community and facility dwelling respondents who were not interviewed via proxy, was utilized.[11] This sample totalled 4344 respondents of which 3433 were community residents and 911 were residents within institutions.[12]

Important to note is the fact that the interview schedule which was used consisted of both questions which were addressed to all respondents in addition to numerous questions which were directed to facility-dwelling respondents alone. As a result, some of the items included in the present analysis were asked only of the facility dwelling subsample. It was therefore necessary to conduct separate analyses for the total sample and for the facility-dwelling subsample.

b) Operationalizations[13]

The Dependent Variable - Perceived Well-Being

The use of 'perceptions of well-being' as the

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11. This was necessitated by the fact that proxy respondents were not asked the attitudinal items. For comparative data on proxy and non-proxy respondents, refer to Appendix B.

12. Twenty-eight respondents who were originally coded in the facility category were also excluded. These consisted of 25 respondents who were mental hospital outpatients, foster home residents, or elderly residents of guest homes.

3. While frequency distributions are provided for some of the variables, in most cases these are reported in Appendix C.

dependent variable within the present research reflects the major focus of theoretical as well as empirical endeavors within contemporary social gerontology (Blau, 1973). To date, sociological interest in the aging process has been concentrated on the construction and testing of theories of "successful aging". Prompted by an awareness of the social, economic, and political positions of the elderly in modern society which have rendered problematic the ability of increasing numbers of elderly to service their own needs and to maintain an integral role in society (see page 1), gerontologists have become interested in associations between such factors and the attitudinal and behavioral characteristics of the elderly.

Early attempts at accounting for "success" in aging focused on the notion of 'adjustment' as being the primary indicator of success or lack of success in aging. Reflecting this perspective, research focused, to a large extent, upon the behavior of the elderly - on their competence in performing a variety of social roles (Cavan et al, 1949; Havighurst, 1957 cited in Neugarten et al, 1961) or of the social acceptability of their behavior (Havighurst and Albrecht, 1953 cited in Neugarten et al, 1961; Scott, 1955). Although, to a lesser extent, attitudes were taken into account, these were measured in relation to the performance of social roles (Lepkowski, 1956).

With the development of a number of theoretical frameworks to account for success in aging, and particularly

with the introduction of the disengagement theory of aging (Cumming and Henry, 1961), attention began to be focused as well upon the more subjective or psychological aspects of the aging process as indicators of success or adjustment. Recognizing the value judgement underlying attempts to define adjustment behaviorally, investigators began to focus upon the individual's "internal frame of reference...(and their)... own evaluations of satisfaction... or happiness..." (Neugarten et al, 1961:134). Replacing the assumption that the greater the amount of social participation and the less the discontinuity of activity which characterized the individual in his/her middle ages, with the assumption that the individual him/herself was the only proper judge of his/her own well-being (Neugarten et al, 1961), a number of scales and indexes, attempting to operationalize "success" independently of the external conditions of life, were developed. These included the Kutner Morale Scale (1956), Srole's Anomia Scale (1956), the PCG Morale Scale (Lawton, 1972), the Bradburn Affect Balance Scale (1969), and a number of single item measures of well-being (Spreitzer and Snyder, 1974). The most widely used measure however, is the Life Satisfaction Index 'A' originally developed by Neugarten et al (1961).

In attempting to assess the utility of the perspectives discussed previously, the present research focuses upon perceptions of well-being as expressed by the residents themselves. This is operationalized through the Life Satisfaction Index 'A' (LSIA). The labelling of the construct

as perceived well-being rather than life satisfaction reflects recent findings indicating that such concepts as morale and life satisfaction may properly be considered in terms of a more general, summary construct (Larson, 1978).

The LSIA contains twenty items to which the respondent is asked to express agreement or disagreement. Positive responses (those indicating satisfaction) are each given a score of 'one' so that the range of scores possible is from 'zero' to 'twenty'. In the present study were recoded into the following categories: excellent (scored from 17 to 20); good (scored from 13 to 16); fair (scored 9 to 12); poor (scored from 5 to 8); and very poor (scored from 0 to 4). The shortened version correlates very highly with the extended one (r=.98).

Because only the final scores were coded,[14] it was not possible to compute measures of internal reliability. However others have made assessments of the LSIA (see Adams, 1969; Neugarten et al, 1961). Adams (1969) based upon his rather extensive analysis of the index, concluded that on the whole, it did provide a fair estimate of life satisfaction. He did however, suggest that two of the items in the index be deleted. Similarly, Larson (1978) suggests that although there are problems with all survey measurements of well-being, the LSIA provides as good an estimate of subjective well-being

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14. The researchers are presently in the process of coding the separate scores.

as do any of the others which have been developed. In addition, the use of the complete index has certain advantages for the present research in that it allows comparisons with Myles' (1977a) findings as well as with previous research on the correlates of perceived well-being among the elderly.

The Independent Variables

i) The Bureaucratic Perspective

The major independent variable specified within the bureaucratic model is the extent of bureaucratic organization or 'bureaucratization' evident within the residence. In that a scale measuring this concept was unavailable, it was operationalized for use in the present study through a number of separate indicators. Those which appeared consistent with the bureaucratic interpretation include: the level of care within the residence, the size of the residence, and whether or not residents had access to a private place for their own belongings.[15] Similar items have been used in the past to indicate the degree of totality characterizing institutions for the elderly (see Bennett and Nahemow, 1965; Coe, 1965).

Level of Care

Reflecting the observation that institutions offering a more intensive level of personal care should also reflect a higher degree of organization than those not offering similar levels (see Myles, 1977a), residence types were ranked according to the nature and extent of services provided. Because, within

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15. The latter two variables are applicable to the institutional sample only.

community, individuals were considered to be entirely responsible for the servicing of their own needs, respondents living independently within the community were assigned the lowest score on the level of care variable. Increasingly higher scores were given to residents of housing units, hostels, nursing homes, and mental and extended care hospitals. Thus the higher the score, the more extensive the care provided, and the lower the score, the less extensive the care provided.

The majority of residents (N=3433 or 79%) were community residents and thus received no formal care. Three hundred and seventy-six were residents of housing units receiving minimal care and 191 residents of hostels received some degree of assistance. Higher levels of care were provided to 302 nursing home and 42 mental and extended care hospital residents (see Table 2).

Analysis using the level of care variable for the facility dwelling subsample requires some revisions. First, community dwelling respondents were excluded, and the rankings of the other facility types adjusted. The lowest score was given to residents of housing units followed by residents of hostels, nursing homes and mental and extended care hospitals. Also, because early analysis revealed that a number of additional variables were highly correlated with the level of care provided and that these variables also appeared to indicate the level of care, they were submitted to Guttman scalogram analysis. As a result, the following items were formed into

TABLE 2

DISTRIBUTION OF RESIDENTS BY THE LEVEL OF CARE PROVIDED

TOTAL SAMPLE

Level of Care	N	%
1 (lowest)	3433	79
2	376	9
3	191	4
4	302	7
5 (highest)	42	1
Total	4344	100

a Guttman scale (coefficient of reproducibility = .91; coefficient of scalability = .73):

5) The respondent does not have a room where s/he can be alone.

4) The respondent did not visit the facility prior to moving there.

3) The respondent was allowed to bring fewer than eight items of furnishing with them.

2) The respondent is a resident of a hostel, a nursing home, or a mental or extended care hospital rather than of a housing unit.

1) The respondent regularly performs fewer than 5 work related chores in the residence. This scale is also

labelled the 'level of care' provided.[16] The higher the score, the higher the level of care provided and the lower the score, the lower the level of care provided (see Table 3 for scale pattern).

Institutional Size

Although not available within the original data bank, separate information[17] on the total number of residents living within each of the facilities from which the facility dwelling respondents were drawn, made possible a comparison of facilities on the basis of size (as of 1971). Using total number of residents as an indicator of size, facilities were ranked from small to large and grouped into the following categories: less than 20 residents; 21 to 40 residents; 41 to 70 residents; 71 to 120 residents; and more than 120 residents.

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16. Each of the items is reflective of a relatively high level of care. Because this implies that services be of an intensive nature and that a premium be placed upon surveilance and administrative efficiency, it follows that the environment must be such that patients are easily observed (thus lacking a private room and too many personal furnishings). Similarly, because such an environment is defined more in terms of the nature of the services provided than in terms of attractive housing and because it presumably attracts those in poorer health, residents are more likely not to visit prior to entrance. Also, in that such environments are oriented to the care of the infirm, there is no expectation that residents help in chores. Finally, while in housing units, only housing is provided, each of the other facilities does provide or make provision for some form of medical service.

17. This information was made available from data collected by the Manitoba Department of Health and Social Development on resources within the province in 1971 as an extension to the data on the needs of the elderly (see Aging in Manitoba, 1973).

TABLE 3

THE LEVEL OF CARE PROVIDED SCALE

FACILITY SAMPLE

A. Scale Pattern

Scale Score	Private Room	Prior Visit	Number Furnish	Type of Residence	Aids in Residence
5	+	+	+	+	+
4	-	+	+	+	+
3	-	-	+	+	+
2	-	-	-	+	+
1	-	-	-	-	+
0	-	-	-	-	-

B. Frequency Distribution		N	%
0	Low Level of Care	86	20
1		68	16
2	Medium Level of Care	43	10
3		90	21
4	High Level of Care	103	24
5		39	9

Coefficient of reproducibility = .91
Coefficient of scalability = .73

The 175 facilities from which the respondents were drawn ranged in size from the very small - one nursing home having only two residents - to the very large - an extended care hospital with 3809 residents. However, more than half (N=97; 55%) were relatively small, having fewer than 41 residents in all. The mean number of residents was 93 (see Table 4).

Of the 175 facilities represented, 76 (43%) were housing units, 32 (18%) were hostels, 57 (33%) were nursing homes and 10 (65%) were mental and extended care hospitals. For the most part, the housing units tended to be quite small in size with 42 per cent having fewer than 20 residents. Hostels and nursing homes tended to be somewhat larger. 75 per cent of the hostels ranged in size from 21 to 70 reisdents while for nursing homes 51 per cent were within this range. Finally, mental and extended care hospitals were the largest with 8 out of 10 surveyed having more than 120 residents (see Table 5).

Also of importance to the bureaucratic model are a number of intervening variables including: perceived health status (sick role identification), social participation (withdrawal), and length of residence.

Perceived Health

The response to the question: "For your age would you say that, in general, your health is excellent, good, fair, or poor?" was used as an indicator of sick role identification.

TABLE 4

FREQUENCY DISTRIBUTION: SIZE OF THE INSTITUTION

Number of Residents	N	%*
1 - 20	45	26
21 - 40	52	30
41 - 70	35	20
71 - 120	22	13
121 +	21	12
Total	175	100

* Percentage have been rounded to the nearest whole number.

TABLE 5

SIZE OF INSTITUTION BY TYPE OF INSTITUTION

Number of Residents	Housing Units	Hostels	Nursing Homes	Mental & Extended Care Hospitals
1 - 20	42%	9%	18%	0%
21 - 40	30	38	28	10
41 - 70	13	38	23	0
71 - 120	8	9	21	10
121 +	7	6	11	80
	(N=76)	(N=32)	(N=57)	(N=10)
Totals	100	100	100	100

Social Participation

The measure of social participation which was used was the Social Life Space Index adapted from the work of Cumming and Henry (1961). Reflecting the total frequency of interactions engaged in by the respondent, the measure includes frequencies of interaction with others in the household, with friends, neighbours, and relatives, with people seen for specific purposes (such as storekeepers), and individuals seen in the course of work (for those who are employed). The inter-item correlations are reported in Table 6. Because of the relatively weak correlations among the items, both the composite measure and alternatively, the individual items within it are used, thereby facilitating an examination of the relative importance of the various types of interactions for perceptions of well-being among the elderly.

Length of Residence

The final variable, length of residence referred to the number of years spent in the current residence. Responses were grouped into the following categories: over five years; three to five years; one to three years; six months to one year; and less than six months.

ii) The Social Welfare Model

Because, within the social welfare perspective, institutions are defined in terms of relief functions, and because increasing levels of care can therefore be interpreted

TABLE 6

CORRELATIONS AMONG ITEMS IN THE SOCIAL LIFE SPACE INDEX

A. Total Sample

	Contact With Others in House-Hold	Contact With Close Relatives	Contact With Close Friends	Contact With Neigh-bours	Contact With Specific People
Close Relatives	.45				
Close Friends	-.07	.04			
Neighbours	-.11	-.02	.32		
Specific People	-.02	-.04	.09	.05	
Co-Workers	-.02	-.05	-.04	.02	-.10

B. Facility Sample

	Contact With Others in House-Hold	Contact With Close Relatives	Contact With Close Friends	Contact With Neigh-bours	Contact With Specific People
Close Relatives	.07				
Close Friends	-.14	.08			
Neighbours	-.08	.04	.28		
Specific People	.05	-.02	.09	.02	
Co-Workers	.07	-.05	-.07	-.04	-.03

as reflecting increases in the amount of relief provided, the level of care vaiables (operationalized previously - see pp. 76-79) also served as the major independent variables for empirical assessment of this latter model.

Of additional importance to this model are variables reflecting the major forms of relief provided - i.e. relief from poverty, illness, and social isolation. Necessary therefore, are indicators of perceived economic well-being, perceived health, and social participation. Operational definitions of perceived health and social participation were discussed earlier.

Perceived Economic Well-Being

Perceived economic well-being was operationalized in terms of both perceived present well-being and perceived future well-being. All respondents were asked the following questions: "How do you think your income and assets currently satisfy your needs?" and "How do you think your income and assets will satisfy your needs in the future?". In each case, the respondent was asked to indicate whether income and assets were capable of meeting needs very well, adequately, with some difficulty, or inadequately.

The objective counterpart of each of the specific relief variables is also included. Objective health status was operationalized as the sum of 14 health problems from which the respondent had suffered. The total score was utilized as coded and the responses grouped into four categories: (1) no health problems; (2) one health problem;

(3) two health problems; and (4) three or more health problems. Average income per month was utilized as an indication of objective economic well-being. Finally, reflecting the availability of social supports (a fundamental aspect of social isolation) were a number of separate items dealing with the presence or absence of children, grandchildren, brothers and sisters, and other relatives. Also used were items reflecting the respondent's marital status and the proximity of the nearest relatives.

iii) The Disengagement Theory

As was the case with both the bureaucratic and social welfare models, the single institutional dimension evident within the disengagement perspective is also operationalized through the level of care variables. This was considered appropriate since higher levels of care, insofar as they ought to reduce the need for active participation by elderly residents, should therefore serve to facilitate withdrawal.

Also utilized as an indication of withdrawal is the age of the respondents. Although it has been argued that age may not be an adequate indicator of disengagement (see Chappell, 1975), it has been rather extensively used in past research efforts.

iv) Heterogeneity Among Institutions

The independent variables used in exploratory analysis of the multi-dimensional approach include (1) the availability of privacy within the residence; (2) opportunities for freedom of decision making and behavior, etc.; (3) the integration

of the setting into the larger community; (4) the availability of resources allowing for participation and interaction; (5) the major service orientation of the residence; and (6) the size of the facility.

Privacy

The availability of privacy within the residence was operationalized in the form of a number of items which offered face validity as being representative of the extent to which the resident was able to "maintain a personal domain" (see definition - Appendix A). Respondents were asked to indicate whether or not they had an adequate and/or convenient place for their own belongings, whether or not they had a secure place for personal possessions, and how satisfied they were with their present dwelling in terms of privacy. These items were used within both parts of the analysis. In addition, one item dealing with whether the respondent had access to a private room was used only within the analysis of the sample as a whole. For the facility dwelling subsample, it became part of the level of care variable.

Freedom

A number of separate items were also used as indices of the availability of freedom within the particular residence. For purposes of analysis, questions dealing with voting arrangements, scheduling of activities, and resident council representation were included.[18]

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18. Similar items were not available for the sample as a whole.

Integration

Analysis of the integration of the setting into the larger community in which it was situated made use of a number of individual items dealing with such factors as the respondent's satisfaction with the location of the residence, the adequacy of public transportation and activities for senior citizens, and attendance at clubs and church-sponsored activities. Consideration was also given to the factor of geographic location - using the Winnipeg - non-Winnipeg distinction - in that "opportunities for communication and interaction with people and places" may be greater within a large urban area than in smaller centres or rural areas (see definition in Appendix A).

Resources

Measurement of the availability of resources to the facility - dwelling population consisted of twelve items dealing with the availability and adequacy for use of a variety of resource items. Respondents were asked to indicate which items from a list were made available and whether or not they were adequate. Those items which were included were: telephone(s), T.V. set(s), radio(s), record player(s), table games, magazines, a library or reading room, lounge(s), dining room(s), arts and crafts supplies, a shop or store, and activity room(s). Scores of either 'zero" or 'one' were assigned for each of the responses depending upon whether the respondent reported that the specific item was both available and

and adequate (a score of one) or was either unavailable or available but inadequate (a score of zero). The sum of the numerical responses to each of the twelve items served as an indicator of the availability of resources within the facility. Possible scores ranged from zero, indicating that none or few resource items were made available or that they were inadequate, to 12, indicating that numerous resource items were made available as well as adequate for use. (The inter-item reliability coefficient for this scale, Cronbach's alpha, was .86-see Table 7).

Service Orientation

In assessing the relationship between the service orientation of the residence and perceptions of well-being, consideration was given to the degree to which the setting was oriented specifically towards the care of the elderly - i.e. whether this was considered an exclusive, primary, or secondary role of the institution. Also considered an aspect of the service orientation within the multidimensional model was the level of care provided. Operationalization of this variable was discussed previously as was the variable - size (the final dimension included within this latter model).

c) Procedures for Data Analysis

For the purposes of analyzing the data, two main methods were employed. First, in order to examine the basic distributional characteristics of each of the variables included within the analysis, one way frequency distribution tables were constructed. In instances where distributions appeared

TABLE 7

FREQUENCY DISTRIBUTION: RESOURCE INDEX

FACILITY SAMPLE

	N	%
0	16	3
1	24	5
2	35	7
3	38	8
4	24	5
5	36	8
6	37	8
7	51	11
8	34	7
9	39	8
10	47	10
11	37	8
12	53	11
Totals	471	100

severely skewed, an attempt was made to collapse one or more response categories (if theoretically justifiable). Secondly, multiple regression techniques as provided by the Statistical Package for the Social Sciences were then used to analyze the relationships specified within each of the theoretical frameworks.

The present analysis makes use of the step-wise procedure available with multiple regression analysis so as to isolate those predictors which jointly account for most of the variance explained in the criterion variable. The variable which is entered at each step of the analysis is that predictor which displays the highest partial correlation with the criterion variable once the effects of all those variables which are already in the equation have been partialled out (Kerlinger and Pedhazur, 1973:291).

The decision regarding the continued inclusion of specific predictor variables within further analyses was based upon the size of the standardized partial regression coefficients (Beta weights).[19] At each stage of the analysis, predictor variables having Beta weights either greater than or equal to .10 were retained while those with smaller Beta

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19. According to Nie et al (1975), Beta weights provide the only sensible way of comparing the "relative effect on the dependent variable of each independent variable when there are two or more independent variables measured on different units". Also, see Nie et al (1975) for a discussion of the use of 'dummy' variable analysis for nominal level variables and Kim (1975) for a discussion of the use of ordinal level variables in multiple regression.

weights were excluded (Chappell, 1978).

d) Summary

The present chapter provided the methodological basis for the present investigation. A brief description of the data, the data collecting techniques, and of the study sample was provided, and the implications of these for the present investigation, noted. Also discussed were the operational definitions of the major variables specified within each of the theoretical perspectives, and the techniques used in analyzing the data.

In the following chapter, the results of statistical analysis are presented. The implications of the findings for each of the three hypotheses and for the formulation of an alternative approach to an examination of institutional effects are also examined.

CHAPTER IV

RESEARCH FINDINGS

a) Sample Characteristics

The study sample consisted of 4344 respondents of which 3433 were community residents and 911 were residents of housing units, hostels, nursing homes, and mental and extended care hospitals (see Table 2).

In order to estimate the representativeness of the sample, it was compared to the populations of elderly in Manitoba (1971) and Canada (1971) utilizing the 1971 Canadian Census. In general, the study sample appears to be fairly representative. The overall sex distribution approximates that within both Canada and Manitoba (1971) for individuals ages 65 years of age or older (see Table 8). Similarly, reflecting the distribution of marital status within the population of elderly in general, a relatively large proportion of the study sample (36%) is widowed. Within the study sample, as is the case in Manitoba and Canada generally, more than one half of the elderly are married (Table 9). The educational level of the respondents is, in general, quite low. More than one half (68%) of the sample had less than nine years of schooling. This, once again, is reflective of the educational levels of elderly individuals in Canada and Manitoba in 1971 (Table 10).

The mean age of the sample as a whole is 75 years with a range from 65 to 111 years. The modal age is 66. A comparison of the age distributions of the study sample with

TABLE 8

SEX DISTRIBUTION OF THE STUDY SAMPLE AS COMPARED WITH THOSE AGED 65 AND OVER IN CANADA AND MANITOBA 1971

	Canada*	Manitoba*	Study
Male	45%	47%	48%
Female	55	53	52
Totals	100	100	100

* Source: 1971 Census of Canada

TABLE 9

DISTRIBUTION OF MARITAL STATUS IN STUDY SAMPLE AS COMPARED WITH THOSE AGED 65 AND OVER IN MANITOBA AND CANADA, 1971

	Canada	Manitoba	Study
Single	11%	10%	10%
Married*	55	56	55
Widowed	35	35	36
Totals	100	100	100

*includes divorced and separated
Source: 1971 Census of Canada

the populations of elderly in Manitoba and Canada in 1971 reveals that, within the study sample, the older age groups are somewhat overrepresented relative to their numbers in the actual population, and conversely, the younger age groups are somewhat underrepresented (Table 11). This difference appears to be due to the inclusion of facility dwelling respondents within the study sample. The mean age of the facility dwelling respondents is somewhat older than that of the sample as a whole - 80 years. Ranging in age from 65 to 104, the median is 81 years. Once facility dwelling respondents are selected out, the age distribution (of community respondents) closely approximates that within Manitoba and Canada for 1971 (Table 12).

Although the proportion of males to females in the overall study population reflects the distribution of the larger populations of elderly in Manitoba and Canada (Table 8), analysis of the distribution of men to women within the various types of residences reveals a large degree of variation (Table 13). Whereas there are more men than women within the community, women tend to outnumber men in housing units, hostels, and nursing homes. The proportion of males to females in mental and extended care hospitals appears uniform (perhaps a reflection of the small sample size). The increasing proportion of women within the higher levels of care appears to reflect the fact that women tend to outlive men. Therefore, as the age of the respondents increases so does the proportion of women. Due to the fact that older elderly are more likely to

TABLE 10

EDUCATIONAL DISTRIBUTION OF THE STUDY SAMPLE AS COMPARED WITH THOSE AGED 65 AND OVER IN CANADA AND MANITOBA - 1971

Years of Schooling	Canada	Manitoba	Study
0 to 4 years	)	)	26%)
	) 61%	) 60%	) 68%
5 to 8 years	)	)	42)
9 or more years	39	40	33
Totals	100	100	100

Source: 1971 Census of Canada

TABLE 11

AGE DISTRIBUTION OF THE STUDY SAMPLE AS COMPARED WITH THOSE AGED 65 AND OVER IN CANADA AND MANITOBA - 1971

Age (Years)	Canada	Manitoba	Study
65 to 69	36%	34%	28%
70 to 74	26	25	25
75 to 79	19	19	20
80 to 84	12	13	15
85 to 89	6	7	9
90 +	2	2	3
Totals	100	100	100

Source: 1971 Census of Canada

TABLE 12

AGE DISTRIBUTIONS OF COMMUNITY AND INSTITUTIONAL SAMPLES

Age (Years)	Community (N=3433)	Institution (N=911)
65 to 69	33%	10%
70 to 74	27	16
75 to 79	21	20
80 to 84	13	24
85 to 89	5	21
90 +	2	9
Totals	100	100

TABLE 13

SEX DISTRIBUTION BY TYPE OF RESIDENCE - TOTAL SAMPLE

Type of Residence	Male N	Male %	Female N	Female %
Community	1756	85%	1677	74%
Housing Unit	111	5	265	12
Hostel	69	3	122	5
Nursing Home	111	5	191	8
Mental or Extended Care Hospital	24	1	18	1
Totals	2071	100	2273	100

be institutionalized in higher level of care facilities, the proportion of females within these categories also increases.

In the present study sample, the majority of respondents (59%) indicated that they were retired. However, a relatively large number (41%) indicated that they were still employed. Comparison of these figures with similar figures for Manitoba (1971) and Canada (1971) indicates a large discrepancy between the study sample and both the Manitoban and Canadian figures (Table 14). This discrepancy appears to be due to the fact that within the 1971 Canadian Census, employment was defined in terms of participation in the wage earning labor force. Within the study however, respondents were asked to indicate their major occupation in life and whether or not they were still engaged in this major occupation or in another occupation. As a consequence, while housewives would not be considered to be employed by the census, they would be in the present study if they indicated that they were still active in this occupation. Evidence for this interpretation is provided by the finding that, within the study sample, whereas 21 per cent of the males indicated that they were still employed, 59 per cent of the women gave the same response.

Economically speaking, the population of elderly as a whole, is a disadvantaged one. In June, 1971 the mean income of elderly men and women in Canada was less than $4,000.00 per year. In the present sample, the mean income is $180.84 per month or the equivalent of $2,170.08 per year.

TABLE 14

DISTRIBUTION OF LABOR FORCE PARTICIPATION IN THE STUDY SAMPLE AS COMPARED WITH CANADA AND MANITOBA - 1971

	Canada	Manitoba	Study
Employed	15%	16%	41%
Retired	85	84	59
Totals	100	100	100

Source: 1971 Census of Canada

The mean income for men is higher than that for women - $191.38 per month or $2,296.56 per year for men and $171.29 per month or $2,055.48 per year for women (Table 15). Although the mean income of women in the study sample is reasonably representative of that of women in the population in general, the income of the male respondents is considerably lower than that of elderly males in Manitoba and Canada (1971). This appears to be a result of the fact that within the Aging in Manitoba study married respondents' total income was divided in half in order to yield one of the partner's individual income. Because of the higher income of males in general, this method would have a greater effect on the male (than on the female) respondents' income.

The mean income of the respondents varies a great deal with the level of care provided (Table 16). In general,

TABLE 15

MEAN AND MEDIAN INCOME OF THE STUDY SAMPLE AS COMPARED WITH THOSE AGED 65 AND OVER IN CANADA AND MANITOBA - 1971

	Canada	Manitoba	Study
Mean Income			
Men	$4053.	$3578.	$2297.
Women	2450.	2087.	2055.
Median Income			
Men	2450.	2292.	1742.
Women	1607.	1595.	1621.

TABLE 16

MEAN INCOME OF THE STUDY SAMPLE BY TYPE OF RESIDENCE

	Male	Female	Total
Community	$2195.	$1836.	$2020.
Housing Unit	1824.	1709.	1743.
Hostel	2859.	2693.	2755.
Nursing Home	4216.	4107.	4145.
Mental or Extended Care Hospital	2607.	3651.	3054.

as the level of care increases, the mean income of respondents also increases. An exception to this is found in the housing unit population where the mean income is less than that of residents of all other types of residences. In general, the higher incomes of respondents within the higher level of care categories corresponds with the higher cost associated with more extensive services. Also, it reflects the fact that residents in such facilities received, on the average, more than twice the amount of money in transfer payments (i.e. old age security and old age assistance) than did the noninstitutionalized elderly (see Myles, 1977a:157-8). The finding that the housing unit population had the lowest mean income can be explained by the facts that low income is a condition for entry into housing units and greater than 70 per cent of the respondents in this category were female.

Summary

The present sample appears, in general, to approximate the populations of elderly in Canada and Manitoba in 1971. It is highly representative in terms of sex, schooling, and marital status. However, discrepancies appeared in comparisons of the ages, income levels and percentage employed. While the slight differences in age appear to reflect the inclusion of the facility dwelling respondents within the study sample, the employment differential reflects the classification of the occupation - housewife. Finally, the lower income of the male respondents is a result of the division (by two) of married respondents' total income in order to

reflect each of the partner's individual income. Insofar as the sample is a representative one, the results of the present analysis can be generalized to the elderly in Manitoba and Canada.

b) Research Results - Perceived Well-Being Among the Elderly

In Chapter II, three hypotheses were developed. Each was regarded as being representative of the major theme within a specific theoretical framework, a framework which adopted an unidimensional stance to an examination of the effects of institutionalization on the elderly resident. Based upon a critique of such a focus, an alternative model was also suggested. As a result, two opposing models - a model depicting views resting on assumption of institutional homogeneity and a model illustrating a view of institutions as heterogeneous environments - were constructed.

In the present chapter, the results of statistical analyses are presented and the implications of these findings for each of the perspectives, examined. Through orienting much of the discussion around each of the perspectives, it becomes possible to present a more comprehensive comparative assessment not only of the strengths and weaknesses of each perspective, but also of each of the two models of analysis. The final results of the regression analyses are therefore presented first. This is followed by a discussion of the relevance of these findings for each of the perspectives.

i) Predictors of Well-Being Among the Elderly

As discussed previously, two separate analyses were

conducted - one for the sample as a whole and one for the facility dwelling sample alone. The final results of the regression analyses are reported in Tables 17 and 18.

Three independent variables emerged as important predictors within both analyses. They were: perceived health status, perceived future economic well-being, and the degree of autonomy involved in the choice of the residence.

Perceived health proved to be the best predictor within both analyses. It independently accounted for 10.7 per cent of the variance in perceived well-being for the total sample and for 7.9 per cent of the variance for the facility sample (both statistically significant at the .001 level). For both samples, the relationship between perceived health and perceived well-being was positive. This indicates that the more positive the elderly's perceptions of their health status, the more positive their overall evaluations of personal well-being. This is consistent with the results of past research on the correlates of morale, life satisfaction, or perceived well-being among the elderly (see Larson, 1978; Myles, 1977a; Palmore and Luikart, 1972; Spreitzer and Snyder, 1974).

The importance of perceptions of health to a sense of well-being among the elderly appears understandable in view of the decline of physical capacities which tends to accompany growing older. However, although objective health status is correlated with perceived well-being (r=.25 for

TABLE 17

REGRESSION COEFFICIENTS: PERCEPTIONS OF WELL-BEING

TOTAL SAMPLE

Independent Variables **	Standardized Betas	F*	p
Perceived Health	.28	374.52	.001
Perceived Future Economic Well-Being	.14	94.46	.001
Church Membership	.11	55.95	.001
Degree of Autonomy in Choice of Residence	.11	54.18	.001

*D.F. = 1 and 4196

Overall F = 186.27; D.F. = 4 and 4196; p. = .001

R^2 = .15

The following were deleted because their standardized coefficients were less than .10 in the original analysis: age, sex, health, education, current and past occupation, income, nationality, marital status, length of residence, social participation, level of care, the availability of privacy and freedom, etc.

** Subprogram Anova was utilized to test for interaction effects among the predictor variables. Although no significant interaction effects were found there appeared to be some interaction between: perceived future economic well-being and degree of autonomy in choosing the residence (Sum of Squares = 14.24; D.F. = 6; Mean Square = 2.37; F = 2.52; p = .02); and between perceived health and church attendance (Sum of Squares = 12.33; D.F. = 3; Mean Square = 4.11; F = 4.37; p = .004).

TABLE 18

REGRESSION COEFFICIENTS: PERCEPTIONS OF WELL-BEING

FACILITY SAMPLE

Independent Variables **	Standardized Betas	F*	p
Perceived Health	.21	47.52	.001
Frequency of Contact With Closest Friends	.19	36.91	.001
Nationality - Polish, Russian, Ukranian	-.16	27.21	.001
Degree of Autonomy in Choice of Residence	.14	18.51	.001
Perceived Future Economic Well-Being	.11	12.68	.001
Frequency of Contact With Closest Relatives	.11	12.25	.001

*D.F. = 1 and 863
Overall F = 36.78; D.F. = 6 and 863; p. = .001

R^2 = .20
The following were deleted because their standardized coefficients were less than .10 in the original analysis: age, sex, health, education, current and past occupation, income, marital status, length of residence, frequencies of contact with others in household, neighbours, specific people, and co-workers, the availability of social supports, the availability of privacy and freedom, the availability of resources, and the integration into the community, service orientation, level of care provided, and size of residence.

** Examination of interaction effects using Anova revealed no significant interaction among the predictor variables. Some interaction was however, evident between: nationality and degree of autonomy in choosing the residence (Sum of Squares = 7.32; D.F. = 2; Mean Square = 3.66; F = 3.66; p = .03); nationality and frequency of contact with close relatives (Sum of Squares = 10.38; D.F. = 3; Mean Square = 3.46; F = 3.46; p = .02); and nationality and perceived health (Sum of Squares = 8.74; D.F. = 3; Mean Square = 2.91; F = 2.93; p = .03).

the total sample and r = .15 for the facility sample) and with perceived health (r = .48 for the total sample and r = .36 for the facility sample), the present research confirms earlier findings revealing that the individual's own evaluation of health is of greater importance to overall assessments of well-being than is his/her actual level of health or disability (Myles, 1977a; Palmore and Luikart, 1972).

The appearance of perceived future economic well-being as an important predictor of perceptions of well-being within both parts of the analysis is also consistent with the results of past research (Larson, 1978; Myles, 1977). The more secure one feels about one's future financial situation, the higher one's evaluation of morale or well-being. Similarly, evaluations of current economic sufficiency are also related to perceptions of well-being (Note: perceived current and future economic well-being are highly correlated: r = .66 for the total sample and r = .71 for the facility sample).

As was the case with perceptions of health, perceived economic well-being appears to be of greater importance to general assessments of well-being than does actual economic situation. In fact, income displayed very modest correlations with both perceived future economic well-being (r = .14 total sample and r = .06 facility sample) and with perceived well-being (r = .06 for the total sample and r = .11 for the facility sample).

The greater importance of the subjective than of the

objective indicators of both health and financial well-being to overall assessments of well-being may reflect the fact that it is not one's health or one's financial situation per se which is important but rather, the meaning that these have for the elderly individual, particularly in terms of the limitations which they may pose on the ability to engage in other activities which are of importance to a sense of personal well-being (see Smith and Lipman, 1972).

The final predictor variable to emerge as important within both parts of the analysis was the extent of autonomy involved in choosing the place of residence. Among the institutionalized as well as the noninstitutionalized elderly, those who were more directly involved in choosing the residence were more satisfied than those who were either less involved or were totally uninvolved (significant at the .001 level).

Just as choosing the place of residence appears to reflect individual autonomy or independence in decision making, perceptions of health status and economic self-sufficiency appear to be indicative of the extent to which the elderly individual is free from constraints (physical and economic) which impose limits on behavior (Maxwell et al, 1972; Palmore and Luikart, 1972; Smith and Lipman, 1972; Wolk and Telleen, 1976). In this way, they all appear to be reflecting (at least partially) the importance of autonomy (of behavior and of decision making, etc.) to the well-being of the elderly.

Much of the literature on the correlates of perceptions of well-being among the elderly have found levels of formal and informal activity to be highly related to morale (Bley et al, 1972; Lemon et al, 1972; Palmore and Luikart, 1972; Tobin and Neugarten, 1961). Within the present research, frequency of contact with closest friends and frequency of contact with closest relatives, emerged as important predictors of perceived well-being, but only among the institutionalized elderly. For the total sample, only church membership (perhaps indicative of a more formal level of participation) was important. This latter variable did not appear as important to well-being for the institutional sample.

It can be argued that these differences reflect major differences in the living arrangements of the institutionalized and noninstitutionalized elderly. The failure of frequencies of contact with close friends and relatives to emerge as important predictors of well-being within the total sample (a sample in which 79 per cent were community residents) may be due to the fact that, within the community, the range of activities open for involvement are much greater than they are within the institutions. Thus the appearance of church membership as an important predictor may reflect the greater importance of a diversified range of activities to elderly community residents. Similarly, although institutional residents display higher levels of contact with friends (though less with relatives), limitations on the variety of activities within the institution may result in the

increased importance of the more informal types of participation to feelings of well-being. In other words, it appears plausible that the greater importance of church membership for the noninstitutionalized elderly and of contact with friends and relatives for the institutionalized elderly may reflect variations in the relative forms of social isolation and dependence which accompany residence within particular living environments. It has been suggested that while activity, in and of itself, is relatively unimportant to the elderly's well-being, it becomes important "when it is meaningful to the actor" (ef. Havens, 1968). Consequently, the differential importance of the various activities for different groups of 'actors' may be reflective of the characteristics of different living arrangements. This view receives some support from the research conducted by Wolk and Telleen (1976) which revealed that the most important correlates of satisfaction among the elderly did vary with environmental characteristics - in this instance - constraint. It also supports the notion of institutions and the community as distinctive living environments.

Just as contact with friends and relatives appears to represent a form of contact with the 'outside' for elderly residents of institutions, church attendance appears to represent a form of contact with the 'outside' or, with the larger community, by non-institutionalized elderly (Hadaway and Roof, 1978).

Much of the literature on the effects of aging in

contemporary societies points to the exclusion of the elderly from active participation in many areas of social life (Cumming and Henry, 1961; Myles, 1977a; Rosow, 1974). It has been suggested that church related activities may be one of the more accessible sources for participation in voluntary associations by the elderly (ef. Payne and Whittington, 1976). Thus, for the noninstitutionalized elderly, the importance of church membership for perceptions of well-being may reflect their need for involvement in formal organizations.

Alternatively, within the framework of the institution, which is itself defined in terms of a 'formal' level of organization, the elderly appear to be relatively isolated from contact of an informal nature. Lemon et al (1972) note that frequent associations of an informal nature are necessary for the maintenance of a positive self-concept, and therefore, for perceived well-being. Potential support for this interpretation appears in the research conducted by Dowd and Bengston (1978). Although concerned specifically with the problems encountered by the minority aged, their results may also be of relevance to a consideration of the institutionalized elderly. In investigating the association between minority group status, interaction, and life satisfaction, the authors suggest that the higher levels of contact with friends and (in this case) relatives displayed by minority group members may serve to "indicate a source of reward... which contributes significantly to overall 'quality of life' ... (and which)... may constitute an important resource that

enables the older individual to insulate himself from the breakdown in self-esteem... often associated with old age..." (Dowd and Bengston, 1978:432). In the case of the institutionalized elderly, it may serve to 'insulate' the individual from the breakdown of self-esteem and of the low levels of morale often associated with entrance to and residence in an institution. Therefore, the maintenance of contact with friends and relatives may represent an independent link to the outside community among those in institutions as does perhaps church attendance among those not institutionalized. However, important to consider as well is the possibility that the respondents' friends may also be residents within the particular institution. Although not testable within the present analysis, the question of whether the friends are made within the institution or are a means of maintaining contact with the outside, is important in terms of distinguishing specific environmental characteristics affecting resident well-being.

There is a considerable amount of debate in social gerontology over the importance of the various demographic variables as indicators of perceived well-being. While associations have been reported between sex, age, health, education, occupation, and income, etc. and perceptions of well-being (Larson, 1978; Palmore and Luikart, 1972; Riley and Foner, 1968), the results of the present research fail to find evidence of their importance. In the present study, a single demographic variable - nationality - was found to be an important predictor of perceptions of well-being among the

institutionalized elderly. It appears that being Polish, Russian, or Ukranian, is indicative of relatively low levels of well-being. While this finding initially appears relatively difficult to explain due to the lack of research (and particularly, Canadian research) which has been done relating nationality to well-being, it appears that this variable may be reflecting the combined effects of a number of factors. Being of Polish, Russian, or Ukrainian descent was found to be associated with having a low level of education ($r = -.33$) and residence in a high level of care facility ($r = .10$). Also, 66 per cent of this ethnic minority were still using their native language and were more likely than were respondents of other nationalities to have been interviewed in this language. Original analyses from these data (Havens and Thompson, 1975) reports that Polish , Russian and Ukrainian (in addition to Asia/Oceanic) groups tended to rank unmet ethno-cultural needs as highly important (second or third) while other groups ranked it as less important (seventh or eighth). Thus the appearance of nationality appears to reflect the distinctiveness of Polish, Russians, and Ukrainians as ethnic subcultures.

So far, the findings suggest that perceptions of well-being among the institutionalized elderly as well as among the elderly in general are contingent upon a number of factors (see Tables 17 and 18). This is further supported by the finding that those factors which emerged as most important in predicting well-being together succeeded in explaining

only 15 per cent of the variance in perceptions of well-being for the total sample and for only 20 per cent of the variance within analysis of the facility sample. The failure of the level of care variables and the other variables used to measure "bureaucratization', 'relief functions', or 'withdrawal functions' to emerge as important reveals that the unidimensional approach is inadequate in accounting for perceptions of well-being. Also, because some different factors emerged as important within the two analyses, it appears that the institutional sample is, in some ways, a distinctive one. The findings therefore support the necessity of taking a number of factors or dimensions into account when attempting to explain perceptions of well-being for the institutionalized elderly as well as for the elderly in general. Particularly important appear to be those factors associated with the respondents' ability to participate and to exercise autonomy and independence.

A more detailed discussion of the implications of these findings for each of the hypotheses and the theoretical frameworks from which they have been derived are presented below.

ii) Bureaucratic Organization and the Experience of Institutionalization

Hypothesis One

Consistent with the major tenets of the 'bureaucratic' perspective, it was hypothesized that the greater the degree of bureaucratization within the environment, the lower the level of perceived well-being among elderly residents.

Examination of the distribution of levels of perceived well-being (see Table 19) reveals that within the sample as a whole, the majority of respondents (63%) received scores on the satisfaction index which indicated above average assessments of personal well-being. In general, community dwelling respondents received higher scores than did facility dwelling respondents. Within the former sample, 65 per cent indicated good to excellent perceptions while within the latter sample, 58 per cent indicated similar levels. While elderly respondents in the community (65%), housing units (67%), and hostels (62%) similarly tended to receive scores indicating good to excellent levels of perceived well-being, respondents living in nursing homes and mental and extended care hospitals had somewhat lower assessments. Among nursing home residents, the majority of responses (59%) indicated fair to good assessments while within the mental and extended hospital category, somewhat fewer responses (52%) indicated similar levels.

Although levels of perceived well-being decrease slightly as the level of care increases, the association between these variables is weak (G= .16). Examination of the results of the regression analyses reported previously (see Tables 17 and 18) reveals that the level of care provided is not an important predictor or perceptions of well-being. This is further made evident by the presence of relatively low zero-order correlations between the level of care and perceived well-being within the analysis of the total sample (see Figure 5a). A somewhat higher negative correlation

TABLE 19

DISTRIBUTION OF PERCEPTIONS OF WELL-BEING

a. Community and Institutional Residents

Perceived Well-Being	Community N	Community %	Institution N	Institution %
Excellent	812	24%	158	17%
Good	1413	41	368	40
Fair	769	22	212	23
Poor	439	13	173	19
TOTALS	3433	100	911	100

Gamma = .15

b. The Level of Care Provided (Total Sample)

Perceived Well-Being	Very Low (N=3433)	Low (N=376)	Medium (N=191)	High (N=302)	Very High (N=42)
Excellent	24%	22%	18%	12%	7%
Good	41	45	44	36	19
Fair	22	24	19	23	33
Poor	13	9	19	29	41
TOTALS	100	100	100	100	100

Gamma = .16

between the level of care and perceived well-being within the facility sample (Figure 5b) suggests that within the category of institutions for the elderly, there is a tendency for higher levels of care to be accompanied by lowered assessments of well-being. However, to the extent that the level of care failed to emerge as a significantly important predictor of perceived well-being (within either regression analysis) when other factors were controlled for, it appears that variables other than the level of care provided (or, bureaucratization) are more relevant to perceptions of well-being among the elderly.

Similarly, residence size, also used as an indicator of bureaucratization within institutions, was not found to be an important predictor of perceptions of well-being. Although a tendency was found for respondents living in the larger institutions to display lower evaluations of personal well-being than respondents within smaller institutions ($r=-.10$), this was, once again, not significant.[20]

The results fail therefore to establish support for the view that increasing bureaucratization within institutions is directly responsible for lowered evaluations of well-being among elderly resident. The results of the regression

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20. The final variable used as a measure of bureaucratization - i.e. access to a place for personal belongings - was also weakly related to well-being ($r=.14$). However, the measure proved to be nondiscriminating with greater than 90% of the respondents having access to such a place.

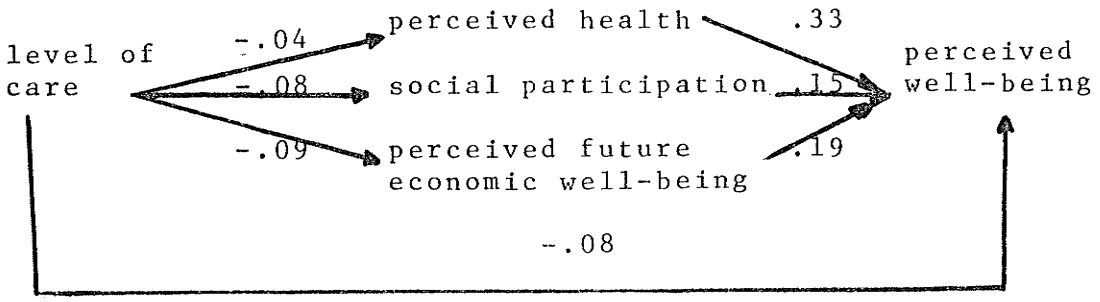
analysis suggest that the intervening process may be of greater importance. The finding that perceived health emerged as an important predictor within both analyses appears to be of particular significance to the bureaucratic perspective which emphasizes the role of the institution in causing the inmate to adopt the inmate role. With reference to the category of institutions for the elderly, this role becomes that of the patient or the sick role. If, as the 'bureaucratic' model suggests, institutionalization forces the resident to adopt the sick role, and consequently, to define themselves as ill, then elderly institutional residents should display lower levels of perceived health than elderly community residents. Increased levels of care should be accompanied by lowered evaluations of health status on the part of residents.

Examination of the distribution of self-assessed health by the level of care provided appears to bear this out (Table 20) as does the appearance of a weak though negative association between level of care and perceptions of health. It is possible however, that the differences in perceived health reflect actual differences in health status within each of the level of care categories. If this is the case, then institutionalization cannot be accredited with producing a tendency for inmates to adopt the 'sick role'. Figure 6 illustrates the correlations between the items. In both analyses, the correlations between the number of health problems and perceived health were negative and moderately strong ($r = -.48$ for the total sample and $r = -.36$ for the facility sample),

FIGURE 5

CORRELATIONS AMONG VARIABLES IN THE UNIDIMENSIONAL MODEL

a. Total Sample



b. Facility Sample

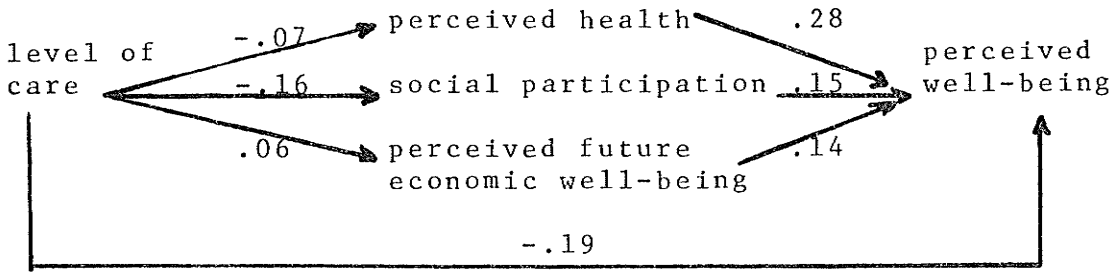
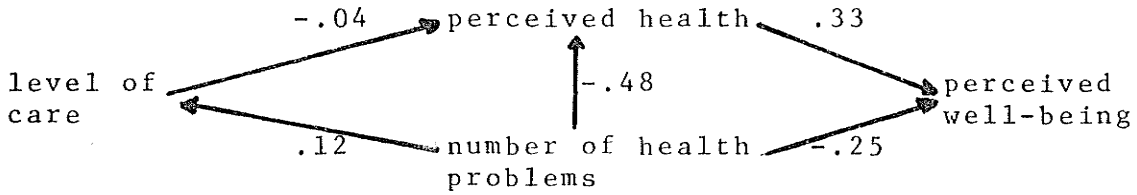


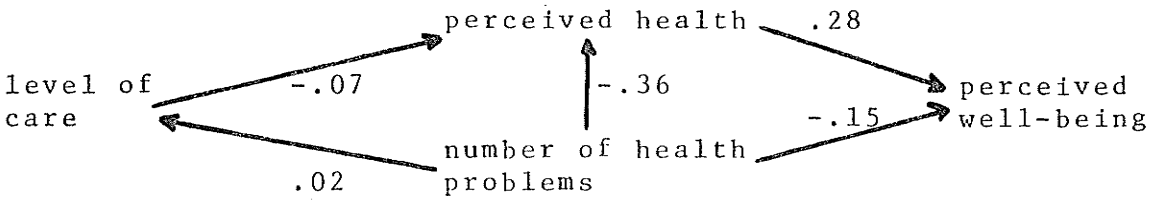
FIGURE 6

CORRELATION COEFFECIENTS: OBJECTIVE AND PERCEIVED HEALTH

a. Total Sample



b. Facility Sample



indicating that the greater the number of health problems, the lower the level of perceived health. In addition, although elderly respondents who suffered from a number of health problems were somewhat more likely to be institutionalized than were those suffering from fewer or no health problems, there was no association between the number of health problems and the level of care received within institutions (r= .02). What appears evident is that although objective health status may have an impact on perceived health (and, in this way, directly as well as indirectly upon perceived well-being), the results of the analysis suggest that increasing bureaucratization (as evidenced by increased levels of care) has little or no role in altering this relationship. Because size was also found to be unrelated to perceived health, these findings appear to contradict the expectation that residents of institutions characterized by increasing bureaucratization will be more likely to define themselves as ill and consequently, to have adopted the 'sick role'. Although perceived health proved to be an important predictor of well-being for both the total sample and the facility sample, it appears that while perceptions of health are of importance to perceptions of well-being, this is the case despite the degree of bureaucratization of the setting. It is also the case whether or not the individual is an institutional resident.

Consistent with the bureaucratic model are the appearance of negative correlations between the level of care and social participation; particularly within the analysis of

TABLE 20

DISTRIBUTION OF PERCEPTIONS OF HEALTH BY THE LEVEL OF CARE

Perceived Health	Community	Housing Unit	Hostel	Nursing Homes	Mental or Extended Care
Excellent	14%	10%	12%	10%	13%
Good	48	46	54	43	43
Fair	28	36	28	31	25
Poor	10	8	7	16	20
Totals	100	100	100	100	100
N	(N=3424)	(376)	(189)	(293)	(40)

Gamma = .10

the facility sample. Insofar as social participation is positively associated with perceived well-being (Figure 5), the finding that overall social participation decreases somewhat as the level of care increases appears to lend some preliminary support to the theoretical argument that in generating withdrawal, increasingly 'total' institutional environments indirectly adversely affect perceptions of well-being.

Entrance of the combined social participation index and of the component items into early regression analyses resulted in the deletion of four of the six component items

(see pages 83-84). Two of the indicators - frequency of contact with close friends and frequency of contact with close relatives - proved to be better predictors of well-being than did the other four or the index itself for both the total and facility samples. However, while neither emerged as significant for the total sample, both proved to be strong predictors of perceived well-being in the facility regression (see Table 18).

The finding that these factors are of importance to facility dwelling respondents is, in and of itself, of little significance to the bureaucratic perspective. Rather, what appears necessary to support this interpretation is evidence suggesting that increased levels of care and size adversely affects frequencies of contact with close friends and relatives and, in this way, indirectly affects levels of perceived well-being among elderly residents of such environments.

Comparison of the mean levels of contact with friends for the total and facility samples (Table 21) reveals little difference in the amount of contact, although frequencies of contact with relatives are somewhat lower for facility respondents. In addition the appearance of a negative correlation between the level of care provided and frequency of contact with close friends ($r = -.13$) within the facility sample, suggests that within institutional facilities, increasing levels of care are accompanied, to some extent, by decreasing amounts of contact with close friends. This is so despite

TABLE 21

MEANS, STANDARD DEVIATIONS AND ZERO-ORDER CORRELATIONS FOR CONTACT WITH FRIENDS AND RELATIVES WITH LEVEL OF CARE[a] AND PERCEIVED WELL-BEING[b]

	Total Sample				Facility Sample			
	Mean*	S.D.	r^a	r^b	Mean*	S.D.	r^a	r^b
Contact with Close Friends	2.63	1.13	.01	.14	2.52	.126	-.13	.26
Contact with Close Relatives	2.81	.87	-.30	.09	3.35	.75	-.19	.15

* Scores range from 'one' to 'five'. A score of 'one' indicates a high level of contact while a score of 'five' indicates a low level of contact.

the finding that within the institutional sample, increased levels of care were not indicative of decreased objective health status, a factor which may have otherwise served to explain reduced frequency of contact.

The appearance of modest negative correlations between level of care and frequency of contact with friends and relatives in the facility analysis suggests that institutionalization is to some extent negatively associated with a high level of contact, and that within institutions, the higher the level of care, the less the contact. Therefore to the extent that the frequencies of contact with friends and relatives are important predictors of perceived well-being among the institutional-

ized elderly, and that the amount of contact appears to decrease slightly with increased levels of care in institutions, it can be argued that institutionalization may indirectly have a slight adverse effect on perceptions of well-being among the elderly. However, increasing size of institutions (also on indication of bureaucratization) was unrelated to participation ($r = .06$). As a result, there does not appear to be a great deal of strength to the argument.

The final variable which is of particular significance to the bureaucratic perspective is the length of residence. As the results of the regression analysis indicate (Tables 17 and 18), contrary to the prediction of this perspective, length of residence within the institution does not appear as an important predictor of perceived well-being.

In conclusion, the results of statistical analysis fail to provide support for the bureaucratic perspective. Although there was a tendency for perceptions of well-being to decrease slightly as the level of care provided increased, this relationship was not maintained when controlling for other variables. Some support was also evident in analysis of the indirect effects. Although little support appeared for the view that institutionalization has an adverse effect on perceived well-being through increasing the propensity of individuals to identify with the sick role, somewhat stronger support was found for the view that through decreasing the amount of contact with close friends and relatives (both of which were significant and important predictors of well-

being for elderly institutional residents), institutionalization, or more specifically, increasing bureaucratization within institutions results in decreased levels of perceived well-being. In this way, it appears possible that there is a tendency towards 'withdrawal' among the elderly institutional residents. Institutional size however was found to be unrelated to both the intervening and to the dependent variables. Finally, no support appeared for the view that increases in the time spent in institutions adversely affected perceptions of well-being.

iii) Institutionalization and the Provision of Relief - Hypothesis II

Contrary to the major tenets of the bureaucratic perspective, the social welfare model emphasizes the need for institutional facilities by the elderly. Ameliorating the individual and combined effects of poverty, illness, and social isolation, which tend to accompany growing old in contemporary society, the major characteristic is regarded as being the provision of relief. Reflecting this emphasis, it was hypothesized that institutionalization (the provision of relief) would be positively related to perceptions of well-being among elderly residents.

Examination of the direct effects of institutionalization on perceived well-being also made use of the level of care variable. This reflected the observation that a greater measure of relief would be evident in institutions offering higher levels of care. As discussed previously, the level of

care provided failed to emerge as an important predictor of perceptions of well-being for either the total or facility samples. Contrary to the social welfare model, there appeared to be a tendency for increased levels of care to be accompanied by decreased levels of perceived well-being (see page 116).

More adequate assessment of the social welfare perspective also requires an examination of the indirect effects of the provision of relief on perceptions of well-being. If, as this model suggests, such increases are accompanied by more positive perceptions of health, higher levels of social participation, and increased feelings of future economic security, and these latter variables prove to be important predictors of well-being reflecting the provision of relief, then there would appear to be some support for the assertion that institutionalization is an experience which is beneficial to perceptions of well-being among the elderly. Similarly, evidence indicating that perceptions of health, social participation, and perceptions of economic well-being are higher for the institutional than for the total sample would also tend to be supportive of a social welfare interpretation.

In general, elderly institutional residents perceive their health as being somewhat poorer than do the elderly in general (p. 117). Although to some extent reflecting differences of objective health status, the finding that within institutions there was no apparent association between the level of care provided and objective health status (despite

the appearance of a small though negative correlation between the level of care and perceived health), leads to the conclusion that institutionalization has no significant impact upon perceived health. Also, the appearance of perceived health as an important predictor within both analyses indicates that perceptions of health are important to all elderly regardless of their place of residence.

Also contrary to the social welfare perspective are the findings that increased levels of care are negatively associated with frequencies of contact with close friends and relatives (despite no differences in the availability of social supports for the two samples). Although the facility sample displayed more contact with close friends and approximately the same amount of contact with relatives as did the total sample, residence in facilities characterized by increasing levels of care was found to be associated with decreases in the frequency of contact. Therefore, it appears that rather than facilitating social participation, institutions characterized by higher levels of care (and therefore, within this view, by a greater measure of relief) are detrimental to high levels of social participation. Because frequencies of contact with close friends and relatives are of importance to perceptions of well-being for the institutional sample, the findings appear to indicate that level of care may indirectly adversely affect perceptions of well-being among the elderly.

Perceived future economic well-being was also found to be an important predictor of perceptions of well-being

within both regression analyses (Tables 17 and 18). The results suggest that the more positive one feels about one's future economic security, the higher one's evaluations of overall well-being. Does institutionalization result in increased levels of perceived economic well-being as predicted by the social welfare model? Examination of the distribution of perceptions of economic well-being suggests that it may (see Table 22). Whereas the majority of institutional residents (71%) had perceptions ranging from good to excellent, a smaller percentage (63%) of elderly within the total sample had similar assessments. Also, analysis of the zero-order correlation coefficients (Figure 5, p.118) and regression coefficients indicates that perceptions of future economic well-being are more highly related to overall assessments of well-being within the total sample ($r = .19$) than within the facility sample ($r = .14$), and that they are slightly stronger as predictors of well-being for the total sample ($B = .19$; Beta = .14) than for the facility sample ($B = .17$; Beta = .11). However the mean income of institutional respondents is also considerably higher than that of community residents. As a result, there is a possibility that the higher perceptions of economic well-being within the former sample reflects these actual differences in financial situation. This interpretation appears to be borne out by the presence of very low correlations between the level of care variables for both samples and perceived future economic well-being ($r = .09$ combined and $r = .06$ facility; Diagram 5). Once the effects of income

TABLE 22

DISTRIBUTION OF PERCEPTIONS OF ECONOMIC WELL-BEING

TOTAL SAMPLE

Perceived Economic Well-Being	Community (3362)	Facility (852)	Combined (4214)
Excellent	7%	7%	7%
Good	55	64	57
Fair	27	22	26
Poor	12	7	11
Totals	100	100	100

Gamma = -.18

TABLE 23

ZERO-ORDER AND PARTIAL CORRELATIONS BETWEEN PERCEIVED ECONOMIC WELL-BEING AND LEVEL OF CARE AND PERCEIVED WELL-BEING CONTROLLING FOR INCOME

	Total		Facility	
	r	Partial r	r	Partial r
Level of Care	.06	.04	.09	.05
Perceived Well-Being	.19	.18	.14	.13

are partialled out, the associations between the level of care and perceived future economic well-being remain negligible (Table 23). Similarly, partialling out the effects of income on the association between perceived economic well-being and the dependent variable results in very little change. As a result, it appears that whereas perceptions of economic well-being are related to actual conditions of economic well-being, the role of the institution in increasing feelings of future economic well-being is negligible. Therefore, there is little support for the view that institutions positively affect perceptions of well-being by elevating perceptions of economic security.

In conclusion, the results of the present analysis fail to provide major support for the social welfare hypothesis. The provision of relief through increased levels of care does not result in higher levels of participation, of perceived health, of perceived economic well-being, nor in higher evaluations of overall well-being. It thus contradicts Myles' (1977a) findings to the effect that institutions facilitate social participation and positive perceptions of health and economic well-being.

The failure to find support for Myles' findings is surprising since both analyses utilized the same date. While within both analyses, perceptions of health, perceptions of economic well-being, and frequencies of contact with friends and relatives, were found to be important to the elderly's perceptions of well-being, Myles suggests that these result

in higher levels of perceived well-being for the institutionalized elderly. In the present analysis however, there was no indication that institutionalization had any strong effect. This may be a result of major differences in the strategies employed. While in the present research, analysis focused upon two samples - the total sample and the facility sample - and utilized level of care (reflecting the type of residence) as an independent variable, Myles investigated the relationships between social participation, perceived health, and perceived economic well-being and overall assessments of well-being separately for each of three subsamples - i.e. the community sample, the housing unit sample, and the institutional sample. He did not therefore utilize type of residence as an independent variable and did not examine directly the effects on well-being.

iv) The Environment and the Disengaging Elderly - Hypothesis III

Generalizing from the 'disengagement' theory of aging which defines the aging process as one in which elderly individuals become increasingly self-centered and withdrawn, displaying decreased concern with aspects of their social and physical environments, it was hypothesized that, in general, assessments of well-being would tend to be positively related to institutionalization (defined in terms of withdrawal functions). Because increasing levels of care appeared to imply decreasing necessity for active involvement in social participation, the level of care variables were

also utilized as an indicator of the extent to which the institution facilitated withdrawal.

The findings that the level of care provided was not an important predictor of perceptions of well-being fails to provide support for the disengagement hypothesis. According to the disengagement perspective, perceptions of well-being by the elderly gradually cease to be contingent upon aspects of either their social or physical environments. While, within the present analysis, none of the predictors associated with the physical environment emerged as important in explaining perceptions of well-being (an issue which is discussed later), the findings suggest that aspects of the social environment are associated with more positive assessments of well-being by the elderly.

The results indicate that for the sample as a whole, the greater the frequency of interaction with others, the more positive are perceptions of well-being (Figure 5). The appearance of frequencies of contact with close friends and relatives as important predictors of well-being for elderly institutional residents (see Table 18) also appears to contradict the view of institutions as vehicles for disengagement by the elderly.

Similarly contradicting the disengagement view is the failure of 'age' to emerge as an important predictor variable. As noted previously, according to the theory increased withdrawal with age is presumed to have positive consequences for perceptions of well-being among the elderly. (Also noted

however, was the fact that the importance of this variable has been the subject of debate). Additional contrary evidence is provided by the finding that the frequencies of interaction with friends and relatives appeared highly important predictors of well-being within analysis of the facility dwelling sample, a sample which, as a whole, is considerably older than the total sample. Although within both parts of the analysis, age was negatively correlated with social participation ($r = -.18$ for the total sample and $r = -.09$ for the facility sample), it also displayed a low but inverse relationship with perceived well-being ($r = -.08$ for the total sample and $r = -.02$ for the facility sample) despite the appearance of stronger positive associations between social participation and perceived well-being ($r = .14$ for the total sample and $r = .15$ for the facility sample).

Suggestive also of the alternative interpretation that the elderly in general, are not unconcerned with aspects of their social environments is the appearance of perceived future economic well-being as an important predictor of well-being. Contrary to the expectation of the disengagement theory, the elderly do not appear to have "withdrawn emotional investment from their environment".

Central to the disengagement theory also, is the notion that the process of disengagement is more problematic for men than it is for women. The theory argues that because the central role of men in industrial societies is instrumental, and because the central role of women is socio-emotional, the

process of disengagement (symbolized by retirement for men and widowhood for women) requires that men relinquish the entirety of their major role while women give up only the major part of this role. On this basis, the theory asserts that the transition into disengagement is more difficult for men than for women and that this is reflected in their subjective assessments of well-being. However, in the present analysis, the sex of the respondents proved to be unrelated to perceptions of well-being within either sample. As a result, there is no support for the argument that disengagement is more difficult for elderly men than for elderly women.

On the basis of the present analysis therefore, there appears to be little support for the view that withdrawal is beneficial to perceptions of well-being and, as a result, for the view that institutions, because they facilitate withdrawal, are beneficial to well-being. Although there was some indication that increases in the level of care provided (and therefore of withdrawal functions) were associated with lower levels of contact with friends and relatives, higher rather than lower frequencies of contact were found to be important for positive perceptions of well-being within the institutional sample. Also, the appearance of other measures reflecting the importance of engagement (i.e. perceived economic well-being and degree of autonomy in choosing the residence) rather than disengagement for the well-being of the elderly suggests the inadequacy of the dis-

engagement theory in accounting for the relationship between institutionalization and resident well-being.

v) Variations in the Experience of Institutionalization - An Alternative Model

In contrast to each of the former perspectives, the multidimensional approach emphasizes the necessity for distinguishing between those socio-environmental characteristics which, in addition to various socio-personal characteristics (such as sex, age, health, social participation) may affect residents' perceptions of well-being. Reflecting this orientation, it was argued that because institutions for the elderly are not homogeneous, assessments of well-being would be related to variations along a number of dimensions characterizing the particular setting.

The ranges, means, standard deviations, and zero-order correlations for those independent variables included within the multidimensional model are reported on Table 24. Very few of the items were found to be highly important as predictors of perceptions of well-being. However, a number of individual items did display modest correlations with perceived well-being within one or both parts of the analysis.

Inclusion of the individual items into multiple regression analysis resulted in all but one of the items - the amount of automony involved in the choice of residence - being deleted (see Tables 17 and 18). Within both analyses, the extent of automony involved in the choice appeared as an important predictor of perceived well-being. In general, the

TABLE 24

RANGES, MEANS, STANDARD DEVIATIONS, AND CORRELATIONS WITH PERCEIVED WELL-BEING FOR PREDICTOR VARIABLES INCLUDED IN MULTIDIMENSIONAL MODEL

a. Total Sample

Independent Variables	Range	Mean	Standard Deviation	r
1) Privacy				
private room	0-1	.94*	.24	.11
satisfaction with privacy	1-3	1.03*	.17	.06
2) Freedom				
automony in choice	1-3	1.20	.49	.13
3) Resources	___	___	___	___
4) Integration				
church membership	0-1	.58	.49	.17
satisfaction with location	1-3	1.06*	.23	.09
adequacy of public transp.	1-3	1.18	.51	.03
senior citizen activities	1-3	1.11	.38	.02
5) Service Orient	___	___	___	___
level of care	1-5	1.37	.88	-.09

* non-discriminating

b. Facility Sample

Independent Variables	Range	Mean	Standard Deviation	r
1) Privacy				
private place for belongings	0-1	.92**	.28	.14
satisfaction with privacy	1-3	1.05**	.23	.03
secure place for personal possessions	0-1	.67	.47	.07
private room*	0-1	.83	.38	.07
personal furnishings*	1-3	1.63	.79	.20
2) Freedom				
autonomy in choice of residence	1-3	1.62	.77	.23
voting arrangements	0-3	.57	.50	-.10
resident council	1-3	.66	1.01	-.04
visited before moving*	0-1	.56	.50	.14
3) Resources				
staff not rotated	0-1	.58	.49	.14
volunteers	0-1	.27	.44	-.05
friendly visitors	0-1	.42	.49	-.02
resident helps in chores*	1-3	2.20	.86	.21
resource index	0-12	6.66	3.50	-.11

4) Integration				
satisfaction with location	1-3	1.06*	.24	.12
adequacy of public transport	1-3	1.20	.55	-.03
senior citizen activities	1-3	1.08	.31	.03
attends day centres	1-4	2.89	1.15	.02
attends church	0-1	.53	.50	.14
5) Service Orient.				
to care of elderly	1-3	1.37	.53	.13
level of care	0-5	2.31	1.66	-.16
6) Size	1-5	3.26	1.34	-.10

* Items included in level of care scale
** non-discriminating

less the respondent was involved in choosing the place of residence, the less positive his/her peceptions of well-being. Although utilized as an indicator of the amount of 'freedom' (see definition - Appendix A), its interpretation in relation to this model is not unambiguous. Because the choice of residence is made prior to actual entrance to the institution, its referent is not the actual place of residence in which the respondent is located. Rather, it depicts the extent to which the respondent, prior to entrance, was "permitted, encouraged, or required to exercise any choice, decision-making or initiative" (Pincus, 1968: 207) and the implications of this former freedom to consequent perceptions of well-being. Therefore, although this item does not directly

represent a significant aspect of the respondents' current environments, it does suggest in a more general sense, that elderly individuals' perceptions of well-being are influenced by the extent to which they are able to exercise freedom of decision making. (Although not testable within the present study, it is also possible that living environments which are chosen by the respondents themselves differ somewhat from those which are chosen by others such as friends, relatives, or professionals.)

Although none of the individual items used to measure the availability of privacy within the residence emerged as important predictors of well-being, there appears to be a slight indication that the more privacy one is provided, the higher the level of perceived well-being. All individual indicators of the availability of privacy were positively correlated with perceived well-being for both parts of the analysis. Within the facility sample, modest (though not significant) correlations were found between whether the respondent had a private place for their own belongings, the number of personal furnishings which they were allowed to bring (an indication of the extent to which they are allowed to establish a "personal domain") and perceptions of well-being. It appears that those who had a place for their own belongings and those who were allowed to bring a number of items of furnishing were slightly more satisfied than those who had no place for personal belongings and were allowed to bring few or no personal furnishings.

Among those items used to measure the availability of freedom of decision-making and of behavior within the institution, items dealing with the extent of automony involved in the choice of residence (discussed above), whether or not the respondent was able to visit prior to moving in, and whether or not arrangements were made for voting displayed modest correlations with assessments of well-being. However, once again, these were not significant.

Analysis of the importance of resource items to facility dwelling respondents revealed somewhat of a tendency for residents to be more satisfied if the staff was not rotated frequently, and if they themselves were required to perform work related chores within the residence. These once again appear to reflect the importance of interaction and participation to perceptions of well-being among the elderly.

Among the items used to measure the integration of the setting into the larger community, both satisfaction with the location and church attendance displayed modest positive correlations with perceived well-being. The more satisfied that the respondent was with the location of the residence, the more positive his/her assessments of well-being. Respondents belonging to and attending church were somewhat more likely to be satisfied than those not belonging and/or attending.

Because the service orientation of the residence was highly correlated with the level of care variable ($r = .62$), analysis of the service orientation is based on

the latter variable. As noted previously, the level of care provided failed to emerge as a strong predictor of perceptions of well-being for either the total or facility samples. There was however some indication that perceptions of well-being tended to decrease as the level of care provided increased.

The final dimension which was examined was that of the size of the residence. Using total number of residents as an indication of institutional size, it was found that there was a slight tendency for respondents living in the larger institutions to display lower evaluations of well-being than residents in institutions of smaller size. This is consistent with the findings of Curry and Ratliff (1976) and Greenwald and Linn (1971). It also appears to reflect the effects of congregate living patterns on well-being and in this way is partially supportive of the bureaucratic model as well.

Although the results of the present analysis do not provide a great deal of support for the importance to perceptions of well-being of the particular environmental dimensions suggested by Kleemeier (1961) and Pincus (1968), they do support the necessity of adopting a multidimensional model of analysis. As the results of the regression analyses indicate, a number of independent factors are of importance to perceptions of well-being among the elderly. Although, in some cases, the same factors were operative within the institution as were operative for the sample as a whole, different

factors also emerged. While within analysis of the facility dwelling sample, frequency of interaction with friends and relatives was important, this was not the case for the total sample for whom church attendance was of greater importance. As a result, it appears that the institutional environment is a distinctive one and that numerous factors are important in determining the experience of institutionalization by the elderly.

Conclusions

The results of the present analysis support the critique made of the bureaucratic, social welfare, and disengagement perspectives. Perceptions of well-being among the institutionalized elderly do not appear to be conditioned by a single defining characteristic of the institutional environment. As a result, neither bureaucratic organization, the provision of relief, or the facilitating of withdrawal are, by themselves, sufficient in explaining the experience of institutionalization by the elderly. Alternatively, it appears that a number of factors must be considered in attempts to explain perceptions of well-being and that different factors are of importance depending upon the living environment in which the resident is located.

CHAPTER V

SUMMARY AND CONCLUSIONS

a) Summary

The purpose of the present thesis involved the assessment of a number of theoretical perspectives which have been developed in an attempt to explain the experience of institutionalization, particularly as this applies to the elderly. Examination of the major tenets of each of three perspectives (i.e. of the bureaucratic, social welfare, and disengagement perspectives) revealed that all tended to rest upon an assumption of inter-institutional homogeneity -explaining the experience in terms of a single overriding dimension or characteristic of the environment of the aging process. All were criticized for their failure to take into account the heterogeneity of institutions and thus for their inability to account for variations in the experience of institutionalization by the elderly. An alternative model which asserted the necessity of recognizing the heterogeneous nature of the living environment was then developed.

Using secondary data collected on an original sample of 4805 institutionalized and noninstitutionalized elderly in the Province of Manitoba (1971), step-wise procedures of multiple regression analysis were used to assess the theoretical relationships specified within each of the perspectives. Because, within the original study, specific questions were addressed to specific subsamples only, it was necessary to conduct two separate analyses - one for

the total sample and one for the institutional sample.

Consistent with the results of past research on the correlates of perceptions of well-being among the elderly, perceived health and perceived economic well-being were found to be important predictors of perceptions of well-being for both samples. Similarly, the degree of autonomy involved in the choice of the residence appeared as an important predictor of well-being for both samples. However, while frequencies of contact with friends and relatives emerged as being important to perceptions of well-being among the institutionalized elderly, this was not the case for the total sample for whom church attendance was of greater importance. Finally, nationality appeared as an important predictor for the institutional sample.

The results of the analysis supported the critique made of each of the three unidimensional perspectives. No support appeared for the view that, in providing relief from poverty, illness, and social isolation, institutionalization is beneficial to perceptions of well-being among the elderly. Neither did it lend support to the argument that institutions, in facilitating withdrawal, are beneficial to perceptions of well-being. Minor support was found for the view of institutions as harmful to perceptions of well-being. Although there was little indication that institutionalization resulted in the identification by inmates with the 'sick role', some support appeared for the view that, in generating withdrawal, institutions may indirectly adversely affect perceptions of

well-being. The view that institutions vary on a number of dimensions which may positively or negatively affect perceptions of well-being received the greatest measure of support. While little evidence indicated the importance of the particular dimensions suggested by Pincus (1968) and Kleemeier (1961), the finding that a number of factors were of importance to perceptions of well-being within both the analysis of the total sample as well as of the institutional sample, and the finding that different factors were of importance within the two samples, illustrates the necessity of assuming multidimensionality when - attempting to account for the experience of institutionalization by the elderly.

b) Limitations of the Research

A major limitation evident within the present study, one which particularly affected the search for environmental characteristics of importance to perceptions of well-being, was the secondary nature of the analysis. Although there are a number of problems ordinarily associated with the use of secondary data, particularly important to the present research was the design of the interview schedule for a different theoretical question. Because of the necessity of seeking operational definitions of the various dimensions included, within the framework of a study differing in purpose and orientation, constraints were necessarily imposed upon the scope and quality of the measurements used, relative to the objectives of the present research. This was particularly problematic with regards to the operationalizations of

the dimensions included in the analysis of the multidimensional perspective. For example, indicative of this problem was the inability to operationalize the availability of freedom within the environment for the noninstitutional sample, due to the fact that suitable questions were unavailable. Also because, at the time of this study the resource file was unavailable, the present research was not able to take into account the impact of different sources of ownership of facilities.

Additional problems ordinarily associated with the use of the secondary data include the inability to judge the rigour with which the original study was conducted as well as the inability to make finer distinctions than allowed for by the original coding procedures. Somewhat reflective of this latter problem as it affected the present inquiry was the fact that only the final scores of the Life Satisfaction Index were coded. This precluded analysis of the inter-item reliability and item to total reliability as well as of the deletion of those items which have been suggested for exclusion (Adams, 1969).

Also, as noted in Chapter III, a number of respondents were interviewed via proxy (N=433) due to their inability to participate in the interview. Although excluded from the present analysis, it is possible that those factors investigated in the study may be related in some ways to the inability of these respondents to participate - i.e. they may represent those individuals who are most adversely

affected by institutionalization, those who are least satisfied and have the lowest levels of morale, etc. Proxy respondents tended to be older, unmarried, in poorer health, and more likely to be residents of institutions displaying higher levels of care (for example, nursing homes and mental and extended care hospitals) than did non-proxy respondents. These are all factors which have been found to be related to lower levels of perceived well-being among the elderly (Kasl, 1972; Larson,1978; Palmore and Luikart,1972; Riley and Foner, 1968; Smith and Lipman,1972).

An additional limitation of the present research is that it relied upon the use of cross-sectional data. As a result, it may be subject to problems of selection (see Kasl, 1972; Lieberman,1969).

c) Suggestions for Future Research

As noted previously, the results of the present analysis offer support to the potential of an inter-institutional comparative approach in assessing the impact of the experience of institutionalization upon the perceptions of well-being of the elderly. What appears to be necessary for theoretical refinement in the area is additional research relating various characteristics of the elderly to the social and physical characteristics of their living environments. In other words, what appears necessary is that stress be placed on the multidimensionality of the living environment (both within institutions and within the community). In line with this, as attempt should be made to determine what factors are

important to the behavior and attitudes of the elderly and how they affect the everyday lives of elderly residents, particularly with reference to their ability to exercise independence and autonomy and to interact with significant others. Specific dimensions which appear to warrant further investigation include those utilized in the present study (i.e. the availability of privacy, freedom, and resources, etc. to elderly residents). In this regard, an attempt should be made to differentiate specific areas in which these dimensions may be seen to operate. For example, in investigating the importance of 'freedom', an attempt should be made to isolate specific facets of the everyday lives of residents which may be affected by restrictions of autonomy. Limits on certain activities may be of greater importance to residents than similar restrictions in other areas. Therefore, while in the present analysis, it was necessary to examine the impact of restrictions of autonomy cumulatively, in terms of general scheduling procedures, future research should examine such restrictions in relation to specific spheres of residents' lives. It could therefore include such things as the ability to participate in activities either within or outside of the residence; the right to patient self-government; the residents' right to handle their own legal and financial affairs; and their freedom to refuse medication. Attention should be paid as well to other factors or dimensions which may affect resident well-being (for example, staff behavior and sources of ownership).

In an effort to examine directly the impact of type of residence on perceptions of well-being (necessary for examination of the bureaucratic, social welfare and disengagement perspectives), the present analysis utilized a comparison of a sample consisting of both institutionalized and noninstitutionalized elderly with a sample of institutionalized elderly alone. As a result, little generalization was possible regarding those factors of importance to perceptions of well-being among the elderly in the community. Of value therefore, as a next step, would be research comparing institutionalized and community dwelling elderly.

Also of particular value to an understanding of institutional effects would be research utilizing a longitudinal design. Such a design would enable the investigator to better differentiate among factors associated with moving into an institution, factors associated with relocation to a new living environment, and those factors associated with living within a particular institutional setting or a particular type of institutional setting.

In general, given the theoretical and empirical underdevelopment of a multidimensional approach, what appears necessary is the redirection of current efforts away from unicausal interpretations and towards a framework capable of reflecting the complexity of the social and physical environments.

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APPENDIX A

DEFINITION OF THE DIMENSIONS

PROPOSED BY PINCUS (1968)

The dimensions which are explored within the study were originally defined by Pincus (1968:207) as follows:

Privacy

> "... the degree to which the environment allows the resident to establish and maintain a personal domain which is not open to public view or use and into which the institution will not transgress. A personal domain may encompass a personal life-space... a physical living space, and a social life space."

Freedom

> "... the degree to which the resident must adjust his life to imposed rules and discipline and the extent to which he is permitted, encouraged, or required to exercise any choice, decision-making or initative."

Integration

> "... the degree to which the environment affords opportunities for communication and interaction with the larger heterogeneous community (people and places) in which the institution is located."

Resources

> "... the degree to which the environment provides opportunities for the resident to engage in a variety of work and leisure activities and to participate in social interaction with staff and other residents in a variety of social roles and statuses other than the patient role..."

APPENDIX B

COMPARISON OF PROXY AND NON-PROXY RESPONDENTS

TABLE 24

SEX

Sex	Proxy	NonProxy
Male	42%	48%
Female	58	52
Totals	100	100

TABLE 25

AGE

Age (years)	Proxy	NonProxy
65 to 69	16%	28%
70 to 74	15	25
75 to 79	18	21
80 to 84	20	15
85 to 89	21	9
90 +	11	3
Totals	100	100

TABLE 26

CURRENT OCCUPATION

	Proxy[a]	NonProxy[b]
Employed	9%	41%
Retired	91	59
Totals	100	100

a Missing cases = 17
b Missing cases = 30

TABLE 27

NUMBER OF HEALTH PROBLEMS

	Proxy[a]	NonProxy[b]
None	5%	15%
One	16	23
Two	23	22
Three +	56	40
Totals	100	100

a Missing cases = 2
b Missing cases = 22

TABLE 28

TYPE OF RESIDENCE

	Proxy	NonProxy
Community	31%	79%
Housing Unit	2	9
Hostel	7	4
Nursing Home	30	7
Mental or Extended Care Hospital	30 (N=433)	1 (N=4344)
Totals	100	100

TABLE 29

MARITAL STATUS

	Proxy[a]	NonProxy[b]
Single	21%	10%
Married*	32	55
Widowed	47	36
Totals	100	100

*includes divorced and separated

a Missing cases = 1
b Missing cases = 3

TABLE 30

MEAN INCOME

Proxy	$221./month
Non-Proxy	$181./month

TABLE 31

NATIONALITY

	Proxy[a]	NonProxy[b]
North American	16%	12%
British	39	44
Other European	21	23
Polish, Russian, or Ukrainian	21	18
Other	4	3
Totals	100	100

a Missing Cases = 6
b Missing Cases = 6

APPENDIX C

ABBREVIATED QUESTIONNAIRE

1. Sex

    1. Male
    2. Female

2. Sample Status

    1. General population
    2. Resident in facility

3. Region

    1. Metro
    2. Eastman
    3. Interlake
    4. South Central
    5. Norman
    6. Parkland
    7. Westman

4. Person(s) Interviewed

    1. Respondent alone
    2. Respondent in presence of another
    3. Respondent with some assistance from Proxy
    4. Respondent with much assistance from Proxy
    5. Proxy

5. When were you born (month,year)?

6. What is your marital status?

    1. Single
    2. Married
    3. Widowed

4. Divorced/separated

7. Of what nationality do you consider yourself?

1. Canada
2. USA or Western Hemisphere
3. British (Isles) English
4. French
5. German
6. Norwegian, Danish, Swedish, Icelandic
7. Dutch, Belgian
8. Russian, Ukrainian
9. Polish
10. Other European - Middle East (Italian, Spanish, Portugese, Greek, etc.)
11. Asia Oceanic (Chinese, Japanese, Polynesian, East Indian, etc.)
12. Native, Indian or Eskimo

8. How many years or grades did you complete in school?

1. 0 years
2. 1 to 4 years
3. 5 to 8 years
4. 9 to 10 years
5. 11 to 12 years
6. 13 to 16 years
7. 16 years and over

9. Do you have any children?

1. Yes
2. No

10. Do you have any grandchildren?

1. Yes
2. No

11. Do you have any brothers/sisters?

    1. Yes
    2. No

12. Do you have any other relatives?

    1. Yes
    2. No

13. Where are your nearest relatives?

    1. In household
    2. In building
    3. In neighbourhood/community
    4. Less than one day's journey (by land)
    5. More distant or has no relatives

14. How long have you been living in your present household/facility/hospital?

    1. Less than six months
    2. Over six months but less than one year
    3. One year to three years
    4. Three to five years
    5. Over five years

15. Who chose this household/facility/hospital?

    1. Self and/or spouse
    2. Relative/friend/neighbour
    3. Social worker, doctor, or other person from a social agency or a hospital other than this facility
    4. Person working for this facility
    5. Don't remember

ASKED OF FACILITY DWELLING RESPONDENTS ALONE:

16.

a) Facility Name

b) Were you visited by a staff member from this facility before you moved here?

1. Yes

2. No

c) Were you able to and did you visit this facility before you moved here?

1. Yes, visited before move

2. Yes, allowed to but did not do so

3. No, not allowed to visit before move

17. Number of furnishings you were allowed to bring with you.

1. 9 or more items
2. 7 or 8 items
3. 5 or 6 items
4. 3 or 4 items
5. 2 or less items

ASKED OF ALL RESPONDENTS:

18. How many persons in the household in addition to the respondent?

Number_____ X 30 = _____

19. Of the relatives (including any in household) you feel closest to, how many do you see and how often?

1. everyday	___ No. X 30	= _____
2. once a week	___ No. X 4	= _____
3. a few times a month	___ No. X 3	= _____
4. once a month	___ No. X 1	= _____
5. less than once a month	___ No. X 0	= _____
	Total	÷ _____

20. How often do you get together with the neighbour which you see most frequently?

30. everyday

04. at least once a week

03. a few times a month

01. about once a month

00. less than once a month or see no neighbours

21. Now take the friends that you're closest to - about how often do you get together with any of them?

1. everyday	___ No. X 30	= _____
2. once a week	___ No. X 4	= _____
3. a few times a month	___ No. X 3	= _____
4. about once a month	___ No. X 1	= _____
5. anything less than once a month	___ No. X 0	= _____
	Total	= _____

22. Now, about the people you see for specific purposes, like storekeepers, bus drivers, waiters,... About how many of these do you see fairly regularly in a week?

Number X 4 = _____

23. In the course of a day's work, about how many people do you see and talk to?

Number X 20 = _____

ASKED OF THOSE LIVING WITH OTHERS IN SAME HOUSEHOLD AND ALL WHO LIVE IN ANY FACILITY:

24. Do you have a room where you can be by yourself when you wish?

1. Yes

2. No

25. Do you have an adequate and/or convenient place (cupboard, cupboard section, drawers) for your own belongings?

    1. Yes, convenient in most or all ways
    2. Yes, convenient in some or few ways
    3. Yes, it is not convenient
    4. No

26. Do you have a secure place (locked drawer, box, access to safety box in building) where you can keep any articles?

    1. Yes
    2. No

ASKED OF ALL RESPONDENTS:

27. How satisfied are you with your present dwelling in terms of privacy?

    1. Satisfied
    2. Partly satisfied
    3. Not satisfied at all

28. How satisfied are you with your present dwelling in terms of location?

    1. Satisfied
    2. Partly satisfied
    3. Not satisfied at all

ASKED OF FACILITY DWELLING RESPONDENTS ALONE:

29. Do staff persons change or are they rotated throughout the residence on a regular basis?

    1. No, the same staff stays in one area continuously
    2. Yes, staff changes or is rotated occasionally
    3. Yes, staff changes or is rotated frequently

30. Are there any volunteer workers in this facility?

1. Yes, in most or all areas
2. Yes, in some areas
3. No
4. Don't know

ASKED OF ALL RESPONDENTS:

31. How long have you lived in this community?

1. All my life
2. 11 to 25 years
3. 6 to 10 years
4. 3 to 5 years
5. 0 to 2 years

32. How much need is there for the following services or opportunities?

a) Public Transportation (Bus)?

1. convenient and adequate, not needed
2. very little need
3. some need
4. considerable need
5. extreme need

b) Employment Opportunities?

1. convenient and adequate, not needed
2. very little need
3. some need
4. considerable need
5. extreme need

c) Senior Citizen Activities?

1. convenient and adequate, not needed
2. very little need
3. some need
4. considerable need
5. extreme need

ASKED OF THOSE LIVING IN FACILITIES:

33. Do you or any of the other residents have planned, friendly visitors?

1. Yes, most at least weekly
2. Yes, some weekly, most less than weekly
3. Yes, a few weekly, some less than weekly
4. Yes, a few less than weekly
5. No friendly visiting

34. As residents of a facility, are the following things made available by the facility for your use and/or entertainment?

	Yes, Adequate and Convenient	Yes, Inadequate and Inconvenient	No
a) Telephone			
b) T.V. Set(s)			
c) Radio(s)			
d) Record Player(s)			
e) Table Games			
f) Magazines			
g) Library or Reading Room(s)			
h) Lounge(s)			
i) Dining Room(s)			
j) Activity Room(s)			
k) Arts and Crafts Supplies			
l) Shop or Store			

35. How is participation in activities such as recreation, religious services, meals, rest periods, and visting, carried out?

1. Totally optional participation
2. Usually optional participation
3. Partially optional participation
4. Completely compulsory participation

ASKED OF THOSE LIVING WITH OTHERS IN SAME HOUSEHOLD AND ALL IN ANY FACILITY:

36.

a) Do you help regularly in your residence?

1. Yes
2. No

b) If yes, what do you do?

1. Wash dishes
2. Lay tables, serve
3. Clean own rooms
4. Make beds
5. Prepare or cook food
6. Garden
7. Assist with laundry
8. Entertain others
9. Tidy up general rooms
10. Mail and messages
11. Mop hallways
12. Other

ASKED OF ALL RESPONDENTS:

37. Do you belong to any church or religious organization? If so, do you go to church or any other place of worship as often as you wish? If not, what is your major reason for not going?

1. Yes, go as often as I wish
2. No, do not care much (or at all) about church

3. Yes, don't go as much as would like, it interferes with other schedules

4. No, do not go at all due to one or more of following reasons:

   a) no religious services available

   b) this facility has services only on religious holidays;

   c) difficulty in arranging and/or affording transportation

5. No, do not go at all due to one or more of the following reasons:

   a) there is no church in own language close to home

   b) no church of own religion close to home

   c) poor health

ASKED OF FACILITY RESPONDENTS ONLY:

38. Are any arrangements made for voting?

1. Yes, conveniently

2. Yes, not conveniently

3. No

ASKED OF ALL RESPONDENTS:

39. For your age, would you say, in general, your health is good, fair, or poor?

1. Excellent

2. Good for age

3. Fair for age

4. Poor for age

5. Bad for age

40. Now I have a list of health problems that people often have. I'll read them and you tell me if you have had any of them within the last year or otherwise still have after effects from having had them earlier.

	YES	NO
a) Heart and circulation problems		
b) Stroke		
c) Arthritis or rheumatism		
d) Palsy		
e) Eye trouble not relieved by glasses		
f) Ear trouble		
g) Dental problems		
h) Chest problems		
i) Stomach trouble		
j) Kidney trouble		
k) Diabetes		
l) Foot trouble		
m) Nerve trouble		
n) Skin problems		
o) Other (Specify_____)		

41. Life Satisfaction Index "A"

Here are some statements about life in general that people feel differently about. Would you read along with me each statement on the list and tell me if you agree with it, disagree with it or if you are not sure one way or the other. Please be sure to answer every question on the list.

	AGREE	DISAGREE	?
a. As I grow older, things seem better than I thought they would be.....	x		
b. I have gotten more of the breaks in life than most of the people I know	x		
c. This is the dreariest time of my life		x	
d. I am just as happy as when I was younger.....	x		
e. My life could be happier than it is now.....		x	
f. These are the best years of my life	x		
g. Most of the things I do are boring or monotonous.....		x	

	AGREE	DISAGREE	?
h. I expect some interesting and pleasant things to happen to me in the future.....	x		
i. The things I do are as interesting to me as they ever were....	x		
j. I feel old and somewhat tired...		x	
k. I feel my age but it does not bother me.....	x		
l. As I look back on my life, I am fairly well satisfied.....	x		
m. I would not change my past life even if I could.....	x		
n. Compared to other people my age, I've made a lot of foolish decisions in my life.....		x	
o. Compared to other people my age, I make a good appearance.....	x		
p. I have made plans for things I'll be doing a month or year from now	x		
q. When I think back over my life, I didn't get most of the important things I wanted.....		x	
r. Compared to other people I get down in the dumps too often.....		x	
s. I've gotten pretty much what I expected out of life.....	x		
t. In spite of what people say, the lot of the average man is getting worse, not better.....		x	

TOTAL LSIA SCORE....._____

(Code score of 17-20 as 1; 13-16 as 2; 9-12 as 3; 5-8 as 4; 0-4 as 5)

ASKED OF FACILITY DWELLING RESPONDENTS ALONE:

42. Does this facility have a residents council or a committee

of residents? If so, in which of the following areas is the council involved?

1. Involved in 5 or more of the areas listed
2. Involved in 4 of these areas
3. Involved in 2 or 3 of these areas
4. Involved in only one of these areas
5. No council, no committee of residents, or involved in none of the areas listed

(Areas of involvement: (a) movies, games, parties, special day celebrations, or other entertainment for residents; (b) attending theatre, sporting events, concerts, and other community events; (c) tourist trips or tours; (d) assisting with menu planning; (e) meal hours; (f) activity schedules; (g) operating shops; (h) gardening).

43. If facility does not have a residents council or a committee of residents, would you and other residents be interested in having one?

1. Yes
2. No

44. Do you and/or other residents attend day centres, clubs, societies outside the facility?

1. Yes, most of the residents
2. Yes, many residents
3. Yes, some residents
4. Yes, but few residents
5. None

ASKED OF ALL RESPONDENTS:

45. What was your major occupation most of your life?

1. fishing, trapping, prospecting, guiding
2. mining

3. forestry, logging

4. farming

5. housewife

6. unskilled or skilled labour, crafts

7. management, professional

8. clerical, sales and services

9. transportation, communication, recreation

46. Are you presently employed in the same occupation or another occupation?

1. Yes, in major occupation

2. Yes, in another occupation

3. No, fully retired

47. Now I would like to ask you a few questions about your income and expenses (and that of your spouse).

a) Monthly Income - From Own Resources (Private pensions, pension from private company, wages, salary, income from business, farm, professional practice, rents, interests from dividends, insurance annuities) $_____

b) Monthly Income - From Pensions or Allowances (Such as: Old age security, guaranteed income supplement, war veterans allowance/ pension, social allowance, public welfare agency, unemployment insurance, Canada pension plan, Old age assistance) $_____

c) Monthly Income - From Other Sources (Regular cash help from children, relatives or friends, church service groups, or private agency, etc.) $_____

TOTAL MONTHLY INCOME $_____

48. How do you thing your income and assets (including that of your spouse where applicable) currently satisfied your needs?

    1. Very well

    2. Adequately

    3. With some difficulty

    4. Not very well

    5. Totally inadequate

49. How do you thing your income and assets (including that of your spouse where applicable) will satisfy your needs in future?

    1. Very well

    2. Adequately

    3. With some difficulty

    4. Not very well

    5. Totally inadequate

APPENDIX D

FREQUENCY DISTRIBUTIONS - INDEPENDENT VARIABLES

(Note: only those not included in body of thesis)

TABLE 32

REGION OF RESIDENCE

	Total *	Facility **
Winnipeg	40%	48%
Non-Winnipeg	60	52
Totals	100	100

*N = 4344
**N = 911

TABLE 33

NATIONALITY

	Total *	Facility **
Canada or USA	12%	10%
British	44	50
French/German/ Scandinavian/ Dutch/Belgian	23	28
Polish/Russian/Ukrainian	18	10
Other	3	2
Totals	100	100

*N = 4338
**N = 910

TABLE 34

MARITAL STATUS

	Total**	Facility***
Single	9%	14%
Married*	55	26
Widowed	36	60
Totals	100	100

*includes divorced and separated
**N = 4341
***N = 911

TABLE 35

YEARS OF SCHOOLING

	Total*	Facility*
0 to 4 years	26%	23%
5 to 8 years	42	44
9 + years	33	32
Totals	100	100

*N = 4285
**N = 888

TABLE 36

CURRENT OCCUPATION

	Total*	Facility **
Employed	41%	21%
Retired	59	79
Totals	100	100

*N = 4314
**N = 903

TABLE 37

NUMBER OF HEALTH PROBLEMS

	Total*	Facility**
None	15%	8%
One	23	19
Two	22	23
Three +	40	51
Totals	100	100

*N = 4322
**N = 909

TABLE 38

FREQUENCY OF CONTACT WITH CLOSEST RELATIVES

	Total*	Facility**
1. (high)	5%	1%
2.	34	13
3.	36	33
4. (low)	26	53
Totals	100	100

*N = 4344
**N = 911

TABLE 39

FREQUENCY OF CONTACT WITH CLOSEST FRIENDS

	Total*	Facility*
1. (high)	24%	33%
2.	17	14
3.	30	18
4. (low)	29	35
Totals	100	100

*N = 4344
**N = 911

TABLE 40

FREQUENCY OF CONTACT WITH NEIGHBOURS

	Total*	Facility**
everyday	57%	81%
once a week	22	10
1 to 3 times per month	10	2
rarely or never	12	8
Totals	100	100

*N = 4344
**N = 911

TABLE 41

FREQUENCY OF CONTACT WITH PEOPLE SEEN FOR SPECIFIC PURPOSES

	Total*	Facility**
1. (high)	12%	15%
2.	19	18
3. (low)	70	68
Totals	100	100

*N = 4344
**N = 911

TABLE 42

FREQUENCY OF CONTACT WITH OTHERS SEEN IN THE COURSE OF WORK

	Total*	Facility**
1. (high)	3%	3%
2.	2	4
3.	8	7
4. (low)	87	86
Totals	100	100

*N = 4344
**N = 911

TABLE 43

PROXIMITY TO NEAREST RELATIVE

	Total*	Facility**
in household	52%	13%
in neighbourhood	31	55
further/no relatives	17	32
Totals	100	100

*N = 4323
**N = 904

TABLE 44

THE AVAILABILITY OF SOCIAL SUPPORTS

A. Children	Total*	Facility**
Yes	81%	76%
No	19	24
Totals	100	100

*N = 4335
**N = 910

B. Grandchildren	Total*	Facility**
Yes	76%	73%
No	24	27
Totals	100	100

*N = 4339
**N = 909

C. Brothers/Sisters	Total*	Facility**
Yes	81%	73%
No	19	27
Totals	100	100

*N = 4341
**N = 910

D. Other Relatives	Total*	Facility**
Yes	84%	80%
No	16	20
Totals	100	100

*N = 4326
**N = 906

TABLE 45

LENGTH OF RESIDENCE

	Total*	Facility**
Over 5 years	67%	22%
3 to 5 years	12	19
1 to 3 years	13	34
6 months to 1 year	5	16
less than 6 months	3	8
Totals	100	100

*N = 4339
**N = 908

TABLE 46

EXTENT OF AUTONOMY IN CHOOSING PLACE OF RESIDENCE

	Total*	Facility**
chosen by self and/or spouse	84%	58%
chosen by relative/friend/ neighbour	11	26
chosen by professional	4	16
Totals	100	100

*N = 4302
**N = 895

TABLE 47

PLACE FOR PERSONAL BELONGINGS (Facility Sample)

Yes	92%
No	8
Total	100

N = 902

TABLE 48

SECURE PLACE FOR PERSONAL POSSESSIONS (Facility Sample)

Yes	66%
No	34
Total	100

N = 908

TABLE 49

SATISFACTION WITH PRIVACY

	Total*	Facility**
Completely satisfied	95%	94%
Partially/Totally unsatisfied	5	6
Totals	100	100

*N = 4283
**N = 858

TABLE 50

SATISFACTION WITH LOCATION

	Total*	Facility**
Completely satisfied	95%	94%
Partially/Totally unsatisfied	5	6
Totals	100	100

*N = 4284
**N = 858

TABLE 51

STAFF CHANGES (Facility Sample)

Staff stays in one are continuously	58%
Staff rotated	42
Total	100

N = 456

TABLE 52

VOLUNTEER WORKERS (Facility Sample)

Yes	28%
No	43
Don't Know	29
Total	100

N = 465

TABLE 53

FRIENDLY VISITORS (Facility Sample)

Yes	44%
No	56
Total	100

N = 467

TABLE 54

ATTENDS CHURCH

	Total*	Facility**
Yes, as often as wishes	58%	51%
No, not as often as wishes or not at all	42	49
Totals	100	100

*N = 4306
**N = 900

TABLE 55

VOTING ARRANGEMENTS (Facility Sample)

Yes, Adequate	61%
Yes, inadequate or No	39
Total	100

N = 434

TABLE 56

RESIDENT COUNCIL REPRESENTATION (Facility Sample)

Have active council	48%
Have inactive council	24
Have no council	28
Total	100

N = 483

TABLE 57

ATTENDANCE AT DAY CENTRES AND CLUBS (Facility Sample)

Many residents attend	16%
Some residents attend	24
Few residents attend	15
No residents attend	45
Total	100

N = 456