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Preconceptions about institutionalisation at public nursing homes in Spain: views of residents and family members

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ABSTRACT
The aim of this article was to ascertain nursing home residents' preconceptions about institutionalisation and analyse the causes and circumstances of and the justification for their admission. Grounded theory was used to design and analyse a qualitative study based on in-depth interviews in a theoretical sampling of 20 persons aged over 65 years with no cognitive impairment, and eight proxy informants of residents with cognitive impairment, institutionalised at a public nursing home in Spain. Our analysis revealed that preconceptions about nursing homes differ between residents and relatives, and are strongly influenced by the views held by society about such centres and by previous experiences. Regarding the causes and circumstances underlying nursing home placement, while the principal cause of institutionalisation among residents with cognitive impairment was the ineffectiveness of informal care systems, in the case of residents without cognitive impairment reasons tended to revolve around two main themes: social causes (loneliness, not be a burden to the others, household-related, comfort and absence of relatives in the vicinity), and limitations in physical functioning, with the former predominating. This study shows society's perception of such centres and the circumstances surrounding admission. These points of view are useful for analysing why informal care systems prove inadequate, and are crucial for designing programmes targeted at acceptance and successful adaptation to institutionalisation when this becomes necessary.

KEY WORDS– nursing home care, qualitative research, placement issues, older people.

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Introduction

Institutionalisation is one of the most significant changes that an older adult can experience (Buhr, Kuchibhatla and Clipp 2006; Lee, Woo and Mackenzie 2002*a*). Admission to a nursing home tends to be an important source of stress and anxiety for residents and family members alike. New residents often perceive this process as a traumatic experience and a threat to their quality of life (Davies and Nolan 2004; Lee 1999; Lee, Woo and Mackenzie 2002*b*), *i.e.* not only are they changing a known environment for another that is alien to them, but their daily activities, lifestyles, social relationships, support systems (Lee, Woo and Mackenzie 2002*a*) and personal autonomy (de Veer and Kerkstra 2001) may also be affected. Furthermore, the ending of direct home care tends to give rise to ambivalent feelings among traditional informal care-givers (family members), in that their sensation of relief at being free of the burden of care co-exists with feelings of anxiety, sadness and guilt about their family members' failure to adapt to their new role in the residential setting (Davies and Nolan 2004; Ellis 2010; Kong, Deatrick and Evans 2010; Nolan and Dellasega 1999; Ryan and Scullion 2000).

Different types of feeling of loss after institutionalisation have been described, including abstract loss (role, lifestyle, freedom, self-esteem, autonomy and privacy) (Hauge and Kristin 2008; Lee, Woo and Mackenzie 2002*a*), material loss (home and personal belongings) and social loss (family members, friends and pets) (Lee, Woo and Mackenzie 2002*a*). Residents often manifest these emotions in the form of stress, anxiety, depression, sadness, anger, feelings of impotence, betrayal, neglect or abandonment by the family (Harrefors, Sävenstedt and Axelsson 2009; Hauge and Kristin 2008; Hodgson *et al.* 2004; Lee, Woo and Mackenzie 2002*a*). Moreover, these feelings are known to be exacerbated in cases where nursing-home placement is not appropriately planned (Lee, Woo and Mackenzie 2002*a*).

Post-admission concerns of new residents have also been analysed by a number of qualitative studies, which highlight the following: the public nature and ensuing absence of privacy of life in a residence; the lack of control; the changes in daily life brought about by institutional rules and regulations; and the presence of other residents with cognitive impairment or worse physical conditions (Hauge and Kristin 2008; Lee, Woo and Mackenzie 2002*a*).

Then again, institutionalisation may serve to allay fears of social isolation and insecurity, particularly among frail senior citizens (Ryan and Scullion 2000). In addition, it may serve to improve medical care, to foster new social networks (Ellis 2010), and to get free of domestic chores and/or family obligations (Lee 1999).

Insofar as preconceptions about nursing homes are concerned, the negative social perception of institutionalisation *versus* home care is well known (Rivera *et al.* 2009; Ryan and Scullion 2000), as is its traditional stigmatisation (Ellis 2010; Kong, Deatrick and Evans 2010; Ryan and Scullion 2000; Sergeant and Ekerdt 2008; Tse 2007), with placement in a nursing home being linked to the idea of personal, family or social failure (Lee, Woo and Mackenzie 2002*a*; Ryan and Scullion 2000), dependency and social isolation (Harrefors, Sävenstedt and Axelsson 2009; Sergeant and Ekerdt 2008). The news media may contribute to the spread of such views (Ellis 2010). Although community-dwelling older adults' perceptions of institutionalisation generally follow this negative trend (Harrefors, Sävenstedt and Axelsson 2009; Lee 1997; Sergeant and Ekerdt 2008; Tse 2007), there has been no concerted attempt to analyse the preconceptions of the residents themselves, in order to complete the image of these centres currently held by society, since most of the studies have been conducted in settings other than nursing homes or only offer partial explanations of the phenomenon under study, focusing only on some of the residents, mostly without cognitive impairment, or on particular aspects of the admission in nursing homes (Davies 2005).

In this respect, personal perceptions and expectations prior to admission may contribute to a successful adaptation to the residential setting (Lee, Woo and Mackenzie 2002*a*; Schulz *et al.* 2004) and, though personal experiences of life and socio-cultural values can directly influence conceptualisations about admission, few studies have conducted an in-depth analysis of institutionalisation taking these aspects into account (Lee, Woo and Mackenzie 2002*b*; Schulz *et al.* 2004; Tse 2007).

The success or failure of adaptation to new residential settings depends, in large measure, on the circumstances in which institutionalisation occurs, the degree of planning that goes into it and prior expectations (Lee, Woo and Mackenzie 2002*a*; Schulz *et al.* 2004). Knowledge of the causes and circumstances of institutionalisation, and of preconceptions of residents and family members about this process, are indispensable for designing action plans that will improve adaptation to institutionalisation, and will provide new insights about how the nursing-home placement is lived by the actors themselves. In this respect, there is a need for qualitative studies to examine the causes and justifications underlying institutionalisation and the decision to place someone at a given centre, as perceived by the residents themselves and by relatives of cognitively impaired persons (Murray and Laditka 2010; Ryan and Scullion 2000). As far as we know, these issues have never been studied using qualitative methodologies in the Mediterranean area, where it is known that family ties are very strong, and formal care systems are not very appreciated as a consequence of the predominant hierarchical

compensation model in the decisions of the kind of care system for the elderly people (Daatland and Herlofson 2003; Rogero-García 2009).

Accordingly, our study sought to use qualitative techniques to ascertain preconceptions about institutionalisation and analyse the underlying causes, circumstances and justification for nursing-home placement from the standpoint of residents and family members.

Methods

We used in-depth interviews and grounded theory dimensional analysis to collect and analyse the data (Caron and Bowers 2000: 285; Glaser and Strauss 1967; Strauss and Corbin 1998). This inductive method allows us to obtain a theoretical explanation by analysing participants' conceptualisations regarding institutionalisation. The research team included expert researchers in qualitative methodology, with different socio-health backgrounds (sociology, anthropology, nursing and public health) and different theoretical standpoints.

Sample and data collection

In-depth interviews were conducted using a purposeful sample of 20 persons living at a public nursing home in Talavera de la Reina (Spain), aged 65 years and over, with no cognitive impairment; eight relatives of residents with cognitive impairment were also interviewed. Spain has 5,293 nursing homes, classified by type of funding as public, private or mixed public–private, *i.e.* where some beds are financed with public funds (Costa-Font and Garcia González 2007). Currently, 26.6 per cent of the nursing homes are public funding facilities. This kind of facility provides supervision or assistance with activities of daily living, services of junior nursing staff, nurses, doctor, occupational therapist, speech therapist, social worker and recreational assistance. The study sample comes from a nursing home with 180 places for assisted and unassisted older people. The residents pay 75 per cent of their net income for their accommodation, and the allocation of staff and equipment is regulated by current Spanish legislation. In Spain, these types of institutions are generally standardised in terms of amenities and staff (Costa-Font and García González 2007; Damián *et al.* 2004).

We used theoretical sampling to ensure the inclusion of informants of both sexes, and different age groups and socio-demographic characteristics, in an effort to record a wide spectrum of residents' opinions (Tables 1 and 2). Two nurses from the nursing home, acting as key informants,

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TABLE 1. *Socio-demographic characteristics of the sample: residents without cognitive impairment*

Variables	Women	Men
Age:		
65–75	2	3
76–85	3	3
86–95	6	3
Marital status:		
Married	1	1
Single	1	3
Widowed	9	4
Separated	0	1
Educational level:		
Unable to read and write	3	0
Able to read and write	6	6
Primary education completed	2	3
Previous institutionalisation:		
Yes	2	2
No	9	7
Date of admission:		
1–5 years ago	5	5
6–10 years ago	4	3
Over 10 years ago	2	1

Note: N = 20.

selected the participants. Both of them had been involved in the study, and had been fully informed of the study's goals and the importance of recording all the profiles of opinion in the theoretical sample. Sampling continued until saturation of information had been reached, the point at which enlarging a sample ceases to furnish new analytical concepts (Strauss and Corbin 1998).

Inclusion criteria of informants were persons aged 65 years and over, living in the nursing home at least for the last three months, the minimal estimated time to know about the facilities, services and staff. Residents admitted on a temporary-stay basis were not considered eligible because they may have different needs and characteristics (Castle and Ferguson 2010). In the case of residents whose degree of cognitive impairment prevented them from directly participating in an interview (score higher than 2 on Pfeiffer's Short Portable Mental Status Questionnaire; Pfeiffer 1975), the closest family member to the resident (proxy) was interviewed instead. Since such relatives were well acquainted with the personal history of the resident's life, his/her habits and preferences, they were deemed more appropriate than professional care-givers in terms of understanding the resident's views on institutionalisation.

TABLE 2. *Socio-demographic characteristics of the sample: residents with cognitive impairment*

Variables	Women	Men
Resident's age:		
65–75	1	1
76–85	1	1
86–95	2	2
Age of interviewee's relative:		
45–55	2	1
56–65	2	1
Over 65	0	2
Interviewee's relationship with the resident:		
Daughter/son	3	2
Spouse	1	2
Resident's marital status:		
Married	0	2
Widowed	4	2
Resident's educational level:		
Unable to read and write	0	0
Able to read and write	4	4
Primary education completed	0	0
Previous institutionalisation:		
Yes	2	4
No	2	0
Date of admission:		
1–5 years ago	1	3
6–10 years ago	2	1
Over 10 years ago	1	0

Note: N=8.

TABLE 3. *Interview topics list*

- Conceptualisations and preconceptions about nursing homes prior to admission, in terms of staff, facilities and services.
- Expectations about institutionalisation prior to admission.
- Personal circumstances at the time of admission, *i.e.* social, health and financial status.
- Causes of and personal justification for admission.
- Personal experience of institutionalisation.

Interviews were held by appointment, and after the interviewees had given their consent to a sound recording being made for subsequent analysis and had been given a guarantee of confidentiality in the processing of their data. The interviews were conducted in the residence in a peaceful and quiet place at each interview, the interviewer (BRM) had a list of topics that had to be openly introduced (Table 3), if and when they arose during the interview. Interviews were conducted in the period 2009–10 and lasted 50–120

minutes. All interviews were recorded using a digital recorder, rendered anonymous and literally transcribed.

Ethical considerations

The study was approved by the Clinical Research Ethics Committee of Nuestra Señora del Prado Hospital, in Talavera de la Reina, Spain, and by the management of the nursing home where the study was undertaken. All participants were asked to give their informed consent after a full explanation adapted to the research project. In the case of residents with cognitive deterioration, the consent of the proxy or, where applicable, the legal guardian, was obtained.

Data analysis

After transcribing the in-depth interviews, the texts were collated and sorted. Using grounded theory methods, three qualitative methodology research experts drawn from different disciplines analysed the transcriptions, with the aim of ascertaining participants' perception of institutionalisation and their conceptualisations around the causes, circumstances and justification of admission in a nursing home and obtaining a theoretical explanation for this issue (Bowers, Fibich and Jacobson 2001).

Data collection, analysis and interpretation were simultaneously undertaken in an interactive process, so the results of the first data analysis informed subsequent data collections, thereby enabling key topics to be studied in depth (Strauss and Corbin 1998). This implied constantly going back and forth among the interview transcriptions, analytical memoranda (theoretical ideas about the codes and their relationships) and a review of the literature (Silverman 2001).

Coding is one of the key and specific aspects of analysis in the grounded theory methodology, and is also the way to determine the quality of emerging theory (Strauss and Corbin 1998). According to grounded theory principles, our analysis identified specific concepts and meanings of institutionalisation for the informants. These concepts were labelled and classified into categories using open, axial and selective coding processes. Firstly, each of the three persons in the analysis team (BRM, BCM and MMA), in an independent way, in an open coding process, labelled the emergent concepts from the interviews, and sorted them into categories. Once this individual coding had been completed, the process was then repeated on a joint basis and the previously identified categories were reorganised. The analysis team shared their research notes and hypotheses, helping the consensus process about categories and hypotheses, and improving the comprehension of the texts. Finally, an axial and selective

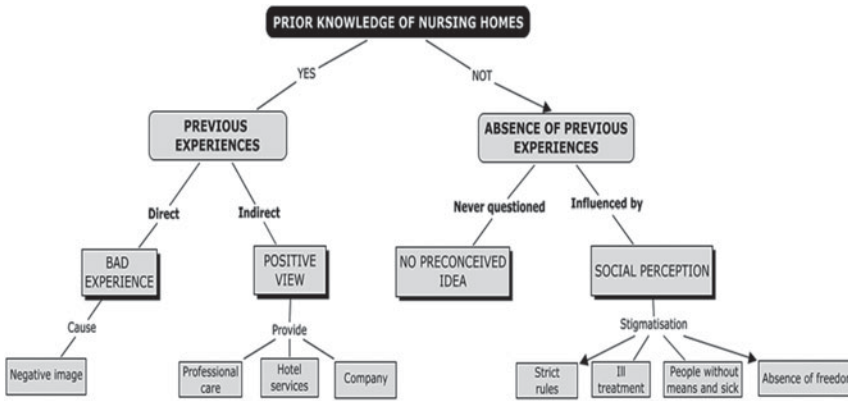

Figure 1. Coding diagram 1.

coding process was performed jointly. Whereas open coding fractured the data, axial coding connected them into categories and sub-categories in a hierarchical order, and finally selective coding integrated the categories to build a substantive theory. This theory described the relationship among a set of categories that emerged from the data through the constant comparative method.

We used the Atlas-Ti 5.0 software program as a technical aid in the coding stage, enabling large amounts of text to be coded and the data to be shared among the research team. Figures 1 and 2 depict the coding diagrams. Finally, after the analysis, the results report and the quotations were translated into English.

Validity and reliability/rigour

The validity and reliability of the conclusions of the analysis were ensured by the following methods: literal transcription of all interviews, analysis of the data in the context of the whole interview in which they had surfaced, and triangulation methods. Data were triangulated by conducting in-depth interviews with residents and proxies of different ages, sex and socio-demographic characteristics. To complete the triangulation process, data analysis was performed using multiple researcher perspectives.

Results

The emergent theoretical categories that explained participants' preconceptions are described in Figures 1 and 2, forming the basics of substantive theory.

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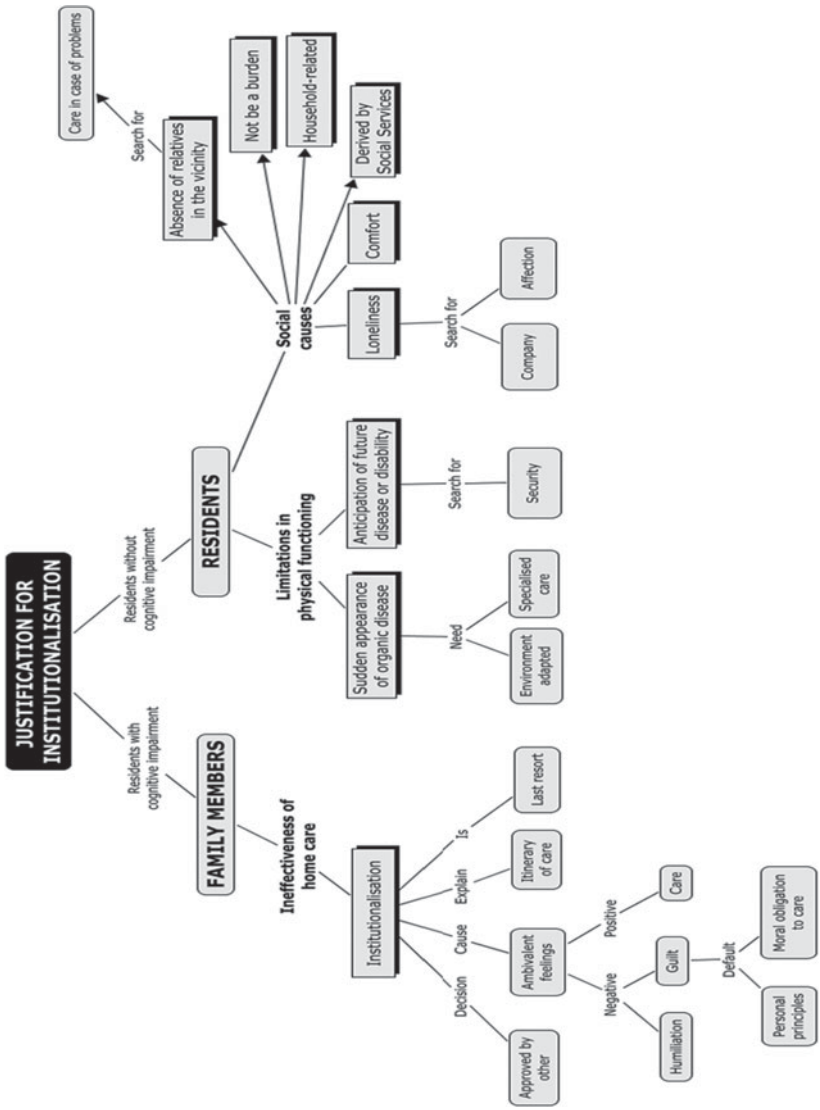

Figure 2. Coding diagram 2.

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Preconceptions about nursing homes

Analysis of the data showed that conceptualisations of nursing homes fell into three main categories, according to the respective participants' degree of prior knowledge of such centres.

Absence of previous experiences. Over half the participants had never been in a nursing home prior to institutionalisation. We found cases, such as those of residents from isolated rural areas, in which the person concerned had no preconceived idea of such centres:

I'd never had any real idea of what they were. I had always lived in the country and didn't know what nursing homes were like. (P. 12)

Before being in one, I had no idea of what they were like because I'd never seen one before. (P. 26)

It was more usual for participants to have some mental image of centres devoted to the care of senior citizens. Analysis of their statements showed that participants' different approaches could have been influenced by the socially predominant stereotypes about nursing homes, but also by the news media, with subjects forming a positive or negative impression of institutionalisation according to the image promoted by their respective source of knowledge.

Some participants perceived nursing homes as places where people had to submit themselves to rules and timetables, with order and control being the prevailing element. Male residents were observed to liken institutionalisation to army life experienced during their period of compulsory military conscription:

I thought that being in a nursing home was like being called up [military service]. You were all under someone's command, there were timetables, and you had to do as you were told. (P. 18)

Other participants reported negative impressions of institutionalisation linked to traditional social stigmatisation of such centres in Spain, where institutionalisation is usually identified with neglect of duty of care, and with old charity institutions for care of elder people without means. Likewise, the participants' impressions about nursing homes emphasise the image of ill treatment, strict rules, reprimands and absence of freedom, being considered the last resource for caring.

I imagined it was a place where they didn't treat you well. I thought that if I messed myself, they'd hit me. (P. 27)

I reckoned you'd have a series of timetables, only stricter and more severe. (P. 24)

I thought you couldn't get out, like jail . . . I figured that if anything was left over [food], you'd get a telling off. (P. 10)

I imagined that it was some kind of charity to care for the needy. (P. 9)

Previous indirect experiences in current centre. Future residents usually had indirect knowledge of nursing homes, with the positive experiences of family members and friends having a marked influence.

I already knew what they were like because one of my sisters was here. I felt pleased about coming here, considering how well they treated you. (P. 25)

I had some idea because of the things I'd heard about it, people said it was a very good nursing home. (P. 7)

Previous direct experiences in another centre. One group of participants (four residents and five family members) had previous experience of institutionalisation, in all cases at privately financed nursing homes. This is quite common in Spain, in view of the difficulty of obtaining a permanent place at a publicly funded centre.

The family members laid stress on their initial negative image of nursing homes, the result of prior bad experiences at private institutions, which led them to perceive these centres as places that were depressing or unsuitable for living.

My first experience at a [private] nursing home was very hard; I used to cry every day when I left. I regarded nursing homes as pretty depressing. (P. 2 Proxy)

We already came from another two private centres, and the experience at those places was that there was no way you could possibly stay there. This place [present nursing home] is like night and day. (P. 3 Proxy)

Justification for institutionalisation

Residents with cognitive impairment. The main cause of institutionalisation, as cited by family members of residents with cognitive impairment, was the impossibility of coping with the state of their loved ones on the basis of home care alone. It is noteworthy that institutionalisation was always seen as the last resort, and emerged after initial family resistance and after home care had been shown to be ineffective:

I always swore that my parents would never go to a residence because they were depressing places, but in the end there was no alternative because at home we had one home helper in the morning, another in the afternoon, there was us at night, and yet we still couldn't manage to see to all their needs. (P. 2 Proxy)

Following this line of inquiry, we found that some family members had come to realise that their loved ones were not happy with the persons who had been engaged to provide home care for as long as possible during the day:

They were cared for by a girl, and they weren't happy with her, and so that led to their going to the nursing home. (P. 17 Proxy)

All family members coincided in accompanying their account of the causes of their loved one being placed in a nursing home with a detailed explanation of the entire course of care prior to institutionalisation:

For six months, she was looked after at home by two girls, night and day, but she didn't want to be with the girls. So then we took her home with us, and at home there was no way of dealing with her, it was impossible. (P. 3 Proxy)

The decision to institutionalise a loved one became a source of negative feelings for family care-givers. In some cases they felt that they had fallen short of their principles or their moral obligation to care for their parents:

We were a bit against nursing homes because we conceived of the residence as a place where you are going to wait for death when your children don't want to hear anything from you. (P. 11 Proxy)

It's very important to me to keep an eye on my mother. With everything she's done for me, I feel the least I can do is to be attentive to her. (P. 17 Proxy)

In some cases, family members perceived institutionalisation as a humiliation, in that their role as care-givers might be questioned. This conceptualisation appeared mostly among the wives of residents with cognitive impairment, who were especially reluctant to consider the institutionalisation of their spouses, and in the end only accepted it at the urging of physicians and the remaining family members:

I feel bad about having my husband where he is [nursing home] but the fact is that the doctors told me that he was in no state to be kept at home . . . and my brother- and sister-in-law also agreed that he should be moved there. (P. 6 Proxy)

Moreover, we found that in their account of events all family members endeavoured to make it clear that, despite the institutionalisation of their loved ones, they had neither forgotten nor ceased to be concerned about them. Hence, family members stressed that one of the reasons for choosing one centre over another was its proximity to the family unit, so as to allow them to continue participating in some way in the care of the resident:

It's not as though I've shoved my mother out of the way so that someone else looks after her for me and I've washed my hands of her; in our case it isn't like that because I come here every day. It's very important that you can keep an eye on her, and not say, I've put her into a nursing home and can forget I have a mother. . .; this way, they have the feeling that they're being cared for and haven't been abandoned by their children and family. (P. 17 Proxy)

Although it was the family members in most cases who were responsible for the final decision to institutionalise their relatives, there were some instances in which it was the older persons themselves, at a time when their cognitive status was already not optimal, who decided to go to the nursing home with

the intention of alleviating their loneliness or trying not to be a burden to their children:

All of a sudden, one day I said to myself, 'I'm going to go to a nursing home'. I always thought that my father didn't want to be a problem to me, because my husband and I looked after our in-laws and saw what happened to them. (P. 28 Proxy)

We didn't bring my mother here; it was her choice because she was by herself at home and was seeking company. (P. 15 Proxy)

Residents without cognitive impairment. The causes of institutionalisation cited by residents centred around two main themes, namely social causes and limitations in physical functioning. In the explanations given by residents, the social outweighed the physical reasons.

Social causes. The principal cause of institutionalisation perceived by participants of both sexes was loneliness. In most cases, this feeling appeared among older persons who were single, widows or had children who did not live nearby. In their search for company and affection, residents preferred institutionalisation to living alone at home but stated that, if they had enjoyed family support at home, they would have remained there.

Participants in the 86–95 age group displayed more marked feelings of loneliness. Some had already experienced the death of friends, neighbours and spouses, and some had even survived their own children.

I wanted to be with people. It's better being in a nursing home than being on your own at home. (P. 26)

I had a daughter but she died ten years after my husband passed on. I have another child but he's away. My two next-door neighbours, one upstairs and the other downstairs, died. Every evening I would lock myself in until the next day, and that was just awful; I felt like a prisoner in my own home. I was desperate for company. (P. 5)

Akin to the feelings of loneliness, the second social cause of institutionalisation conceptualised by residents was the absence of direct family members in the vicinity who could take care of them if they were in difficulty. In some cases residents had no direct family members; in other cases they did, but these relatives were away or unable to look after them due to work or family commitments.

My children work far away and if I stayed at home and took a turn for the worse, who was going to take care of me? (P. 25)

I had no family, I had nobody, just brothers and sisters, and they had their own lives to lead. (P. 19)

In other cases, residents did enjoy good family support but disclosed that they had chosen to go to a nursing home to avoid being a burden when their

functional or cognitive state began to deteriorate. Many of the residents had gone through the experience in their own homes of older persons being cared for and wanted to relieve their children of the obligations flowing from caring for them. To avoid arguments, they often tended to try to conceal the arrangements from their direct family members, informing them only when it was already a *fait accompli*.

I came because I was living with my sisters, who are already getting on, and I didn't want to give them work. I preferred to come to a nursing home rather than being there and bothering them. (P. 9)

I'd had my mother-in-law, my father and three more elderly people staying in my own home. As I'd gone through that myself, I didn't want to be a weight on my children and that's why I came here. (P. 5)

I did all the paperwork without my children knowing a thing . . . when the kids found out they said to me, 'But how come you're doing this?', and I told them, 'so that, if I should ever lose my eyesight or need something, I'll be well cared for there'. (P. 25)

In some cases, residents tried other types of accommodation prior to institutionalisation, such as the system of rotation of care by family members, but they finally chose to go to a nursing home on the grounds of greater personal and family comfort. Furthermore, in the case of male residents aged 86–96 years, institutionalisation emerged as a way of freeing themselves of tedious domestic chores which they were not used to doing when they lived with their spouses:

I didn't want to be at home alone. At night, I used to stay over at my son's house one day, at my daughter's the next, and so on. Then they tried to put me on a monthly schedule. What matters to me is my comfort and that of my children, so I took myself off to the nursing home. (P. 13)

A person all alone at home doesn't do a thing, and even less if he's a man. The answer is to be here [nursing home] and be waited on hand and foot. (P. 7)

Two of the participants were referred to a nursing home by the Social Services Department, due to not being able to afford any other type of accommodation:

I came to the nursing home for shelter. (P. 4)

I'm separated. I was looking for a place to stay because I didn't have anything. (P. 24)

Another two social causes that emerged from residents' accounts, albeit with less specific weight in terms of number of appearances, were household-related reasons and recommendations of family members and acquaintances.

I saw the expenses of running a home, the fact that we weren't making it to the end of the month, and then what would we live on? (P. 18)

I knew people in the town who spoke well of the nursing home and they painted such a bright picture that I came here. (P. 5)

Limitations in physical functioning. The second subject block encompassing the residents' underlying reasons for institutionalisation was made up of limitations in physical functioning caused by diseases or organic impairment.

The main physical cause of institutionalisation was the sudden appearance of an organic disease, for the most part stroke, broken hips and sensory deficits. This new disease accompanied by a failure to adapt to their domestic environment and/or need to receive specialised care, triggered institutionalisation:

I was ill [stroke]. I couldn't move my left arm or my legs. I had a house with a lot of stairs. What I was looking for in a nursing home was a place where they'd look after me. (P. 27)

I came down with 'paralys', I was in hospital and they chucked me out [discharged me] and I couldn't stay on my own. (P. 20)

We couldn't stay in our house in the village any longer because my wife went blind. The house had some very steep steps leading down to the street. (P. 10)

Another cause of institutionalisation mentioned by residents involved anticipation of possible physical deterioration, future disease or disability. In such cases, institutionalisation was associated with the idea of security and peace of mind. Faced with the prospect of loneliness and a lack of household resources, nursing homes were perceived by residents as places in which they would have the possibility of receiving physical and specialised health care when they needed it. In addition, having a roommate on whom they could call if they had a problem increased their feelings of security.

I'd rather be in a nursing home because at our age there's no telling what may happen to us. (P. 23)

If you have a bad turn during the night, here you have someone who can care for you. (P. 7)

Having a roommate, both of us are safer. If she feels bad, I'll call the nurse; and if I feel bad, she'll call her. (P. 5)

Discussion

The following theories emerge from the findings of this study. First, positive or negative views of institutionalisation of participants depend on whether they have previous personal experiences. Thus, positive previous experiences make the acceptance of institutionalisation easy, whereas previous

stressful experiences condition a negative view of this transition process. Besides, this fact is highly influenced by predominant cultural stereotypes about care systems for older people.

Secondly, residents without cognitive impairment interiorise nursing homes as good quality resources to be considered when social motivations appear (loneliness, not be a burden to others, household-related, comfort, absence of relatives in the vicinity). Conversely, family members of cognitively impaired residents are still influenced by the hierarchical compensation model; they consider placement in a nursing home as the only remaining option in terms of care, and show feelings of guilt when their care-giver's role is questioned, since they consider the institutionalisation as a failing in their duty of care. Thus, being a resident of a nursing home, or conversely, being a family member of the resident, is a more important determinant of the preconception about institutionalisation than whether the cognitive impairment is or not the reason that justifies the admission in the nursing home.

To our knowledge, our study is the only one to have examined these conceptualisations by means of in-depth interviews conducted at a nursing home in a Mediterranean cultural setting. In addition, simultaneous analysis of the perceptions of residents without cognitive impairment and of proxy informants of residents with cognitive impairment has enabled us to give an overall picture of these conceptualisations, something that, as far as we are aware, no previous study has done.

Prior to admission, there was a prevailingly negative view of institutionalisation, despite the fact that most participants had no direct experience of this. We observed that, before institutionalisation, residents assumed that nursing homes were characterised by strict rules, loss of control over daily life, lack of privacy and identity (Lee, Woo and Mackenzie 2002*a*), reprimands, abuse and ill treatment, and that they were depressing places where sickly old people lived or where there was an absence of freedom (Lee, Woo and Mackenzie 2002*a*). This might be due to the above-mentioned influence of the news media and the spread of stereotypes (Harrefors, Sävenstedt and Axelsson 2009; Lee 1997; Sergeant and Ekerdt 2008; Tse 2007). As in other studies, our participants had a stigmatised view of the quality of nursing home *versus* home care, with the former being a symbol of personal, family or social failure (Kong, Deatrick and Evans 2010; Lee, Woo and Mackenzie 2002*a*; Rivera *et al.* 2009; Ryan and Scullion 2000; Schulz *et al.* 2004; Sergeant and Ekerdt 2008).

Some studies have sought to explain the negative view of institutionalisation by reference to circumstances of personal crisis that tend to precede admission (Lee, Woo and Mackenzie 2002*a*; Reed and Roskell Payton 1997). Although we agree that this social view can partly be explained by the

association between institutionalisation and negative events occurring in the latter stages of life, our results nonetheless show that certain residents opt for institutionalisation when their physical and cognitive state is optimal, so that social and physical loss would not wholly account for this phenomenon. Unlike earlier studies (Keefe and Fancey 2000; Lee, Woo and Mackenzie 2002*a*; Reed and Roskell Payton 1997; Ryan and Scullion 2000; Sergeant and Ekerdt 2008), ours observed that residents in such cases did not resign themselves to or stoically accept institutionalisation as an inevitable adjunct of ageing: instead, they freely made the choice, whether to release their family unit of a future burden of care (Keefe and Fancey 2000; Sergeant and Ekerdt 2008) or for reasons of personal comfort, finding it more advantageous at a financial, social or health level. In this same vein, our study also reports the view specifically held by a group of single or widowed male residents over age 85 years, who regarded institutionalisation as the best option to free themselves of tedious domestic chores. These findings, which have already been reported in women (Lee, Woo and Mackenzie 2002*a*), lead us to suggest that there is a need for social resources aimed at preventing institutionalisation in such cases.

We also found evidence of a prior positive image among those participants who, thanks to the experiences of family members, friends or acquaintances, had already been informed about nursing homes and stressed values such as company, support and affection (Ryan and Scullion 2000; Tse 2007), and a perceived feeling of peace of mind and security owing to the availability of specialised care or purpose-adapted facilities where required (Ellis 2010; Tse 2007). These findings are in line with studies which show the influence exerted by a positive role model on the experience of others (Sergeant and Ekerdt 2008), and are in contrast to the predominantly negative view found on analysing the influence of indirect experiences on community-dwelling older adults who have never considered admission to a home (Lee 1997).

In other cases, such as that of family members of residents with cognitive impairment, institutionalisation gives rise to an eruption of ambivalent feelings, ranging from guilt, humiliation and failure to relief, security and peace of mind (Buhr, Kuchibhatla and Clipp 2006; Davies and Nolan 2004; Ellis 2010; Nolan and Dellasega 1999; Ryan and Scullion 2000; Schulz *et al.* 2004). The internalisation of nursing-home placement as the last resort, as seen from the sentiments expressed by family members (Nolan and Dellasega 1999; Rivera *et al.* 2009; Ryan and Scullion 2000; Schulz *et al.* 2004; Tse 2007), and the concealment of institutionalisation from the older person until it is a *fait accompli* (Nolan and Dellasega 1999), show that prior personal and cultural expectations can influence acceptance of admission to a nursing home (Ellis 2010; Lee 1997; Schulz *et al.* 2004).

While resistance to institutionalisation has been recorded in cultures with strong traditional family values, such as those of China, Japan, Hong Kong and certain Central European countries (Kong, Deatrick and Evans 2010; Lee, Woo and Mackenzie 2002*b*), until now it has never been studied in countries in the Mediterranean and Latin cultural sphere, in which nursing homes are commonly viewed in a negative light (Daatland and Herlofson 2003; Lundh, Sandberg and Nolan 2000). Interviewees' family members – the majority of whom were aged over 50 years – and the women in particular, tended to regard the filial and familial duty to take care of older adults as an item of faith (family solidarity, associated both with reciprocal feelings of care and with the gratification felt by some care-givers), and were strongly in favour of family-based rather than formal care systems (Rivera *et al.* 2009; Ryan and Scullion 2000). Furthermore, as reported by other studies (Davies and Nolan 2004; Ellis 2010), feelings of guilt were more marked among the wives of cognitively impaired residents, who had previously entered into a joint commitment with their spouses to resist institutionalisation. This feeling of guilt among family members of residents with cognitive impairment might be linked to the considerable physical and emotional involvement which the care of such persons demands of family members (Schulz *et al.* 2004).

One peculiarity of Spanish seniors, which could reinforce their negative perception of nursing homes, is the persistence among them of the stigma that attaches to these centres as places devoted to the care of persons with no family and/or financial resources, and that stems from the timeworn tradition of asylums administered by religious orders which survived on charity (Rivera *et al.* 2009).

We feel that simultaneous analysis from the standpoint of residents and family members, respectively, is a key element in this study, since examining the phenomenon as a whole enabled us to establish the predominant role of the family in decisions about nursing-home placement (Sergeant and Ekerdt 2008) and detect divergences between the narratives of the two sets of participants. We observed that, unlike residents, no family member perceived institutionalisation as just another resource, free of negative connotations, a finding that is not in line with the modern model which recent European studies have begun to note (Rivera *et al.* 2009) and which is already in evidence in countries such as the United Stated of America, where care is more consumer-oriented (Nolan and Dellasega 1999). Moreover, we found a tendency among family members to justify admission socially, in an attempt to sever the culturally assumed association between institutionalisation, on the one hand, and abandonment or lack of family involvement, on the other (Keefe and Fancey 2000; Tornatore and Grant 2002). The age of interviewees, their degree of relationship with the resident, the presence of

diseases with strong emotional involvement and the socio-cultural values in which subjects had been immersed as part of the process of acculturation were found to exert a great influence on these differences.

Limitations

The use of qualitative methodology can be both a limitation and a strength. This approach serves to gain a deeper understanding of participants' opinions about the phenomenon under study and identify new ways of improving care (Murray and Laditka 2010). We believe that institutionalisation is a unique experience and that the best way to get a whole understanding is via the standpoint of the protagonists.

Because our study did not consider previous studies covering these topics in the Mediterranean area, in our opinion, our coding process was not influenced by previous analysis. On the other hand, constant comparative methods, a critical aspect of grounded theory, let us maintain theoretical sensitivity in every step of the research process. This enables researchers to generate theory grounded in the research data and not from their preconceived ideas or existing theories, through strategies of comparing and asking questions in order to clarify concepts and test hypotheses derived from the data while producing precise descriptions (Glaser and Strauss 1967). In order to increase the reliability of the study and avoid personal influences of the researchers in the coding process, data were triangulated by three researchers of different disciplines.

To ensure accurate interpretation and prevent participants' words being taken out of context, we took the precaution of analysing statements within the broader context of the interview as a whole.

The size of our sample, the result of theoretical sampling, albeit insufficient to ensure external validity in terms of other empirical research models, was nevertheless sufficient to provide great analytical richness, by including participants of widely different socio-demographic backgrounds. Furthermore, it is important to bear in mind that the data were collected at a publicly owned, mixed nursing-and-rest home in an urban setting, and that our results may not be valid for other types of nursing homes, particularly those where the end-user has to pay for the entire range of services on offer and thus feels entitled to other rights as a client.

Conclusions

While our study findings show that, in terms of causes of institutionalisation, psycho-social aspects play a greater role than do limitations in physical

functioning, it is the latter that nevertheless tend to receive more attention and resources in social policies directed at older persons.

Our results are important because they make for a better understanding of the causes and circumstances which, according to participants, lead to institutionalisation, something that will be useful when it comes to establishing why other health-care systems prove inadequate, and by extension, may also help design social elderly care and support policies aimed at delaying institutionalisation.

In addition, analysis of preconceptions about nursing homes makes it possible to identify key aspects that should be targeted by programmes aimed at integrating institutionalisation within the existing armoury of elderly care facilities. Similarly, analysis of these preconceptions will allow interventions to be designed to mitigate negative feelings during the admission process and ensure successful adaptation to institutionalisation.

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References

Bowers, B. J., Fibich, B. and Jacobson, N. 2001. Care-as-service, care-as-relating, care-as-comfort: understanding nursing home residents' definitions of quality. *The Gerontologist*, **41**, 4, 439–45.

Buhr, G. T., Kuchibhatla, M. and Clipp, E. C. 2006. Caregivers' reasons for nursing homes placement: clues for improving discussions with families prior to the transition. *The Gerontologist*, **46**, 1, 52–61.

Caron, C. and Bowers, B. 2000. Methods and application of dimensional analysis: a contribution to concept and knowledge development in nursing. In Rodgers, B. and Knafl, K. (eds), *Concept Development in Nursing: Foundations, Techniques, and Applications*. Saunders, Philadelphia, 285–20.

Castle, N. and Ferguson, J. C. 2010. What is nursing home quality and how is it measured? *The Gerontologist*, **50**, 4, 426–42.

Costa-Font, J. and García González, A. 2007. Long-term care reform in Spain. *Eurohealth*, **13**, 1, 20–2.

Daatland, S. O. and Herlofson, K. 2003. 'Lost solidarity' or 'changed solidarity': a comparative European view of normative family solidarity. *Ageing & Society*, **23**, 5, 537–60.

Damián, J., Valderrama-Gama, E., Rodríguez-Artalejo, F. and Martín-Moreno, J. M. 2004. Health and functional status among elderly individuals living in nursing homes in Madrid. *Gaceta Sanitaria*, **18**, 4, 268–74.
Davies, S. 2005. Meleis's theory of nursing transitions and relatives' experiences of nursing homes entry. *Journal of Advanced Nursing*, **52**, 6, 658–71.
Davies, S. and Nolan, M. 2004. 'Making the move': relatives' experiences of the transition to a care home. *Health and Social Care in the Community*, **12**, 6, 517–26.
de Veer, A. J. E. and Kerkstra, A. 2001. Feeling at home in nursing homes. *Journal of Advanced Nursing*, **35**, 3, 427–34.
Ellis, J. M. 2010. Psychological transition into a residential care facility: older people's experiences. *Journal of Advanced Nursing*, **66**, 5, 1159–68.
Glaser, B. and Strauss, A. 1967. *The Discovery of Grounded Theory*. Aldine, Chicago.
Harrefors, C., Sävenstedt, S. and Axelsson, K. 2009. Elderly people's perceptions of how they want to be cared for: an interview study with healthy elderly couples in Northern Sweden. *Scandinavian Journal of Caring Sciences*, **23**, 2, 353–60.
Hauge, S. and Kristin, H. 2008. The nursing home as a home: a field study of residents' daily life in the common living rooms. *Journal of Clinical Nursing*, **17**, 4, 460–7.
Hodgson, N., Freedman, V., Granger, D. and Erno, A. 2004. Biobehavioral correlates of relocation in the frail elderly: salivary cortisol, affect, and cognitive function. *Journal of the American Geriatrics Society*, **52**, 11, 1856–62.
Keefe, J. and Fancey, P. 2000. The care continues: responsibility for elderly relatives before and after admission to a long term care facility. *Family Relations*, **49**, 3, 235–44.
Kong, E.-H., Deatrick, J. A. and Evans, L. K. 2010. The experience of Korean immigrant caregivers of non-English-speaking older relatives with dementia in American nursing homes. *Qualitative Health Research*, **20**, 3, 319–29.
Lee, D. T. F. 1997. Residential care placement: perceptions among elderly Chinese people in Hong Kong. *Journal of Advanced Nursing*, **26**, 3, 602–7.
Lee, D. T. F. 1999. Transition to residential care: experiences of elderly Chinese people in Hong Kong. *Journal of Advanced Nursing*, **30**, 5, 1118–26.
Lee, D. T. F., Woo, J. and Mackenzie, A. E. 2002*a*. A review of older people's experiences with residential care placement. *Journal of Advanced Nursing*, **37**, 1, 19–27.
Lee, D. T. F., Woo, J. and Mackenzie, A. E. 2002*b*. The cultural context of adjusting to nursing home life: Chinese elders' perspectives. *The Gerontologist*, **42**, 5, 667–75.
Lundh, U., Sandberg, J. and Nolan, M. 2000. 'I don't have any other choice': spouses' experiences of placing a partner in a care home for older people in Sweden. *Issues and Innovations in Nursing Practice*, **32**, 5, 1178–86.
Murray, L. M. and Laditka, S. B. 2010. Care transitions by older adults from nursing homes to hospitals: implications for long-term care practice, geriatrics education and research. *Journal of the American Medical Directors Association*, **10**, 4, 231–8.
Nolan, M. and Dellasega, C. 1999. 'It's not the same as him being at home': creating caring partnerships following nursing home placement. *Journal of Clinical Nursing*, **8**, 6, 723–30.
Pfeiffer, E. 1975. A short portable mental status questionnaire for the assessment of organic brain deficit in elderly patients. *Journal of the American Geriatrics Society*, **23**, 10, 433–44.
Reed, J. and Roskell Payton, V. 1997. Understanding the dynamics of life in care homes for older people: implications for de-institutionalizing practice. *Health and Social Care in the Community*, **5**, 4, 261–8.

Rivera, J., Bermejo, F., Franco, M., Morales-González, J. M. and Benito-León, J. 2009. Understanding care of people with dementia in Spain: cohabitation arrangements, rotation and rejection to long term care institution. *International Journal of Geriatric Psychiatry*, **24**, 2, 142–8.
Rogero-García, J. 2009. Distribution of formal and informal home care for people older than 64 years in Spain. *Revista Española de Salud Pública*, **83**, 3, 393–405.
Ryan, A. A. and Scullion, H. F. 2000. Nursing home placement: an exploration of the experiences of family carers. *Journal of Advanced Nursing*, **32**, 5, 1187–95.
Schulz, R., Belle, S. H., Czaja, S. J., McGinnis, K. A., Stevens, A. and Zhang, S. 2004. Long-term care placement of dementia patients and caregiver health and well-being. *Journal of the American Medical Association*, **292**, 8, 961–7.
Sergeant, J. F. and Ekerdt, D. J. 2008. Motives for residential mobility in later life: post-move perspectives of elders and family members. *International Journal of Aging and Human Development*, **66**, 2, 131–54.
Silverman, D. 2001. *Interpreting Qualitative Data: Methods for Analyzing Talk, Text Interaction*. Sage, London.
Strauss, A. and Corbin, J. 1998. *Basic of Qualitative Research. Techniques and Procedures for Developing Grounded Theory*. Sage, London.
Tornatore, J. B. and Grant, L. A. 2002. Burden among family caregivers of persons with Alzheimer's disease in nursing homes. *The Gerontologist*, **42**, 4, 497–506.
Tse, M. M. Y. 2007. Nursing home placement: perspectives of community-dwelling older persons. *Journal of Clinical Nursing*, **16**, 5, 911–7.

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