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Empowering the Elderly by Giving Dignity

Irudaya Rajan Sebastian and Sunitha Syamala

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Abstract

Elder care is the most pivotal topic in any society today. Indian culture of living with parents is a common thing, living arrangement and care is a part of it. However, living with partner and living alone is increasing among the elderly, especially the elderly in Kerala. This paper analyzed the data of Kerala Aging Survey 2013 of Centre for Development Studies, Kerala. This paper analyses whether the elderly living with their family are empowered by giving dignity to them. For this, it analyses the living arrangement of the elderly living in Kerala with their need for special care. It also analyses with their ADL, depression and chronic diseases. The result shows that elderly who live with children need special care and have more than two chronic diseases compared to elderly who live with their partner. Among the elderly who live alone or are living with other non-relatives, the depression scale shows a high value compared to the elderly who live with their partner or with their children. Thus, though the elderly need special care or are suffering from chronic diseases, they are living with the attention of their family, especially with the attention of their children or their partner.

Keywords: living arrangement, care, depression

1. Introduction

The word empowerment has been articulated in many ways according to the state of affairs. When we talk about the empowerment of the elderly, it is different from the other types of empowerment such as women empowerment, youth empowerment, financial empowerment and so on. The ways to empower the elderly are different from that of other means of empowerment, though they are a bit similar. The main thing is to give dignity to the elderly which will automatically enable them to get empowered. The joint family system in India gave a notable status to the older persons in the family as the decision maker. But, the restructuring

of the family system from joint to nuclear have put the situation of the elderly at risk. The focus of the family shifted to the children and the status of the elderly, who once ruled the family got degraded. Thus, they became a liability to the family and caring for the elderly became a challenge to the family as well as the society. There is an increase among the elderly living alone or living with partner only as the children left the family in search of employment or a better livelihood. No one no longer cares to accompany the elderly to the hospital when they need to go. It is time to talk about familial bonding rather than economic stability. Thus, elderly care is one of the most challenging topics in any society today. If someone got care at the right time, that represents giving dignity to them. The aging population, irrespective of its composition, requires care and shelter as it is one of the basic needs of life with dignity [1].

Dignity was found to have two attributes: self-dignity, which is the individual's sense of self-worth; and interpersonal dignity, that is given to the elderly by others and manifested by the respect they received [2]. Concerns about the standard of care for an important number of elderly people abound, despite global aging being a challenging phenomenon. One among these concerns is regarding how to ensure that the elderly will be able to live out their days with dignity [3]. Dignity is an inherent characteristic of being human, it can be subjectively felt as an attribute of the self, and is made evident through the behavior that demonstrates respect for oneself and others. Dignity must be learned, and an individual's dignity is affected by the treatment received from others [4]. Dignity violation in health care occurs through processes of rudeness, indifference, condescension, dismissal, disregard, dependence, intrusion, objectification, restriction, labeling, contempt, discrimination, revulsion, deprivation, assault, and abjection. The conditions that promote these processes reside in the positions of the actors involved; in the asymmetrical relationships between the actors; in the health care setting itself, which is characterized by multiple tensions—including those between needs and resources, crisis and routine, experience and expertise, and rhetoric and reality; and in the embeddedness of health care in a broader social order of inequality [5]. Dignity may be defined as a concept that relates to basic humanity. Dignity consists of inherent and external dimensions, which are common for all humans and at the same time are unique for each person, relating to social and cultural aspects. The attributes of preserving dignity are individualized care, control restored, respect, advocacy and sensitive listening [6]. Several care actions were identified relating to all themes contained within the Dignity Model, except aftermath concerns. Examples include: controlling symptoms; listening to the elderly patient and taking them seriously; providing advice concerning how to cope on a daily basis; treating them as equals and with respect, and; encouraging the family members' presence [7]. Dignity is a complex phenomenon, which differs according to the people's perspectives and cultural variations by region. It is also well-known that elderly people belong to an age group, which demands not only financial support but also emotional and physical assistance to help them lead a dignified life [8]. The proportion of life expectancy free of disability decreases with age and the proportion of life expectancy spent in a disabled state increases with age [9]. The most crucial aspect of living arrangements for the elderly is co-residence with adult children in extended families or multi-generational households where kin provide income, personal care and emotional support to the elderly [10]. This chapter explains the dignity of the elderly as the care and love given to them. According to Census of India 2011, Kerala has 4.2 million elderly,

which accounts for 4 per cent of India's total elderly. Economic progress and human development have improved the quality of lives and thus increased the longevity of the people. The senior citizens should be able to enjoy these additional years [11]. However, In India, as many studies indicate, the abuse and neglect of the elderly mostly by the relatives and care givers, people the elderly know and trust, and which affects their quality of life as well as is a violation of their rights to a life of dignity and respect is emerging as a serious concern [12]. The research question is whether the elderly living with their family are empowered by giving dignity to them, especially if they need special care.

2. Data and methodology

In order to highlight the plight of the elderly in Kerala, the Centre for Development Studies, Kerala, conducted a survey entitled "Kerala Aging Survey (KAS), 2013," which covered 14 districts of Kerala. The 2011 Census data on aged population in Kerala was used for sampling purposes. The samples of KAS 2013 were obtained from Kerala Migration Survey (KMS), 2011. Those households which have people above 60 years of age and those which had people who would attain 60 years within the next 2 years were taken from KMS 2011 to form samples of KAS, 2013. There were 15,000 households in the Kerala Migration Survey 2011 out of which 5713 households had elderly people. KAS 2013 covered 7768 elderly people. Though there were 7768 samples, 2301 elderly who need special care that they have some disability or limitation were selected for the analysis. These elderly are being analyzed with respect to their living arrangements. The variables selected for the analysis are age, education, financial status, standard of living, perception of health, cognition level, depression level and overall life satisfaction. To identify the effect of each independent variable over the dependent variable according to their living arrangement, a multinomial logistic regression has been carried out.

3. Analysis

Most of the elderly who need special care are living with their children. Educated elderly prefer to stay with their partner or to live alone. If they are illiterate or have less than primary education they would stay with their children. They need assistance to manage their routines including health checkup. Elderly who have more than two chronic diseases live with their children. On the other hand, those who have no diseases live alone or with other relatives. This has an effect on the perception of caring. The elderly living with children are vulnerable to more than two chronic diseases, which means that these elderly need more attention and care from their beloved ones (**Table 1**). But those who are living alone or with others should take care of their own health; otherwise they will face a thick condition of caring imbalance. In urban areas, most of the elderly live with their partners, while in rural areas most of them live with their children.

It is obvious that someone will take care of the elderly if they get financial benefit. Here, the elderly who are fully independent live with others or live alone than living with children.

		Others/Alone	Partner	Children
Age group	80+	24.4	11.9	27.5
	70–79	39.6	32.6	36.8
	60–69	36.0	55.4	35.6
Education	Illiterate	20.9	10.6	19.5
	Less than primary	18.7	14.6	21.0
	Primary but less than secondary	40.4	47.5	47.0
	Secondary and above	20.0	27.3	12.6
Financial status	Fully dependent on others/spouse	52.9	61.0	64.6
	Partially dependent	20.4	14.1	20.8
	Fully independent	26.7	24.9	14.7
SLI	Low	61.3	57.6	58.0
	Medium	23.6	25.7	26.3
	High	15.1	16.7	15.7
Perception of health	Poor	71.1	70.0	66.7
	Fair	15.6	19.4	21.1
	Good	13.3	10.6	12.2
Chronic disease	2 or more diseases	44.9	41.9	46.3
	One disease	32.0	37.1	32.8
	No disease	23.1	21.0	20.8
Cognition	Severe cognition impairment	28.0	14.6	22.4
	Mild cognition impairment	25.8	18.8	30.7
	No cognition impairment	46.2	66.6	47.0
Depression index	High depression	41.3	32.4	29.5
	Medium	50.2	60.5	64.9
	No depression	8.4	7.2	5.6
Life satisfaction	Low	64.4	38.2	25.0
	Medium	21.8	26.3	29.6
	High	13.8	35.5	45.4

Table 1. Profile of the elderly who need special care according to their living arrangement, 2013.

But the standard of living of households is low for those elderly who live with others or live alone. Elderly who live with others or alone have severe cognition impairment compared to

the elderly who live with their partner or children. Most who have no cognitive impairment live with their partners. Most of the elderly have some sort of depression irrespective of their living arrangement. But high depression can be seen more among the elderly who live with others or alone. It is quite natural that they get depressed at their later ages when they are alone or when they are not living with their blood relatives. Overall, life satisfaction is very low when they are living with others or alone. Among the elderly living with children, 75% have a high or medium life satisfaction.

4. Multinomial logistic regression analysis

The dependent variable selected for the analysis is the living arrangement of the elderly who need special care in which three categories of living arrangement such as with children, with partner and with others or alone have been selected. The regression is applied by taking the elderly living with children as the reference category. Is the life satisfaction more among the elderly who are living with children or living with partner or with others or living alone? Here the analysis estimates the degree of effect of independent variables on the dependent variable (**Table 2**).

The reference group considered here is the highest coded categories of each variable. The parameter estimates focus on the role of each independent variable in differentiating between the group specified by the dependent variable [13]. The likelihood ratio test explains the overall relationship between dependent and independent variables based on statistical significance. That is, independent variables such as age, education, financial status, standard of living, life satisfaction, depression and cognition are statistically significant. The coefficient under log (P1/P3) represents the effect of predictor variables on living with others/alone (P1) over living with children (P3), log (P2/P3) represents the effect of predictor variables on living with partner (P2) over (P3).

The elderly who live with others or alone and need special care have a lower chance to have an education level of less than secondary compared to secondary or above level. Also, these elderly have a higher chance of having a low standard of living, but have a lower chance to depend on others. Also, they are less likely to become depressed but more likely to have low or medium level of life satisfaction. The elderly with older ages are less likely to be living with their spouse as widowhood would occur at some point compared to the elderly living with their children.

The elderly who live with their partner have a lower chance of having an education level of less than secondary than secondary or above level. So, we can conclude from the analysis that elderly at their later age have a higher chance to stay with their children and also with no cognitive impairment, high life satisfaction and better standard of living than to live with their partner or others or live alone. Thus, the elderly living with their children are empowered with a dignity and care that they have achieved over their life. Elderly living with others or living alone are less likely to get dignity and family care.

Variables	Categories	Reference category	Others/Alone		Partner	
			B	Exp(B)	B	Exp(B)
Three age group		Intercept	-1.819		-0.524	
	80+	60–69	0.008	1.008	-1.124	0.325**
	70–79		0.198	1.219	-0.482	0.618**
Education	Illiterate	Secondary and above	-0.378	0.685	-1.220	0.295**
	Less than primary		-0.587	0.556*	-1.039	0.354**
	Primary but less than secondary		-0.467	0.627*	-0.597	0.551**
Financial status	Fully dependent on others/spouse	Fully independent	-0.749	0.473**	-0.191	0.826
	Partially dependent		-0.427	0.653	-0.586	0.556*
Std. of living	Low	Best	0.847	2.334**	0.723	2.060**
	Average		0.427	1.533	0.033	1.034
	Better		0.249	1.283	0.025	1.025
Health perception	Poor	Good	-0.019	0.981	0.427	1.533*
	Fair		-0.355	0.701	0.148	1.159
Depression index	High depression	No depression	-0.778	0.459*	-0.253	0.777
	Medium		-1.014	0.363**	-0.312	0.732
Chronic diseases	2 or more diseases	No disease	-0.155	0.857	-0.247	0.781
	One disease		-0.172	0.842	0.105	1.111
Cognition	Severe cognition impairment	No cognition impairment	0.270	1.309	-0.342	0.711
	Mild cognition impairment		-0.079	0.924	-0.524	0.592**
Life satisfaction	Low	High	2.206	9.079**	0.682	1.977**
	Medium		0.878	2.405**	0.147	1.158

* < 0.05 and ** < 0.001 - significant levels.

Table 2. Multinomial logistic regression coefficient: Living arrangement of elderly who need special care (P3 = living with children, P1 = living with other/alone and P2 = living with partner).

5. Conclusion

Living arrangement of the elderly plays a vital role in empowering elderly by giving dignity. Unlike the earlier traditional family system where the elderly were the key decision makers in the household, today’s family system has changed with change in the role of each individual; the elderly has an unimportant role. However, it is indirectly understood that elderly who experienced life satisfaction have dignity when they are living with their family. One can enjoy their life at the later stages of life if they would get proper care and love. This chapter explored how dignity is different among elderly when they are living with children and living with others/alone.

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