

Dignity in old age

Helena Kisvetrová¹

¹Centre for Science and Research, Faculty of Health Sciences,
Palacký University Olomouc, Czech Republic

Today's consumer-centric and highly secular society connects the respect and dignity of a person to their performance, role, and function in society. The accentuation of the ideal of youth, strength, and success is also reflected in the perception of personal dignity among the senior population. Maintaining and protecting the dignity of seniors is therefore becoming an important part of health and social care.

Dignity can be described as an inherent characteristic of human beings that can be perceived as an attribute of oneself, and is manifested through behavior that demonstrates respect for oneself and others (1). Dignity exists in two complementary but different forms. In this context, dignity is understood as a dual concept involving human (fundamental) and social (personal) dignity (2).

Human dignity is an abstract, universal value that belongs to every human being, on the basis of their being human. The spiritual concept of human dignity is based on the belief that human beings have a privileged place among all of God's creations (3). The secular concept of human dignity stems from the belief that the importance of dignity is rooted in the rationality of human beings and their ability to act as moral individuals (4). Therefore human dignity cannot be measured, created, or destroyed.

The social dignity of an individual is formed by interaction with other individuals and within groups and society. It can be divided into the dignity that individuals attribute to themselves and the dignity that others attribute to them. The dignity attributed to one's own self is self-esteem and pride. The dignity ascribed to others involves ways in which individual and collective behavior attributes value and respect to the individual. Because social dignity arises from social interaction, it can be measured, violated, or improved. In old age, this form of dignity in the provision of nursing care is easily influenced, either positively or negatively.

The four categories of dignity, as per Lennart Nordenfeldt (4), are based on the concepts of absolute and relative dignity. The first category is *dignity as a hu-*

man right (Menschenwürde) and represents an absolute value. This dignity is shared equally by all people because of the fact that they are human beings. Therefore, it is innate (internal) and belongs to all people, regardless of their gender, age, race, or religion. It creates the basis for a moral obligation to respect other people and to experience dignity or humiliation in the other three categories, namely: the dignity of merit, the dignity of moral power, and the dignity of personal identity. These three categories represent dignity as a relative value. This means that it depends on the behavior, autonomy, and integrity of the individual and the person with whom one is in contact. These categories also create a precondition for self-esteem. *The dignity of merit* is determined by the formal and informal status of the individual in society. It is attributed to people on the basis of certain roles or functions or the merit of the acts performed. *The dignity of moral power* is based on moral integrity and emphasizes the individual's ability to live in accordance with moral principles. *The dignity of personal identity* is related to the identity of oneself as a person, to self-esteem, and to concepts such as integrity, autonomy, and inclusion. It can be endangered and disrupted if older people are offended and treated as objects. It is therefore the most important type of dignity in relation to seniors in care.

While Nordenfeldt (4) identified four positive categories of dignity, Jonathan Mann (5) created a taxonomy of four categories of violations of dignity. The first can be described as *"to be not seen"*. This happens when someone feels they are not recognized and ignored. An example in nursing practice is a geriatric patient trying to attract a nurse's attention. However, the nurse avoids eye contact with the patient and ignores him. The second category is *to be seen only as a member of a group*. In such situations, seniors are perceived stereotypically only as members of a certain group (e.g., retired or demented, etc.). As Mann (5) emphasizes, group classification can be a source of pride, but in this case the perception of a senior as a member of a group is pejorative. The third category involves *a threat to dignity caused by a breach*

of *personal space*. This can occur, for example, when performing personal hygiene without ensuring the senior's privacy. The last category is humiliation. This arises when seniors are segregated, differentiated, or separated from a group or society, and become a subject of criticism and ridicule.

Oosterveld-Vlug (6) describes the *Model of dignity in illness*, which describes how illness affects the patient's personal dignity. According to this two-stage model, disease does not directly affect a patient's dignity. It acts indirectly, in the way the patient is perceived through the three components that shape their self-concept: the individual self, the relational self, and the social self.

Seniors associate the concept of dignity primarily with *respect* (respect for themselves [self-respect] and for others, and respect *from* others) and *participation* (involvement in events). They most often put threats to dignity in the provision of care in the context of dependence on the care of others, poor communication, and depersonalization of care. Understanding the issues that could compromise the dignity of seniors helps healthcare professionals protect older people against losing their personal and social dignity. Suitable tools for assessing dignity in old age are the Patient Dignity Questionnaire or the Jacelon Dignity Scale of Dignity.

The *Patient Dignity Inventory* (PDI) is based on Chochin's Model of Dignity. The PDI contains 25 items covering a wide range of physical, psychosocial, spiritual, and existential issues affecting a patient's dignity (7). Although primarily designed as an assessment tool for terminally ill cancer patients, it is currently used in early dementia patients and seniors who are not in the terminal stage of the disease, but are experiencing the end of their lives (8).

The *Jacelon Attributed Dignity Scale* (JADS) was designed specifically for the senior population. It consists of 18 positively formulated statements aimed at determining the degree of dignity attributed to a senior. The high value attributed to dignity is a protective factor in relation to health, self-sufficiency, independence, quality of life, and successful aging (9).

Maintaining dignity from the perspective of seniors thus means that they have their life under control, and are treated with respect for their autonomy and personal identity. To achieve this, a senior must be perceived by other people as a unique human being, as well as an integrated and respected member of society.

REFERENCES

1. Jacelon CS, Connelly TW, Brown R, Proulx K, Vo T. A concept analysis of dignity for older adults. *J Adv Nurs*. 2004; 48(1):76-83.
2. Jacobson N. A taxonomy of dignity: a grounded theory study. *BMC International Health and Human Rights*. 2009; 9:3
3. Quante M. Quality of life assessment and human dignity: Against the incompatibility – assumption. *Poiesis Prax*. 2005; 3(3):168-180.
4. Nordenfelt L. The varieties of dignity. *Health Care Anal*. 2004; 12(2):69-81.
5. Mann J. Dignity and Health: The UDHR's Revolutionary First Article. *Health Hum Rights*. 1998; 3(2):31-38.
6. Oosterveld-Vlug MG, Pasman HR, van Gennip IE, Muller MT, Willems DL, Onwuteaka-Philipsen BD. Dignity and the factors that influence it according to nursing home residents: a qualitative interview study. *J Adv Nurs*. 2014; 70(1):97-106.
7. Chochinov HM, Hassard T, McClement S, Hack T, Kristjanson LJ, Harlos M, Sinclair S, Murray A. The Patient Dignity Inventory: a novel way of measuring dignity-related distress in palliative care. *J Pain Symp Manage*. 2008; 36(6):559-571.
8. Kisvetrová H, Herzig R, Bretšnajdrová M, Tomanová J, Langová K, Školoudík D. Predictors of Quality of Life and Attitude to Ageing in Older Adults with and without Dementia. *Aging Ment Health*. 2019; doi: 10.1080/13607863.2019.1705758 (in press).
9. Jacelon CS, Dixon J, Knafl KA. Development of the Attributed Dignity Scale. *Res Gerontol Nurs*. 2009; 2(3):202-213.