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Community-dwelling older adults' perceptions of dignity: core meanings, challenges, supports and opportunities

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ABSTRACT
Dignity is a universally important issue for all people, and particularly vital for older adults who face multiple losses associated with ageing. In the United States of America and beyond, the maintenance of dignity is a key aim of policy and service provision for older people. Yet surprisingly little research has been conducted into the meaning of dignity to community-based older adults in the context of everyday life. As life expectancy continues to increase worldwide, unprecedented numbers of people are living longer than ever before. The majority of older adults will face declining health and other factors that may impact dignity in the course of ageing in their communities. This paper reports on a study that explored older people's understandings and experiences of dignity through focus groups and a survey. Three key components of dignity are identified: autonomy, relational and self-identity. In addition, the paper discusses a range of factors that can facilitate or inhibit a sense of dignity for older people, including long-term health issues, sensory deficits and resilience to life events. Finally, the implications of these findings for policy and practice are considered in the context of American social structures and values.

KEY WORDS – community, gerontology, autonomy, ageing, older adults, qualitative research.

Introduction

Dignity is a universally important issue for all people, and particularly vital for older adults. Despite the multiple losses associated with ageing, dignity represents an enduring semblance of self (Moody 1998). In the United States of America (USA) and abroad, the concept is grounded in policy and services provided to older people. Dignity is a key objective of the United

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Nations Principles for Older Persons (United Nations 1991), as well as the Older Americans Act (OAA) and Administration on Ageing – the USA's premiere legislation and organisation exclusive to older adults (US Public Law 89–73, 79 Stat 218 1965). As life expectancy continues to increase across the USA, an unprecedented number of people are living longer (Murphy, Xu and Kochanek 2012). Today, many Americans will live well into their eighth, ninth and even tenth decades of life. According to the US Census, older adults aged 90 and older constitute the fastest growing age group (Werner 2011). However, the vast majority of the nation's older population will experience declining health and functional incapacity with age. According to the United States Centers for Disease Control (2011), eight out of ten people age 65 and older have at least one chronic condition, and 50 per cent have two or more. Consequently, many older adults may struggle to maintain their dignity throughout the later years, yet surprisingly little is known about the ways in which older adults view their dignity in the course of everyday community life. Moreover, the views of older adults on what factors promote or impede one's sense of dignity in the context of daily life are not well researched or documented. Such views are particularly important in giving voice to the lived experience of older persons in community-based settings. It is hoped that developing this knowledge can support communities in enhancing dignity, as well as ameliorating factors that lead to undignified experiences among older citizens.

Dignity in ageing

It is a basic human right that all persons have a fundamental need to be treated with dignity. However, despite widespread agreement regarding its importance, dignity in ageing is not well understood. Research on dignity is compounded by multiple interpretations of the term. According to *Merriam-Webster's Dictionary* (2010), dignity is defined as 'the quality or state of being worthy, honored, or esteemed'. Dignity in ageing is also closely aligned with related concepts such as: 'successful ageing', 'healthy ageing', 'spiritual ageing', 'quality of life' and 'positive ageing'. In America, contemporary research on dignity and ageing has focused on improving experiences at the end of life (Chochinov *et al.* 2002) and in institutionalised settings (Kane and Kane 2001). However despite the world-wide increase in community-based ageing, there is relatively little research literature on dignity and ageing in the context of daily living. Fortunately, seminal research on dignity among older adults in the United Kingdom provides a basis for further inquiry in the USA and beyond (Woolhead *et al.* 2004).

Research suggests that dignity in ageing is multifaceted and complex, revealing the importance of both personal perspectives and interpretation

within a broader social context. The Dignity in Older Europeans project prompted study about the topic in six nations and yielded numerous findings regarding how older Europeans view dignity in a range of settings and circumstances, including family care, acute care, long-term, residential care and care at the end of life (Tadd 2006: 1–19). Subsequent cross-country themes identified in the studies pertained to issues of dependence and independence, involvement in decision-making, access to care, dignified care and death with dignity. Barriers to dignified care were also identified, including organisational factors such as limited resources, health professional behaviour such as personal attitudes and broader influences such as the media portrayals of older people.

There is a growing body of international work regarding dignity as it pertains to the dying experience. Indeed, the promotion of dignity in care at the end of life is included in a statement of principles for the American Geriatrics Society (Lynn 1997). As a concept pertinent at the end of life, dignity has been associated with psychological wellbeing and functioning (Field and Cassel 1997), and in relation to achieving a sense of control at life's end, as well as in relation to strengthening relationships (Singer, Martin and Kelner 1999). Chochinov *et al.* (2002) developed a dignity-conserving model that identifies supports and barriers to dignity at the end of life. In the model, dignity-conserving actions include maintaining a continuity of self through role preservation, fostering generativity and legacy, maintenance of pride, hopefulness, autonomy and control, and resilience, as well as a fighting spirit. Research on the dignity-conserving model suggests that many older adults experience distress impacting dignity at life's end, not as a result of their thoughts about dying, but due to the cumulative, multiple losses experienced in old age (Hall, Longhurst and Higginson 2009). Therefore, dignity in old age may be fundamentally associated with a meaningful existence throughout the later years.

A philosophical model of dignity and its relevance to old age has been advanced by Nordenfelt (2004). This model describes four types of dignity including dignity of merit, moral status, personal identity and universal human dignity. Dignity of merit is ascribed by role and status in society, whereby someone is respected for their social standing or accomplishments. Dignity of moral stature alludes to a sense of self-respect based on a personal sense of integrity in living one's life. The dignity of personal identity pertains to self-respect as affected by a sense of self and maintenance of sense of self over time, including changes in physicality and interactions and relationships with others. Universal human dignity avows the basic human rights allotted to all persons.

Qualitative research on dignity affirms and enhances the model proposed by Nordenfelt (2004). Studies conducted in England identified that dignity

pertained to the following domains: (a) identity (self-respect, esteem, pride, integrity, trust); (b) human rights (equality, choice, human entitlement to dignity); and (c) autonomy (independence, self-determination, freedom of choice, control) (Calnan, Badcott and Woolhead 2006; Woolhead *et al.* 2004). Findings suggest that both psychological and social dimensions are strongly aligned with older adults' perceptions of dignity in old age. For example, identity was shown to be salient as it affected the self in relation to other peer groups; that is 'keeping up appearances' to maintain self-respect and resisting stereotypes and social exclusion, which can lead to a lack of respect. Earlier research on dignity in old age in Sweden suggested that loneliness and isolation result when older adults are treated without respect (Randers, Olson and Mattiasson 2002). Similarly, basic human rights are infringed when someone is not consulted for decisions or is prevented from living life as one wants. Autonomy in life is upheld by having control over activities of daily living and maintaining mental abilities. Although many older adults experience cognitive limitations and increasing rates of dementia with age, research suggests that older people do retain the ability to make decisions regarding aspects of daily living and everyday care (*e.g.* what to eat and what to wear) (Whitlatch and Menne 2009). Thus, dignity among older adults is best understood within the social realm of daily life, and in the context of everyday life and interactions with others in one's local community.

This paper reports on findings from an exploratory study of how older adults in a mid-sized community (approximately 350,000 residents) located in the Southeastern USA view the concept of dignity in the context of their daily lives. The community under study can be characterised as territorial and relational; that is residents are linked by geography and hold common ties and sites for interaction between members (Gusfield 1975). Nearly one-third of the community's residents are 65 or older (Florida Department of Elder Affairs 2011). The cohort of elders participating in the study was raised in the early to mid-20th-century America, encompassing traditional US cultural values of individualism and a strong work and family ethic. A sizeable number of older adults in the community have relocated to the area after reaching retirement age. Consequently, many are geographically distant from their families. These community characteristics are particularly notable because Americans typically define themselves by way of their work status, which is lost in retirement. Furthermore, even though family remains an important social network for older people in the USA and abroad, the community under study includes a considerable volume of older adults without relatives living nearby. The community can also be characterised as predominantly Caucasian and well-representative throughout the post-retirement age span, including 14 per cent young-old (age 65–74), 12 per cent middle-old (age 75–84) and

6 per cent old-old (85+). The study reported in this paper was conducted in order to explore salient themes pertaining to dignity in the context of everyday life, according to the collective perspectives of older community-based residents. In addition, the study sought to determine factors, both facilitative and inhibitory, that impact on how dignity is experienced by older adults in their daily lives.

Methods

Study design and sample

This study used multiple methods of qualitative inquiry, including focus groups and open-ended surveys, to explore older adults' perceptions of dignity within the context of community-based daily living. Qualitative methods provide insight through the collection of detailed subjective narratives based on lived experiences (Patton 2002). The research team conducted focus groups as an initial step to identify core themes regarding older adults' perceptions of dignity. As issues pertaining to dignity are inherently subjective, focus groups were chosen as a method for stimulating discussion of the topic and encouraging a range of thought, ideas and expression. According to Krueger (2000), focus groups are also useful for capturing processes because the group experience itself can enhance dialogue as members consider and respond to the input of others. Surveys were also conducted to achieve a greater saturation and breadth of responses. Surveys allowed for personal commentary and time for greater reflection in response to the topic, independent of what others might say or think (Fink 2002). Thus the study provides complementary modes of data collection, combining the results from two different samples of participants through seven focus groups (N=51) and survey responses (N=216), yielding a total sample of 267.

The study was conducted in a community in the Southeastern USA with a high proportion of older adults (31% age 65 and older) (Florida Department of Elder Affairs 2011), one of the nation's top ten most populous counties of older adults. Purposive sampling was used to target older adults residing throughout the county by selecting sites which included high volumes of older adults. These sites comprised settings across a range of residential and recreational community venues including a continuing care retirement community with more than 200 high-income units, a senior residence that was home to nearly 100 low-income residents, a senior centre in which dozens of programmes are offered daily to older residents, a community centre and four libraries serving communities with high a proportion of older adults.

TABLE 1. *Socio-demographic characteristics of older adult participants*

Characteristics	Focus groups	E-survey
N	51	216
Age:		
Mean	79·4	75·9
Range	65–98	65–96
Gender: % female	80	70
Education (%):		
Less than high school	15	2
High school/equivalent	17	7
Some college	21	24
College degree	25	30
Post-graduate	21	37
Religious affiliation:		
Protestant	42	42
Catholic	22	20
Jewish	12	11
No preference	8	19
Other religion	16	8
Hispanic (%)	6	1
Race (%):		
White	83	98
African American	15	2
Other	2	0
Marital status: % married	26	53
Have children (%)	92	89
Living arrangement (%):		
Live with spouse	26	55
Live with other	6	5
Live alone	68	40
Difficulty with activities of daily living (%)	14	5
Difficulty with instrumental activities of daily living (%)	10	11
Mean self-report health[1]	3·57	3·75
Currently work (%)	10	20
Currently drive (%)	82	85
Income in US dollars (%):		
<13,000	19	6
13,001–26,000	23	18
26,001–55,000	19	30
>55,000	39	46

Notes: Missing responses ranged from 0–3 on individual items. Percentages for each item are based on those who responded. 1. Self-report status of health ranges from 1=poor to 5=excellent.

The socio-demographic characteristics of the focus group and survey samples are shown in Table 1. The participants ranged from 65 to 98 years of age, were primarily female (70%), white (98%) and Protestant (42%), which is proportionately representative of the community demographics.

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In addition, the majority of the participants were educated (90% attended or graduated college), lived with others (52%) and had children (89%). The participants overall had high degrees of functioning, with only 16 per cent reporting needing help with various activities of daily living (16%). Lastly, almost half (46%) of the participants represented high-income status according to US categorisations, with representation from all socio-economic groups including 6 per cent poor, 18 per cent low income and 20 per cent middle income.

The combined focus group and survey participants (N = 267) reflected the composition of the community under study in terms of age, gender, ethnicity, socio-economic status, living arrangement, religion, educational attainment, family composition, functional status and geographic location within the community. However, the sample differed from the broader American population in several ways. Our sample represented a community in which nearly a third of its residents are age 65 and older (31%) compared to the 13 per cent of older Americans nationwide, and by race, as nationally 80 per cent of older Americans are Caucasian compared to 98 per cent in this study (Federal Interagency Forum on Aging Related Statistics 2010). In addition, our sample included a high proportion of high-income older adults (46% compared to 19% nationally), as well as a higher percentage of high school graduates – 91 per cent compared to 9 per cent among the broader US older adult population. Breakdown by gender, marital status, living arrangement and health status are largely comparable to national statistics.

Processes and procedures

A search was conducted at the start of the study to assess contemporary and international literature using the keywords ageing, older adult and dignity. The Ageline and Abstracts in Social Gerontology databases were searched in order to find journal articles published between 2000 and 2010. The search yielded a total of 60 articles in the defined time period, a figure that was reduced to 52 after the removal of duplicates. The articles were subsequently reviewed to determine whether dignity was addressed through the qualitative input of older adults and in a community-based context, consistent with the specific aims of this study. Only one article met these criteria (Woolhead *et al.* 2004). This underscores the need to better understand dignity in the daily, social realm of older adults' lives, particularly as the majority of older adults age in community, non-institutional settings. Figure 1.

The focus groups were conducted throughout the community from the following sites: a continuing care retirement community, a senior residence,

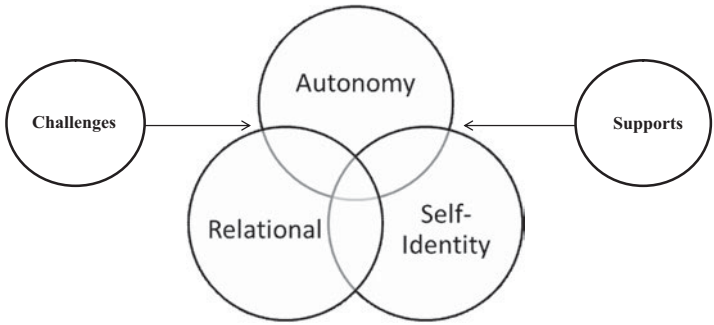

Figure 1. Core themes of older adults' perspectives on meanings of dignity.

a senior centre, a community centre and four libraries. These are all venues where older people reside or congregate in the community. Staff at each venue helped to recruit participants and arrange the meeting rooms on site. The focus groups were conducted in private rooms at the respective sites and each lasted approximately 1.5 hours. Informed consent was obtained and the sessions were audio-taped. The survey was made available in both hard copy and online forms and a range of media were employed to promote dissemination of the survey throughout the community including leaflets, local radio, newspapers and electronic media. Recruitment focused on the sites at which the focus groups were held, as well as other places with high volumes of older adult presence such as the grocery stores and health-care settings. Volunteers were available to assist persons in the completion of the survey at several sites. Prior to commencement, the study received approval from the University Institutional Review Board.

Measures

The data collection tool was developed to elicit older adults' perceptions of dignity within the context of everyday living. The tool utilized a list of questions that were used as a semi-structured topic guide for the focus group and in written for those completing the survey. The questions addressed a range of issues pertaining to dignity and participants were encouraged to reflect upon their past personal experiences (*e.g.* 'Have you ever experienced a challenge to your dignity?'). Probes were used to further elicit participants' responses, such as 'Are there any persons, groups, or organisations that you believe affect your dignity in the course of everyday life in the community?' Debriefing comments were made by the researchers after each focus group to provide the opportunity for reflection on the researcher's impressions of the discussion. The tool was piloted with older adults prior to usage.

Data analysis

The data were analysed by a research team consisting of two primary investigators, both gerontologists and qualitative methodologists, along with two graduate students in ageing studies. The focus group interviews were audiotaped and transcribed and entered into ATLAS.ti (2003), a software program used for the management of textual data, along with the written and electronic survey data that was collected. All transcribed tapes were double checked for accuracy by the co-investigators. Open coding and axial coding were used (Strauss and Corbin 1998). The open coding strategy was used for a line-by-line content analysis of the responses to the questions asked in the focus group and survey data. *A priori* coding, or a start list of codes, consistent with the study's focus was also used during the preliminary content analysis (Miles and Huberman 1994). Themes common to all the focus groups were identified and, as a final check, each participant's comments were re-examined verbatim to affirm coding or identify any uncoded data. Codes were clarified to account for any differences in coding between researchers. The data were subject to iterative analysis and after saturation of the initial themes identified in the focus groups, survey data analysis added a greater breadth to the themes. Themes are presented here in order of the prevalence in which they were identified in the data and subsequent analysis. As recommended by qualitative experts (Berg and Lune 2012, 349–58), themes and sub-themes are included if there are a minimum of three occurrences.

The paradigm underlying the study is based on a reality-oriented perspective (Patton 2002). This stance acknowledges the subjective construction of phenomenon, influenced by the researchers' prior knowledge, beliefs and experiences. Therefore, a variety of actions were taken to facilitate rigorous interpretation of the data. Credibility of the data were enhanced through six practices: (a) triangulation of data was accomplished by maintaining and recording events throughout data collection and analysis by using colleagues with expertise in ageing and qualitative research to improve the conceptual clarity and completeness of the findings; (b) multiple researchers analysed the data independently; (c) researchers reviewed the findings at different stages of analysis; (d) the process of data collection was enhanced by careful documentation and organised record keeping, so that data were maintained in retrievable and easily audited form by peers (Miller and Crabtree 1999); (e) multiple methods of data collection were employed; and (f) data were shared with older adults who participated in the interviews as a source of member checking to enhance trustworthiness of the data.

TABLE 2. *Themes and sub-themes of older adults' perspectives on meanings of dignity*

Theme	Sub-theme
Autonomy	Self-direction/self-choice
	Self-reliance/self-sufficiency
Relational	Respectful treatment of self and others
	Public persona/interpersonal behaviour and appearance
Self-identity	Self-pride/self-acceptance and appreciation
	Self-worth/earned and inherent worth

Findings

The findings that emerged from the data described perspectives on dignity across three core themes: autonomy, relational and self-identity. Factors perceived as challenges or supports to dignity were found to impact one or more of the three core themes as discussed below.

Meanings of dignity

Dignity as autonomy. As shown in Table 2, autonomy was the most prevalent theme that captured the meaning of dignity, and was further expressed as two distinct sub-themes: 'self direction/self-choice' and 'self-reliance/self-sufficiency'. Foremost, the participants attributed a sense of dignity to having individual choice and decision-making in all areas of their lives. This is exemplified by the following statement from a 73-year-old female:

> I can do whatever I want when I want to do it. Each time I make a decision that comes from my . . . innermost beliefs, I feel dignity.

Self-choice was described as having options without the influence of others. In the words of a 67-year-old female, dignity means 'having someone ask what I would like rather than tell me what I need. It means having choices and having a voice'. This applied to end-of-life decision-making as well, as illustrated in the following comment from a 75-year-old female who noted that dignity means 'living without pain all the way to death' and 'being able to make decisions for myself such as accessing or choosing not to access intensive medical care'.

Participants further described self-reliance and self-sufficiency as aspects of one's dignity, as in the following statement by a 76-year-old male: 'Being self-sufficient and not becoming a burden on or dependent on others', which was referenced in terms of all areas of daily living and decision-making such as 'Being able to control your everyday functions', according to an 80-year-old female. Once again, this meaning of dignity also applied

throughout the end of life, as evidenced by a 75-year-old female who anticipated 'some quality of life' by 'not to have someone do everything for me' at the final stage of her life.

Relational dignity. The second most prevalent theme that described the meaning of dignity according to the participants was relational. That is, interactions and relationships with others were reported as an important and vital aspect of one's dignity. Respectful treatment of both self and others was cited most prominently. In the words of an 84-year-old female participant, 'A lot of self-respect comes from the way others treat you'. According to an 88-year-old female, dignity means 'being treated like a person and not being talked to like a baby'.
Dignity was also expressed in broader terms of respect, as described by a 65-year-old woman:

> Maybe it's easier to define what the opposite of dignity is: being the object of condescension, derision, lack of empathy, lack of respect and appreciation, dislike, disgust, pity – attitudes felt, expressed and/or exhibited by others who in one sense or another have control of a situation that you do not.

Further reflecting the relational theme, older adults identified the importance of dignified treatment *of others* as an aspect of *one's own* dignity. In the words of an 88-year-old male: 'Giving respect, not just accepting it, but providing it'.

Relational dignity also referred to one's public persona including self-behaviour and appearance. Examples include the following from an 84-year-old male: 'The way I conduct myself, the way I carry myself', and an 86-year-old female: 'Acting my age and portraying my maturity to other people'. The importance of managing one's public persona was also conveyed, as noted in the comments of a 79-year-old male: 'holding your head up high no matter what the circumstances'. Behavioural and appearance attributes specifically cited included one's manners, behaviour and grooming, keeping oneself in shape, pride in one's appearance, cleanliness and being well dressed.

Dignity as self-identity. The third most prevalent theme that emerged from the data pertained to self-identity. Key sub-themes here include 'self-pride/self-acceptance and appreciation' and 'earned/inherent worth'. Participants felt that self-pride is possible at any age, as noted in the following comment from a 77-year-old male:

> Dignity has a lot to do with still being proud of accomplishment in your life . . . just because you're old doesn't mean that you can't add accomplishments in your life. Accomplishments and abilities at every stage of one's life!

TABLE 3. *Themes and sub-themes of older adults' perspectives on challenges to dignity*

Theme	Sub-themes
Health problems	Conditions impacting self-care/self-esteem
	Increased dependency
Ageism	Disregard by others
Adverse lifecourse situations	Care-giving
	Widowhood
	Economic insecurity
Family circumstances	Lack of acceptance by adult children
	Dependency on adult children
	Over-involved children
	Lack of availability of family care-givers

Self-identify was further described in personal terms of acceptance and appreciation of oneself. For example, a 78-year-old female described it as 'the ability to accept my flaws, my physical problems and deal with them'. In contrast to the relational aspect of dignity discussed above, a female aged over 65 described the primacy of personal acceptance: 'I don't believe anyone can give you dignity. You give yourself dignity. What people or communities can do is give you respect . . .'

Dignity also invoked meanings of self-worth with both personal and universal connotations. Self-worth is earned as well as innately possessed. For example, a 66-year-old male noted that old age is particularly deserving of respect by others and people should be 'treated as a resource for the years lived and experience/wisdom gained'. At the same time, everyone's needs should be met unconditionally through, for example, the provision of 'the essentials of food, shelter, medical care . . .' by people 'that respect and value one another', as noted by a 76-year-old male.

Challenges to dignity

The themes and sub-themes describing the participants' perspectives on challenges to dignity are noted in Table 3. The most prevalent challenges impacted their sense of 'self-identity' and revolved around health problems and their consequences. Particularly, conditions limiting self-care and self-esteem were cited as the greatest threats to dignity. In the words of an 84-year-old male participant: 'Illness is the greatest challenge to dignity'. Specifically cited health conditions included dementia, cancer, hearing loss, macular degeneration, incontinence, falls, hip fracture, diabetes, stroke and

impotence. A 79-year-old female explained how dementia affected her dignity:

> When I was diagnosed with Alzheimer's . . . I told everybody . . . If I had to do it over again, I'd tell . . . just a few of my close friends. Because people look at you differently . . . you just aren't looked on as capable anymore . . .

Sensory deficits in vision and hearing were also thought to affect 'relational' dignity when people cannot interact with others in their environment, as illustrated in this comment by a 78-year-old female:

> if we are blessed with good health, we can maintain our dignity . . . with Alzheimer's and Parkinson disease . . . or completely deaf and it's very, very difficult to communicate. So if you're unfortunate enough to have one of those things, you're dependent on somebody else.

Participants further reflected on how age-related health changes impinged upon their 'relational' and 'self-identity' aspects of dignity. This included decreased connections with others as well as increased dependence on others. A 91-year-old woman explained that ageing causes the 'loss of ability to function independently' as 'physical and/or mental abilities are likely to decline', which lead to 'less self-confidence and self-respect', as well as 'needing to ask assistance for things you used to do yourself'. A 76-year-old female added that 'dependence on others often means loss of dignity' because 'losing the confidence of loved-ones and friends that I can take care of myself or make good decisions affects my dignity'. In the words of a 76-year-old female:

> As one is able to accomplish less and less, one's sense of worth is worn away and with it, the dignity with which one is treated and which one feels.

Thus, one's 'relational' sense of dignity is compounded by the perception of the broader public, which is internalised into one's private persona. This in turn affects participation in society, as suggested by the words of an 88-year-old female:

> The world can get smaller as we can get around less. It's easy to . . . feel left out of what matters, to feel forgotten, feeling that suddenly I'm invisible. I'm not. I'm still very much here.

Ageism was the second most mentioned challenge to dignity, and particularly to self-identity. According to a 79-year-old male, 'Ageism is alive and active' as 'people see either wrinkles, grey hair, or frailties and respond in a dismissive manner'. The experience was commonplace, as noted by a 74-year-old male:

> I think we've all experienced it, whether we are conscious of it all of the time or not, is when you get to a certain age bracket, people do look at you as if 'it's time for you to be on the shelf', or worse yet, 'You're taking up space'.

Challenges to a 'relational' sense of dignity were noted throughout health-care settings. According to a 67-year-old female: 'Doctors can be difficult, because some forget that the patient needs time to assimilate knowledge'. A 76-year-old female further recounted the following 'undignified treatment' received in a medical encounter:

> When you are undressed and undergoing a physical exam and the doctor engages in conversation with nurses and/or other assistants as if you were just a piece of meat on the chopping block.

In addition, the consequences of ageist treatment on one's sense of dignity were specifically cited and include embarrassment, forced retirement, loss of income, unable to resume regular activities, unable to attend cherished events, unable to remain at home, unable to participate in conversations, forced dependency on others, having to adjust to others' schedules for meals, self-doubting, and feeling frightened and anxious.

The third most prevalent challenge reported by the participants pertained to adverse life events. Chief among these were care-giving and widowhood, both of which were described as prolonged periods that were 'ongoing', 'hard', 'tough' and 'traumatic'. Economic insecurity was also reported to influence dignity through threats to one's self-identity. For example, the inability to support oneself financially growing older is challenging as noted by a 73-year-old male: 'when you don't have the wherewithal to provide [for your financial needs] ... there is a certain amount of dignity connected with that'.

Family circumstances were another core theme in terms of challenges to one's dignity. Specific sub-themes were 'lack of acceptance by', 'dependence on', 'overly involved' or 'lack of available children'. Family can negatively affect one's dignity by not accepting the older person's autonomy. For example, an 84-year-old female noted that her dignity was maintained by 'being myself as long as I'm able without my children saying, "oh now mom, you better do this"', while others specifically noted the 'lack of respect from adult children'.

Supports to dignity

The themes and sub-themes describing the participants' perspectives on supports to dignity are presented in Table 4. Chief among these are a variety of helpful networks including friends and neighbours, who help maintain one's sense of dignity during difficult lifecourse events. Other older adults were prominently identified as helpful. For example, a 75-year-old female reported: 'I have many close friends and we are all pretty similar in our life experiences and we all support one another'.

TABLE 4. *Themes and sub-themes of older adults' perspectives on supports to dignity*

Themes	Sub-themes
Supportive networks	Friends and neighbours
	Family
	Formal providers
Positive attitudes	Positive beliefs
	Defying ageism
	Adaptive coping
	Helpful attributes
Action-oriented behaviours	Staying active
	Meaning and contribution
Resolution of lifecourse experiences	Stronger sense of self

Family was also identified as supportive of dignity. Dignity was enhanced by 'unconditional approval' by family members, including grandchildren, siblings, children and spouses. Pertaining to autonomy and one's self-identity, supportive families continue to recognise the older adult for their unique contributions. For example, an 83-year-old male explained that dignity is 'always enhanced and reaffirmed every time my children look to me for help, guidance, etc.', and another 79-year-old male said that his family 'presumes that [he is] the same guy with the same abilities'.

Formal providers were also noted as helpful to maintaining dignity. Aspects here included the provision of tangible supports that enhance the ability to live independently at home, as noted in the following statement from a 78-year-old female: 'services available for older people, to make them aware of [supports to help maintain dignity]'. Relational aspects of dignity can also be enhanced by formal providers as noted by an 84-year-old female:

> There are a lot of places you go the staff is there for the money, or you know, it's a job. You know they don't care about how you feel or if you're not feeling good . . . they do [only] what they absolutely have to do.

Positive attitudes were cited as a primary way in which dignity was maintained. For example, a 79-year-old male exclaimed: 'I think ageing with dignity is keeping your chin up and soldier on'. Optimistic attitudes were also useful in countering ageism, as highlighted in the following comment from an 83-year-old female: 'I do not like to be shelved like an old book when I do not feel old; I refuse to be considered an antique'.

Positive beliefs were also fuelled by religion, expressed as 'strength from God', and personal ageing. For example, a 79-year-old female reported that ageing 'increases dignity' because one is 'more centred in one's core of inner beliefs and life'. A female participant commented that ageing presents

'the feeling that I'm continuing to evolve, new challenges' leading to feeling 'more dignified now than I ever have been in my life'. In the inspirational words of an 81-year-old female:

> I'm not as healthy or attractive as I once was – but my dignity is still intact. I didn't expect to remain young forever and I think ageing has other benefits that make up for any deficits.

Action-oriented behaviours also accounted for the maintenance of dignity according to some participants. Specifically mentioned were physical activities ranging from individual 'walking' to group 'sports', as well as primarily social activities such as clubs, and artistic and creative activities such as 'painting' and 'crafts'. The successful resolution of past lifecourse experiences such as care-giving and death of a spouse were widely reported as factors that positively impact one's sense of dignity. Self-identify and relational aspects of dignity were enhanced by sharing such universal experiences of trial, tribulation and loss. A deeper understanding and appreciation of other's dignity is exemplified in the following quote from an 82-year-old female:

> The realisation that illness and death are an integral part of life and are inevitable. I also have gained more compassion for others knowing we all walk the same walk.

Discussion

The study reported in this paper sought to explore community-dwelling older adults' perceptions regarding the meanings, supports and challenges associated with dignity in the course of everyday life. However, the findings should be interpreted with several caveats in mind. First, the study was conducted in a moderately sized American city located in Southeastern USA, in which a third of the residents are aged 65 and older. Although our sample is representative of the residents' socio-demographic characteristics across a range of variables, we have not explored differential perceptions and experiences by such variables as gender, race, socio-economic status and genetics. Indeed, factors impacting ageing with dignity in one's community depend on a multitude of individual factors, and are also relative to each community. For example, women, and particularly those from minority groups, experience greater disadvantage in older ages as a result of cumulative lifelong social and economic inequities (Gonyea and Hooyman 2005). As a result of broader social, political and environmental influences, older people with health impairments and limited mobility are also marginalised by society (Holstein and Minkler 2003). The oldest old (age 85 and older) are particularly vulnerable to marginalisation as American

society continues to devote preferential attention towards the culturally dominant younger and healthier cohorts (Jacoby 2012). Though the findings are salient in the identification of themes reflective of older persons representing a wide range of socio-demographic characteristics, our study's findings should be interpreted within this tempered and relativistic view. Despite the limitations, however, we believe the findings are applicable to many older adults and communities throughout the USA and beyond as the concept reflects a universally important goal.

Our findings suggest that dignity remains a particularly important concept to older adults, who described collectively that the concept underscores personal autonomy in many aspects of daily life and decision-making. This is consistent with Western cultural values in which autonomy is a leading principle. In addition, the findings suggest that the meanings are multi-faceted, representing fundamental aspects of self and personal identity. These findings are consistent with other studies which have identified the importance of dignity in later life (Baltes 2006; Calnan, Badcott and Woolhead 2006; Nordenfelt 2004; Woolhead *et al.* 2004).

This study's findings also suggest that dignity is relational; that is, dimensions of how one experiences dignity are derived in a social context through the reciprocal exchange of respectful treatment of self as well as others. This finding underscores previous research by Woolhead *et al.* (2004), which highlighted the prominence of social dimensions in the perception of dignity. Although dignity as a concept is widely known to be challenged by disrespectful treatment such as ageist behaviours by others, this study's findings suggest that one's own sense of dignity is also realised by respectful treatment of others in return. Indeed, this study's cohort of elders was raised decades ago at a time in which American societal behaviour followed more traditional forms of etiquette. However, based on this finding, and its particular importance to the current cohort, opportunities for older adults to engage in interactions with others may be viewed as essential, and not simply an insignificant element to enhancing dignity among older adults. Indeed, enhancement of one's own sense of dignity may represent yet another benefit of increased socialisation by older adults.

As noted by Nordenfelt (2004) and Woolhead *et al.* (2004), self-identity was a core element of dignity in the study. For the older adults in the sample this was predominantly described as self-pride and worth, based on personal value. Our study did not explore the extent to which older Americans' sense of personal valuations of worth differ among their global contemporaries. It is not surprising that even at later ages, older Americans view dignity in terms of past personal accomplishments and amassed possessions – both tangible and symbolic. After all, American culture is largely centred on such concrete

expressions of individuality (Holstein and Minkler 2003). Also consistent with the Nordenfelt (2004) and Woolhead *et al.* (2004) models of dignity, our study determined that self-identity, autonomy and relational aspects of dignity are dynamic and interactive constructs. Indeed, challenges and supports to dignity that were identified in the study were commonly found to impact multiple aspects of dignity's core meanings as identified by the participants.

Opportunities to enhance dignity among older adults also emanate from this study's findings regarding challenges and supports to dignity. Foremost, efforts to enhance autonomy, promote positive relations and boost self-identity could be undertaken by others who interact with older adults in both formal and informal encounters. For example, greater efforts can be undertaken by all people interacting with older adults who are experiencing health problems that limit self-care abilities and sensory deficits that affect the ability to communicate with others. Certainly an increased sensitivity and greater awareness of these issues by the broader public would lead to a reduction in ageist behaviours, also cited as a key challenge to dignity in old age. Other scholars have called for revised conceptions of autonomy in advanced ages and chronic illness to include interdependence, thus acknowledging issues of dependency that are inherent to deteriorating health (Atkins 2006; Plath 2009).

Likewise, greater understanding of the key lifecourse events experienced with increasing age, such as widowhood, could serve to better support the dignity of older adults. Although care-giving and widowhood, or loss of a significant other, are regularly experienced by most older people, these experiences are not widely discussed in American culture and remain largely personal journeys for those afflicted. Although the behaviours of family members and service providers may challenge a sense of dignity among older people, it is likely that these impacts are unintentional. Openly discussing and role modelling positive family exchanges that demonstrate dignity-enhancing benefits to older adults would be particularly helpful to educate families about their important role. Media, either intentionally or inadvertently, portraying older adults in undignified ways, could instead disseminate stories of family and provider relations that clearly reveal the benefits to older adults' dignity.

The study also revealed that economic insecurity impacted one's sense of dignity in a variety of ways, including increasing dependence on family members and providers to meet one's needs. As noted by Nordenfelt (2004) and demonstrated by participants in this study, dignity is based on inherent worth and not tied to one's economic status. However American culture, particularly for the cohort of older adults in this study, ascribes a premium value on financial independence. This is currently very problematic in light

of the nation's dismal economy, in which large numbers of older adults are facing dwindling assets as a result of reduced property values, decreased pensions and venture losses.

The findings reported in this paper also underscore the importance of dignity in the course of advancing illness. The importance of maintaining decision-making and choice in end-of-life care options was reported by the participants. Families and service providers that care for older adults with terminal illness would benefit from education about practices such as the model developed by Chochinov *et al.* (2002) to uphold dignity. For example, actions that provide opportunities for autonomous decision-making could enhance dignity at the end of life, as well as efforts to promote the continuity of self (self-identity) and interactions with others (relational).

Lastly, this study identified positive aspects of ageing reported by the older adult participants as well as many helpful personal strategies to augment one's dignity. Positive beliefs, active involvement in fitness, social groups and creative expression, and resiliency as identified in the adaptive coping shared by participants could be harnessed for the benefit of others whose dignity is challenged with advancing age. Mobilising older adults who have experienced and overcome challenges to their own dignity in support of their contemporaries would provide substantial social support to many ageing people. Future research could examine the ways in which meaningful support by older adults on behalf of others can enhance dignity and other measures of successful ageing.

Conclusion

This study extends our understanding of community-dwelling older adults' perceptions of dignity and provides support from American settings for the models set forth by Nordenfelt (2004) and Woolhead *et al.* (2004). The core themes presented here suggest that concepts such as autonomy, self-identity and relationships are relevant across continents and among Western societal cultures. Moreover, the concepts reflect universally important aspects of ageing with dignity. The study's findings also suggest several practical opportunities for enhancing ageing with dignity by explicating factors that support or challenge the core themes identified. As noted throughout the discussion section, the findings indicate a variety of ways to enhance the dignity of ageing persons by older adults themselves, their families, community members of all ages, and health and social care providers. Organisations and government programmes for older adults could adapt current practices by recognising the importance ascribed to dignity by older adults themselves. Overall, this study has additional insights into the

meaning and importance of dignity from the perspective of older adults, a concept that is one of the key aims of service delivery to older adults in America and beyond.

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