Preserving Dignity in Later Life*

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RÉSUMÉ

Cet article examine comment les personnes âgées qui recoivent l'aide sociale dans la communauté subissent une perte de la dignité et comment ils conservent leur dignité. La recherche qualitative a révélé que la perte de dignité est une préoccupation majeure pour ces aînés, et qu'ils conservent leur dignité de differentes manières, variant de s'engager activement à la vie jusqu'à s'en détacher. Nous concluons que, dans la vie plus tard, la préservation de la dignité tout en recevant des *soins sociaux* diffère de conserver la dignité dans le contexte des *soins de sante*, en particulier les soins de santé fournis dans un cadre institutionnel. En outre, conserver la dignité en fin de vie, tout en recevant des soins sociaux, est un processus complexe, qui dépend non seulement de l'exécution des activités et la prise des actions individuelles et de leurs responsabilités, mais aussi d'autres actions, dont certaines impliquent une certaine inactivité/passivité, ainsi qu'interagir avec les autres, surtout les soignants. Cet article propose meilleures politiques et pratiques pour la promotion de la dignité des personnes âgeés dans le contexte de la protection sociale à base communautaire.

ABSTRACT

This article examines how elders who receive social care in the community experience loss of dignity and how they preserve their dignity. Qualitative research revealed that loss of dignity is a major concern for these elders and that they preserve their dignity differently, ranging from actively engaging with life to detaching themselves from life. We conclude that, in later life, preserving dignity while receiving social care differs from preserving dignity in the context of health care, especially health care provided in institutional settings. Furthermore, preserving dignity in later life, while receiving social care, is a complex process, depending not only on performing activities and individual action and responsibility, but also on other actions, some of them involving a certain inactivity/passivity, and interactions with others, especially caregivers. This article offers some insights to developing better policies and care practices for promoting dignity in the context of community-based social care.

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Dignity in care (health and social care) is an important issue not only for older individuals who receive care (Grenier, 2012; Lloyd, Calnan, Cameron, Seymour, & Smith, 2014; Tadd & Calnan, 2009), but also for public policy and professional practice (Black & Dobbs, 2014; Lin, Watson, & Tsai, 2012). In the context of modern Western societies, which highly value independence, autonomy, and individual action and responsibility (Bauman, 2000; Beck & Beck-Gernsheim, 2002; Giddens, 1991), dignity is normally associated with autonomy, independence, respect, and privacy. It is also conceived as eminently relational, given that it is produced in the interactions with others.

Although there is a general trend towards more integration between health and social care, care, particularly

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for older people, continues to be divided into health care and social care in most of the literature as well as in the organization of welfare services in most countries belonging to the Organization for Economic Cooperation and Development (OECD) (Glasby, 2012; Hofmarcher, Oxley, & Rusticelli, 2007; Leichsenring, 2004). Broadly speaking, *health care* consists of goods and services aimed to meet the physical and psychological health needs of individuals (Baggott, 2008) whereas *social care* consists of goods and services aimed to help individuals meet basic needs of daily living, such as feeding and bathing, and also social-emotional needs, such as companionship and moral support (Sipilä & Kröger, 2005). However, in some countries, such as Canada, social care (both home and community-based care services) is an integral part of the overall health care system (Hermus, Stonebridge, Thériault, & Bounajm, 2012).

The literature on dignity in care focuses primarily on health care, especially end-of-life care and health care provided in institutional settings, and it has primarily explored the factors that, in practice, promote or undermine dignity. This means that the literature on dignity in community-based social care – that is, social care provided in the community, such as in day care centres and in the elders' homes – is scarce. This scarcity is relevant because, as already stated, dignity in care is an important issue for older people, policy, and practice; moreover, in the OECD countries, the great majority of long-term care users, almost all aged 65 and over, receive care at home (Colombo, Llena-Nozal, Mercier, & Tjadens, 2011; Fujisawa & Colombo, 2009).

Long-term care policies in most of these countries, particularly in the Netherlands, Iceland, Denmark, and Norway (Bettio, Verashchagina, & EU Expert Group on Gender and Employment, 2010), have favored home care and other forms of community-based care over institutional care (Huber, Rodrigues, Hoffmann, Gasior, & Marin, 2009; Marin, Leichsenring, Rodrigues, & Huber, 2009). In the northern European countries, traditionally more than 15 per cent of the older-adult population receive home care (Huber et al., 2009; Marin et al., 2009). However, in other countries, such as Canada, a significantly lower percentage of older people receive long-term care at home, and this situation has remained roughly the same since the mid-1990s (Huber et al., 2009). Conversely, the demand for community services in Canada "is expected to grow dramatically over the coming years" (Hermus et al., 2012, p. 1). Therefore, to develop better policies and care practices to promote dignity, and in a context characterized both by a growing importance of community-based social care for older people and the high value put on dignity in care, we need to better understand the role of dignity in later life for those receiving that care.

This article explores how older individuals receiving social care in the community, specifically home care, experience the loss of dignity and how they preserve their dignity. Data were collected through participant observation and informal conversations with older persons, their home care workers, and, in some cases, also with their relatives. Several modes of preserving dignity were identified, making it clear that preserving dignity in the context of community-based social care is, in general, a different process from preserving dignity in the context of health care, especially that provided in institutional settings.

In addition, this article identifies important dignity factors heretofore not mentioned, or mentioned only partially, by the literature. Finally, this article discusses how preserving dignity in later life while a person receives community-based social care is pursued. Older persons preserve dignity not only through activities and individual actions and responsibilities, both of which are central to the successful and active aging discourses, but also through actions which go beyond "being active", as well as through interactions with others, especially caregivers. This article extends our knowledge on dignity in later life and offers an opportunity to develop better policies and care practices for promoting dignity in the context of community-based social care.

Literature Review

Dignity is "a complex concept and difficult to define" (Tadd & Calnan, 2009, p. 120). Jacelon, Connelly, Brown, Proulx, and Vo (2004) define dignity as "an inherent characteristic of being human, which can be felt as an attribute of the self, and is made manifest through behaviour that demonstrates respect for self and others" (p. 81). Other authors, such as Street and Kissane (2001), suggest that dignity "is relational and constructed through relationships with others. It is also embodied, as it involves aspects of how people experience the disintegration and decay of their bodies" (p. 94). Nevertheless, one of the most used definitions of dignity is the one offered by Nordenfelt (2009): "a basic value (or a set of values) that a human being can possess. Furthermore, it is a value that should be respected both by the person him or herself and by other human beings" (p. 26).

The word "dignity" is frequently associated with human dignity; however, from Nordenfelt's (2009) viewpoint, this is not the only form in which dignity can be conceptualized. Nordenfelt proposed four forms of dignity: dignity of merit, dignity of moral stature, dignity of identity, and human dignity.

Dignity of merit is associated with prestige or high social rank. This form of dignity can be bestowed upon people through some formal act, as happens with a king or a cabinet minister, or can be achieved through certain deeds which deserve respect, as happens with artists, scientists, or athletes. Dignity of merit can come and go and exists in different degrees.

In turn, *dignity of moral stature* is associated with a special type of merit that is derived from behaviour that complies with moral standards. However, it can also result from actions of exceptional moral value, which implies that this form of dignity can be reduced or disappear through immoral acts. This form of dignity is unevenly distributed among individuals and to differing degrees.

Additionally, *dignity of identity* is not associated with merits or moral statutes. As Nordenfelt suggested (2009, p. 33): “It is the dignity that we attach to ourselves as integrated and autonomous persons, with a history and a future, with all our relationships to other human beings.” This form of dignity includes the notions of autonomy, independence, respect, and privacy, although these can also be present, by means of rights, in the last form of dignity proposed by Nordenfelt (2009): that is, human dignity. Dignity of identity can be affected by external events, the acts of other individuals, injuries, illnesses, and old age. As a result of these events and actions, dignity of identity can come and go. Nordenfelt emphasized that this type of dignity is perhaps the most important one in the contexts of illness and aging. Tadd and Calnan (2009) found empirical evidence of this, as many elders receiving health and social care identified several situations which threatened their dignity of identity, such as being ignored, being treated as objects, being humiliated, and so on.

Finally, *human dignity*, a more universal concept expressed by the German term *Menschenwürde*, is a form of dignity that is present or should be present in all human beings to the same extent. It is based on certain basic rights that all human beings possess simply because they are humans, and it persists as long as we exist. All of these forms of dignity, except that of dignity of merit, are relevant to the study presented in this article.

A critique of Nordenfelt’s conceptualization of dignity, provided in an earlier publication (Nordenfelt, 2004), can be found in work by Wainwright and Gallagher (2008), although these authors did not strongly question the four forms of dignity. This work draws our attention primarily to the risks of adopting a “strong, Aristotelian or Kantian view of dignity” that circumscribes dignity to those who possess autonomy and rationality (Wainwright & Gallagher, 2008, p. 53).

The literature on dignity in care, both health and social care, initially emphasized capturing the understanding of dignity by care receivers, including older people, and caregivers. This specific line of literature, which we may designate as “dignity meanings”, has identified several key meanings of dignity in care. The most cited meanings involve (a) autonomy: that is, the capacity to act and to make decisions for oneself (Coventry, 2006; Griffin-Heslin, 2005); (b) respect, including self-respect and respect demonstrated by others (Griffin-Heslin, 2005; Jacelon et al., 2004); and (c) privacy (Scott et al., 2003; Turnock & Kelleher, 2001).

More recently, another line of research has emerged, which we designate as “dignity factors”. This line of research explores not so much the various ways in which dignity is understood but those factors that, in practice, protect or undermine dignity. This line of research has identified several factors that, from the viewpoint of care receivers and caregivers, protect or promote dignity (most of which correspond to the previously noted meanings of dignity). The most cited factors are (a) having autonomy (Hickman, 2004; Hilário, 2015; Lloyd et al., 2014; Randers & Mattiasson, 2004; Tadd & Calnan, 2009); (b) being treated with respect (Bayer, Tadd, & Krajcik, 2005; Tadd & Calnan, 2009); (c) receiving practical assistance (Godfrey, Randall, Long, & Grant, 2000; Janlöv, Hallberg, & Petersson, 2006); (d) having privacy (Tadd & Calnan, 2009; Woogara, 2005); and (e) maintaining confidentiality and appropriate communication (Baillie, 2007; Matiti & Trorey, 2008; Tadd & Calnan, 2009). Some of these studies (e.g., Tadd & Calnan, 2009) also found that maintaining independence and “not being a burden” are important factors for preserving dignity. Other studies draw attention to different factors that have an important role in the provision of dignified care, namely systemic and organizational factors such as the design of hospital wards and an organizational culture of care (Gallagher, Li, Wainwright, Jones, & Lee, 2008; Hillman et al., 2013; Tadd et al., 2012).

The great majority of the studies included in these two lines of research – dignity meanings and dignity factors – have focused on health care, chiefly end-of-life care and health care provided in institutional settings. Only a small number of these studies address the topic of dignity in community-based social care (Godfrey et al., 2000; Janlöv et al., 2006; Lloyd et al., 2014; Tadd & Calnan, 2009). These studies converge on two conclusions. First, dignity is not only a salient concern to older people, but also part of a set of values (as defined by Nordenfelt, 2009) and which can be threatened – especially in the fourth age (when people reach very old ages – about age 85 and older – and generally become frail) – by lack of resources (social, economic, psychological, and physical) to control their lives and conditions such as illness and dependency.

The second conclusion is that one's sense of dignity depends on the aforementioned dignity factors, mainly on being treated with respect by others and having the ability to exercise control over one's life (autonomy) even when dependent on others. The importance of others, typically the regular caregivers, in maintaining one's autonomy and sense of dignity has been noted in previous studies (e.g., Lloyd et al., 2014; Tadd & Calnan, 2009); nevertheless, the few studies that focused on dignity in community-based social care failed to provide clear evidence of how elders preserve their dignity.

Other studies have emerged at the intersection of dignity meanings and dignity factors research, proposing conceptual models of dignity in care, although these models do not exclusively include older individuals. The models developed by Chochinov, Hack, McClement, Kristjanson, and Harlos (2002) in Canada and Gennip, Pasman, Oosterveld-Vlug, Willems, and Onwuteaka-Philipsen (2013) in the Netherlands are illustrative. The first model, the leading model in the field of health care, focuses on *dying with dignity*, and the second model focuses on *living with dignity while seriously ill* although they have been used in contexts beyond palliative care and chronic illness. These two models primarily account for the factors that protect or undermine dignity (e.g., illness-related issues, patients' perspectives, and social relationships). However, Chochinov's model also accounts for the strategies used to address terminal illness, including "living in the moment" (not dwelling on the illness), "maintaining normalcy" (sticking to a routine), and "seeking spiritual comfort" (finding solace in spiritual or religious practices).

It is noteworthy that some studies focused on elders' perceptions of dignity in those circumstances where the elders found themselves with social care that was either absent or irrelevant (e.g., Black & Dobbs, 2014; Woolhead, Calnan, Dieppe, & Tadd, 2004). Some studies focused on the experiences and meanings of growing old (e.g., Tanner, 2010); others focused on the aging experience within the contexts of frailty and serious illnesses (e.g., Lawton, 1998; Nicholson, Meyer, Flatley, Holman, & Lowton, 2012), but these studies do not explicitly address the issue of dignity.

In conclusion, the literature on dignity in care has largely focused on health care provided in institutional settings, neglecting community-based social care. A recent systematic review of the literature on the elders' experiences and perspectives of receiving social care in the community also demonstrates that the topic of dignity is nearly absent (São José, Barros, Samitca, & Teixeira, 2016). However, if we want to ensure a life with dignity for older individuals who are receiving social care in the community, we must make an effort to understand not only the elders' conceptions of dignity, but also what they, in practice, do to preserve their dignity. This understanding is crucial not only from a gerontological viewpoint, given that it will extend our knowledge on later life, but also from a public policy and care practice viewpoint, as it may facilitate the development of more-effective interventions to promote dignity within the context of community-based social care.

Finally, it is relevant to make reference to several macro social structures which could shape the experience of loss of dignity and the actions to preserve dignity. Public policy for older people, including long-term care policy, has been framed by discourses of successful, active, and healthy aging (Malderen, Mets, De Vriendt, & Gorus, 2013; Rodrigues, Hofmarcher, Leichsenring, & Winkelmann, 2013). These discourses emphasize, for example, performance or ability, functionality, and activity; specifically, they emphasize undertaking physical and mental activities and neglect other domains such as spirituality. Furthermore, these discourses tend to overestimate individual action and responsibility, neglecting the role of other individuals (e.g., the caregivers) and institutional systems (e.g., the social care system). This emphasis on individuals and individual responsibilities is somewhat in opposition to the definitions of active aging proposed by the World Health Organization and the European Union, which also attribute importance to collective action and responsibility (São José, Barros, Samitca, & Teixeira, 2016). The core ideas of these discourses, from the moment they shape the long-term care provision, have implications for dignity in care in the sense that they can either promote or compromise dignity. For example, a long-term care service which completely adheres to the discourse of successful aging, with its emphasis on physical and mental activity, could compromise the dignity of those elders who are unable to be active due to several impairments. (For a systematization of the critiques of successful aging models in the social gerontology literature, please refer to Martinson and Berridge, 2015.)

Another macro social structure that undoubtedly could constrain the experience of loss of dignity or efforts to preserve dignity is ageism or age-related stigma (Carstensen & Hartel, 2006; North & Fiske, 2012). Ageism in several social systems can lead to loss of dignity and can impose extra barriers to preserve dignity.

Research Aims and Methods

Aims and Methodological Approach

The overall aim of the research project from which this article derives was to develop an explanatory model of the experience of receiving social care in later life, with particular focus on the actions and interactions of older adults. However, the analysis of our initial data revealed that the main concern of older adults (hereafter, "elders") did not have to do solely with receiving social care but also with the loss of dignity resulting from other situations (e.g., health problems). These "accidental" discoveries are designated by serendipity, and are typical in many qualitative research approaches, especially in grounded theory methodology (Konecki, 2008). Subsequently, we added a specific research aim: to understand the sense of loss of dignity and to understand how elders preserve their dignity. Therefore, this article does not account for the findings of this research project as outlined but only for the findings related to the issues of loss of dignity and of preserving dignity. Considering both aims, we chose the classic grounded theory (Glaser, 1978, 1998; Glaser & Strauss, 1967) as the study's methodological approach because it emphasizes conceptualizing patterns of human behaviour to produce an inductive theory regarding a substantive area.

Sampling and Research Participants

The primary study participants were elders who were receiving home care, although their home care workers and, in most cases, their family caregivers also participated. We used the following criteria to select the elders: aged 65 or older; receiving home care; able to maintain a conversation in Portuguese; and able to provide verbal informed consent (elders with dementia were excluded). The first criterion was justified by the fact that Western societies tend to associate age 65 with the beginning of old age (Gorman, 2000), although there is no consensus regarding this among both academic and non-academic individuals.

The selection and recruitment of the elders were performed in collaboration with a not-for-profit institution that provides social care services for older adults in the region of Algarve, Portugal. This institution approved the study and granted formal access to care workers and recipients. The directors of the participating home care unit identified the elders who satisfied the study criteria. As much as possible, we used theoretical sampling (Glaser, 1978, 1998); more precisely, we recruited an initial number of elders (six) that was as diverse as possible in terms of social care needs and a subsequent recruitment of elders dictated by the need to test the five emerging categories or modes of preserving dignity (e.g., *keeping going*; *reaffirming power*) and the relationships between them. During the sampling process, all of the elders and family caregivers who were approached to participate in the study agreed to participate and so provided their verbal informed consent.

A total of 24 elders were included in the final sample (one participant died near the end of the fieldwork). All of these participants were receiving home care provided by professional home care workers combined with family care provided by some of the elders' relatives. The elders' characteristics are shown in Table 1. The sample of home care workers consisted of eight women. The sample of family caregivers consisted of nine spouses, seven sons or daughters, and one daughter-in-law.

In Portugal, formal home care is typically provided by the voluntary sector, although the formal professional care market has been growing during recent decades. The state has a minor role in home care provision but it subsidizes the services provided by the voluntary sector. All Portuguese people who need care and support with activities of daily living are eligible to receive home care provided by the third sector. Home care includes services such as personal hygiene, meals, laundry, and house cleaning.

Data Collection and Analysis

We collected study data between 2011 and 2013 from the elders, their home care workers, and, in most cases, their family caregivers, using participant observation and informal conversations. Although all of the elders were receiving home care combined with family care, in a few cases the family caregivers were not present during the home visits and were thus unavailable to talk with us (the researchers). The primary aim was to

Table 1: Characteristics of elders receiving social care ($n = 24$)

Variable	*n*	(%)
Sex		
Male	10	42
Female	14	58
Age (years)		
65–75	3	13
76–86	10	42
>86	11	46
Marital Status		
Single	2	8
Married	11	46
Widower/Widow	11	46
Level of dependence[a]		
Total dependence–bedridden	8	33
Total dependence–homebound	4	17
Severe dependence–not homebound	3	13
Moderate dependence–not homebound	8	33
Mild dependence–not homebound	1	4

[a] **The level of dependence was assessed based on the Barthel Index (BI) (Mahoney & Barthel, 1965) and complemented by the participant's degree of spatial confinement (bedridden, homebound, not bedridden, and not homebound). The correspondence between the BI scores and the categories that we use is as follows: total dependence (0–20); severe dependence (21–60); moderate dependence (61–90); mild dependence (91–99).**

capture the elders' own accounts of their experiences and perspectives. The accounts of home care workers and family caregivers were used as complements to the elders' accounts in order to better understand what the elders did to preserve their dignity. A triangulation of data sources was pursued by comparing the different accounts on the issue of preserving dignity in order to examine their consistency and, consequently, the confidence in findings. We opted for participant observation, because observing the "care encounter" was considered crucial to understand the elders' experiences and perspectives of receiving home care, particularly those concerned with dignity. In turn, we opted for informal conversations instead of interviews, because our initial contacts in the field revealed that a formal situation, such as an interview would involve, could generate some concealment in the elders' answers.

The observations were conducted in the elders' homes, as we accompanied the home care workers on their visits. The aim of these observations was to capture "what was going on" in the "care encounters" in the home visits, paying special attention to the elders' actions and interactions potentially relevant in terms of strengthening, maintaining, or taking away dignity. In all of the care encounters at the elders' homes, two researchers were present, as were two home care workers, and in most cases, also family caregivers.

The informal conversations occurred during the observations in the elders' homes and on other occasions, such as when the researchers and home care workers were travelling to the care receivers' homes. The informal conversations were undertaken to capture the elders' own accounts of sensing the loss of dignity and the actions taken to preserve their dignity, to learn "what was going on" in other moments outside the home visits and to investigate in-depth the reasons for the behaviour of the elders and their caregivers.

Informal conversations with the elders were initiated with open questions regarding the experience of receiving home care (e.g., Could you please tell me about your experience of being cared for? How would you describe your experience of being cared for?). Aspects related to dignity were explored by the researchers whenever introduced, explicitly or implicitly, by the elders in the informal conversations. For example, whenever elders introduced the issue of losses (e.g., loss of control over bodily functions) the researchers asked them how they felt about that and how they have dealt with it (i.e., how they have managed losses). However, neither research participants nor researchers introduced the term "dignity" during informal conversations. The researchers decided not to introduce this term for two main reasons: first, because in Portugal *dignity* is rarely mentioned in daily conversations, and it has many possible meanings that could lead to misinterpretations. Second, the introduction of this term would force the elders' accounts of their understandings and experiences both of the loss, and preserving, of dignity. Whenever we raised the issue of dignity, we used more neutral terms such as "respect" "independence, and "privacy". Researchers' avoiding abstract and conceptual language during fieldwork is a common research strategy, mainly in grounded theory studies (for examples, see Lloyd et al., 2014; Timonen, Conlon, Scharf, & Carney, 2013).

The data collected during the observations and informal conversations were initially recorded through jotted notes (the informal conversations were not audiotaped). Later, these notes were converted into more detailed notes via word processor. Both types of notes were written by two researchers, the author of this article and one other researcher. When the notes we produced referred to the same observation or conversation, they were compared, and the final notes were word-processed. We undertook 185 visits, each lasting up to 15 minutes, and a large number of informal conversations, altogether producing 288 pages of typed notes.

Consistent with the classic grounded theory dictum that "all is data" (Glaser, 1998), we also produced hundreds of pages of handwritten memos during the process of our research data collection and analysis. Similarly, we compared these memos and the final versions were word-processed (a total of 124 pages).

Data collection ended when theoretical saturation was reached, that is, when the analysis of new data we had researched ceased to add anything relevant to the emerging modes of preserving dignity (Glaser, 1978, 1998).

Data analysis was conducted by the author of this article according to the procedures of classic grounded theory: open coding, selective coding, theoretical coding, memoing, and constant comparison (Glaser, 1978, 1998) with the help of QSR International's NVivo9 software.

Ethical Considerations

In addition to the due diligence performed by the directors of the participating institution with respect to obtaining informed consent from the elders and, in certain cases, their family caregivers, we obtained verbal informed consent directly from the study's participants. The informed consent was conceived as an "ongoing process" (Plankey-Videla, 2012), as we sought it whenever it was deemed necessary. When the care provided during home visits included body hygiene, the observations were performed with discretion to protect the elders' privacy.

During our observations, we found indications of negligence of the elders by their family caregivers. This discovery raised ethical dilemmas, given that in Portugal there is no tradition of research ethics regulation in the fields of the social sciences and social care: There are no research ethics committees in universities, research organizations, or social care services. The dilemmas were solved in accordance with the ethical sensitivity of the researchers: We informed the home care workers of the negligence and suggested that they report it to the directors of the institution. Subsequently, we were informed that the negligence was reported.

Results

This article reveals that, although not the only concern, loss of dignity is a major concern for the elders who receive social care in the community. Furthermore, although other modes may exist, this article identifies five modes of preserving dignity adopted by the elders: (a) keeping going, (b) sheltering in personal spaces, (c) reaffirming power, (d) cherishing the caregivers, and (e) disconnecting from life.

Loss of Dignity

Consistent with what has been suggested in other studies (e.g., Tadd & Calnan, 2009; Twigg, 2000), our data indicate that receiving social care creates varied levels of discomfort, primarily in the short or medium term. However, in our study, the primary concern faced by the elders was the loss of dignity that derived from losses of a multiple nature that were associated not only with the receipt of care (e.g., the loss of privacy expressed by several elders who needed intimate personal care), but also with health problems and other incapacities (e.g., loss of control over bodily functions found in several elders who needed to use a diaper).

Our data are full of incidents that indicate the importance of losses experienced in the lives of these elders that ultimately produced an overarching sense which was conceptualized as loss of dignity. As an 80-year-old woman stated, "everything gets lost with age." All study participants had to address multiple and undesirable losses, nearly all of which were permanent and irreversible. Certain losses were subtle or minor, but others were dramatic or major. Certain losses were expected; others were unexpected. Beyond these multiple characteristics of the identified losses, data analysis revealed a difference between primary and secondary losses. The former relate directly to the condition of the body and the mind (e.g., the loss of vision). The latter are a consequence of the former (e.g., losing the capacity to drive an automobile).

Several types of primary and secondary losses have emerged from our data, such as the (a) loss of control over bodily functions, (b) loss of activities, (c) loss of social contacts, (d) loss of privacy, (e) loss of power, (f) loss of respect from others, and (g) loss of self-worth. These losses assault the sense of dignity of the older participants, particularly the dignity of identity and human dignity, as defined by Nordenfelt (2009). The sense of loss of dignity was evident in many of the elders' statements in our study. Two bedridden men felt that they had no value anymore (in the sense of social value/recognition) and that they had become a burden for their caregivers, two negative aspects which correspond to discontinuities with their past identities:

> Today I'm nothing; I'm an encumbrance without energy to live. (72-year-old man, married, totally dependent–bedridden)
>
> Now I have no value at all, and I once had so much value … Now I demand more work than a baby! (81-year-old man, married, totally dependent–bedridden)

There were also testimonies of very negative feelings originating from the use of a diaper to control incontinence. In these situations, it was the status of "adulthood" (independent adult) that was threatened:

> Researcher: "How do you feel using nappies?"
>
> Older person: "I feel I'm finished. I feel that I'm beneath everything." (89-year-old man, married, moderately dependent, not homebound)
>
> "I don't like to urinate in bed [with a diaper]. I'm an adult person, not a baby!" (88-year-old woman, widow, totally dependent–homebound).

Some older participants felt neglected by their family caregivers, and that made them feel very sad. In the following testimonies, it is also possible to detect disbelief. Here, it was the status of "personhood" that was severely damaged:

> Older person: "I'm here in this state [being bedridden] … They [family caregivers] feed me, but I'm here, alone all day … in this room … [very unclean room with an intense odour of urine] … this is … [facial expression showing disbelief]." (84-year-old man, married, totally dependent–bedridden).
>
> Researcher: "How are you today?"
>
> Older person: "I'm sad."
>
> Researcher: "Why are you sad?"
>
> Older person: "Because … I was here, fallen on the floor, *so* long … "
>
> Researcher: "You are sad because your daughter left you here fallen on the floor for a long time?"
>
> Older person: "Yes, and full of urine …"
>
> Researcher: "How do you feel about this?"

> Older person: "I don't know what to say! Look … [silence accompanied by a facial expression showing a combination of sadness and perplexity]." (84-year-old man, married, totally dependent–bedridden).

Recalling the conceptualization of dignity Nordenfelt (2009) had proposed, we see that the first four testimonies illustrate the sense of loss of *dignity of identity*, whereas the last two illustrate the sense of loss of *human dignity*, a more basic and essential value that goes beyond "identity". This demonstrates that the concept of dignity, as defined by Nordenfelt (2009), fits the data better than the concept of identity, as the former includes not only the dimension of identity but also other dimensions which were found in our data, mainly *human dignity* and *moral stature*.

Preserving Dignity

The patterns of behaviour through which the elders in this study continually addressed the effective and potential loss of dignity were conceptualized as preserving dignity. The overarching category of preserving dignity includes many actions and interactions oriented towards the preservation of those matters that, in the last instance, are perceived by the elders to possess the potential to preserve a degree of dignity. Preserving dignity is a process of struggle and resistance, which implies a level of agency, as will be shown in the next paragraph. Preserving dignity, it must be emphasized, is one pattern of behaviour among others undertaken by these elders although our data revealed that this particular process was a major one in their lives.

Preserving dignity by the elders was practiced in different modes, in different ways of acting and interacting. As mentioned, our analysis identified five coping modes: (a) keeping going, (b) sheltering in personal spaces, (c) reaffirming power, (d) cherishing the caregivers, and (e) disconnecting from life. Each elder tended to adopt one mode in most circumstances, although they occasionally acted and interacted in accordance with other modes temporarily. Additionally, the elders were more or less involved in each mode of preserving dignity.

Keeping Going

Keeping going is a pattern of behaviour that includes two properties: maintaining activities and maintaining relationships. *Maintaining activities* refers to several types of actions, such as continuing to perform established activities without help (e.g., bathing), continuing to undertake former activities but with some adjustments (e.g., watching football games on television instead of at the stadium, taking short walks instead of long walks), or continuing to undertake old activities with help from others or from assistive devices (e.g., bathing with the help of care workers, taking regular walks with the help of a cane). Keeping going may also include undertaking new activities with the aim of optimizing the performance of other activities (e.g., regularly exercising on a stationary bicycle to strengthen the muscles for taking regular walks). Therefore, in most cases, *maintaining activities* is a reactive response to losses, but in other cases it is also proactive, by preventing or postponing additional losses.

In turn, *maintaining relationships* means endeavouring to remain in contact with others. These contacts are established by face-to-face encounters and by telephone. All elders in the study had regular contact with relatives, not only with those who provided them with regular help or care, and had some contact with friends. The following testimony illustrates what it means to maintain activities and relationships:

> I do not like being with nothing to do. … After breakfast I normally take care of the house, but I have a domestic employee once a week. After lunch I have a nap until 4:30 pm. Then, if I have to go shopping, I go. After dinner I normally watch TV, with the exception of those days when my relatives pick me up to do outdoor activities. Every week I have a tea meeting with my cousins, and I visit my nephews. One of my nephews had a car accident and became paraplegic. I am very concerned about this nephew. (82-year-old woman, single, mildly dependent–not homebound)

An important aspect of maintaining activities and relationships is that the elders viewed these activities and relationships as a "good thing", something enjoyable and meaningful and made them feel good, as exemplified in the following testimony:

> Researcher: "Do you like to take outings?"
>
> Older person: "Yes, I do, I like it very much. I like to talk with people, to be with other people. Being alone is sad; I'm used to being with people." (84-year-old woman, married, moderately dependent–not homebound)

Additionally, maintaining activities and relationships contributed to sustaining a sense of "still having a life", that is, a life with certain routines (e.g., shopping and having tea with friends), which provided the elders with the confidence to pursue and sustain positive perspectives regarding the future, although they acknowledged that the future would not last for long. Moreover, maintaining activities and relationships facilitated retaining continuity with the past (not only in terms of activities and relationships but also in terms of self-image and self-confidence), although in certain cases, these continuities were sustained by a small range of activities and a few relationships. In combination, these behaviours, particularly the sense of "still having a life" and the maintenance of continuity with the past, facilitated the preservation of a degree of dignity, primarily the dignity of identity.

Sheltering in Personal Spaces

Whereas the elders in the *keeping going* mode "swam against the tide" to a certain extent as they endeavoured to remain active and occupied, the elders who emphasized *sheltering in personal spaces* did not, because they were more concerned with finding a "refuge" in this mode. It was precisely this kind of refuge that the elders perceived as a means to preserve a certain degree of dignity. Sheltering in personal spaces has two properties: resigning oneself to emptiness and slipping into inwardness. *Resigning oneself to emptiness* means resignedly accepting the perceived emptiness of life. These elders viewed the emptiness of their lives as an inescapable consequence of their advanced age. This resignation before the perceived inevitability of age-based emptiness is accompanied by *withdrawing into inwardness:* that is, by a gradual orientation towards personal or intimate "territories of the self" (Goffman, 1971), which is characterized by a tendency to introspection (looking inward) and lethargy (spending most of the day watching TV or sleeping). The following testimony illustrates both properties:

> What is the point going outside for a walk? It is no longer worth the effort. Time is lost, I am already 89 years old. … There is nothing that inspires me … I spend the day looking inward, thinking of the past; I like very much talking about the past … and I watch TV and I spend most of the time sleeping … That's it; my life is already lived. (89-year-old man, married, moderately dependent, not homebound)

Note that in both the *keeping going* and *sheltering in personal spaces* modes of preserving dignity, the elders have lost certain rewarding, meaningful, and enjoyable activities and relationships. However, whereas the activities and relationships maintained by the elders in the keeping-going mode were perceived as enjoyable and meaningful, those activities and relationships maintained by the elders in the sheltering-in-personal-spaces mode were considered trivial and meaningless. That is, those elders did not have a sense of "still having a life"; they acknowledged that their lives had already been lived and that their futures were bleak. They maintained fragile lines of continuity with the past and no hopes regarding the future, as evidenced in the following testimony:

> Researcher: "How do you spend your day?"
>
> Older person: "I have many books in my house; in the past I used to read a lot but now reading bores me. … What can I do? There is nothing that interests me, nothing that enthuses me. I have nothing, no interests, no plans … everything bores me." (79-year-old man, single, moderately dependent, not homebound)

In these circumstances, the "territories of the self" (Goffman, 1971) that these elders continued to possess were confined to personal or intimate spaces – their homes and a way of living generally oriented towards inwardness. Focusing on these "territories of the self" and simultaneously not insisting on retaining other territories that could "hurt" the self enabled these elders to preserve a degree of dignity, primarily the dignity of identity. These elders were convinced, on the basis of past experiences, that to persist in doing certain activities would be harmful to their selves:

> Researcher: "Do you spend the most part of the day at home?"
>
> Older person: "Yes. I'm always at home.
>
> Researcher: "Why?"
>
> Older person: "Because I already have many difficulties in walking and seeing, so I prefer to not persist."
>
> Researcher: "Why do you prefer not persisting?"
>
> Older person: "I feel bad, I feel that I'm not able to undertake normal things anymore. I feel I'm an old man … when you reach my age you will understand …" (79-year-old man, single, moderately dependent, not homebound)

It is worth pointing out that in the sheltering-in-personal-spaces mode, we found elders who were not housebound (they did not have mobility problems), but still they chose to restrict themselves to personal or intimate spaces. Based on the description of this mode of preserving dignity, it is plausible that the main explanation for this behaviour is the stigma associated with old age and the ageism which exist in our Western contemporary societies (Carstensen & Hartel, 2006; North & Fiske, 2012).

Reaffirming Power

Reaffirming power is a mode of preserving dignity characterized by actions and interactions intended to maintain family roles that are invested with power rather than maintaining meaningful activities and relationships (these elders maintained a limited range of activities and few relationships due, greatly, to their levels of dependency). *Demanding and complaining* constitutes the first property of reaffirming power. The elders in this mode of preserving dignity demand attention and care, and they think that these demands should be satisfied according to their wishes and preferences. If this satisfaction does not occur, they complain, occasionally vehemently. Let us examine the following statement of a married man who was homebound. According to his wife, he used to have a dominant role in his family.

> Older person: "I have things to discuss with my wife … I do not like it when I call her and she does not come immediately."
>
> Researcher: "You don't like that she does not come immediately?"
>
> Older person: "No, I do not. I'm her husband."
>
> Researcher: "What do you do when your wife does not come immediately?"
>
> Older person: "I get furious, and I protest with her." (75-year-old man, married and totally dependent–homebound)

The other property of reaffirming power is *accentuating status*. These elders were concerned with reminding their caregivers, primarily their family caregivers, that they still possessed a family role: that is, a level of status in the family that must be respected. Notice what the following daughter said about her mother:

> My mom is "I want, I can, and I command." OK, she is the mother and we can do nothing against it. … She decides what she wants to eat, where to go, everything, and if things are not going according to her will, she gets angry." (daughter of an 88-year-old woman, widow, totally dependent–homebound)

This daughter emphasized that her mother was always a very "strong" person in the family; that it was she (the mother) who always "ruled" the family, and that she wanted to continue to behave as in the past. The daughter also said that this role was very important for her mother.

Maintaining ascendancy or power in care relationships, primarily with their family caregivers, is a way to sustain continuity with the past, because in the past this ascendancy marked the relationships between these elders and their relatives and was a source of identity. Thus, maintaining power in care relationships is a way of maintaining dignity, primarily the dignity of identity.

Cherishing the Caregivers

Cherishing the caregivers consists of actions and interactions with the primary purpose of maintaining good relationships with caregivers, particularly with family caregivers. *Being friendly* is the first property of cherishing the caregivers and includes smiling, praising, and caressing. *Cooperating* is the second property and involves responding positively to caregiver requests to make the caregiver's work easier. The third property is *transferring power*, which is characterized by allowing the family caregivers to make decisions regarding care organization and care practices. The following field notes help to explain these properties:

> In every home care visit the older person praises his wife a lot. He says, "I have my queen, my saint, my sweetheart. Women like her do not exist anymore." (Field note written on 20 March 2013; morning visit to a 72-year-old man, married, totally dependent–bedridden)
>
> The home care worker asked him if he wanted to take a bath and immediately he looked to his wife in order to get an answer from her. Later on, he also let his wife decide on the position of his pillow. (Field note written on 18 April 2012; afternoon visit to an 81-year-old man, married, totally dependent–bedridden)

When we tried to understand why these elders had this behaviour pattern, two reasons emerged: fear of being abandoned or neglected, mainly by their family caregivers on whom they totally depended, and also gratitude towards the caregivers. These elders, who were totally dependent and bedridden, recognized that the care they received was very demanding for their family caregivers; consequently, they feared that their family caregivers might abandon their roles or start to neglect them, which would put their human dignity and well-being at risk. To reduce this risk, the elders endeavoured to promote a good relationship with the family caregivers. The fear of losing the family caregivers and the concern to maintain good relationships with them is evident in the following testimony:

> "What would I do without my wife? It is she who takes care of me, so I have to treat her well, I have to show good manners." (72-year-old man, married, totally dependent–bedridden)

At the same time, "showing good manners" with the family caregivers and praising them was an implicit form of gratitude, as the elders acknowledged that their caregivers provided them with very demanding care in terms of time and energy:

> "I want my wife to be satisfied with me because she is the one who takes care of me. Poor her, at her age … it is difficult for her to handle this … She has a hard time with me … Therefore, I have to do what she wants … What she is doing is hard but very important for me! It is she who takes care of me." (81-year-old man, married, totally dependent–bedridden)

This pattern of behaviour preserves two main forms of dignity. First, it preserves human dignity, as it is a behaviour aimed at preventing possible abandonment and neglect from the caregivers. Second, it preserves the dignity of moral stature, whereby these elders acted according to moral standards, given that their behaviour expressed gratitude towards the caregivers, particularly family caregivers.

Disconnecting from Life

The last mode of preserving dignity is *disconnecting from life*, a counterintuitive mode. The central characteristic of this mode is an intentional desire to cut all links with the world, which is perceived as the only way to escape indignity and to preserve some dignity. Disconnecting from life has three properties: *closing oneself off*, *not cooperating*, and *wanting to die*. *Closing oneself off* is cutting the connections with the world, including not watching television, not initiating or maintaining conversations, and excessive sleeping. *Not cooperating* includes actions such as not responding positively to caregiver requests, inertia, and irritability or aggressiveness. The following field note illustrates the first two properties:

> The older person is always sleeping or sleepy, lying in a fetal position. He does not watch TV, listen to the radio, or read a book or a newspaper. He is completely turned in on himself. … Once again he offered resistance to the home care workers' requests (he is reluctant to obey their requests). He only speaks if someone asks him something. (Field note written on 12 April 2012; afternoon visit to an 87-year-old man, widower, totally dependent–bedridden)

The last property includes the wish to die, as explicitly expressed in the following testimony:

> "I have to die. Someone should give me death, right now. This entire situation has to have an end. I'm sick of this." (84-year-old man, married, totally dependent–bedridden)

Data analysis revealed that *closing oneself off* and *not cooperating* are linked with the wish to die, as they are an attempt to "speed up" the coming of death.

These elders expressed high levels of suffering and discontent, as they felt disrespected by their home care workers and family caregivers and neglected by their family caregivers. In addition, they felt that they were a burden for their caregivers, especially their family caregivers. Apparently, the perception of being a burden for their caregivers is incongruent with the perception of being neglected by them. However, the elders implicitly established disrespect and negligence as a consequence, at least partially, of the type of care they received (very demanding, given that they were bedridden). When talking about the poor conditions in which he lived, an 87-year-old man, a widower and totally dependent and bedridden, offered us the following justification: "Yes, I know, it is not easy caring for people like me …" Another elder gave us implicitly the same justification for the neglect he had faced:

> Researcher: "You often fall on the floor and then you stay lying on the floor for a long time?"
>
> Older person: "Yes. Many times" [facial expression showing sadness].
>
> Researcher: "Why does this happen to you?"
>
> Older person: "I don't know!"
>
> Researcher: "You don't know?"
>
> Older person: "I don't know … Having a father in this situation [bedridden] … needing all of this … I don't know!" (84-year-old man, married, totally dependent–bedridden)

This man did not explicitly express the wish to die, but he tried to commit suicide. During informal conversations, the home care workers told us that he talked about wanting to die several times. They also said that they had no doubt that family negligence was the main reason for his suicide attempt.

Considering that *disconnecting from life* implies a wish to die, to what extent does this pattern of behaviour contribute to the preservation of dignity? As evidenced in previous testimonies, in a situation of extreme suffering and discontentment, in which the older individuals cannot find joy in life and feel they are a burden, dying emerges as the only way to escape indignity and to preserve the human dignity they still have (however minimal), as well as dignity of moral stature (their death would liberate the caregivers from a burden). According to Nordenfelt (2009), putting an end to one's life can be the only way to maintain self-respect and can be viewed as an act of exceptional moral value. As Améry (1994, p. 119) clarified, the wish for negation, "for the anti-ego of nothingness", appears only when the level of torment is extremely high. Undoubtedly, this is a drastic and extreme mode of preserving dignity that should not be an option.

Selecting the Modes of Preserving Dignity

Data analysis indicated that two evaluative processes play a significant role in the selection of the preserving-dignity modes. We conceptualized the first process as *inventorying what one still has*, a subjective process of practical reasoning, more or less conscious, through which the elders took stock of several life aspects. The second process was conceptualized as *judging the worthiness of living*, a subjective process of moral reasoning, more or less conscious, that was characterized by an evaluation of one's satisfaction with life (a subjective appreciation of life in general, including cognitive and emotional elements) weighed against an evaluation of the impact of caregiving on the lives of one's caregivers, primarily the family caregivers. Each mode of preserving dignity is associated with different inventories and different judgments.

These two processes are, in turn, shaped by several structures and dynamics. The structures include the elders' *internal structures*, that is, the condition of the body and mind (reflected in the level of dependency), as well as the *external social* and *cultural structures*, that is, the macro social norms, values, and discourses or ideologies that are mobilized by the elders to make sense of their experiences. Finally, the *dynamics* refer to the *quality of the interactions* between the elders and their caregivers.

The links between the processes of inventorying and judging and the modes of preserving dignity on the one hand, and the links between the structures and dynamics and those processes of inventorying and judging on the other hand, need to be further explored and will be the focus of future research studies.

Discussion and Conclusions

This article has explored how elders who received social care in the community experienced the loss of dignity and how they preserved their dignity. The findings presented in this article reveal that loss of dignity is a major concern for those elders who receive social care in the community, which is consistent with the findings of other studies carried out in several Western countries (e.g., Lloyd et al., 2014; Tadd & Calnan, 2009). Loss of dignity is a major concern in the lives of these elders because the losses of independence, autonomy, privacy, and other losses are particularly problematic in Western contemporary societies, as these societies put a high value on independence, autonomy, individual action, and responsibility (Bauman, 2000; Beck & Beck-Gernsheim 2002; Giddens, 1991). Also in accordance with other studies (e.g. Bayer et al., 2005; Hall, Longhurst, & Higginson, 2009), our findings suggest that the sense of loss of dignity is caused by a confluence of different kinds of related losses. Some elders felt that they lost "identity" (past self-images), and they struggled to preserve it whereas others felt that they had lost basic values, such as human dignity, and struggled to preserve those also.

Our findings also demonstrate that preserving dignity was a pattern of behaviour among these individuals as a response to the effective and potential loss of dignity. But what is particularly interesting is that preserving dignity was put into practice through different modes, which ranged from active engagement with life (*keeping going*) to the desire to put an end to life (*disconnecting from life*). However, as we had the opportunity to verify, the modes of preserving dignity did not, in our study, preserve the same forms of dignity identified by Nordenfelt (2009), and the degree of preserved dignity differed (for example, the elders in the *keeping going* mode would preserve more dignity of identity than the elders who were in the *sheltering in personal spaces* mode).

Our *keeping going* category of dignity preservation resembles the "keeping going" category identified in the study by Tanner (2010), as this category also includes actions such as "keeping busy", "having routines", and "not putting on others". In turn, the content of the *sheltering in personal spaces* category of dignity preservation is partially addressed in the study by Nicholson et al. (2012), more specifically in the theme "sustaining connections within the home." Finally, the content of the *disconnecting from life* category of dignity preservation is found in similar terms in Lawton (1998) as the "unbounded patients" (patients who had no control over their intestines and bladders) "disengaged" from life before their physical cessation, or death. The other two modes of preserving dignity (*reaffirming power* and *cherishing the caregivers*) are not found, at least in a systematic form, in the literature reviewed here earlier.

The five modes of preserving dignity are constituted by actions of struggle against the loss of dignity, which contradicts certain stereotypes that associate elders with passivity and resignation. Other studies have also reported that elders exert agency even in adverse situations (e.g., Grenier, 2005, 2012; Hammarström & Torres, 2010; Lloyd et al., 2014; Wiles, Wild, Kerse, & Allen, 2012). Nevertheless, preserving dignity is inevitably shaped not only by micro contexts (family resources and dynamics) but also by macro contexts (prevalent social discourses on ageing, ageism/age-related stigma, etc.).

In addition to concluding that the elders who receive social care in the community preserve their dignity through different modes, there are three other main conclusions worth emphasizing. First, our findings suggest that preserving dignity in later life while receiving social care in the community is, in general, a different process from preserving dignity in the context of health care, mainly health care provided in institutional settings. In the literature review section, we saw that Chochinov's model identifies three responses or strategies to cope with a terminal illness, namely "living in the moment" (not dwelling on the illness), "maintaining normalcy" (sticking to a routine), and "seeking spiritual comfort" (finding solace in spiritual or religious practices). While "maintaining normalcy" has some similarities with the *keeping going* mode, given that in both responses there is an emphasis on maintaining a routine, the other responses/strategies found in Chochinov's model have no similarities with the other modes of preserving dignity described in this article.

In turn, we hypothesize that most of the modes of preserving dignity presented in this article are less likely to be found in the context of health care provided in institutions, especially in hospitals. For example, the sense of "still having a life", which is very important in the *keeping going* mode, would have a lower probability of being found in elders who are hospitalized or who are living in a care home rather than in elders who are living in the community. A systematic review on care home life (Bradshaw, Playford, & Riazi, 2012) found that some residents try to maintain certain activities and relationships and that these are associated with perceived quality of life. However, this review also highlighted that in many care homes daily life is regimented and restricted, with few opportunities for each elder to develop their own routines based on their individual wishes and preferences. Hence, we admit that older people living in care homes are engaged in preserving dignity, but the modes they use to do that might differ from those described in this article and which could be further investigated.

On the other hand, *personal spaces* and *power*, important elements in the dignity preservation modes *sheltering in personal spaces* and *reaffirming power* respectively, are ingrained in the meaning of home. Home is the primary locus of security and freedom for older people (Dahlin-Ivanoff, Haaqk, Fänge, & Iwarsson, 2007) as well as the place where older people have more control and power in care relationships (Twigg, 2000). In health care settings, including care homes, the rigidity of time schedules and routines (Bradshaw et al., 2012), the surveillance exerted by the staff, and the institutionalized power asymmetries that still exist between the patients and the staff will inhibit *sheltering in personal spaces* and *reaffirming power*. The modes of preserving dignity that will have a higher probability of being found in the context of health care are the modes of *cherishing the caregivers* and *disconnecting from life*, although the properties of these two modes are strongly connected with regular family caregiving.

A second conclusion is that, in the context of community-based social care, there are other important dignity factors in addition to those that have been highlighted by the literature already reviewed. In each mode of preserving dignity, there are central dignity factors, such as activities and relationships in the *keeping going* mode, personal or intimate spaces in the *sheltering in personal spaces* mode, power in the *reaffirming power* mode, caregivers and gratitude towards the caregivers in the *cherishing the caregivers* mode, and death in the *disconnecting from life* mode. Some of these dignity factors do correspond to those identified by the literature reviewed. In turn, other dignity factors identified in the literature reviewed are relevant in these modes of preserving dignity, but mainly by their absence rather than their presence. This is the case for "privacy" and "being treated with respect" which are absent in the *disconnecting from life* mode. Nevertheless, our study also identified dignity factors not mentioned, or mentioned only partially, in the reviewed literature, such as personal spaces (somehow different from privacy), power (somehow different from respect), and death (not mentioned in the reviewed literature).

Finally, our findings also demonstrate that preserving dignity in later life, while elders receive community-based social care, is not circumscribed to performing physical and mental activities, the core ideas of the discourses of successful and active aging. Being physically, mentally, and socially active is crucial in the *keeping going* mode of preserving dignity, but when performing these activities is strongly limited because of health problems or for other reasons, or when performing these activities is perceived as more harmful than beneficial for the elders' selves, other important and complex activities or processes – some of them including aspects of a symbolic nature – emerge as fundamental to dignity preservation. The properties of the other three modes of preserving dignity are examples of these complex activities/processes such as resigning oneself to emptiness, slipping into inwardness, demanding and complaining, accentuating status, and so on. Furthermore, preserving dignity in later life does not depend solely on individual action and responsibility, as idealized by the most radical discourses of successful and active aging; it also depends on the relationships with other persons, especially with the caregivers. This is clearly evident in all five modes of preserving dignity as presented here. Other studies have also emphasized the relational nature of care (e.g., Lloyd et al., 2014; Tadd & Calnan, 2009).

Therefore, while individuals receive social care in the community, preserving dignity in later life is a process put in place by different modes, which differs from the process of preserving dignity while receiving health care, especially health care provided in institutional settings. Furthermore, it is a complex process, depending not only on performing activities (being active) and individual action and responsibility, but also on other actions, some of them involving a certain inactivity or passivity, and interactions with others, especially caregivers.

This article, in addition to contributing to a deeper understanding of preserving dignity in later life in the context of community-based social care, offers insight into an approach to develop policy measures and professional practices which better promote dignity in this domain of reality. The conclusions of this article point to the need to develop policy measures specifically aimed at promoting dignity in the context of social care, given that preserving dignity in the context of community-based social care is a different process from preserving dignity in the context of health care.

These measures could include, among other things, the development of a framework for guiding social care practice that integrates the finding that preserving dignity is a process with multiple possible "routes" (not only the "route" of maintaining physical, mental, and social activities) in which the support from caregivers plays an important role. Such a framework could be helpful, because the different modes of preserving dignity require different approaches from the social care workers and family members in order to effectively ensure dignity. For example, knowing that an older person is in the *sheltering in personal spaces* mode, in which personal or intimate spaces are valued, helps the social care workers and/or family members be aware that insisting on activity, outdoor outings, and other similar activities could be counterproductive for the older person. Other examples could be offered. Furthermore, such a framework for guiding social care practice to promote dignity could function as a "counter-perspective to the rational–technocratic practices" focused essentially on the bodies and impairments which remain dominant in the social care services of many countries around the world (Grenier, 2008, p. 207).

The main limitations of our study are a restrictive sampling and a cross-sectional bias. Theoretical sampling was used with several constraints, given that certain cases that could contribute to the process of constant comparison were not available at the institution from which the elders were recruited. For example, it would have been useful to find other research participants in similar circumstances as those who are designated as in the *disconnecting from life* mode in order to better saturate this category, as some of its evidence is based on implicit accounts. Furthermore, the sample includes elders who were receiving home care provided by the voluntary sector (private not-for-profit organizations), not including elders who were receiving such care from the market (private for-profit organizations). It is also noteworthy that the elders would probably be more comfortable in disclosing certain aspects related to the care relationship if their caregivers (family members and/or home care workers) were not present during the informal conversations with the researchers. Finally, although data collection was performed for nearly two years, the patterns of transition between the modes of preserving dignity were not captured. In future research, it would be interesting to study the transitions between modes over time.

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