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Dignity from the perspective of institutionalized elderly and their families: an integrative review

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Abstract

Human dignity is constituted by what is lived and experienced; therefore, it is relevant to investigate the relationships between sense of dignity by elderly and institutionalization. This review aimed to identify international articles on dignity in long-term care institutions from the perspective of institutionalized elderly and their families. The empirical material, selected in June 2024, consisted of 18 studies published between 1998 and 2023. The data were coded and analyzed according to thematic similarity. Two thematic units were established: dignity for aged adults and their families from the perspective of the external dimension, and dignity for elderly and their families from the perspective of the internal dimension. It is concluded that the quality of care, environmental conditions, family support, and psycho-emotional and spiritual experiences play a fundamental role in the preservation (or not) of dignity.

Keywords: Homes for the aged. Respect. Aged. Review.

Resumo

Dignidade na perspectiva de idosos institucionalizados e familiares: revisão integrativa

A dignidade humana se constitui naquilo que é vivido e sentido, portanto é relevante investigar as relações entre o senso de dignidade dos idosos e a institucionalização. Esta revisão teve como objetivo identificar produções internacionais sobre dignidade em instituições de longa permanência na perspectiva de idosos institucionalizados e seus familiares. O material empírico, selecionado em junho de 2024, foi composto por 18 estudos publicados entre 1998 e 2023. Os dados foram codificados e analisados quanto a similaridade temática. Duas unidades temáticas foram estabelecidas: dignidade para idosos e seus familiares na perspectiva da dimensão exterior e dignidade para idosos e seus familiares na perspectiva da dimensão interior. Conclui-se que a qualidade do cuidado, as condições do ambiente, o suporte familiar e as experiências psicoemocionais e espirituais têm papel fundamental na preservação (ou não) da dignidade.

Palavras-chave: Instituição de longa permanência para idosos. Respeito. Idoso. Revisão.

Resumen

Dignidad en la perspectiva de adultos mayores institucionalizados y sus familiares: revisión integradora

La dignidad humana se constituye en aquello que se vive y se siente; por ello, resulta relevante investigar las relaciones entre el sentido de dignidad de los adultos mayores y la institucionalización. Esta revisión tuvo como objetivo identificar producciones internacionales sobre la dignidad en instituciones de larga estancia desde la perspectiva de los adultos mayores institucionalizados y sus familiares. El material empírico, seleccionado en junio de 2024, estuvo compuesto por 18 estudios publicados entre 1998 y 2023. Los datos fueron codificados y analizados según la similitud temática. Se establecieron dos unidades temáticas: la dignidad para los adultos mayores y sus familiares desde la perspectiva de la dimensión exterior, y la dignidad para los adultos mayores y sus familiares desde la perspectiva de la dimensión interior. Se concluye que la calidad del cuidado, las condiciones del entorno, el apoyo familiar y las experiencias psicoemocionales y espirituales desempeñan un papel fundamental en la preservación (o no) de la dignidad.

Palabras clave: Hogares para ancianos. Respeto. Anciano. Revisión.

Research

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Dignity refers to the intrinsic value and humanity of each being, it represents what determines the character of a person and what attributes value to existence. It is an innate quality, independent of biological conditions, which can vary according to moralities, social, or behavioral concessions and that lasts throughout life. Human dignity, which is above all existential and constituted by experiences, is linked to individuality, to the unique character of each being and to the distinction from other beings, marked by the ability to regulate oneself through autonomy and freedom [1].

Human dignity can be analyzed in two main dimensions, the interior and the exterior. The inner dimension comprises aspects of identity, self, self-esteem, self-confidence, respect for oneself and self-expression. The second involves the relationship with the outside, the values, what is shared and captured from the world in the interaction with the other and what is subjective [2]. Experiences related to dignity can be apprehended based on narratives and emotional states, especially those linked to situations of remorse, grief and love [1].

Remorse enables you to access the value of the one who has been wronged, harmed by someone, because of his unique characteristic. Grief, especially linked to loss, brings to the awareness that no one can replace the one who was lost, because this was a unique being. Love makes it possible to recognize that if someone loves a person, he does so not because of his qualities or abilities, but because of his essence. Such states reflect the preciousness and irreplaceable value, that is, the dignity of each being [1].

In this sense, the concept of dignity has been used in different areas of knowledge, such as health. In medicine, for example, dignity contemplates a *Status* or value guided by the defense of autonomy and respect for the choices of sick or disabled people in their trajectories in the health system. In clinical evaluation, it is important to consider autonomy, self-respect, and spirituality as intrinsic elements to be mobilized to preserve dignity, in addition to the content and quality of care, extrinsic elements. The culture of care based on excessive bureaucracy and asymmetrical relationships between patients and physicians, marked by actions such as indifference, rejection, objectification, labeling, contempt, discrimination, repulsion and deprivation, are factors that weaken the promotion of health-related dignity [3].

In nursing, dignity is considered the essence of care and is related to individual and social characteristics, with individual characteristics perceived as an inner feeling of being good, self-esteem, being valued and respected, and social characteristics associated with relationships established with friends, family, and professionals, mediated by communication, culture and beliefs [4]. In its individual attributes, dignity also includes aspects of personality and the special value that each one contains. And, as social attributes, respect and autonomy should guide nursing actions with regard to the promotion of human dignity. Such actions include, for example, respect for privacy, confidentiality and belief, and the recognition of the rights and needs of those who are cared for [5].

Moreover, dignity in care must consider the specificities of the phase of illness, old age, and the end of life [4]. Internationally [3], tools and interventions have been developed to assess and promote dignity. Among the assessment tools, the question of patient dignity (patient dignity question [PDQ]), the measuring instrument for dignity Amsterdam (measurement instrument for dignity Amsterdam [MIDAM]), the inpatient dignity scale (IPDS), and the patient dignity inventory (patient dignity inventory [PDI]). As for interventions, dignity therapy (*dignity therapy* [DT]), the approach of dignity in care and life review are among the most used both in hospital environments and in long-term care institutions for older adults (LTCF).

LTCFs are public or private institutions that are characterized by welcoming and assisting people aged 60 or over, that is, older adults, usually with some dependence, with or without family support [6]. In most cases, especially in public institutions, residents are identified as being at social risk due to violence, abandonment, and dependence arising from illness, especially psychological and/or neurological [7]. In such institutions, the right to live life (or the end of it) with freedom, citizenship and dignity must be ensured [6].

From a global perspective, the most accepted chronological definition for older people considers the age of over 65 years for those who live in developed countries and 60 for those who live in developing countries [8]. Japanese Study [9] proposed changing this age limit to 75 years in order to change the lifestyle at this stage, which became more active and healthier, especially in developed countries. This change has led to an increase in life years due to better physical abilities, rejuvenation and reduction of neurovascular and circulatory diseases, which, in turn, requires reforms of social security systems to better assist the older population. Regardless of the delimiter, it is essential that conceptualizations based on chronological parameters observe the social, economic, and historical contexts of each country [9].

Even so, older adults usually show functional decline associated with the progression of chronic diseases and multimorbidity, which results in a greater probability of institutionalization according to age, especially in the absence of a partner and children, or in the presence of low education, sedentary lifestyle, use of medications, need for mobility support, in addition to a diagnosis of Alzheimer's or other dementias, cognitive impairment, and dependence to perform basic activities of daily living [10].

From this perspective, the promotion of dignity in older adults with dementia, for example, requires the identification of personal values and self-identity early, that is, before the complete loss of cognitive functions. With this, it is possible to promote respect for preferences even in the face of commitment and ensure a minimum of autonomy by adapting care and the environment to preserved abilities [11].

Nevertheless, institutionalization can cause depression, feelings of loneliness, isolation, lack of purpose, and a feeling of uselessness, consequences that can be reduced with socialization strategies aimed at sharing moments, life stories, personal, and/or intergenerational knowledge [12]. Likewise, the stay in LTCF can compromise basic psychobiological, psychosocial, and psychospiritual human needs of older adults and have repercussions on nursing diagnoses such as impaired urinary elimination, impaired physical mobility, deficit in self-care for bathing, frail elderly syndrome, hopelessness, low situational self-esteem, risk of loneliness, fear, and ineffective relationships [13].

Therefore, the relevance of investigating the relationships between institutionalization and impairment of the sense of dignity of older adults is justified, both in relation to individual or interior attributes and to social or external attributes. This study aimed to identify international productions on dignity in long-term care institutions from the perspective of institutionalized older adults and their families.

Method

This is an integrative review based on six stages: identification of the theme and definition of the guiding question; establishment of inclusion and exclusion criteria; definition of the information to be extracted; analysis of included studies; interpretation and discussion of the results; and presentation of the review [14].

To define the guiding question, the PICo strategy was based on: in this case, population (P) corresponds to institutionalized older adults and their families; interest (I), dignity; context (Co), institutionalization. This perspective poses the following question: "*What are the productions on the dignity of older adults in long-term care institutions?*".

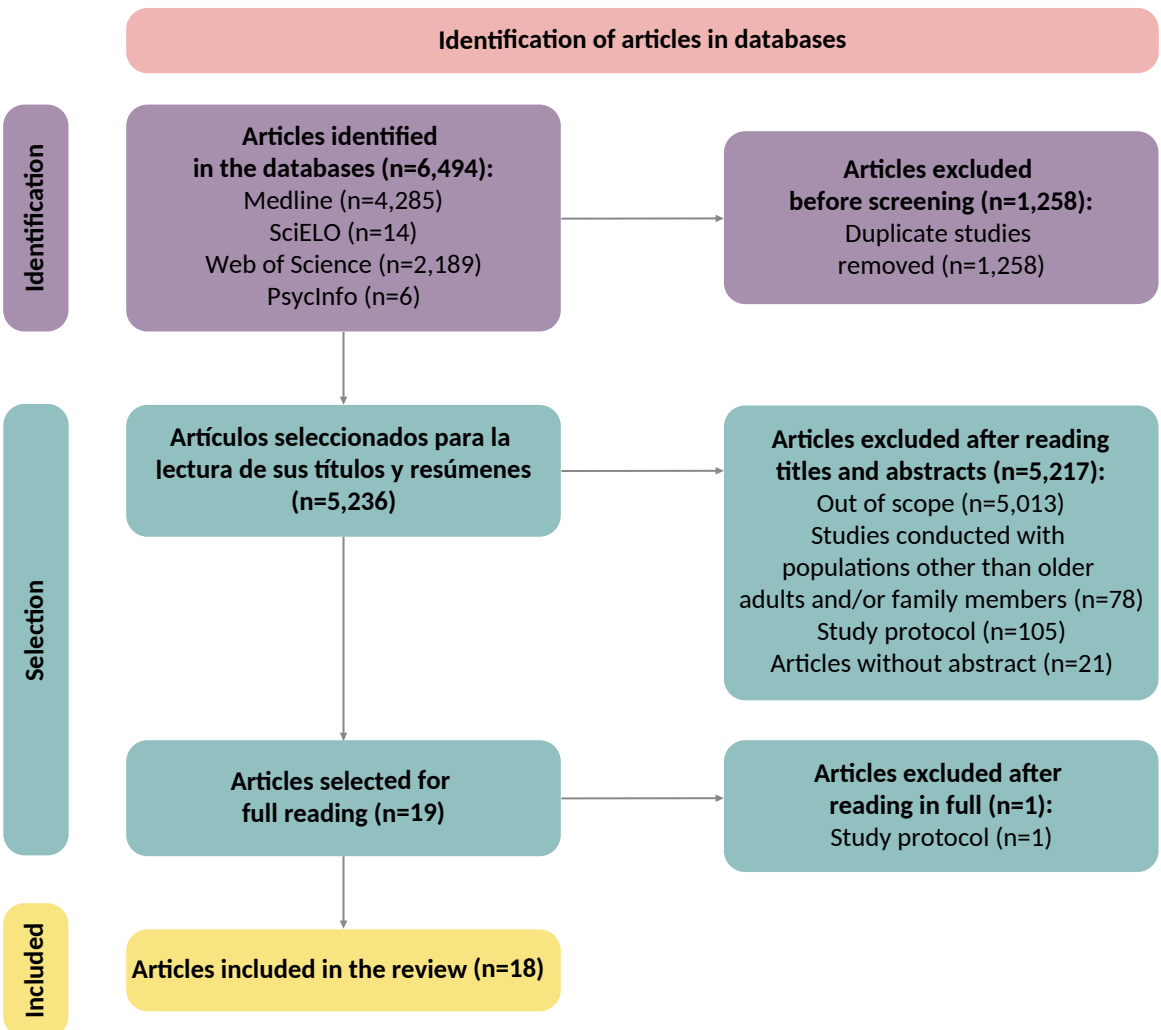
The survey of the studies took place in June 2024 in the electronic databases Medical Literature and Retrieval System Online (Medline), Scientific Electronic Library Online (SciELO), Web of Science, from Clarivate Analytics, and PsycINFO, from the American Psychological Association. The indexed descriptors Medical Subject Headings (MESH) were used: "*respect*", "*dignity therapy*", "*aged*", "*homes for the aged*", "*family and health of institutionalized older adults*" with the Boolean operator "*and*".

Original articles in English, Portuguese, or Spanish with institutionalized older adults or their family members were included, available for access in full free of charge or via the journal

portal Coordination for the Improvement of Higher Education Personnel (CAPES) linked to the Federated Academic Community platform, provided by the National Education and Research Network. No time limit was established to obtain a greater number of studies. Documents such as theses, dissertations, editorials, review articles, research protocols, essays, comments, experience reports, and abstracts or articles published in event annals were excluded.

After associating the descriptors, 6,494 documents were identified. The files extracted from the databases were transferred to the application Online Rayyan – Intelligent Systematic Review. The reading was performed using the blind double-check method. In case of conflict, a third reviewer was called to determine whether or not to include the document. The flowchart in Figure 1, based on the model *Preferred Reporting Items for Systematic Reviews and Meta-Analyses* (PRISMA) [15], shows the step-by-step of this step.

Figure 1. PRISMA Flowchart



For data extraction and characterization, a form built in the Google search management application was used. The following information was extracted: title, authors, year, country, journal, study approach, authors' area of expertise, study participants, data production technique,

framework or theoretical framework, research design, study aim, study participant's illness, and dignity and aspects involved in dignity.

Data collected on dignity and aspects involved in dignity were stored in the program *Atlas.ti* for coding and analysis by thematic similarity [16]. In the end, 16 codes made up the code book selected in 153 excerpts, which were grouped to compose the two thematic units: dignity for older adults and their families from the perspective of the external dimension; and dignity for older adults and their families from the perspective of the inner dimension, based on the model in which human dignity is divided into two main concepts (dignity from the perspective of the outer dimension and dignity from the perspective of the inner dimension) [2].

Results

Box 1 characterize the 18 studies analyzed.

Box 1. Characterization of the empirical material.

Title	Method	Aspects involved in dignity in LTCFs
Oral care, loss of personal identity and dignity in residential care homes (2023) [17]	Qualitative/ descriptive	Positive: oral hygiene performed with privacy, independence, in a respectful way and maintaining personal identity (whether with dental prostheses or natural teeth). Negative: loss of personal identity, abandonment, shame with dental prostheses.
Dignity and the provision of care and support in 'old agehomes' in Tamil Nadu, India: a qualitative study (2022) [18]	Qualitative/ descriptive	Positive: better health care and personal support, freedom of movement and promotion of a sense of autonomy, leisure and socialization, quality of care, medical care and social support. Negative: shortage of professionals, limited freedom, absence of recreational activities and precarious environments.
Dignity in bodily care at the end of life in a nursing home: an ethnographic study (2022) [19]	Qualitative/ ethnography	Positive: leisure and socialization, reinforcement of autonomy and encouragement of self-care. Negative: suffering from physical symptoms, physical limitation, dependence, loneliness, long waiting times to receive care, lack of comprehensiveness in care and deteriorated routines, lack of social interactions, concerns about the disease.
Experiences with dignity among older people confined to beds living in a nursing home: a qualitative descriptive study (2022) [20]	Qualitative/ descriptive	Positive: individualized care, communication, respect, encouragement of autonomy, feeling of being heard. Negative: lack of autonomy, dependence, disrespect on the part of the team, dehumanization, failure to maintain care, unprepared team.
Concept synthesis of dignity in care for elderly facility residents (2019) [21]	Integrative/ qualitative/ descriptive hermeneutic review	Positive: respected individual preference, care with appreciation and equality, preservation in relationships with the external support network. Negative: lack of recognition and involvement with the team, absence of communication and sensitivity, lack of active listening, insensitive approach, feelings of abandonment, strict rules, and lack of privacy.
Factors influencing the quality of life perceptions of cognitively impaired older adults in a nursing home and their informal and professional caregivers: a mixed methods study (2018) [22]	Mixed/descriptive methods and based on the quantitative quality questionnaire of quality of life—Alzheimer's disease (QoL-AD)	Positive: social interaction, kind and respectful caregivers, visits, leisure time, respect for privacy, preservation of identity. Negative: lack of interaction with the team and failure to provide care.

continues...

Box 1. Continuation

Title	Method	Aspects involved in dignity in LTCFs
Tension between freedom and dependence: a challenge for residents who live in nursing homes (2018) [23]	Qualitative/ hermeneutic and descriptive	Positive: freedom, autonomy, respect and preservation of integrity, autonomy and faith. Negative: helplessness, feeling of being ignored, lack of freedom, neglect of autonomy, dependence, insecurity, unprepared caregivers.
Manifestation of respect in the care of older patients in long-term care settings (2015) [24]	Qualitative/ descriptive	Positive: respectful and empathetic nurses, humane care, good professional-patient interaction, basic needs met, comfort, encouragement of self-care and independence. Negative: nurses focused on routines and not on care, haste, lack of interest and attention.
Instituição de longa permanência para idosos: um lugar de cuidado para quem não tem opção? (2014) [25]	Qualitative/ descriptive	Positive: basic needs met, access to health services. Negative: a place without meaning, destined to await death.
Patterns of dignity-related distress at the end of life: a cross-sectional study of patients with advanced cancer and care home residents (2014) [26]	Qualitative/ secondary analysis of merged baseline data from two randomized controlled trials	Positive: unidentified. Negative: dependence, lack of appreciation, anguish due to physical symptoms, difficulty in dealing with diseases, functional limitations, loss of continuity of the self, concern about the future.
The meaning of dignity in nursing home care as seen by relatives (2014) [27]	Qualitative/ hermeneutic	Positive: feeling of "being at home", attentive and interested caregivers, respect for individuality and autonomy, safe and familiar environment, positive interaction with the team. Negative: infantilization, disempowerment, lack of attention to needs, disrespectful interaction, helplessness.
Dignity and the factors that influence it according to nursing home residents: a qualitative interview study (2014) [28]	Qualitative/ descriptive	Positive: maintenance of meaning in life, acceptance of the situation, ability to make decisions, meaningful communication, cognitive acuity, religion, participation in the lives of loved ones, adequate and quality care, preserved self-esteem. Negative: loss of identity, feeling of worthlessness, rigid rules, dependence, loss of control, memory loss, devaluation, feeling of economic overload, lack of professionals, difficulty in the relationship with the team, hurried environment and lack of attention.
Feasibility, acceptability and potential effectiveness of Dignity Therapy for older people in care homes: a phase II randomized controlled trial of a brief palliative care psychotherapy (2011) [29]	Quantitative/ randomized controlled clinical trial	Positive: groups that receive DT show reduced levels of distress and good hope, quality of life, reduced suffering, greater sense of purpose, and benefits for the family. Negative: unidentified.
How respect and kindness are experienced at the end of life by nursing home residents (2011) [30]	Mixed methods/ retrospective research	Positive: respect and kindness, death in a respectful environment, clear and inclusive communication, adequate intimate care, emotional support, family support. Negative: lack of communication, lack of family involvement, inadequate and impersonal care, lack of family support.

continues...

Box 1. Continuation

Title	Method	Aspects involved in dignity in LTCFs
Living and dying with dignity: a qualitative study of the views of older people in nursing homes (2009) [31]	Qualitative/ descriptive	Positive: symptom management, respect for privacy, encouragement of independence, and respect for social and emotional needs. Negative: dependence, anguish and worries about the disease, death and loss of value.
Dignity and the challenge of dying in nursing homes: the residents' view (2007) [32]	Qualitative/ descriptive	Positive: social relationships. Negative: impact of cognitive diseases on social relationships, dependence, loss of identity, insufficient care, lack of control over the dying process.
Dimensions of quality in long-term care facilities in Taiwan (2005) [33]	Qualitative/ descriptive	Positive: recognition of needs by the team, respect for individual preferences, emotional support, social interaction, supportive environment, accessible care. Negative: feelings of neglect, unmet food and cultural needs, feelings of loneliness, emotional repression, lack of trust, difficulties in social interaction, flawed supportive environment, and inaccessible care.
The experience of living-dying in a nursing home: self-reports of black and white older adults (1998) [34]	Qualitative/ descriptive	Positive: religion as a source of comfort, care of the residents for each other. Negative: anxiety, inadequate pain relief (black residents), helplessness, hopelessness, loss of appetite, unprepared staff with no interest or understanding, anger as a way of coping.

In 14 studies [17-23,25,26,28,31-34], the participants were institutionalized older adults; two [27,30] were conducted with family members; and two [24,29], with institutionalized older adults and family members. The main technique for producing data was the interview [17-26,28,30-34], and only one study used the therapeutic tool TD [29]. Among the countries where the studies are conducted are Brazil [25], Germany [32], Canada [30], Slovenia [20], United States [34], Finland [24], Netherlands [28], Japan [21], Switzerland [22], Sweden [19], Taiwan [33], India [18], United Kingdom [17,26,29,31], Denmark, Sweden, and Norway [23,27].

Dignity for older adults and family members

Perspective of the external dimension

The behavior of health professionals impacts the perception of dignity of institutionalized older adults [19]. Harsh words, long waiting periods for care, lack of attention and comprehensiveness in care, unpreparedness and rigidity of the team in routines [19,20] constitute attitudes that neglect dignity and generate negative feelings in residents, such as powerlessness [20] and helplessness [23]. Moreover, care practices that disregard the privacy and autonomy of the individual can further diminish the sense of dignity [31].

The articles showed that the absence or scarcity of professionals in the institutions aggravates the feeling of helplessness [18,28]. Lack of time, absence of staff and overload of tasks make it difficult to build relationships between older adults and their caregivers and compromise attention and quality of care [18,28,32], resulting in the disruption of the dignity of institutionalized older adults, who are often forced to wait for help or to receive care in conditions of haste and neglect [28].

Individualized care is essential to ensure the dignity of older adults [27]. When the team is sensitive, kind, attentive, willing to listen, and encourage older adults to perform daily activities independently, the quality of care improves and allows older adults to feel valued and respected [22,24]. Professionals who prioritize dialogue [21], which make routines more flexible to meet specific needs [24] and that encourage independence [26] demonstrate commitment to dignity.

Moreover, when basic needs are met with empathy and respect, the perception of dignity increases. Care with food, hygiene, help to carry out daily activities independently [25], symptom management [31] and help maintain physical and psychological health [22] provide well-being and satisfaction with care and, thus, favor in residents the perception of living a dignified life, despite physical limitations when performed in a respectful, sensitive, and individual way [27,30].

The use of DT can make the lives of institutionalized older adults more meaningful and improve quality of life, increase the sense of purpose and will to live, and reduce suffering. Moreover, it can help families, as it has been shown to be an effective practice to promote a good end-of-life experience [29].

Respect is also manifested when decisions about residents' lives are shared not only with them, but also with their families. The active participation of older people and their loved ones in decisions about care and in receiving clear and continuous information is essential to preserve dignity and ensure that the needs of older people are met [30].

In addition, social interactions and family support play a crucial role in preserving the dignity of institutionalized older adults [33]. Family reunions, relationships with other residents and social encounters were reported as basic requirements for the construction and maintenance of dignity [32]. Also, effective communication, which often involves overcoming language and cultural barriers, was portrayed as fundamental to avoid social isolation [33].

LTCFs can be good places to live [25], and, even if confined, some residents feel that life preserves its meaning, which strengthens dignity [28]. Nevertheless, for others, the institution is nothing more than a place to wait for death [25], loaded with feelings of abandonment, non-belonging, uselessness before society, devaluation, where they must follow rules and wills imposed by others [28].

Discourses about institutionalization range from "home is where you do it", in an attempt to assign new meanings to the environment, to others associated with the feeling of abandonment, such as "I just got thrown out" [21]. In this context, some older adults are able to adapt to the new routine and accept institutionalization and dependence, which maintain a greater sense of dignity than those who refuse to accept the new reality [28].

One of the main benefits of institutionalization is guaranteed access to health services. Continuous access and availability of care are essential factors for improving the quality of life of many older adults. For those who have fragile health conditions, LTCFs can represent a safe and appropriate environment for the treatment of diseases, which translates into a significant improvement in their physical conditions [25,33].

Another important factor for dignity is the environment and the quality (or not) of the facilities. Poor conditions influence the well-being of residents and compromise the sense of dignity [18]. Some older adults report that living in shared rooms offers a feeling of security and company [28]. However, others say that privacy is an essential factor for maintaining dignity [31].

Leisure also occupies an important space in the routine of institutionalized older adults. This works not only as a form of distraction, but as a means of preserving dignity, whether with activities such as physical exercise and walking [19] or even with social gatherings or religious events [18], insofar as they provide moments of pleasure and interaction [22].

Perspective of the inner dimension

Dependence, whether to perform daily activities or to take care of their own health, is experienced by residents as a constant threat, as they find themselves unable to take care of themselves [19,23,32]. Physical problems such as tiredness, pain, and loss of functions are the main responsible for this feeling of loss of dignity, as the loss of self-care skills is progressive [19].

Dependence entails feelings of being a burden for those who care [20,23], loneliness [19,28], distress and disability [26], lack of purpose [19], embarrassment [31], anger and sadness [20]. Moreover, institutionalized older adults consider that being dependent is a threat to autonomy [23] and to their own identity [17], as health declines while illness progresses,

body and strength are no longer the same, and the need for help increases [17].

Older adults show some resistance to asking for help, as this constantly reminds them of the weight of dependence and loss of autonomy [33]. A study showed that teaching and encouraging older adults to take care of their personal hygiene independently led to ongoing efforts to actively participate in their own care [19]. This quest to maintain autonomy and a sense of dignity in older adults allows them to feel that they still have control over important aspects of their lives [23].

The act of relying on others for such intimate care as personal hygiene and oral hygiene can be seen as an invasion of privacy. For many of these older adults, maintaining dental hygiene, whether with natural teeth or dentures, is directly linked to maintaining personal identity and appearance, a fundamental part of what they consider their dignity [17].

On an emotional level, addiction is not restricted to the physical impact, but also affects the mental health and self-esteem of older adults. The feeling of no longer being able to play important roles, of not being able to fight the challenges of the disease and of being stuck in a routine that no longer reflects who they were generates deep anguish [26]. Loneliness, lack of prospect of improving health [28] and fear of death [31] contribute to feelings of depression and hopelessness. This decline in bodily health and functionality is often accompanied by a feeling that life has lost its value and the loss of continuity of self [26].

The maintenance of personal characteristics despite the disease, communication and the preservation of cognitive skills are considered essential to maintain dignity [19,28]. For many, the loss of the ability to communicate or the development of cognitive diseases such as forgetfulness, feelings of disempowerment, violation, infantilization and undervaluation are seen as factors that affect dignity [27]. Despite this, some older adults still manage to maintain a level of self-esteem by defending themselves or showing indifference to external opinions [28].

Search for dignity is transformed into the search for recognition due to old age from an attempt to maintain dignity in spite of it, either via adaptation to organizational rules or the management of economic and personal implications, self-care and decision-making [32].

Having a dignified death is also something considered important by older adults. Being active until the last moment, having respect for one's wishes, not feeling pain, being close to people important to oneself, saying goodbye in private and dying at the right time means maintaining one's dignity until the last minute of life [32].

In addition, religious faith offers a source of comfort and hope in the face of the difficulties of illness and the loss of autonomy [28,34]. Religious beliefs can mitigate the fear of death and provide a sense of peace and acceptance. Feeling supported by their faith helps older adults to preserve their dignity and to resign themselves to moving forward [28].

Furthermore, the relationship of older adults regarding respect and freedom is essential for the preservation of dignity, especially in the context of institutionalization. Even facing neurocognitive disorders and decreased ability to perform daily tasks, older adults still express the need to respect privacy, autonomy and life history. Respect for their private lives was highlighted as a crucial factor, as it connects them to their identity and personality [22].

The violation of dignity and respect occurs when older adults are not seen by others as unique individuals, but as part of a group, which disregards their needs and desires [27]. When their promises are not fulfilled or when they do not have the opportunity to make their own decisions, the feeling of disrespect intensifies [27,28].

Finally, having freedom is important to maintain dignity [23]. LTCFs, especially private ones, impose severe restrictions that lead to feelings of imprisonment and lack of freedom [18]. Moreover, the older adults feel deprived of the ability to decide for themselves [20], even though they have the freedom to think what they want [23]. Although they maintain the freedom to think, this autonomy is nullified by physical limitations and lack of choice in everyday actions. Locked doors, for example, symbolize the loss of freedom and autonomy, while sharing a room with someone unknown also represents a violation of your personal freedom and intimate space [23].

Discussion

The promotion of dignity from the perspective of the external dimension encompasses both the practices developed by health professionals and the socio-structural factors that permeate the experience of older adults institutionalized in LTCFs, which directly influence the perception of respect, value and recognition of older adults as a singular subject.

The assistance of the multidisciplinary team is central to this promotion, as it favors more effective and comprehensive health care, as long as it assists and prioritizes the individual in all dimensions, whether physical, social, emotional or psychic [35]. Moreover, the way of acting and caring, if based on the domain of the aging process, evaluation of health conditions, management of chronic diseases and, above all, on relational attitudes such as empathetic communication and respect, exerts a significant impact on the perception of quality of life, well-being, autonomy and dignity [36]. Nevertheless, the absence or scarcity of professionals compromises the quality of care, intensifies feelings of anguish and helplessness among institutionalized older adults, and overloads workers, causing damage to the health, especially mental health, of workers in institutions [37].

Respect for individuality is an essential element for the preservation of dignity. Actions aimed at nutritional, hygiene and comfort demands, when conducted in an appropriate and respectful manner, transcend the technical dimension and reaffirm the recognition of older adults as human beings, contributing to the preservation of their identity and self-esteem [38]. In this sense, therapeutic interventions such as dignity therapy stand out for favoring reflection on the trajectory of life, coping with psychosocial suffering and attributing meaning to existence [39].

Institutionalization can give rise to ambiguous feelings, which oscillate between approval and contentment with the environment and discomfort, impotence and loss of autonomy. Changes in routines and social relationships and the need to follow institutional norms can negatively impact the perception of freedom and dignity [40]. In this context, the relationship between health professionals and family members, especially with regard to dialogue, plays a fundamental role because it strengthens bonds, favors shared decision-making, and reduces anguish and uncertainties related to care and institutionalization [41]. Moreover, leisure activities are a relevant strategy within LTCFs, as they promote well-being and satisfaction and help to ward off loneliness [42].

From the inner perspective, dignity is strongly associated with the maintenance of autonomy and independence. Physical and functional limitations intensify feelings of incapacity and loss of purpose, so that they affect self-esteem and the value attributed to oneself [43]. From an emotional perspective, dependence produces negative effects both on mental health, mainly linked to depression, and on the self-esteem of older adults, aggravated by social isolation and institutional routine [44]. Moreover, dignity is related to subjectivity and individualism, and, therefore, stereotyping older adults as a homogeneous group distances their individuality and contributes to the contempt of the right to dignity [45], a notion corroborated by the results obtained in this review, according to which maintaining one's own characteristics and preserving one's self-esteem is a way to cultivate dignity.

From this perspective, autonomy emerges as an expression of social and programmatic relations that reveal different forms of vulnerability (interpersonal, social and programmatic) in the daily care routine. The common challenges faced by older adults, such as social isolation and inadequacies in the routines of the services, function as markers of this vulnerability and require care strategies that respect the unique needs of each individual, while promoting an ethical care practice that is responsive to the life circumstances of older adults [46].

Living with dignity also implies dying with dignity. Dignified death is understood as one that prioritizes relief from suffering, pain control, respect for the natural course of life, and emotional, spiritual, and family support, and thus promotes comfort and serenity at the end of life [47]. In this process, religious beliefs offer comfort and mitigate the fear of death, thus helping to preserve dignity [48].

Finally, dignity is perceived when respect is maintained and life history, liberty and privacy are

preserved. Dignity in the care of older adults is seen when there is an experience of respect, trust, security and charity, and dignified care is based on respect and kindness. Dignity and respect are violated when older adults are seen as belonging to a group and do not participate in decisions about their own health, when there is a feeling of abandonment, non-belonging, forgetfulness and loneliness [49].

Final considerations

By identifying and analyzing international productions on dignity in long-term care institutions from the perspective of institutionalized older adults and their families, this review highlighted an important gap in the literature, especially in the Brazilian context. The privileged languages stand out as a limitation of this work; the fact that only one study was conducted in the national context; and the small amount of research that investigates the opinion of older adults about dignity in the context of institutionalization. Even so, this review promotes progress through the systematization and integration of evidence, which contributes to the understanding of dignity as a multidimensional phenomenon, crossed by individual, relational and institutional factors.

The findings indicate that the quality of care, the conditions of the environment and family support are central to the preservation or violation of the dignity of institutionalized older adults. The performance of attentive, empathetic and respectful health teams, combined with the satisfaction of basic needs, favors the well-being, self-esteem and recognition of older adults as a dignified subject. In addition, social interaction, especially with family members and other residents, strengthens the sense of belonging and continuity of affective bonds and, therefore, is also configured as a protective factor for dignity.

On the other hand, lack of attention, disregard for individual needs, overload of professionals' tasks and precarious conditions in LTCFs can intensify feelings of helplessness, powerlessness and exclusion and compromise the physical and emotional dignity of residents. The institutional environment, therefore, emerges not only as a space of care, but as a structuring element of the experience of dignity.

Moreover, this review shows that psychoemotional and spiritual experiences can impact the preservation of autonomy and the ability to attribute meaning and value to life. Religious beliefs are a source of consolation, relieve the fear of death and provide a sense of peace, acceptance and strength. Faith allows older adults to find a sense of continuity and belonging, essential to maintain their inner dignity until the end of life.

Finally, the results broaden the understanding of dignity beyond an individual attribute, as they highlight its relational and contextual character. These findings offer relevant support for the qualification of care practices, the training of health professionals, and the formulation of public policies aimed at promoting ethical, humanized care centered on the uniqueness of institutionalized older adults.

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