Empowering Marginalized Elders- SPAIN

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CHAPTER 1

DEFINITION OF EME AND GENERAL EUROPEAN PRACTICES

1. 1. Elderlies in Europe profile

The percentage of people aged up to 14 years old decreased from 25 per cent to 16 per cent in the 25 European Union countries between 1960 and 2004, whereas the proportion of the population aged 65 and over rose from 10 to 12 per cent during the same period and is expected to rise to 30 per cent by 2050. Moreover, the biggest population increase affects those aged over 80 years, the number of whom is expected to double by 2050 to 51 million citizens (Eurostat, 2007). Women account for 59 per cent of the population aged 60 or over in Europe and for 70 per cent of the oldest-old. This increment of the age is strongly correlated with three negative and confluent processes: the biological and economical degradation, and the social exclusion (Compan & Sanchez, 2005).

Elderly population have needs of feelings of love and care; to be known from a deep perspective (feelings, believes, wishes, thoughts, etc.); care with humanity and dignity rather than taking them away from their families; to be respected as free citizens, that can take own decissions and not as old children and to receive support to consider themselves and be responsible for their own actions. At the same time, there is

very much evidence rising that older people experience more disability, dependency and morbidity, to be more at risk of living alone, and constitute the majority of those with health problems in developed countries (Grundy & Sloggett 2003; Institute of the Elderly and Social Services, 2006).

1. 2. EME definition

"Social marginalization" (Cury, 2009) might be defined as a process through which a society rejects to a group of persons through indiference, repression, auto-marginalised by own individuals by rejecting values and social rules.

Marginalization is a slippery and multi-layered concept. Whole societies can be marginalized at the global level while classes and communities can be marginalized from the dominant social order. Similarly, ethnic groups, families or individuals can be marginalized within localities. To a certain extent, marginalization is a shifting phenomenon, linked to social status (Burton & Kangan, 2003).

Being poor, unemployed, discriminated against, or being disabled by a society that won't work around the problems of impairment; they all bring with them the risk of exclusion. Being excluded from economic, social and political means of promoting one's self-determination can have adverse effects for individuals and communities alike (Burton & Kangan, 2003).

Some reason for Marginalization of elderly depends of economy, education, culture and health could be:

- Change in family relationships (difficultness for co-living and breaking of family groups).
- Lost of the hegemonic role that elderly used to have in the past.
- Mythicization of the consuming society (praise endless youth)
- Hedonistic view of life (searching always for satisfaction).
- Emigration from the family (children and grandchildren).

People who are marginalized have relatively little control over their lives and the resources available to them; they may become stigmatised and are often at the receiving end of negative public attitudes. Their opportunities to make social contributions may be limited and they may develop low self-confidence and self esteem. If they do not have work and live with service supports, for example, they may have limited opportunities for meeting with others, and may become isolated. A vicious circle is set up whereby their lack of positive and supportive relationships means they are prevented from participating in local life, which in turn leads to further isolation.

It is evident that groups of the population who experience social marginalization are more likely that than the rest of the population to experience mental health problems. They are also more likely to be over-represented (in terms of their proportion of the population) in psychiatric hospital admissions. It is clear that the social determinants of health are relevant here. Factors such as no money, discrimination, social exclusion, lack of education and poor housing standards have a major impact on the mental health of socially marginalised people (CSDH, 2008 - WHO Commission on the Social Determinants of Health).

"Social exclusion" might be defined as living in conditions of deprivation and vulnerability, such as poverty; inadequate access to education, health and other services; lack of political influence, civil liberties, and human rights; geographic isolation; environmental exposures; racism or historical trauma; disruption of social capital and social isolation; exposure to wars and conflicts; alienation or powerlessness. Defined by the International Society for Equity in Health, global inequities (or disparities) of health are the "systematic differences (potentially remediable) in one or more aspects of health across population groups defined socially, economically, demographically or geographically" (Macinko & Starfield 2002).

"Misstreat" (by "Action on Elder abuse" WHO; 2007) might be defined as unique action or repeated, or lost of responses that occur in any relationship where exists expectations of confident and that produce damage or distress to an older person. Types of mistreat: Physical; Psychological (emotional mistreat or neglect); Sexual abuse; Financial abuse (unauthorized illegal use of an elder's resources); Negligence, neglect and omission of care (or bad provisions of care); Self-negligence and self-neglect (the elder attack his/her own health and wellbeing).

Vulnerable fields to suffer mistreats (Sánchez, García-Armesto, Pajares, Otero & Ruiperez, 2004): low pensions; lack of social policies and resources to keep the elders in their own environment; lack of health centers; stigmatization of the elderly as pasive individuals and non-productive, adverse social context. The more aged and poor people (mostly women) are an increasingly important poverty group very poorly attended by the system of public social services.

Settings where mistreat is produced:

- Socio-cultural. When social policies do not ensure resources and social, health, accommodation services, etc., or pensions that do not meet with the minimun requirements.
- Domestic or family. Abuse in taking care of grandchildren and responsibilities, inappropriate nutrition, emotional discomfort, neglect.
- Institutional. Non qualified staff, burnout, dehumanization, deprivation of privacy, active or pasive negligence, physical containment, sedative provision.

"Elder abuse" might be defined as act of commission or of omission (in which case it is usually described as ''neglect''), and that it may be either intentional or unintentional. The abuse may be of a physical nature, it may be psychological (involving emotional or verbal aggression), or it may involve financial or other material maltreatment (WHO, 2007).

1.3. General European practices

Community empowerment has roots in community psychology, education and health promotion, liberatory adult education, community organizing, rural and community development, and social work. Empowerment has been defined as "a process by which people, organizations and communities gain mastery over their affairs" (Rappaport, 1987); with community empowerment as a "a social action process by which individuals, communities, and organizations gain mastery over their lives in the context of changing their social and political environment to improve equity and quality of life" (Wallerstein, 2006).

Empowerment strategies therefore mean challenging control and social injustice, through political, social, and psychological processes that uncover the mechanisms of control, the institutional or structural barriers, the cultural norms and social biases, and therefore enable people to challenge internalized oppression and to develop new representations of reality. Empowerment can be seen as a dynamic interplay between gaining greater internal control or capacity (personal transformation/psychological empowerment) and overcoming external structural barriers to accessing resources (community or institutional transformations) (Speer & Hughey, 1995).

Some studies (Rueda & Artazcoz, 2009) emphasise the importance of using an integrated approach for the analysis of health inequalities among elderly people, simultaneously considering socio-economic position, family characterisctics and social support, as well as different health indicators, in order fully to understand the social determinants of the status of older men and women. In a review of socio-economic indicators in research on health inequalities among elderly people, Grundy and Holt (2001) stated that social class or education combined with a deprivation indicator was the most sensitive indicator.

Some practices for marginalized elders improve psycho-emotional status and general well-being need material resources like money, household, food, clothing, services, etc.

Instruments resources like care, transport, house cleaning, functionality. Emotional resources like feelings, company, empathy, recognition, listening. Cognitive resources like experiences exchange, information, education, councelling.

The focus of PROMO project (Best Practice in Promoting Mental Health in Socially Marginalised People in Europe) was on the delivery of health and social care for people with mental health problems who belong to one of the six following groups: (1) long-term unemployed; (2) homeless; (3) prostitutes/sex workers; (4) refugees and asylum seekers; (5) illegal immigrants/undocumented workers; (6) travellers.

Some initiate measures and develops different services for preventing and combating the violence on the elderly people, both in family and day centres or residential centres through:

- Training of the staff directly involved in the social services having as objectives the identification of the violence, abuzz, neglecting of the old person;
- Develop programmes of communitarian education concerning the preventing and combating of any violence or neglecting of the old people.
- Development of the programmes in the families of the old people where are problems with the alcohol, drugs, poverty, chronically diseases, psychical problems, etc.;
- Establish shelters and temporary assistance for elderly who are victims of the violence in family.

Social politicies and practices may mean they have relatively limited access to valued social resources such as education and health services, housing, income, leisure activities and work. Even though there are already available some innovative methods to improve the skills of marginalized categories of the digital society, to test a unique initiative in Europe that takes into account simultaneously all aspects of learning to use new technologies: teaching methods, training for trainers, use of open source technologies, content development, recovery of obsolete equipment, building local

networks of interest. Establishment of special places and amusement centers for old people to enjoy their time and spend it out of their homes.

Conducting nation wide awareness campaigns regarding the situation of old people, their problems and how they can benefit the society from their experience. These campaigns should include schools (reviewing curriculum to include the senior as part of the family in readings and stories).

Strong and consistent evidence points to an important association between social network involvement and better physical health among older adults (Tucker, Schwartz, Clark & Friedman, 1999). Feeling love and support from others helps encourage individuals to maintain physical health, preventing further need for medical attention. Intervention strategies at personal and community levels can improve quality of life for older adults (Blazer, 2002). Offers a model for positive action in cases of isolation and associated problems.

At the same time the public administrative local authorities have the responsibility to assure the participation of the elderly in the social, public, economic, political, cultural community life through establish and support clubs or recreation centres for elderly; organize social and cultural events where our target group could be actively involved; offer consultancy to the elderly associations in order to develop programmes and local projects for them; develop the voluntarism of elderly people; facilitate the e-communication, assures the access to the IT equipments and internet services.

References

Blazer, G. (2002). Selfefficacy and depression in late life: A primary prevention. *Aging and Mental Health, 6*(4), 315-324.

Burton, M. & Kangan C. (2003). *Marginalization. In Community Psychology: in pursuit of wellness and liberation.* London: Mc Millan/Palgrave.

Compan, D. & Sánchez, D. (2005). Los ancianos al desván. El proceso de degradación biológica y social de la población mayor en el municipio de Granada. *Cuadernos Geográficos, 36*, 255-74.

Cury, S.P. (2009). Estudio del diagnóstico social en residencias para personas mayores asistidas en la Comunidad de Madrid: diseño de un instrumento de valoración y diagnóstico social. *Cuadernos de trabajo social, 22,* 201-26.

Eurostat. (2007). *Europe in Figures. Eurostat Yearbook 2006–07. Office for Official*. Luxembourg: Publication of the European Communities.

Grundy, E. & Holt, G. (2001). The socioeconomic status of older adults : how should we measure it in studies of health inequalities?. *Journal of Epidemiology and Community Health*, *55*(12), 895–904.

Grundy, E. & Sloggett, A. (2003). Health inequalities in the older population: the role of personal capital, social resources and socio-economic circumstances. *Social Science and Medicine*, *56*(5), 935–47.

Institute of the Elderly and Social Services (IMSERSO). (2006). *Las personas mayores en España. Informe 2006 [Older People in Spain. 2006 Report]. Volume I.* Madrid: Institute of the Elderly and Social Services, Ministry of Labour and Social Affairs.

Macinko, J.A. & Starfield, B. (2002). Annotated bibliography on equity in health. *International Journal For Equity in Health*, *1*(1), 1–20.

Rappaport, J. (1987).Terms of empowerment/exemplars of prevention: toward a theory for community psychology. *American Journal of Community Psychology, 15*(2),121–148.

Rueda, S. & Artazcoz, L. (2009). Gender inequality in health among elderly people in a combined framework of socioeconomic position, family characteristics and social support. *Ageing and Society, 29*, 625-647. Doi: 10.1017/S0144686X08008349

Sánchez, F., García-Armesto, S., Pajares, G., Otero, A. & Ruiperez, I. (2004). Estudios cualitativo SEGG-IMSERSO: la perspectiva de los mayores españoles sobre el maltrato al anciano. *Rev Esp Geriatr Gerontol*, *39*(2), 72-93.

Speer, P.W. & Hughey, J. (1995). Community organizing: an ecological route to empowerment and power. *American Journal of Community Psychology*, *23*(5), 729–748.

Tucker, J.S., Schwartz, J.E., Clark, K.M. & Friedman, H.S. (1999). Age-related changes in the associations of social network ties with mortality risk. *Psychology and Aging*, *14*(4), 564-571.

United Nations Organisation. (2005). *Living Arrangements of Older Persons Around the World.* New York: Department of Economic and Social Affairs, UNO.

United Nations Organisation. (2006). *World Population Prospects : The 2006 Revision.* New York: UNO. Retrieved from http://www.un.org/esa/population/publications/wpp2006/wpp2006.htm

Wallerstein, N. (2006). *What is the evidence on effectiveness of empowerment to improve health?.* Copenhagen: WHO Regional Office for Europe (Health Evidence Network report).

CHAPTER 2

COUNTRY REPORTS/ BRIEF REPORTS ON SITUATION IN PARTNER COUNTRIES

2.1. Elderlies in Spain profile

According to the United Nations' population projections for 2050, Spain will be the second most aged country in the world (after Japan), with 33 per cent of the population 65 or more years and 12 per cent aged 80 and over (United Nations Organisation, 2006). At the time being, Spain counts with more than 7.780.830 persons over 65 years old (Institute of the Elderly and Social Services, 2009a), the 16,7% of total population in Spain.

Filial obligation in Spain, as in other Mediterranean countries, is a strong value and it has been stated that breaking the intergenerational contract of support has consequences for the physical and mental health of older adults (Zunzunegui, Kone´, Johri, Be´land, Wolfson & Bergman, 2004). Families, especially women, are making a substantital contribution to both types of care in maintaining the health and quality of life of older people in Spain (Rogero-García, Prieto-Flores, Rosenberg, 2008).

The fact to get certain age "the third age" it does affect the way and conditions of live, in fact the quality of live. At this age there are a lot of changes: physical, familiar, sociological, economical and health changes and all of them together lead, in most occasions, in the intern in the elder centre.

Although institutionalisation rates in Spain are lower than in other European countries, among those aged 85 and over, they are almost four times higher than among the total elderly population and depend on variables such as sex, socio-economic position, family characteristics and health (Arber and Cooper, 1999; Grundy and Jitlal, 2007; IMSERSO, 2006). More specifically, in Catalonia, the most recent data on institutionalisation rates showed that in January 2006, 75 per cent of elderly residents of public institutions were older than 80 years, and that among them, 83 per cent were women (IMSERSO, 2009b).

In Spain, as in the rest of Europe, the majority of elderly people prefer to live in their homes (77%), and only with their children or in institutions as the last options in case of need (IMSERSO, 2007). On November 30th 2006, the Act for the Promotion of Personal Autonomy and Care for Dependent Persons was passed in the Congress of Deputies, with implementation commencing at the end of 2007 and constituting a step forward in social policy in Spain (IMSERSO, 2006). The importance of developing specific policies oriented towards elderly people facing disabilities and their families. 'Ageing at home' requires the expansion of public care services, to date very underdeveloped in Spain, such as respite services to the family of the dependants, the expansion of home visits to elderly people by health professionals, and the adaptation of housing to the ageng process (e.g. installing elevators in flats and showers instead of baths).

2.2. EME in Spain

An integrated approach to socio-economic inequalities, simultaneously studying indicators of household living standards, household structure and social support is needed both in research on inequalities in health as well as in social and health policies addressed to elderly people.

In the study of Rueda and Artazcoz (2009), living alone was associated with poor mental health status in both sexes. It can have different meanings for elderly men and women, with a high negative impact on women´s mental health. A possible explanation of this outcome is the phenomenon of the 'feminisation of poverty' (Pearce 1978), together with higher widowhood rates among women, which especially applies in Spain, where many elderly widows live with very small pensions. The association between deprivation and poor mental health among women would support this hypothesis.

The institutionalized elderly have had to leave their homes, their environment and family that lived with, most of their belongings, daily activities, habits, and they must cope with a new transition time in their lives, normally linked with losses of capacities and asociated diseases to aging, and at the same time, adaptation to the institutionalised new life (Rubio & Aleixandre, 2001). The relationship of institutionalized elderly with their family is very poor and with low quality. The main characteristic in them is their lost of interest for everything and desmotivation "loneliness in the community". Social isolation, lack of social networks,

marginalization, uprooted, might relate to “being alone”, but the real loneliness is related to “feeling alone” (homesickness, sadness, yearning).

Some predictive variables of mistreat in the institutional environment (Barbero y Moya, 2005) are: lack of economic resources; over-crowding; users’ advanced age; staff with poor qualification; wrong management of the center; negative attitude of users; conflicts between staff and users; poor coordination of the staff.

Predictive variables of mistreat in the family environment. Mistreat detection is more complex because the relationships within the families do not facilitate this knowledge (Iborra, 2008). Real cases far exceed the reported cases (just 10% are reported). In Spain, mistreat in elderly is first recognised in 1990. In 1995, “the 1st National Conference for the Consensus about mistreats in the elderly” was organised in Almería. It is a relevant date about this topic in Spain. The 55% of mistreat has been conducted by the son or daughter, 12% by the partner. Abandonment and neglect are the most common ways of mistreat. Males suffer more neglect proportionally (physical and psychological) and in relation to women. Whereas women suffer more abuse (physical, psychological and material) proportionally and in relation to men. The most common profile is “a 75 years old woman and dependent of the attacker”.

The most important impact of abuse seemed to be that on the emotional state of the elders. Elderly people are affected by the absence and the neglect of their families and children. As a result, most of them become depressed, and they might become aggressive and hurt others or even themselves.

In another study carried out in Spain, it has been found that elderly people with more social links presented lower risks of mortality, cognitive deterioration, depression

and disability, and even higher probabilities of recovering after a disability (Otero-Rodríguez et al. 2011). Social isolation among elders has long been recognized as problem that diminishes their well-being, one associated with problems of low morale, poor health, and the risk of premature institutionalization (Seeger & Coble, 2006). Because of their isolation, people experiencing loneliness may not exercise sufficient self-care, being unmotivated themselves and lacking the social contacts that encourage them to do so (Sorkin, Rook & Lu, 2002). From self-care activities to cardiovascular disease to depression and loneliness, social isolation is a complex problem that affects every aspect of a person's life: biological, psychological, social, and spiritual.

Social isolation, lack of social networks, marginalization can be associated to being alone, but real loneliness is associated to feel lonely, the feeling that is created of nostalgia, sadness, etc. Although the person is accompanied by people in a physical way (Rubio & Aleixandre, 2001), it's not enough. Peplau and Caldwell (1978) stated that the feeling of loneliness is given when social relations are less satisfactory than what it was expected. Klein (1982) thinks that lack of love and relations originate this feeling of loneliness.

In Spain, 'attention to diversity' in the education field is increasingly becoming an issue. There is an increasing number of families coming from countries with other cultures, and this has focused attention on the treatment that schools gives to members from ethnic minorities or excluded groups.

Conclusively, it was demonstrated that elders in the Spanish society suffer from various types of abuse, among which the emotional one has the strongest impact and is the most frequently exerted. The economic situation is the main reason leading to elder abuse, for

it is diverting the attention of family members from taking care of their elders towards being kept busy by ensuring the financial needs of their children. It was furthermore depicted that abuse can have a tremendous effect on the psychological health of the elder, which can lead to serious physical conditions. Abuse also affects the family and the society since it weakens family bonds, and increases the gap between society members.

References

Arber, S., and H. Cooper. 1999. "Gender Differences in Health in Later Life: The New Paradox?" *Social Science & Medicine* 48(1):61-76.

Barbero Gutiérrez y Moya Bernal. (2005). "Malos tratos a personas mayores: guías de actuación" en *IMSERSO*, Madrid.

Bazo, M.T. (2001). Negligencia y malos tratos a las personas mayores en España. *Rev Esp Geriatr Gerontol*, *36*(1), 8-14.

Compan, D. & Sánchez, D. (2005). Los ancianos al desván. El proceso de degradación biológica y social de la población mayor en el municipio de Granada. *Cuadernos Geográficos, 36*, 255-74.

Cury, S.P. (2009). Estudio del diagnóstico social en residencias para personas mayores asistidas en la Comunidad de Madrid: diseño de un instrumento de valoración y diagnóstico social. *Cuadernos de trabajo social, 22,* 201-26.

García, J. (2003). *Bioética y Personas mayores.* Madrid: IMSERSO. Retrieved from http: //www.imsersomayores.csic.es

Grundy E and Jitlal M (2007) Socio-demographic variations in moves to institutional care 1991-2001: a record linkage study from England and Wales. *Age and Ageing* 36:4, 424-430

Iborra I. (2008). *Maltrato de personas mayores en la familia en España*. Editorial Centro Reina Sofía.

IMSERSO. (2006). *Ley de Promoción de la Autonomía Personal y Atención a las personas en situación de dependencia [Law on the Promotion of Personal Autonomy and Care for Dependent Persons]*. Madrid: Institute of the Elderly and Social Services, Ministry of Labour and Social Affairs.

IMSERSO. (2007). *A Propósito de las condiciones de vida de las personas mayores. Encuesta 2006. [About Elderly People's Life Conditions. 2006 Survey]*. Madrid: Observatory for Elderly People, Ministry of Labour and Social Affairs.

IMSERSO (Observatorio de Personas Mayores) (2009a). *Las personas mayores en España. Datos estadísticos estatales y por Comunidades Autónomas. Informe 2008/ Tomo I. Serie de documentos estadísticos. Nº 22019*. Madrid: Ministerio de Sanidad y Política Social.

IMSERSO. (2009 b). *Nuevas miradas sobre el envejecimiento. Colección Manuales y guías serie personas mayores. Nº 31005*. Madrid: Ministerio de Sanidad y Política Social.

Klein, S.B. (1982). *Motivation. Biosocial approach*. New York: McGraw Hill.

Otero-Rodríguez, A., León-Muñoz, L.M., Banegas, J.R., Guallar-Castillón, P., Rodríguez-Artalejo, F., Regidor, E. (2011). Life-course socioeconomic position and change in quality of life among older adults: evidence for the role of a critical period, accumulation of exposure and social mobility. *J Epidemiol Community Health , 65,* 964 - 71.

Peplau, I.A. & Caldwell, M. (1978). Loneliness: A cognitive analysis. *Essence*, *2*(4), 207-30.

Rogero-García, J., Prieto-Flores, M.E. & Rosenberg, M. (2008). Health services use by older people with disabilities in Spain: do formal and informal care matter? *Agein and Society*, *28*, 959-78.

Rubio, R. & Aleixandre, M. (2001). Un estudio sobre la soledad en las personas mayores: entre el estar solo y el sentirse solo. *Rev Mult Gerontol*, *11*(1), 23-28.

Rueda, J.D. & Martín, F.C. (2011). El maltrato a personas mayores. Instrumentos para la detección del maltrato institucional. *Alternativas, 18*,7-33.

Rueda, S. & Artazcoz, L. (2009). Gender inequality in health among elderly people in a combined framework of socioeconomic position, family characteristics and social support. *Ageing and Society, 29*, 625-647. doi: 10.1017/S0144686X08008349

Sánchez, F., García-Armesto, S., Pajares, G., Otero, A. & Ruiperez, I. (2004). Estudios cualitativo SEGG-IMSERSO: la perspectiva de los mayores españoles sobre el maltrato al anciano. *Rev Esp Geriatr Gerontol, 39*(2), 72-93.

Seeger, K. & Coble, S. (2006). Elderfriends: relieving loneliness among elders. *Age in action*, *21*(3), 1-5.

Sorkin, D., Rook, K.S. & Lu, J.L. (2002). Loneliness, lack of emotional support, lack of companionship and the likelihood of having a heart condition in an elderly sample. *Annals of Behavioral Medicine, 24*(4), 290-298.

Zunzunegui, M.V., Kone´, A., Johri, M., Be´land, F., Wolfson, C. & Bergman, H. (2004). Social networks and self-assessed health in two French-speaking Canadian community dwelling populations over 65. *Social Science and Medicine,* 5*8*(10), 2069-81.