# PROFESSIONAL EXPERIENCES OF SOCIAL WORKERS IN PRIVATE PAID HOMES FOR THE ELDERLY IN KERALA

*A Dissertation submitted to the University of Kerala in Partial Fulfilment of Requirements for the Master of Social Work Degree Examination*


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# CERTIFICATE OF APPROVAL

This is to certify that this dissertation entitled **"Professional Experiences of Social Workers in Private Paid Homes for the Elderly in Kerala"** is a record of genuine work done by **Ms. Venus Cherian**, fourth-semester **Master of Social Work** student of this college under my supervision and guidance and that it is hereby approved for submission.

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# DEDICATION

I, **Venus Cherian**, do hereby declare that the dissertation **"Professional Experiences of Social Workers in Private Paid Homes for the Elderly in Kerala"** is the result of my original research conducted during the academic years 2024-2026. This work is submitted to the University of Kerala as part of the requirements for the **Master of Social Work** Degree Examination. I confirm that it has not been previously submitted for any other degree, diploma, fellowship, or similar academic recognition.

Venus Cherian

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10-07-2026

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# CONTENTS

# ABSTRACT

The rapid growth of private paid homes for the elderly in Kerala, driven by population ageing and changing family structures, has increased the demand for professional social work services. Although existing research has largely focused on the well-being of institutionalised older adults, the professional experiences of social workers in these institutions remain underexplored in India. This study examines the roles, contributions, working conditions, ethical dilemmas, and future scope of social work practice in private paid homes for the elderly in Kerala.

The study adopted a qualitative approach within a constructivist paradigm using a multiple-case study design. Five qualified social workers employed in private paid homes for the elderly in the Kottayam and Ernakulam districts of Kerala were selected through purposive and snowball sampling. Data were collected through semi-structured in-depth interviews and analysed using Braun and Clarke's (2006) six-phase thematic analysis.

The findings indicate that social workers perform diverse professional and administrative responsibilities beyond their formal roles. They contribute to residents' physical, psychological, social, spiritual, and economic well-being through counselling, care coordination, advocacy, family mediation, crisis intervention, and psychosocial support. However, participants reported role ambiguity, limited professional recognition, inadequate supervision, heavy workloads, emotional labour, and ethical dilemmas arising from competing resident, family, organisational, and commercial interests. They also highlighted the need for specialised gerontological training, professional regulation, institutional recognition, and supportive workplace policies.

The study concludes that social workers play a vital role in institutional elder care but remain professionally under-recognised. Strengthening gerontological social work through policy reforms, specialised education, and improved working conditions is essential for enhancing professional practice and the quality of care for older adults. The findings contribute to the limited Indian literature on gerontological social work and provide evidence for future research, policy, education, and practice.

**Keywords:** Gerontological social work, private paid homes for the elderly, professional experiences, institutional elder care, Kerala, qualitative multiple-case study.

# CHAPTER I
# INTRODUCTION

# CHAPTER I

# INTRODUCTION

## 1.1 BACKGROUND OF THE STUDY

India is currently undergoing a significant demographic transformation that will have profound implications for social policy, family structures, and caregiving. In 2022, the population aged 60 years and older was approximately 149 million, and it is projected to more than double to 347 million by 2050. By that time, nearly one in every five Indians will be a senior citizen (United Nations Population Fund [UNFPA] & International Institute for Population Sciences [IIPS], 2023). Government estimates suggest that by 2036, there will be around 230 million elderly individuals, comprising nearly 15 percent of the total population (Ministry of Social Justice and Empowerment, 2024). The decadal growth rate of the elderly population is approximately 41 percent, which significantly exceeds the overall population growth rate (UNFPA & IIPS, 2023). These statistics signal not only demographic changes but also highlight a fundamental shift in how Indian society will need to organize care, allocate resources, and reconsider the intergenerational relationships within families.

Several interrelated forces drive this transition. Advances in public health, improved access to medical care, better nutrition, and declining fertility rates have together extended the average lifespan of Indians significantly over the past five decades (UNFPA & IIPS, 2023). Yet longevity without corresponding social infrastructure creates its own vulnerabilities. The traditional joint family system, once the bedrock of elder support in Indian society, has been steadily weakened by urbanisation, economic migration, the nuclearisation of households, and the changing aspirations of younger generations (Irudaya Rajan, 2000). The consequence is a growing cohort of older persons who find themselves living alone, with an ageing spouse, or in circumstances where family-based care is either unavailable or inadequate. This is not a phenomenon confined to any single region; however, it has advanced most rapidly in the southern and western states of India, where fertility decline began earlier and where urbanisation rates are higher (UNFPA & IIPS, 2023).

Institutional elder care encompassing old age homes, assisted living facilities, nursing homes, and retirement communities has emerged as a response to this shifting landscape of family and care. Historically, institutional care for the elderly in India was associated with

destitution, abandonment, and charitable intervention. Old age homes were predominantly run by religious organisations, charitable trusts, and government bodies, and were intended for those who had no family or financial resources to fall back upon (Irudaya Rajan, 2000). The social stigma attached to institutional living was considerable: placing a parent in an old age home was widely perceived as a failure of filial duty. However, over the past two decades, this landscape has begun to change in significant ways. The growth of private, paid elder care institutions particularly those catering to middle-class and upper-middle-class populations reflects a broader shift in how ageing, care, and institutional living are understood and experienced in contemporary India (Mayer, 2017).

Kerala occupies a unique and instructive position within this national picture. The state has the highest proportion of elderly persons among all Indian states, with estimates ranging from 16 to 20 percent of the total population aged 60 years and above, substantially higher than the national average of approximately 10.5 percent (Government of Kerala, 2024; UNFPA & IIPS, 2023). These demographic characteristics are the product of Kerala's distinctive developmental trajectory: high literacy rates, early investments in public health and education, low fertility rates, and extensive international labour migration, particularly to the Gulf Cooperation Council countries. The out-migration of working-age adults has had a particularly profound impact on family structures in Kerala, producing large numbers of elderly parents who live alone or with only their spouse while their children reside in other states or countries (Irudaya Rajan, 2000).

The demand for institutional elder care in Kerala has grown accordingly. According to the Kerala Economic Review 2024, the number of residents in care homes across the state increased by over 67 percent in less than a decade, rising from approximately 19,149 in 2016–17 to 32,032 in 2023–24 (Government of Kerala, 2024). What is particularly noteworthy about this growth is the increasing diversification of the sector. Alongside the traditional charitable and government-run homes, there has been a significant expansion of private paid old age homes and private paid retirement communities that cater to elderly. These facilities are concentrated in the urban and semi-urban belts of central Kerala, with the districts of Ernakulam (particularly the Kochi metropolitan area) and Kottayam emerging as prominent centres of this new segment of elder care.

The character of these premium institutions differs fundamentally from that of the traditional old age home. They offer amenities and services that reflect the expectations and purchasing

power of their clientele: private or semi-private rooms, personalised dietary plans, round-the-clock nursing care, physiotherapy, recreational programmes, landscaped gardens, and in some cases, facilities such as swimming pools, libraries, and Ayurvedic therapy centres (Mayer, 2017). The residents are typically retired professionals former government officers, academics, engineers, physicians or Non-Resident Indians (NRIs) who have returned to Kerala after decades abroad, or affluent individuals whose children have settled overseas. For many of these residents, the decision to enter institutional care is not driven by poverty or abandonment but by a pragmatic assessment of their care needs, a desire for companionship and structured daily life, or the recognition that their children, though financially supportive, are geographically unable to provide hands-on care (Irudaya Rajan, 2000; Mayer, 2017).

This shift from elder care as charity to elder care as a market-driven service industry carries profound implications for the professionals who work within these institutions, and in particular for social workers. Social work practice in institutional elder care encompasses a wide spectrum of functions: psychosocial assessment and intervention, crisis management, mediation between residents and their families, coordination with healthcare providers, facilitation of social and recreational activities, grief and end-of-life support, advocacy for residents' rights and dignity, and engagement with the broader community and regulatory systems (Elices Acero et al., 2024; Miller et al., 2021). In the international context, a substantial body of literature has examined these roles and documented the challenges social workers face in long-term care settings, including role ambiguity, insufficient professional recognition, high emotional demands, and ethical conflicts (Miller et al., 2021; Silarova et al., 2022).

However, when the institutional setting is defined by the market logic of premium service provision and the expectations of fee-paying residents clients, the dynamics of social work practice are reconfigured in ways that the existing literature has barely begun to examine. The power relations within such institutions are layered and complex. Residents who are paying substantial fees may approach their relationship with the institution as consumers of a service rather than recipients of care, and this consumer orientation can fundamentally alter the nature of professional interactions (Banerjee et al., 2012). Families who are financially invested in the institution may exert pressure on staff, including social workers, to prioritise their preferences over professional judgements. Institutional management, operating within a competitive market, may emphasise client satisfaction, reputation

management, and occupancy rates over the therapeutic recommendations of social workers (Timonen & Lolich, 2019). The social worker in such a setting is positioned at the intersection of care and commerce, navigating a terrain where professional ethics, institutional interests, family expectations, and the wishes of elderly residents do not always align.

Despite the rapid growth of this sector and the evident complexity of professional practice within it, there is a remarkable paucity of research on the experiences of social workers in private paid elder care institutions in India. The existing Indian literature on old age homes has predominantly focused on the living conditions, health status, loneliness, depression, and quality of life of residents (Gurrapu et al., 2024; Kumar et al., 2016), or on the legal and policy frameworks governing elderly welfare (Dev & Eljo, 2024). A small number of studies have examined the quality of life gap between what elderly residents desire and what institutions actually provide (Gupta et al., 2025). However, the social worker as a professional actor with a distinct identity, a specific set of roles, a unique ethical positioning, and particular experiences of satisfaction, distress, and aspiration remains virtually invisible in the Indian research landscape. This invisibility is not merely an academic oversight; it has practical consequences for policy, training, and the future development of professional social work in the elder care sector. The present study is situated within this gap and seeks to make visible what has thus far been overlooked.

## 1.2 RESEARCHER'S MOTIVATION

The researcher's interest in this study did not originate in the abstract domain of academic curiosity but in the concrete and unsettling realities encountered during field-based learning. As part of the Master of Social Work (MSW) programme at Loyola College of Social Sciences (Autonomous), Thiruvananthapuram, the researcher undertook a 15-day internship at a government old age home as a component of the coursework in Gerontological Social Work. This placement provided the researcher with an immersive, first-hand experience of institutional elder care, its rhythms, its silences, and its gaps.

The most significant observation during this internship was the complete absence of a social worker at the institution. Although the home had previously employed social workers on a contractual basis, these appointments had been discontinued, and at the time of the researcher's placement, no professional social work services were being provided to residents. The implications of this absence were visible in the daily life of the institution.

Residents who were visibly distressed, lonely, or in conflict with staff or family members had no designated professional to turn to for psychosocial support. There was no systematic mechanism for needs assessment, care planning, family mediation, or grief counselling. The functions that a trained social worker would typically perform advocacy, emotional support, linkage with community resources, facilitation of meaningful engagement were simply not being performed by anyone.

This experience left the researcher with a set of questions that refused to be set aside. If the role of social workers is so marginal, so dispensable even in government-run institutions, what is the situation in the rapidly expanding private sector of elder care? Do private paid old age homes and luxury retirement communities, which serve wealthier populations and charge substantial fees, employ social workers? If so, what roles do these professionals actually perform, and how do they navigate the distinctive pressures of working in market-driven, commercially oriented institutions? Are they recognised and valued for their professional expertise, or are they absorbed into administrative and caregiving roles that dilute their identity? What ethical dilemmas do they face, and what support systems, if any, exist to sustain them in their work?

These questions born from the gap between what the social work curriculum advocates and what institutional practice delivers became the foundation of this study. The researcher was motivated not by a desire to critique any particular institution, but by a genuine concern for the professional well-being and recognition of social workers in a sector that is growing rapidly, serving an increasingly vulnerable population, and yet remains largely unexamined from the standpoint of the social work profession itself.

## 1.3 STATEMENT OF THE PROBLEM

Gerontological social work in India remains an emerging and underdeveloped area of professional practice. Although social work education has expanded considerably since its institutionalisation in the mid-twentieth century, gerontology has received relatively limited attention within academic curricula, research, and professional development (Siva Raju & Singh, 2021). As a result, many social workers enter institutional elder care without specialised preparation in areas such as geriatric assessment, dementia care, palliative care, end-of-life decision making, and the management of complex family relationships involving older adults (Elices Acero et al., 2024). This challenge is further intensified by the absence of clear professional standards, regulatory frameworks, and statutory guidelines that define

the role, scope, and responsibilities of social workers in old age homes and similar institutions (Dev & Eljo, 2024; Miller et al., 2021).

These challenges become even more pronounced within private paid homes for the elderly that serve higher socio-economic populations. In such institutions, the professional role of the social worker is often unclear and poorly distinguished from administrative or caregiving responsibilities (Elices Acero et al., 2024; Silarova et al., 2022). Instead of practising their professional competencies in counselling, advocacy, psychosocial intervention, and care coordination, social workers may spend a substantial portion of their time performing administrative duties, maintaining records, coordinating services, and addressing routine institutional concerns. Consequently, their professional knowledge and decision-making authority may not always receive adequate recognition within the organisational structure.

The market-oriented nature of private paid elder care also creates complex ethical challenges for social workers. They are required to balance multiple and sometimes competing responsibilities, including protecting residents' rights and autonomy, responding to the expectations of families who pay for care, meeting institutional priorities, and upholding professional social work values and ethics (Banerjee et al., 2012; Dev & Eljo, 2024). Ethical conflicts may arise when family members influence decisions that differ from residents' wishes, when institutional policies prioritise client satisfaction over professional recommendations, or when social workers experience pressure to protect the institution's reputation rather than advocate for residents' best interests. These situations illustrate the complex realities of practising social work in settings where care and commercial interests coexist.

Working in such environments also places considerable emotional and psychological demands on social workers. They regularly support older adults experiencing chronic illness, cognitive decline, loneliness, grief, loss of independence, and concerns related to ageing and mortality (Takeda & Fukuzaki, 2024; Yau et al., 2024). Providing continuous emotional support under these circumstances requires significant emotional labour, which often remains unrecognised. At the same time, many institutions lack formal supervision, structured peer support, professional debriefing, and self-care mechanisms. Consequently, social workers may experience burnout, compassion fatigue, moral distress, and declining job satisfaction (Silarova et al., 2022). Despite these challenges, their professional

experiences have received limited attention within institutional policy and academic research (Gupta et al., 2025).

To the best of the researcher's knowledge, no previous study in India has specifically examined the professional experiences, roles, ethical dilemmas, and future scope of social workers employed in private paid homes for the elderly serving higher socio-economic populations. Existing Indian research has largely focused on the quality of life of elderly residents (Kumar et al., 2016), the ethical and legal dimensions of elder care (Dev & Eljo, 2024), and the psychosocial well-being of institutionalised older adults (Gurrapu et al., 2024). While these studies have contributed valuable knowledge about residents, they have paid little attention to the social worker as a professional actor within institutional elder care. This represents a significant gap in both gerontological and social work literature in India, which the present study seeks to address.

The central problem guiding this study is therefore: How do social workers working in private paid homes for the elderly in Kerala experience, interpret, and navigate their professional roles, contributions to resident well-being, working conditions, ethical dilemmas, and perceptions of the future scope of social work practice?

## 1.4 SIGNIFICANCE AND RATIONALE OF THE STUDY

The significance of this study resides in its capacity to illuminate a domain of professional practice that has remained largely invisible to academic inquiry, policy discourse, and institutional self-reflection. The study's contributions span four interconnected domains: academic, professional, policy, and contextual.

### 1.4.1 Academic Significance

The international literature on social work in long-term elder care has grown substantially over the past two decades, with systematic reviews and empirical studies from North America, Europe, and Australia documenting the roles, competencies, challenges, and professional experiences of social workers in aged care settings (Elices Acero et al., 2024; Miller et al., 2021). However, this body of knowledge is overwhelmingly rooted in Western institutional, regulatory, and cultural contexts, and its applicability to the Indian situation characterised by different family structures, care norms, regulatory environments, and market dynamics cannot be assumed. The Indian literature on institutional elder care, while growing, has focused primarily on the well-being and quality of life of residents rather than on the professionals who serve them (Gupta et al., 2025; Kumar et al., 2016). This study

contributes to filling this gap by providing empirical, qualitative evidence on the professional experiences of social workers in a specific and under-researched institutional context: private paid elder care homes in Kerala. By doing so, it adds a distinctively Indian voice to the global conversation on gerontological social work practice.

Furthermore, the study's focus on institutions serving higher socio-economic populations addresses a dimension of elder care that has been almost entirely absent from Indian social work scholarship. The intersection of class, care, and professional practice in institutional settings raises questions that are both theoretically generative and practically urgent: How does the socio-economic status of care recipients shape the roles, autonomy, and ethical positioning of care professionals? How do market logics and consumer expectations interact with the values of professional social work? These are questions that this study begins to explore, opening avenues for further research across disciplines and settings (Mayer, 2017).

### 1.4.2 Professional Significance

For the social work profession, this study holds significance as an exercise in professional self-examination. By giving voice to the experiences of social workers in private paid elder care their perceptions of their roles, their satisfactions and frustrations, their ethical struggles, and their visions for the future the study creates a record that can inform professional development, training, and advocacy. The findings may contribute to the design of specialised curricula in gerontological social work within Indian social work education, the development of supervision and mentoring models tailored to the demands of institutional elder care, and the articulation of competency frameworks that recognise the distinctive knowledge and skills required for practice in this setting (Elices Acero et al., 2024; Yau et al., 2024). At a broader level, the study contributes to the ongoing project of professionalising social work in India's elder care sector a project that requires, as a necessary first step, the documentation and analysis of what social workers actually do, how they are positioned, and what they need to do their work well (Silarova et al., 2022).

### 1.4.3 Policy Significance

The study is situated within a policy environment that is evolving but still inadequate in its attention to the professional dimensions of elder care. The Maintenance and Welfare of Parents and Senior Citizens Act, 2007, provides a statutory framework for the establishment and regulation of old age homes and the provision of welfare services for senior citizens, but it does not mandate the employment of qualified social workers in these institutions, nor

does it prescribe standards for psychosocial care (Government of India, 2007; Dev & Eljo, 2024). The National Policy on Older Persons (Ministry of Social Justice and Empowerment, 1999) and the National Policy for Senior Citizens (Ministry of Social Justice and Empowerment, 2011) acknowledge the need for comprehensive elder care but remain silent on the specific role of social workers within institutional settings. At the state level, Kerala has made significant strides in elderly welfare through programmes and policies, yet regulatory oversight of private paid elder care facilities particularly regarding staffing standards, professional qualifications, and quality of psychosocial services remains limited. The findings of this study can inform advocacy for policy reforms that mandate the inclusion of qualified social workers in institutional elder care, define their scope of practice, establish minimum standards for professional support and supervision, and create accountability mechanisms that protect both residents and professionals.

### 1.4.4 Contextual Significance

The choice of Kerala as the site of this research is deliberate and substantively motivated. Kerala's advanced demographic profile, characterised by the highest proportion of elderly persons of any Indian state, makes it a natural setting for the study of institutional elder care. The state's distinctive social and economic history including its high literacy rates, its tradition of social reform, its extensive patterns of international migration, and the consequent reconfiguration of family structures has produced a landscape of elder care that is both diverse and dynamic (Government of Kerala, 2024). The concentration of private paid elder care institutions in the Ernakulam and Kottayam districts, driven by the intersection of urban development, NRI investment, and an affluent retired population, creates a particularly rich and relevant context for this research. Kerala thus serves not merely as a geographic convenience but as a site where the broader forces of demographic transition, market-driven care, and professional social work practice converge in ways that are both locally specific and nationally instructive.

## 1.5 AIMS OF THE STUDY

The present study is guided by the following aims:

1. To explore the formal and informal roles and responsibilities of social workers in homes for the elderly, and to understand how these roles are negotiated within the institutional structure and decision-making hierarchy.

2. To examine how social workers contribute to the physical, psychological, social, spiritual, and economic well-being of residents, and how the higher socio-economic context shapes these contributions.
3. To investigate social workers' perceptions of their professional autonomy, job satisfaction, workload, compensation, emotional labour, and the availability of institutional support and supervision.
4. To identify the ethical dilemmas and structural challenges that social workers encounter while balancing residents' autonomy, institutional policies, family expectations, and market-driven pressures.
5. To understand how social workers envision the future scope of social work practice in institutional elder care, and what policy reforms, governance mechanisms, and training requirements they consider necessary to strengthen professional practice.

## 1.6 CHAPTERIZATION

This research report is organised into the following chapters:

**Chapter I – Introduction:** This chapter presents the background of the study, the researcher's motivation, statement of the problem, significance and rationale of the study, aims of the study, and the organisation of the report.

**Chapter II – Review of Literature:** This chapter reviews the existing national and international literature on ageing, institutional elder care, gerontological social work, ethical dilemmas in elder care, and the professional experiences of social workers in residential settings for the elderly. The theoretical framework underpinning the study is also presented in this chapter.

**Chapter III – Research Methodology:** This chapter describes the research design, research questions, operational definitions of key terms, sampling strategy, data collection methods, research tool, data analysis procedures, scope and limitations of the study, and ethical considerations.

**Chapter IV – Case Description:** This chapter presents detailed case narratives of the five social workers who participated in the study, constructed from the in-depth interviews.

**Chapter V – Thematic Analysis and Discussions:** This chapter presents the thematic analysis of the interview data, organised around the five research questions and their

associated themes and subthemes, discussed in relation to the theoretical framework and existing literature.

**Chapter VI – Findings, Suggestions, and Recommendations:** This chapter summarises the key findings, and offers recommendations for practice, policy, education, and further research.

# CHAPTER II
# REVIEW OF LITERATURE

# CHAPTER II

# REVIEW OF LITERATURE

## 2.1 INTRODUCTION TO THE REVIEW OF LITERATURE

The review of literature provides the conceptual and empirical foundation for the present study. It examines previous research on institutional elder care, gerontological social work, psychosocial well-being, ethical issues, policy initiatives, and the professional experiences of social workers. Reviewing the existing literature helps to understand the current state of knowledge, identify research trends, and recognise the gaps that justify the need for the present study.

A total of 27 studies were reviewed for this research. Of these, 18 studies were international, 5 were conducted in India, and 4 were undertaken in Kerala. In addition, relevant books, theoretical literature, and policy documents were reviewed to provide the conceptual and contextual foundation for the study. Together, these sources provide a comprehensive understanding of institutional elder care from global, national, and state-level perspectives.

Consistent with the objectives of the present study, the literature review focuses on the roles of social workers, their contributions to resident well-being, professional experiences, working conditions, ethical dilemmas, and the future direction of social work practice in institutional elder care. The literature is organised thematically, allowing evidence on these areas to be synthesised rather than presented as isolated studies (Elices Acero et al., 2024; Miller et al., 2021).

The reviewed literature indicates that the role of social workers in institutional elder care has been widely examined in several developed countries. In contrast, research in the Indian context remains limited, particularly with respect to the professional experiences of social workers in private fee-paying homes for the elderly (Elices Acero et al., 2024; Siva Raju & Singh, 2021). Existing Indian and Kerala studies have primarily focused on the quality of life, psychosocial well-being, institutionalisation, and health of older adults rather than on the professionals providing psychosocial care (Gurrapu et al., 2024; Kumar et al., 2016). This gap provides the rationale for the present study.

The chapter is organised into seven sections. Section 2.2 presents the theoretical framework. Section 2.3 reviews the global literature, followed by the Indian literature in Section 2.4 and

the Kerala-specific literature in Section 2.5. Section 2.6 discusses policy, governance, and future directions related to elder care. Section 2.7 identifies the research gap based on the reviewed literature, and Section 2.8 provides a summary of the chapter.

| Category | Number of Studies | Major Focus |
|---|---|---|
| **Global Studies** | 18 | Social work roles, institutional elder care, ethical issues, workforce development, integrated care |
| **Indian Studies** | 5 | Ageing, institutional care, gerontological social work, quality of life, legal and ethical issues |
| **Kerala Studies** | 4 | Institutionalisation, psychosocial well-being, cognitive health among older adults |
| **Total** | **27** | |

## 2.2 THEORETICAL FRAMEWORK

The present study is guided by four complementary theoretical perspectives: Ecological Systems Theory (Bronfenbrenner, 1979; Bronfenbrenner & Morris, 2006), the Strengths-Based Perspective (Saleebey, 2006), the Political Economy of Ageing (Estes, 2001; Phillipson, 2013), and the Ethics of Care (Gilligan, 1982; Tronto, 1993). These perspectives were selected because they provide complementary explanations of the professional experiences of social workers in private paid homes for the elderly in Kerala. Ecological Systems Theory explains how multiple environmental systems shape professional practice; the Strengths-Based Perspective highlights the capacities and resilience of older adults; the Political Economy of Ageing examines how market forces, commercialisation, and institutional structures influence elder care; and the Ethics of Care focuses on ethical relationships, responsibility, and emotional engagement. Together, these perspectives provide a comprehensive framework for understanding the roles, working conditions, ethical dilemmas, and professional experiences of social workers in institutional elder care.

### 2.2.1 Ecological Systems Theory

Ecological Systems Theory was developed by Urie Bronfenbrenner (1979) to explain how human development is influenced by different environmental systems that interact with one another. The theory proposes that an individual's behaviour and well-being are shaped not only by personal characteristics but also by relationships, institutions, communities, and broader social contexts. In the later development of the theory, Bronfenbrenner and Morris (2006) introduced the chronosystem, which recognises the influence of life transitions and changes over time.

The theory consists of five interconnected systems: the microsystem, mesosystem, exosystem, macrosystem, and chronosystem. The microsystem includes the resident's direct interactions with social workers, caregivers, healthcare professionals, and other residents within the institution. The mesosystem refers to the relationships between different microsystems, such as communication and coordination between the institution, family members, healthcare providers, and community agencies. The exosystem includes organisational policies, management practices, staffing patterns, funding arrangements, and regulatory systems that indirectly influence the quality of care and the work of social workers. The macrosystem represents broader cultural values, social norms, and public attitudes towards ageing, institutionalisation, family responsibility, and elder care. The chronosystem highlights the influence of change over time, including retirement, widowhood, declining health, migration of adult children, and the increasing demand for institutional elder care in response to demographic and social changes.

This theory is particularly relevant to the present study because it explains that the professional experiences of social workers are influenced by multiple interacting systems rather than by individual factors alone. Their practice is shaped by direct relationships with residents, collaboration with families and healthcare professionals, institutional policies, and wider social attitudes towards ageing. The theory therefore provides a useful framework for understanding the complex environment in which social workers perform their professional roles in private paid homes for the elderly.

### 2.2.2 Strengths-Based Perspective

The Strengths-Based Perspective, developed by Saleebey (2006), is one of the core practice approaches in social work. It emphasises identifying and building upon the strengths, abilities, and resources of individuals rather than focusing only on their problems or

limitations. The perspective assumes that every individual possesses capacities that can be used to improve well-being, overcome challenges, and enhance quality of life.

In the context of elder care, the Strengths-Based Perspective encourages social workers to recognise the life experiences, knowledge, coping abilities, family relationships, and personal resources of older adults. Rather than viewing elderly residents only as dependent or vulnerable, the approach promotes dignity, participation, resilience, and self-determination. It also encourages collaborative practice by involving residents in decision-making and supporting them to maintain as much independence as possible.

This perspective is relevant to the present study because social workers play an important role in promoting the psychosocial well-being of older adults. Understanding how they identify residents' strengths, encourage participation, provide emotional support, and advocate for person-centred care helps to explain their professional contributions within institutional settings. The Strengths-Based Perspective therefore provides a valuable lens for interpreting the interventions and practice approaches adopted by social workers in private paid homes for the elderly.

### 2.2.3 Political Economy of Ageing

The Political Economy of Ageing emerged within critical gerontology to explain how ageing is shaped not only by individual or biological factors but also by broader political, economic, and social structures. Estes (2001) argues that older adults' experiences are influenced by public policy, labour markets, welfare systems, and the distribution of economic resources, while Phillipson (2013) further emphasises that population ageing must be understood within the context of globalisation, demographic change, and the increasing marketisation of care services. Rather than viewing elder care solely as a family or personal responsibility, the perspective highlights how institutional arrangements and economic interests influence the organisation and delivery of care.

A central concept within this perspective is the commodification of ageing, whereby care for older adults increasingly becomes a market-driven service that is bought and sold rather than provided solely through family or public welfare systems. In commercial elder-care settings, residents become consumers of services, institutions operate within competitive markets, and organisational priorities may include financial sustainability, occupancy rates, and client satisfaction alongside care provision. These structural conditions can shape

professional roles, organisational decision making, and the relationships between residents, families, management, and care professionals.

This perspective is particularly relevant to the present study because it examines social workers employed in private paid homes for the elderly that operate within a commercial model of care. It helps explain how market-based organisational structures, commercial pressures, and institutional priorities influence social workers' professional autonomy, role expectations, ethical dilemmas, and working conditions. The Political Economy of Ageing therefore complements the other theoretical perspectives by providing a structural lens for understanding the interaction between care, professional practice, and market forces within private elder-care institutions.

### 2.2.4 Ethics of Care

The Ethics of Care was introduced by Carol Gilligan (1982) and later expanded by Joan Tronto (1993). This perspective views care as a moral practice based on relationships, empathy, responsibility, and responsiveness to the needs of others. Unlike ethical approaches that focus primarily on rules, rights, or individual autonomy, the Ethics of Care highlights the importance of understanding people's circumstances and maintaining supportive relationships while making professional decisions.

Tronto (1993) identified four interrelated phases of care: caring about, taking care of, care-giving, and care-receiving. These stages emphasise the ethical qualities of attentiveness, responsibility, competence, and responsiveness, which are essential for providing effective and compassionate care. The framework also recognises that ethical care is influenced by institutional practices, organisational support, and social relationships rather than by individual actions alone.

The Ethics of Care is highly relevant to this study because social workers in private paid homes for the elderly frequently encounter ethical dilemmas in their professional practice. They must balance the rights and preferences of elderly residents with the expectations of family members, organisational policies, and professional values. They also provide emotional support to residents experiencing loneliness, illness, grief, and loss of independence. This perspective helps to understand how social workers navigate ethical decision-making, maintain professional relationships, and manage the emotional demands associated with institutional elder care.

### 2.2.5 Relevance of the Theoretical Framework to the Study

The four theoretical perspectives together provide a comprehensive framework for understanding the professional experiences of social workers in private paid homes for the elderly in Kerala. Ecological Systems Theory explains how multiple environmental systems influence professional practice. The Strengths-Based Perspective focuses on recognising the capacities, resilience, and dignity of older adults. The Political Economy of Ageing highlights how market structures, commercialisation, and institutional priorities shape the organisation of elder care and influence professional practice. The Ethics of Care emphasises ethical responsibility, relationships, empathy, and emotional engagement in caring professions.

Together, these perspectives support the interpretation of the roles, challenges, ethical dilemmas, working conditions, and professional contributions of social workers in institutional elder care. They also provide an appropriate theoretical foundation for analysing the findings of the present study and understanding the complexities of social work practice within private paid homes for the elderly.

## 2.3 GLOBAL LITERATURE

### 2.3.1 Roles and Institutional Positioning of Social Workers

The most current synthesis of what social workers do in long-term care is provided by Elices Acero, Prieto-Lobato, and Rodríguez-Sumaza (2024), whose mixed-methods systematic review in *International Social Work* integrated evidence from studies conducted in Europe and North America between 2000 and 2022. They found that service and case management, direct support, personalisation of care, and community engagement constitute the leading roles of long-term care social workers, while identifying persistent limitations including a lack of specialisation, paperwork burden, and work overload. Crucially, the review's explicit geographical restriction to Europe and North America where professional bodies such as the National Association of Social Workers and the International Federation of Social Workers govern practice underscores the absence of Indian and broader South Asian evidence, a gap the present study addresses.

This picture of role ambiguity is reinforced by Miller, Hamler, Beltran, and Burns (2021), whose systematic review in *Social Work in Health Care* synthesised the literature on nursing home social services from 2010 to 2020. Examining qualifications, responsibilities, and the way policy dictates practice, they concluded that the literature on nursing home social

workers is limited and outdated, and that the social worker's role is frequently ambiguous despite regulatory requirements. Read together, these two reviews establish that even in regulated Western systems the social work role in elder care is fragmented and under-specified a condition likely to be more acute in the comparatively unregulated Indian private sector, where the social worker's mandate may be wholly informal.

### 2.3.2 Contribution to the Multidimensional Well-being of Residents

A second body of global literature concerns how social workers and social care services contribute to resident well-being. Behrendt, Spieker, Sumngern, and Wendschuh (2023), in a scoping review in *BMJ Open* following Joanna Briggs Institute methodology, mapped diverse social-support intervention types and concluded that structured social-support interventions can enhance resident well-being when systematically integrated into institutional care. Ebrahimi, Patel, Wijk, Ekman, and Olaya-Contreras (2021), in a systematic review in *Geriatric Nursing*, found that person-centred care approaches improve outcomes for older people but encounter substantial implementation barriers relating to organisational culture, staffing, and resources directly relevant to understanding where social workers' person-centred efforts may be obstructed in market-driven institutions.

The value of social-worker-led models is evidenced more directly by Moreno and colleagues (2021) in the *Journal of the American Geriatrics Society*. Evaluating the Connecting Provider to Home programme, which deployed teams comprising a social worker and a community health worker, their retrospective quasi-experimental study of 420 community-dwelling older adults compared with 700 matched comparators found statistically significant reductions in acute hospitalisations and emergency department visits alongside high patient satisfaction. From the East Asian context, Jiang and Liu (2023), publishing in *Frontiers in Public Health*, demonstrated that community home elderly care services positively affect the social participation of chronically ill older adults in China through a multidimensional-health mediating mechanism. Although not specific to social work, the study empirically links care provision to social participation, reinforcing the conceptual rationale for social-work interventions that target social engagement.

### 2.3.3 Professional Conditions, Emotional Labour, and Job Satisfaction

A third strand examines the working conditions, emotional labour, and professional identity of those who provide elder care dimensions central to the present study. Silarova, Brookes, Palmer, Towers, and Hussein (2022), in a scoping review in *Health & Social Care in the*

*Community*, proposed six primary components of work-related quality of life: organisational characteristics, job characteristics, mental well-being, physical well-being, spill-over from work to home, and professional identity, noting that no single study had examined all of these together. This framework supplies a structured vocabulary for analysing the professional-experience dimension of the present study.

The relational and meaning-making dimensions of care work are illuminated by two complementary studies. Takeda and Fukuzaki (2024), in *Psychogeriatrics*, found through a secondary analysis of data from 406 care workers in Japan a significant association between workplace interpersonal relationships and psychological distress, indicating that collegial relations are a meaningful determinant of care workers' mental health. Yau and colleagues (2024), in *BMC Health Services Research*, found through in-depth interviews with 30 long-term care workers in Hong Kong that workers actively construct positive meanings of their work as a "helping career" even though care work is externally devalued as "dirty work" with the meaning of work functioning as a psychological resource that buffers adverse conditions. This offers a qualitative template for understanding how social workers in Kerala's private institutions may derive resilience despite structural constraints.

The contradictory cultural positioning of care workers is theorised by Timonen and Lolich (2019) in the *Journal of Gerontological Social Work*, who argued from grounded-theory focus groups in Ireland that the home care worker is constructed with fundamental ambivalence, simultaneously "good" and "bad," and connected this to the precariousness and commodification of care work. The relational labour this entails is further specified by Lam and Baxter (2023) in the *Journal of Applied Gerontology*, who theorised a form of work they termed "social labour" the active management of the boundary between professional services and the personal relationships that may develop. Boundary management of this kind is a probable concern in the intimate, ongoing relationships that characterise paid care for affluent elders, where residents may construct fictive-kin relationships with staff.

### 2.3.4 Ethical Dilemmas and Structural Challenges

The structural production of ethical strain is powerfully demonstrated by Banerjee and colleagues (2012) in *Social Science & Medicine*. Drawing on a comparative survey of residential care workers across three Canadian provinces and four Scandinavian countries, they showed that Canadian frontline care workers reported six times more daily physical violence than their Scandinavian counterparts (43.0% compared with 6.6%), attributing the

difference to policy choices and structural conditions rather than individual or national temperament. The study demonstrates how staffing, funding, and regulation generate harm and ethical strain, providing a comparative benchmark for interpreting conditions in Indian private care.

A rare study centring social workers' own perspectives on paid care for affluent elders is provided by Ayalon, Kaniel, and Rosenberg (2008) in *Home Health Care Services Quarterly*. Using focus groups with 31 social workers, they evaluated the arrangement in which lower-socio-economic-status foreign workers provide live-in care to more affluent frail older adults in Israel, identifying both advantages and challenges from the social workers' professional vantage point. This study is exceptionally relevant because it is one of the few internationally to centre social workers' perspectives on paid care for affluent elders the very lens the present study adopts thereby underscoring both the international significance and the local novelty of the topic. The structural vulnerability of frontline carers in Asian contexts is further documented by Wang and Wu (2017) in the *Journal of Women & Aging*, who synthesised the challenges faced by domestic helpers in China and Hong Kong, including lack of legal protection, absence of training, and exposure to abuse a context with clear parallels to India.

The relationship between socio-economic status and care trajectories central to this study is addressed by Bolster-Foucault and colleagues (2024) in *Age and Ageing*. Their mixed-studies systematic review of ageing in place across OECD countries, using an intersectional lens, found that those with greater socio-economic and social resources are generally more likely to age in place, while revealing complex intersectional effects. The study empirically demonstrates that socio-economic status structures care trajectories and the likelihood of institutionalisation, directly informing the present study's focus on elders.

## 2.4 INDIAN LITERATURE

The Indian evidence base on institutional elder care is growing but remains concentrated on residents rather than practitioners. Gurrapu, Ammapattian, and Antony (2024), in the *Journal of Family Medicine and Primary Care*, conducted a descriptive cross-sectional study of 40 elderly residents across four old-age homes in urban Bengaluru, using the Geriatric Depression Scale, the Multidimensional Scale of Perceived Social Support, and a loneliness scale. They found significant associations among low perceived social support, loneliness, and depression, evidencing precisely the psychosocial needs that social workers

are positioned to address. Yet the study, like most Indian work in this area, examined residents' experiences without attention to the professionals responsible for meeting those needs a gap the present study addresses directly.

The quality-of-life dimension is taken up by Gupta, Goel, and Bhargava (2025) in the *Journal of Gerontological Social Work*, who used a mixed-method approach to examine the gap between actual and desired quality of life among institutionalised older Indians, finding a measurable shortfall that implies a clear role for social workers in closing it. A comparative perspective is offered by Kumar, Udyar, Arun, and Sai (2016) in the *National Journal of Community Medicine*, whose cross-sectional study of 112 elderly individuals using the WHO QOL-BREF instrument found that institutional elderly scored higher on the physical domain (50.47 versus 47.18) but markedly lower on the social domain (33.60 versus 47.63), with only 21.42% rating their overall quality of life as good. This demonstrates, with Indian data, the characteristic trade-off whereby institutionalisation may secure physical care while eroding social connectedness precisely the domain in which social-work intervention is most warranted.

The ethical and legal dimensions of Indian elder care are addressed by Dev and Eljo (2024), who explored older adults' lack of understanding of their legal rights, distrust in enforcement, and the compounding effects of high legal costs and inadequate support services. While this is one of relatively few Indian works to address the ethical-legal terrain, its claims should be read alongside the more methodologically robust sources cited above; it is used here primarily to frame the kinds of rights-and-consent dilemmas social workers may encounter.

The professional dimension itself is most directly addressed by Siva Raju and Singh (2021) in their chapter in M. K. Shankardass's edited volume *Gerontological Concerns and Responses in India*. They argued that gerontological social work in India remains an emerging area receiving inadequate scholarly focus, observing a shift towards organising and empowering older persons while documenting selected good practices. Their conclusion that gerontological social work in India is "emerging" rather than "established" directly validates the present study's premise that the professional experiences of social workers in institutional elder care remain undocumented. The chapter is, however, primarily descriptive and presents no primary empirical data from practising social workers precisely the kind of evidence the present study generates.

## 2.5 KERALA LITERATURE

Four Kerala-specific studies ground the present research in its local context, and together they demonstrate that even within Kerala's comparatively well-documented elder-care landscape the social worker as a professional actor remains unstudied.

The foundational survey is Irudaya Rajan (2002), "Home Away from Home," in the *Journal of Housing for the Elderly*, which mapped old age homes across Kerala and assessed the profile of their residents. Strikingly, the study found that a substantial proportion of residents had living children, challenging the assumption that institutionalisation is driven solely by the absence of family, and suggesting that familial support structures were failing for reasons beyond mere absence including emotional neglect and the out-migration of adult children. Conducted over two decades ago and focused on residents rather than staff, it established a baseline understanding of why elderly persons in Kerala enter institutional care a context within which social workers now practise.

A state-level overview is provided by Irudaya Rajan, Shajan, and Sunitha (2020), "Ageing and Elderly Care in Kerala," in *China Report*. Drawing on the Kerala Ageing Survey, the authors examined care concerns at the household, institutional, and societal levels and concluded that existing care systems require substantial reconstruction to accommodate a rapidly ageing population. As the most authoritative Kerala-specific overview, it supplies the demographic and policy context within which the present study's sample institutions operate.

Two further studies document the psychosocial and cognitive needs of institutionalised elders in the region. Fernandez, Zacharias, and Harikrishnan (2018), used a qualitative case-study design to examine institutionalisation in southern Kerala, finding that residents frequently perceived the younger generation's attitudes as unsatisfactory and felt regarded as a burden, and concluding that residents require systematic psychosocial intervention at primary, secondary, and tertiary levels. Philip and Johns (2024), surveyed 535 elderly subjects across 85 registered old-age homes in Kottayam district one of the two districts in which the present study is located and found a substantial prevalence of cognitive impairment (31.80% by MMSE; 34.00% by PMIS), with age, gender, and educational level significantly associated. This finding has direct implications for the scope of social work practice, requiring competencies in cognitive screening and communication with cognitively impaired residents.

Across all four studies, the analytical focus rests on residents, their needs, attitudes, and cognitive health, while the professionals who staff these institutions remain outside the frame.

## 2.6 POLICY, GOVERNANCE, AND FUTURE DIRECTIONS

Policy and governance play an important role in shaping the quality, accessibility, and future development of institutional elder care. As India's older population continues to grow, there is increasing attention towards strengthening elder-care services, improving professional standards, and developing sustainable models of care. Recent research and policy documents highlight the need for better regulation, workforce development, and integrated care systems. This section reviews key studies and policy initiatives that are relevant to the present study.

One of the important contributions to understanding commercial elder care in India is the work of Mayer (2017). Through an ethnographic study conducted in urban India, Mayer examined the emergence of market-based elder-care facilities for affluent older adults. The study linked the growth of these institutions to changing family structures, urbanisation, and economic liberalisation. While it provides valuable insights into the development and cultural meaning of commercial elder care, its focus remains on residents and institutional culture. The experiences and professional roles of social workers employed in these institutions were not explored, leaving an important gap that the present study seeks to address.

Recent international studies have also highlighted future directions for strengthening elder care services. Dadich et al. (2025) identified the need for integrated, person-centred models of care that improve coordination between health and social care services. Similarly, Morrow et al. (2024) emphasised the importance of developing structured career pathways to strengthen the elder-care workforce and improve staff retention. Supporting these findings, Lobanov-Rostovsky et al. (2023) demonstrated that demographic and epidemiological changes increase the demand for formal care services and require stronger long-term care systems. These studies underline the importance of workforce planning and professional development, both of which are relevant to social work practice in institutional elder care.

Within the Indian context, policy initiatives have increasingly recognised the need to strengthen elder-care services. The NITI Aayog (2024) position paper *Senior Care Reforms*

*in India: Reimagining the Senior Care Paradigm* recommends recognising care workers, improving the regulation of senior living facilities, and promoting collaboration between the public and private sectors. Kerala has also emerged as one of the leading states in addressing population ageing. According to UNFPA (2024) projections, the proportion of older adults in Kerala is expected to increase from 16.5% in 2021 to 22.8% by 2036. This demographic transition highlights the growing need for qualified professionals, including social workers, to support the expanding elder-care sector. It also reinforces the importance of examining the professional experiences, roles, and future scope of social workers in private paid homes for the elderly, which is the focus of the present study.

## 2.7 RESEARCH GAP

The literature reviewed across these sections establishes a robust international evidence base on social workers' roles, their contributions to resident well-being, their working conditions and emotional labour, the ethical and structural challenges of elder care, and the policy directions shaping the field. At the same time, it reveals a clear and consequential gap.

- First, the most authoritative syntheses of social work in long-term care are geographically confined to Europe, North America, and East Asia and explicitly exclude South Asia (Elices Acero et al., 2024; Miller et al., 2021); the professional role of the long-term care social worker, well mapped elsewhere, remains empirically uncharted in India.
- Second, the substantial Indian literature on elder care concentrates almost entirely on residents' quality of life, mental health, loneliness, and living arrangements, predominantly within charitable or government-run homes (Gupta et al., 2025; Gurrapu et al., 2024; Kumar et al., 2016), and even the foundational Kerala-specific studies (Fernandez et al., 2018; Irudaya Rajan, 2002; Irudaya Rajan et al., 2020; Philip & Johns, 2024) document residents' conditions without examining the professionals who serve them.
- Third, where social work with the elderly is discussed in India it is treated as an emerging or aspirational discipline rather than studied empirically in practice (Siva Raju & Singh, 2021).
- Fourth, the leading scholarship on India's commercial elderscapes attends to residents and cultural meaning, not to the social workers employed within them (Mayer, 2017).

- Fifth, the strongest evidence internationally on social workers' perspectives regarding paid care for affluent frail elders originates not from India but from Israel (Ayalon et al., 2008), confirming that this analytical lens is well developed abroad yet virtually absent in the Indian literature.

The convergence of these gaps is striking. India is experiencing the rapid growth of a commercial, fee-paying elder-care market serving affluent seniors a development theorised by critical gerontology as the commodification of ageing (Estes, 2001; Mayer, 2017) at precisely the moment when states such as Kerala are constructing pioneering governance frameworks (NITI Aayog, 2024). Yet the social workers who practise within these private institutions the roles they occupy, the scope of their practice, the ethical dilemmas they navigate, their professional experiences, and their views on the future of the field remain entirely unstudied. This is the gap the present qualitative study addresses, by examining social workers in private paid elder-care institutions serving older adults in Kerala, through a theoretically informed, multi-level, and relationally attentive lens.

## 2.8 SUMMARY OF THE CHAPTER

This chapter reviewed the national and international literature on gerontological social work and institutional elder care, organised so as to move from the global evidence base through the Indian and Kerala contexts to the policy landscape and, finally, the research gap. The global literature establishes a well-developed but geographically bounded understanding of social workers' roles, their contributions to resident well-being, their professional conditions and emotional labour, and the ethical and structural challenges of elder care. The Indian and Kerala literature, by contrast, remains sparse and almost entirely focused on residents rather than on the professionals who serve them, even within Kerala's relatively well-documented elderly-care landscape. The theoretical framework drawing on Ecological Systems Theory, the Strengths-Based Perspective, the Political Economy of Ageing, and the Ethics of Care provides a multi-level lens for analysing the findings. The research-gap analysis confirmed that no prior Indian study has examined the professional experiences of social workers in private paid elder-care institutions serving higher socio-economic populations, thereby establishing the necessity, originality, and relevance of the present study.

# CHAPTER III
# RESEARCH METHODOLOGY

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# RESEARCH METHODOLOGY

## 3.1 INTRODUCTION

This chapter presents the methodological framework that guided the conduct of the present study. Research methodology is the systematic and reasoned plan through which a researcher seeks to answer the research questions, and it provides the logical bridge between the aims of a study and the knowledge it ultimately produces. A clearly articulated methodology enables the reader to understand how the study was designed, how participants were selected, how data were gathered and interpreted, and how the trustworthiness and ethical integrity of the research were safeguarded.

The present study explores the professional experiences of social workers employed in private paid homes for the elderly in Kerala. Because the study is concerned with subjective experience, meaning, and interpretation rather than measurement or hypothesis testing, it is situated within the qualitative research tradition and, more specifically, within a constructivist paradigm and a qualitative multiple-case study design. This chapter sets out, in sequence, the title of the study; the conceptualization of the research; the theoretical and operational definitions of the key concepts; the research questions; the research approach, design, and paradigm; the universe and unit of study; the sampling strategy; the inclusion and exclusion criteria; the sources of data; the tool for data collection; the data collection procedure; the method of data analysis; the ethical considerations observed; and the assumptions, limitations, and scope of the study. The chapter concludes with a summary.

## 3.2 TITLE OF THE STUDY

The title of the study is **"Professional Experiences of Social Workers in Private Paid Homes for the Elderly in Kerala."**

## 3.3 CONCEPTUALIZATION

The conceptual foundation of this study emerged from the convergence of three sources: the gaps identified in the review of literature, the aims of the study, and the researcher's own field-based observations. The review of literature established that, while the roles, contributions, and challenges of social workers in long-term elder care have been examined in several international contexts (Elices Acero et al., 2024; Miller et al., 2021), the professional experiences of social workers in India's growing private paid elder care sector

remain almost entirely undocumented, and that gerontological social work in India is still an emerging field of practice and scholarship (Siva Raju & Singh, 2021). The Indian and Kerala literature, moreover, has concentrated on the conditions and well-being of residents rather than on the professionals who serve them (Gurrapu et al., 2024; Kumar et al., 2016).

From this gap, the central concept of the study the "professional experience" of the social worker was derived. This overarching concept was disaggregated into the dimensions that the research questions address: the roles and responsibilities social workers perform; their contributions to the multidimensional well-being of residents; their working conditions, including professional autonomy, job satisfaction, workload, compensation, emotional labour, and institutional support; the ethical dilemmas and professional challenges they encounter; and their vision for the future scope of the profession. These dimensions, drawn from the literature and refined through the research questions, constitute the conceptual architecture of the study and informed the development of the operational definitions and the interview guide. The institutional context private paid homes for the elderly, operating within a market-based model of care was treated as a cross-cutting condition shaping each of these dimensions (Estes, 2001; Phillipson, 2013).

### 3.4 DEFINITION OF CONCEPTS

This section provides both the theoretical definition (the meaning of each concept as established in the scholarly literature) and the operational definition (the specific meaning the concept carries within the present study) for the principal concepts used in the research.

**1. Social Worker**

*Theoretical definition:* Social work is a practice-based profession and academic discipline that promotes social change, problem-solving in human relationships, and the empowerment and liberation of people to enhance well-being, drawing on theories of social work, social sciences, and indigenous knowledge (International Federation of Social Workers [IFSW], 2014). A social worker is a trained professional who applies this knowledge base and value framework in practice.

*Operational definition:* In this study, a social worker is a person holding a recognised qualification in social work (Bachelor of Social Work, Master of Social Work, or an equivalent qualification) who is employed in a private paid home for the elderly and who

performs psychosocial, relational, advocacy, coordination, or welfare functions for residents, irrespective of the formal designation under which they are employed.

**2. Elderly Person**

*Theoretical definition:* An elderly or older person is conventionally defined, in the Indian policy context, as an individual aged 60 years or above (Government of India, 2007; Ministry of Social Justice and Empowerment, 1999).

*Operational definition:* In this study, "elderly" refers to the residents aged 60 years and above who live in the private paid homes in which the participating social workers are employed.

**3. Private Paid Home for the Elderly**

*Theoretical definition:* Institutional elder care encompasses residential facilities that provide accommodation, care, and support services to older persons. Such institutions may be government-run, charitable, or privately operated on a commercial basis (Irudaya Rajan et al., 2020; Mayer, 2017).

*Operational definition:* In this study, a private paid home for the elderly is a privately owned and managed residential facility for older persons that operates on a fee-paying basis, as distinct from government-run or wholly charitable institutions that provide free or subsidised care.

**4. Professional Experience**

*Theoretical definition:* Professional experience refers to the accumulated, lived engagement of a practitioner with the roles, relationships, demands, and meanings of their work, encompassing both the objective conditions of practice and the practitioner's subjective interpretation of them (Silarova et al., 2022).

*Operational definition:* In this study, professional experience denotes the social workers' own accounts and interpretations of their roles, contributions, working conditions, ethical dilemmas, satisfactions, difficulties, and aspirations as practitioners in private paid homes for the elderly.

**5. Professional Role**

*Theoretical definition:* A professional role is the set of expected functions, responsibilities, and forms of conduct associated with a particular professional position within an organisational and social context; in long-term elder care these include case management, direct support, personalisation of care, and community engagement (Elices Acero et al., 2024).

*Operational definition:* In this study, professional role refers to both the formally assigned and the informally assumed functions and responsibilities that social workers carry out within private paid homes for the elderly, and the manner in which these are negotiated within the institutional hierarchy.

**6. Well-being**

*Theoretical definition:* Well-being is a multidimensional construct encompassing the physical, psychological, social, and spiritual dimensions of a person's life, and, in some formulations, economic security as well; it denotes a state of overall functioning and satisfaction rather than the mere absence of illness (Gurrapu et al., 2024).

*Operational definition:* In this study, well-being refers to the physical, psychological, social, spiritual, and economic dimensions of residents' lives to which social workers contribute through their practice within private paid homes for the elderly.

**7. Professional Autonomy**

*Theoretical definition:* Professional autonomy is the degree to which practitioners are able to exercise independent professional judgement and to make decisions within their domain of expertise, free from undue external constraint (Silarova et al., 2022).

*Operational definition:* In this study, professional autonomy refers to the extent to which social workers perceive that they are able to exercise independent professional judgement in their practice within private paid homes for the elderly, given the institutional and market pressures of the setting.

**8. Job Satisfaction**

*Theoretical definition:* Job satisfaction is the affective and evaluative orientation of an individual towards their work, arising from the interaction between the conditions of the job

and the individual's expectations and needs, and constituting a recognised component of work-related quality of life (Silarova et al., 2022).

*Operational definition:* In this study, job satisfaction refers to the social workers' subjective evaluations of contentment or dissatisfaction with their roles, recognition, compensation, working conditions, and professional relationships in private paid homes for the elderly.

**9. Emotional Labour**

*Theoretical definition:* Emotional labour refers to the management and regulation of one's own emotions as a requirement of the work role, particularly in caring occupations where practitioners must sustain supportive relationships under emotionally demanding conditions; care work is frequently characterised by such labour and by its under-recognition (Lam & Baxter, 2023; Timonen & Lolich, 2019).

*Operational definition:* In this study, emotional labour refers to the emotional effort that social workers describe expending in their daily engagement with residents, families, and institutional demands, including the management of their own emotional responses to distress, decline, and death.

**10. Institutional Support**

*Theoretical definition:* Institutional support denotes the organisational resources, structures, and mechanisms such as supervision, training, peer support, adequate staffing, and recognition that enable practitioners to perform their roles effectively and sustain their well-being (Silarova et al., 2022).

*Operational definition:* In this study, institutional support refers to the presence or absence of supervision, professional development, peer support, and organisational recognition that social workers experience within their employing institutions.

**11. Ethical Dilemma**

*Theoretical definition:* An ethical dilemma arises when a practitioner is confronted with a situation involving conflicting professional values, duties, or obligations, such that any available course of action entails the compromise of one legitimate value in favour of another (Banks, 2012; Reamer, 2006).

*Operational definition:* In this study, ethical dilemmas refer to the situations social workers describe in which they must balance competing obligations to residents' autonomy and welfare, institutional policies, family expectations, and the commercial imperatives of private paid elder care.

**12. Professional Challenges**

*Theoretical definition:* Professional challenges are the structural, organisational, and relational obstacles that constrain a practitioner's capacity to fulfil their professional role, including role ambiguity, work overload, lack of specialisation, and inadequate recognition (Elices Acero et al., 2024; Miller et al., 2021).

*Operational definition:* In this study, professional challenges refer to the structural and practical difficulties such as undefined roles, heavy workload, limited recognition, and the absence of supportive systems that social workers report encountering in private paid homes for the elderly.

**13. Future Scope of Social Work Practice**

*Theoretical definition:* The future scope of a field of practice refers to its anticipated directions of development, including the expansion of professional roles, the strengthening of governance and regulation, and the enhancement of education and workforce pathways (NITI Aayog, 2024; Siva Raju & Singh, 2021).

*Operational definition:* In this study, the future scope of social work practice refers to the social workers' own visions of how the profession should develop within institutional elder care, including the policy reforms, governance mechanisms, and training requirements they consider necessary.

## 3.5 RESEARCH QUESTIONS

### General Research Question

How do social workers working in private paid homes for the elderly interpret and experience their professional roles, contributions to well-being, job conditions, ethical dilemmas, and future scope within institutional elder care?

### Specific Research Questions

1. What roles and responsibilities do social workers perform in private paid homes for the elderly, and how are these roles negotiated within the institutional structure and decision-making hierarchy?
2. How do social workers contribute to the physical, psychological, social, spiritual, and economic well-being of residents in these institutions, and how does the private paid institutional context shape these practices?
3. How do social workers perceive their professional autonomy, job satisfaction, workload, compensation, emotional labour, and institutional support within these settings?
4. What ethical dilemmas and professional challenges do social workers encounter while balancing residents' autonomy, institutional policies, family expectations, and market-driven pressures in private paid homes for the elderly?
5. How do social workers envision the future scope of social work practice in these institutions, and what policy reforms, governance mechanisms, and training requirements are necessary to strengthen professional practice?

### 3.6 RESEARCH APPROACH

The study adopts a qualitative research approach. Qualitative research is concerned with understanding the meanings that individuals or groups ascribe to a social or human problem, and it is conducted in natural settings with the researcher as a key instrument of inquiry (Creswell & Poth, 2018). The approach was selected because the aims of this study are exploratory and interpretive. The research seeks to understand how social workers perceive, interpret, and make sense of their professional experiences in private paid homes for older persons, rather than to quantify variables or establish statistical relationships.

A qualitative approach is particularly appropriate when the objective is to explore experiences, perceptions, and meanings within a specific social context, and when the phenomenon under study has received limited scholarly attention (Creswell & Poth, 2018). The professional experiences of social workers in private paid homes for older persons in India remain largely undocumented, and their perspectives have received little attention in the existing literature on institutional elder care. Furthermore, these experiences are closely shaped by the organisational, social, and market context in which they occur. The study is situated within a constructivist paradigm, which assumes that reality is socially constructed

and that knowledge emerges through human interaction and interpretation. This paradigm is consistent with the study's objective of understanding participants' subjective experiences and meanings in relation to their professional practice.

## 3.7 RESEARCH DESIGN

The present study employs a qualitative case study design. A case study is an in-depth empirical inquiry that investigates a phenomenon within its real-life context, and is especially appropriate when the boundaries between the phenomenon and its context are not clearly evident (Yin, 2018). This design was selected because the professional experiences of social workers in private paid homes for the elderly cannot be separated from the institutional, social, and organisational environments in which they occur. More specifically, the study adopts a multiple-case design. Each of the five qualified social workers employed in private paid homes for the elderly in the Kottayam and Ernakulam districts of Kerala is treated as an individual case; the cases are analysed individually and then examined for patterns across cases. This allows a detailed, holistic exploration of each participant's roles, contributions, working conditions, ethical dilemmas, and perspectives on the future of the profession, while permitting comparison across diverse institutional settings.

## 3.8 UNIVERSE AND UNIT OF STUDY

### Universe of Study

The universe of the study consists of qualified social workers employed in private paid homes for the elderly in Kerala. This is a small and specialised professional population, dispersed across the private elder care institutions of the state, for which no comprehensive register or sampling frame exists.

### Unit of Study

The unit of study is the individual social worker, that is, each qualified social worker employed in a private paid home for the elderly who participated in the research and whose professional experiences constitute the focus of inquiry.

## 3.9 SAMPLING

Given the small, specialised, and dispersed nature of the study population, non-probability sampling was both necessary and appropriate. The study employed purposive sampling, supplemented by snowball sampling.

Purposive sampling is the deliberate selection of participants who possess direct knowledge and experience of the phenomenon under investigation and who are therefore "information-rich" cases for the study (Creswell & Poth, 2018). Participants were selected because they met the defined criteria and could speak with first-hand authority about social work practice in private paid homes for the elderly. Because such practitioners are few in number and not easily identified through public sources, purposive sampling was supplemented by snowball sampling, in which initial participants assisted in identifying further eligible practitioners through their professional networks. Snowball sampling is a recognised and appropriate strategy for accessing members of small, hard-to-reach, or specialised populations. Through these combined strategies, five qualified social workers were recruited as participants. The emphasis of the study is on the depth and information value of each case rather than on numerical representativeness, consistent with the case study design.

## 3.10 CRITERIA

### Inclusion criteria

Participants were included in the study if they satisfied the following criteria:

1. Held a recognised qualification in social work (Bachelor of Social Work, Master of Social Work).
2. Were currently employed, or had been recently employed, in a private paid home for the elderly located in Kerala.
3. Possessed a minimum of six months of professional experience in a private paid home for the elderly, sufficient to reflect meaningfully on their roles and experiences.
4. Those willing to participate in the study.
5. Provided informed consent to be interviewed.

### Exclusion criteria

The exclusion criteria were framed to identify categories of personnel and institutions that, although related to the field of elder care, fall outside the specific focus of this study. The following were excluded:

1. Personnel without a recognised social work qualification (for example, nursing, caregiving, or administrative staff who may perform welfare-related duties);

2. Social workers employed in government-run homes for the elderly, which operate under a different organisational and financial logic;
3. Social workers employed in wholly charitable or free homes for the elderly, which lie outside the private paid sector that is the focus of the study;
4. Individuals who did not possess the required professional experience in the setting; and
5. Eligible practitioners who did not consent to participate.

## 3.11 SOURCES OF DATA

### Primary Data

The primary data for the study were generated through individual, semi-structured, in-depth interviews with the five participating social workers. These first-hand accounts of the participants' professional experiences constitute the principal body of data on which the analysis and findings are based.

### Secondary Data

Secondary data were drawn from published scholarly literature, including peer-reviewed journal articles, books, and systematic reviews; government and institutional reports and policy documents, such as the National Policy on Older Persons (Ministry of Social Justice and Empowerment, 1999), the Maintenance and Welfare of Parents and Senior Citizens Act, 2007 (Government of India, 2007), and the NITI Aayog (2024) position paper on senior care reforms; and demographic and statistical sources relating to ageing in India and Kerala. Secondary data were used to develop the conceptual framework, to inform the design of the interview guide, and to interpret and contextualise the primary findings.

## 3.12 TOOL FOR DATA COLLECTION

The tool used for data collection was a semi-structured interview guide developed by the researcher. The semi-structured format was selected because it combines a consistent set of predetermined thematic domains with the flexibility to explore issues that arise spontaneously during the interview, thereby allowing participants to elaborate on the matters they consider significant (Creswell & Poth, 2018).

The interview guide was developed directly from the research questions and the reviewed literature. Its thematic domains corresponded to the five areas of inquiry: the roles and

responsibilities of social workers; their contributions to the physical, psychological, social, spiritual, and economic well-being of residents; their working conditions, including autonomy, job satisfaction, workload, compensation, emotional labour, and institutional support; the ethical dilemmas and professional challenges they encounter; and their views on the future scope of the profession. The guide consisted of open-ended questions accompanied by probes, and the wording and sequence of questions were adapted to the natural flow of each interview. The interview guide was reviewed and approved by the research supervisor.

### 3.13 DATA COLLECTION PROCEDURE

Participants were identified and recruited through purposive and snowball sampling, as described in Section 3.9. Each prospective participant was contacted, informed about the study's purpose and nature, and invited to participate. Those who agreed were provided with an explanation of their rights as participants, and verbal informed consent was obtained before the commencement of each interview. Interviews were audio-recorded with participants' permission.

The interviews were conducted individually at a time convenient for each participant to ensure privacy and comfort. They were carried out primarily in Malayalam, the shared first language of the participants and the researcher, so that participants could express themselves naturally and fully. Interviews were audio-recorded with participants' permission. The interview data were subsequently transcribed and translated into English by the researcher for the purposes of analysis and reporting. The researcher's bilingual and bicultural competence supported both rapport during the interviews and accuracy in rendering participants' meanings during translation; care was taken to preserve the sense and nuance of the original Malayalam expressions. All data were stored securely and were accessible only to the researcher and were used solely for this study.

### 3.14 DATA ANALYSIS

The data were analysed using the six-phase thematic analysis framework of Braun and Clarke (2006), a widely used and methodologically transparent approach to identifying, analysing, and reporting patterns of meaning within qualitative data. The six phases were applied as follows:

1. **Familiarisation with the data.** The researcher read and re-read the interview transcripts in order to become thoroughly immersed in their content, noting initial observations and ideas.

2. **Generating initial codes.** Features of the data relevant to the research questions were identified and labelled systematically across the entire dataset, producing an initial set of codes.

3. **Searching for themes.** The codes were examined and collated into potential themes and subthemes, grouping related codes according to shared meaning.

4. **Reviewing themes.** The candidate themes were checked against the coded extracts and against the dataset as a whole, to confirm that each theme was internally coherent and clearly distinct from the others.

5. **Defining and naming themes.** Each theme was refined, clearly defined, and given a name that captured its central organising concept in relation to the research questions.

6. **Producing the report.** The finalised themes were written up, illustrated with selected verbatim extracts and accompanied by analytical commentary, and presented in the analysis chapter.

The analysis proceeded primarily inductively, with themes derived from the participants' own accounts, while remaining informed by the conceptual framework of the study.

### 3.15 ETHICAL CONSIDERATIONS

The study was conducted in accordance with the ethical principles governing research in social work. The following measures were observed:

**Informed consent.** Each participant was fully informed of the purpose of the study, the nature and extent of their involvement, and their rights, and consent was obtained prior to participation.

**Voluntary participation.** Participation was entirely voluntary. Participants were free to decline to answer any question and to withdraw from the study at any stage without any adverse consequence, and no inducement was offered.

**Confidentiality.** The information shared by participants was treated as confidential and used solely for the purposes of the research.

**Anonymity.** The identities of the participants and their employing institutions were protected. Participants are referred to by codes, and identifying details have been withheld or altered to prevent recognition.

**Privacy.** Interviews were conducted in settings that ensured the privacy of the participants, and matters disclosed in confidence were handled with discretion.

**Data security.** All data were stored securely and were accessible only to the researcher.

**Respect for participants.** The interviews were conducted with sensitivity and respect, with due regard for the emotional dimensions of the participants' work, so as to ensure that participation caused no distress.

## 3.16 ASSUMPTIONS, LIMITATIONS AND SCOPE

### Assumptions

The study proceeds on certain assumptions. It is assumed that the participants understood the questions posed and responded honestly and openly, drawing on their genuine professional experiences. It is further assumed that the participants were able to recall and articulate their experiences with reasonable accuracy, and that the accounts they provided reflect their authentic perceptions of their professional roles, conditions, and challenges. Finally, it is assumed that the researcher's shared language and cultural background with the participants supported, rather than distorted, the accurate understanding and rendering of their accounts.

### Limitations

The study is subject to several limitations. First, it is based on a small sample of five participants; while this is appropriate for an in-depth qualitative case study, it limits the generalisability of the findings, the aim being analytical insight and transferability rather than statistical representativeness. Second, the coding and thematic analysis were undertaken by a single researcher, and the absence of a second coder or formal inter-coder verification is acknowledged, although reflexivity and a careful audit of analytic decisions were maintained to mitigate this. Third, the findings were not subjected to formal member-checking by participants. Fourth, the interviews were conducted in Malayalam and

translated into English by the researcher, and although the researcher's bilingual competence supported accuracy, the process of self-translation introduces a potential source of interpretive variation. Fifth, the study is confined to two districts of Kerala and to the private paid sector, and its findings may not extend to other regions or care contexts.

**Scope**

The scope of the study is confined to the professional experiences of qualified social workers employed in private paid homes for the elderly in Kerala. It examines their roles and responsibilities, their contributions to the well-being of residents, their working conditions, the ethical dilemmas and challenges they face, and their views on the future of the profession. The study does not examine the experiences of residents, family members, or other categories of staff, nor does it address government-run or charitable institutions. Its value lies in opening to scholarly attention a hitherto undocumented area of professional social work practice in Kerala's institutional elder care sector.

## 3.17 SUMMARY OF THE CHAPTER

This chapter has set out the methodological framework of the study. The research adopts a qualitative approach situated within a constructivist paradigm and employs a qualitative multiple-case study design, judged to be the most appropriate means of exploring and understanding the professional experiences of social workers within their real-life institutional context the professional experiences of social workers in private paid homes for the elderly. The chapter defined the key concepts both theoretically and operationally, restated the general and specific research questions, and identified the universe and unit of study. It explained the use of purposive and snowball sampling to recruit five qualified social workers, and set out the inclusion and exclusion criteria, the primary and secondary sources of data, and the semi-structured interview guide used for data collection. The procedures for conducting, transcribing, and translating the Malayalam interviews were described, and the six-phase thematic analysis of Braun and Clarke (2006) was outlined as the method of analysis. The ethical considerations observed throughout the study were detailed, and the assumptions, limitations, and scope of the study were stated. The findings arising from this methodology are presented in the chapters that follow: Chapter IV presents the case descriptions of the five participants, Chapter V presents the thematic analysis and discussion, and Chapter VI presents the findings, suggestions, and recommendations.

# CHAPTER IV
# CASE DESCRIPTION

# CHAPTER IV

# CASE DESCRIPTION

## 4.1 INTRODUCTION

This chapter presents the case descriptions of the five social workers who participated in this study. Each case is presented as a detailed narrative account of the participant's professional experience within their respective elder care institution, constructed from the semi-structured in-depth interviews conducted in Malayalam and subsequently translated into English by the researcher. The narratives capture the participants' professional journey, institutional context, daily practices, emotional experiences, ethical encounters, and visions for the future in a flowing, integrated manner, reflecting the interconnected nature of professional life as it is actually lived and described by the participants. Direct quotations from participants are enclosed in quotation marks to distinguish the participants' own words from the researcher's interpretive narrative. All identifying details have been anonymised to protect the confidentiality of participants and their institutions. The participant codes P1 through P5 are used throughout. The thematic analysis of the data across all five cases is presented in Chapter V.

## 4.2 CASE A: PARTICIPANT 1 (P1)

This case explores the professional journey of Participant 1 (P1), a social worker employed at a private paid elder care institution in Kerala that operates under a well-established organisational foundation with over 16 years of experience in geriatric care. The institution holds the distinction of being the first facility in India to receive Platinum Accreditation for elder care services. P1 holds a Master of Social Work degree and has approximately three years of professional experience in the institution. Currently serving in the dual capacity of Social Worker and Resident Officer, which effectively makes P1 the Institution In-charge, the participant's narrative reveals a professional life that is richly layered, demanding, and shaped in equal measure by institutional culture, the expectations of residents in a private paid facility, and a deepening personal engagement with the realities of ageing and mortality.

The institution itself houses approximately 31 residents across 28 independent living apartment units, with the female population being higher than the male population. The

facility is oriented primarily towards independent care, though it also provides specialised support for residents with conditions such as dementia, depression, and anxiety. Monthly fees vary depending on the level of accommodation and services provided. The resident profile is distinctive: former CEOs, high-level politicians, retired scientists who worked at institutions such as the Bhabha Atomic Research Centre, and returned Non-Resident Indians. This clientele brings with it a set of expectations, capacities, and relational dynamics that fundamentally shape the nature of professional social work practice within the institution.

P1's professional role within the institution is characterised by a significant and deliberate overlap between social work functions and administrative responsibilities. The core social work functions, as P1 describes them, are centred on *"communication with residents and their families, meeting the needs of residents, and providing whatever assistance is assigned be it documentation, paperwork, or clarifying doubts."* P1 is a member of the Multi-Disciplinary Team (MDT) responsible for care plan formulation, accompanies residents for psychiatric consultations to liaise with doctors, and manages all documentation related to admissions and discharges. However, the role extends well beyond these boundaries. As the Resident Officer, P1 conducts interviews for operational staff, provides orientation sessions for new employees, handles front desk duties when colleagues are absent, coordinates activities, and manages minor accounting tasks. The boundary between social work and administration is, in practice, fluid. *"This is a service sector,"* P1 explains. *"When someone from the admin team is off or needs a replacement, we take on that individual's role."*

The residential nature of the post adds another dimension of intensity to P1's experience. Unlike a conventional office-based role, the residential posting means that the boundaries between professional duty and personal time are perpetually blurred. *"Since I am in a residential post, I cannot do this like a typical 8-to-5 job,"* P1 notes. *"There have been times I had to go at 2:00 AM due to a death or health concern. We have to help the nurses with shifting the residents. There is no specific time period where I can just say, okay, my duty is over, I'm leaving."* This round-the-clock availability, while demanding, is accepted by P1 as an inherent feature of institutional elder care rather than an imposition, reflecting a professional identity that has absorbed the rhythms of the institution into its own sense of purpose.

On the question of institutional positioning and decision-making, P1's account is notably positive. The final authority in the institution rests with the head of each location, but P1 is empowered to make day-to-day operational decisions independently. What is particularly striking in P1's narrative is the degree of respect accorded to the social work role within this institution. *"Even when the company starts a new project, we are included in discussions with planning engineers,"* P1 says. *"This is a place that gives that level of respect to social workers. The social worker is the point of contact for the family."* The institution prioritises young professionals, provides them with space to grow, and treats their professional judgements seriously. Decisions, P1 notes, never become *"ego issues"*; if a recommendation is well-reasoned, it is accepted.

P1's contributions to the well-being of residents are structured and comprehensive. The institution prepares a monthly activity calendar in advance, designed as a balanced programme that includes indoor cognitive stimulation activities such as brain teasers, paper exercises, and puzzles; one hour of daily physical exercise; and outdoor interactions. For residents with dementia, specialised morning activities are conducted to improve cognitive levels, including name-writing exercises, puzzles, and guided reading. One-on-one interaction is provided for residents experiencing emotional difficulties, though P1 acknowledges that because the facility focuses on independent living, the scope for deep therapeutic intervention is limited. For residents with depression or anxiety who are on medication, P1 coordinates reviews and uses thought distraction techniques, particularly for those experiencing what P1 refers to as *"Sundown Syndrome."* Spiritual well-being is addressed through weekly prayer meetings and monthly special events, with residents of different religions accommodated through prayer rooms in their individual units. Social engagement is facilitated through gatherings, outings, and visits by external guests such as singers and speakers.

The fee-paying context shapes the nature of care interactions in ways that P1 describes with a blend of professionalism and frank candour. *"They are demanding,"* P1 says. *"Their voices and opinions are loud. Since it is a paid facility, they will demand. Just like if you pay for a biryani and it's not good, you will speak up."* The institution holds monthly meetings where management meets residents to hear their concerns, and social workers conduct daily rounds. P1 identifies consistency in service as the single greatest challenge: *"Consistency in service is the hardest part. If the food quality drops once, all the good work we did previously is forgotten. It is not rocket science, but it requires common sense and patience."* The

framing of care as *"Customer Delight"*a term P1 uses naturally reveals how deeply the market logic of paid service provision has been absorbed into the institutional vocabulary and, by extension, into the professional language of the social worker.

Yet P1's account resists reducing residents to mere consumers. On the question of whether financial comfort masks emotional vulnerability, P1 offers a nuanced response: *"We must view them with equal respect, not just through the lens of mercy. While they have financial comfort, they also have the mental strength gained from living to 85. They might have sorrows we don't know about, but they maintain a happy posture."* This framing respect rather than pity, recognition of resilience alongside vulnerability reflects a strengths-based orientation that aligns with professional social work values even within a commercially structured environment. Admissions to the institution are conditional on the consent of both the elderly person and their children, and all residents maintain connections with their families, some travelling abroad periodically to stay with children who have settled overseas.

P1's experience of professional recognition and career growth is distinctly positive. Having entered the institution as a newly qualified social worker with only academic learning, P1 was recognised within two years and elevated to the role of Resident Officer. *"We arrived as basic social workers with only academic learning, but within two years they recognized us and gave us higher posts,"* P1 recalls. The institution recognises talent regardless of seniority, and P1 has represented the organisation at prestigious external events. The starting salary of twenty-five thousand rupees is described as comparatively good for social work positions in Kerala, and P1 currently receives additional benefits including free food and accommodation. Despite these positives, P1 acknowledges the reality of burnout, attributing it to the residential nature of the post, which requires living and working within the same building with the same daily routine. Management addresses this by allowing periodic breaks and trips.

The absence of a formal supervision system for social work is noted, though P1 does not frame this as a significant grievance; management is described as approachable and functioning informally as mentors. More profoundly, P1 reflects on how working in this setting has reshaped both professional identity and personal values. *"Working in these homes has changed me as a human,"* P1 says. *"I've seen residents who were once head nurses or in elite positions now dealing with dementia. It made me realize we must be humble because we all reach a stage of weakness."* Encountering death at least every three months

given that most residents are over 85 has given P1 a deep and continuing insight into the realities of end-of-life. *"The blessings we get from residents are worth more than the salary,"* P1 adds, locating the emotional reward of the work not in financial compensation but in the relational and spiritual dimensions of caregiving.

On the ethical terrain of practice, P1's account is marked by a relatively low level of conflict, which P1 attributes directly to the institution's values-driven culture. *"The institution's policies are human-centric and rooted in values like transparency and integrity,"* P1 states. Confidentiality is maintained rigorously: *"Family issues aren't tea table talk and are only handled by the social worker, nurse, and admin team."* P1 reports that there are no major conflicts between institutional policy and professional social work ethics, describing the institution as a place where social work principles can be followed with relative ease. The structural tension of working in a paid facility where the rooms cost more than an ordinary person can afford is rationalised by P1 through the institution's charity wing, which uses revenue from paying residents to fund children's education and medical care for the needy. Pressure from families is characterised as generally need-based: families demand quality because they pay substantial fees, but the demands are typically directed at ensuring promised services are actually provided. *"I have never had to compromise my conscience,"* P1 states with evident conviction. *"We do not take an attacking mode even if someone is harsh; we are patient, calm, and polite, but also firm. Even when sending bill reminders, we don't use the tone of a money-lender; there is moderation in our language."*

P1 notes, however, that there are no written ethical guidelines or a formal ethics committee within the institution. Ethical dilemmas, when they arise, are collectively discussed within the management team. P1 expresses the view that there is a definite need for a dedicated Social Work Department to formalise the professional identity and scope of social work within the institution. This observation made by a participant who is otherwise highly satisfied with the institution suggests that even in well-functioning, values-driven settings, the structural professionalisation of social work remains incomplete.

Looking towards the future, P1 identifies several competencies essential for social workers entering private paid elder care: a positive attitude, emotional intelligence, strong communication skills, patience, and intellectual curiosity. *"Social workers must be thinkers,"* P1 argues. *"They should read a lot, know current trends, and contribute ideas to the institution. They shouldn't just stick to social work but be open to multiple*

*responsibilities."* P1 is critical of the current state of gerontological education in social work programmes, noting that the topic received only one chapter during the academic programme. *"We need more focus on gerontology in education. The elderly are often neglected because they aren't a vote bank. There isn't even a regulatory body for institutions like ours."* P1 advocates for the legal mandating of social work roles in schools, hospitals, and elder care institutions; the regulation of starting salaries to a minimum of twenty thousand rupees; the formalisation of supervision systems; and the improvement of field education, arguing that professors who teach social work should also have field exposure. P1 expresses optimism about the future of social work in the geriatric field: *"Social workers will have a great scope in the geriatric field as the elderly population doubles. Doctors have only recently realized that they need a social worker as an assistant to handle the humanitarian side of a client's care. While doctors focus on the disease, social workers take a comprehensive view of the client."*

P1's narrative, taken as a whole, presents a portrait of a social worker who has been shaped profoundly by the institutional context in which practice occurs. The institution's culture of respect, its values-driven policies, and its willingness to invest in young professionals have produced a practitioner who is both professionally confident and personally transformed. At the same time, the narrative reveals the structural ambiguities that persist even in well-functioning settings: the absence of a formal social work department, the lack of written ethical guidelines, the blurring of social work and administrative roles, and the inadequacy of gerontological training in the academic curriculum. P1's case demonstrates that the quality of professional experience in private paid elder care is not determined solely by salary or institutional prestige but by the relational culture of the institution, the degree of professional recognition afforded to social workers, and the practitioner's own capacity for reflective engagement with the complexities of caregiving in a market-driven context.

### 4.3 CASE B: PARTICIPANT 2 (P2)

This case presents the professional narrative of Participant 2 (P2), a social worker employed at a large private paid retirement home located in the Ernakulam district of Kerala. P2 holds a Master of Social Work degree with a specialisation in Community Development, having completed an undergraduate degree in Literature and a postgraduate programme at an institution in central Kerala. P2 has been working at the current institution for three years and has a total of approximately four years of professional experience. P2 currently serves as Senior Executive in the institution's Relations Department, a designation that

encompasses social work functions but is not formally titled as a social work role. The institution itself is among the largest private paid retirement communities in Kerala, housing approximately 157 residents at the time of the interview, with occupancy sometimes exceeding 200. The resident categories include couples, widowed individuals, and single residents. The institution operates as a registered corporate company, established around 2011, with a business model in which residents purchase apartment units, paying a certain amount of which 20 percent goes to the company, with the remainder refunded upon departure or death. Short-stay options for post-surgery recovery and 11-month terms are also available, alongside guest rooms for visiting family members.

What is immediately striking about P2's account is the scale and specialisation of the social work team within this institution. Unlike many elder care facilities where a single social worker operates in isolation, P2 works as part of a team of eight MSW-qualified social workers, all employed within the Relations Department. The core area of practice, as P2 describes it, is what the institution calls *"Residency"* a term that encompasses the comprehensive engagement with residents' psychological needs, family support, and quality of life. *"What we mainly do here is provide therapies for dementia care, case work, and things like that,"* P2 explains. *"Our core area is Residency. We address psychological needs, support the residents' families, and look after their quality of life."* The work is structured around weekly and monthly assessments, follow-ups, and substantial documentation.

The therapeutic dimension of P2's practice is notably developed. The social work team conducts a range of evidence-based interventions including Reminiscence Therapy, MOCA assessments, MMSE evaluations, Progressive Muscle Relaxation (PMR), art therapy, and what the institution calls *"Brain Gym"* a weekly cognitive stimulation programme. Based on these assessments, residents are categorised according to the severity of their cognitive conditions. The institution has approximately 10 to 25 residents with high-level memory issues such as dementia or Parkinson's disease, while the remaining residents are active and independent. For the dementia care group, P2 and colleagues are currently running a project called *"Mindful,"* which involves structured examinations and activities designed to promote socialisation. *"We introduced Reminiscence Therapy ourselves after studying it,"* P2 says with evident professional pride. *"We collect life history materials and photographs with family support. PMR was also a social work initiative."* The social work team has also initiated a physiotherapy centre in coordination with doctors, demonstrating an

entrepreneurial orientation that extends beyond the conventional boundaries of social work practice.

P2's daily practice involves visiting residents, conducting assessments based on body language and orientation, identifying the type and severity of cognitive issues, and educating family members about care needs and status changes. The team uses a process called *"Decline Documentation,"* which tracks changes in residents' daily functioning over time, with comprehensive reassessments conducted every six months. A psychologist visits monthly, and a psychiatrist conducts periodic evaluations, the results of which are shared confidentially with the social work and nursing departments. *"For many, it's visible to their children because this isn't an orphanage setup; it's retirement living,"* P2 notes, drawing a clear distinction between the institutional identity of a paid retirement community and a charitable care home.

The institution's approach to resident well-being is comprehensive and activity-rich. P2 describes 18 structured activities, including trips tailored to residents' requirements, a *"Wednesday Club*" featuring guest interviews and discussions, Brain Gym sessions, health activities, monthly doctor-led classes, Ayurvedic treatments, and weekend movie screenings. *"We try to keep them out of their rooms so they don't feel lonely,"* P2 explains. A recent three-day exhibition titled *"Still Blooming,"* showcasing paintings by residents, exemplifies the creative programming that the social work team has developed. The institution operates, in P2's description, as a space where elderly residents can live according to their wishes while receiving structured support though restrictions apply for those with memory loss regarding guest access and contact with children, a point that generates its own set of ethical tensions.

P2's account of managing loneliness and depression reveals the delicate balancing act required in sustained relational care. *"We can spend up to an hour talking to them,"* P2 says, *"but if we do it continuously, they become dependent. So we keep a distance. If we are off for a day, they might get anxious and start looking for us."* This awareness of dependency dynamics reflects a professional maturity in boundary management that resonates with the concept of *"social labour"* documented in international literature. The social workers must be simultaneously warm and boundaried, present and professional. Some residents resist therapeutic assessments: *"Some residents get upset during MOCA tests, saying 'I don't have any illness, don't make me a patient.' Sometimes we have to get their children to talk to*

*them."* The biggest task, as P2 describes it, is *"talking to and convincing residents who might be stubborn. We have to build a friendship first. Some might get angry or try to hit us mostly those identified with Dementia or Parkinson's."*

The resident profile shapes P2's practice in distinctive ways. The resident population includes former engineers, army officers, and other professionals. *"These are people from high socio-economic backgrounds,"* P2 observes. *"When they sign the agreement, they know what services are provided."* Some residents choose to remain privately in their rooms rather than participate in communal activities, and the institution respects this autonomy. Others form active social groups P2 describes one group of women fondly as *"Kudumbashree,"* after the well-known Kerala self-help group network, *"because they talk openly about everything."* Residents organise trips with friends, hold exhibitions, and suggest skits for cultural programmes. *"It's not a jail; they have freedom,"* P2 emphasises. Yet financial dynamics create their own tensions. Annual fee increases cause distress, particularly for residents relying on pensions. *"Some who have been here a long time pay less than new residents, which causes issues,"* P2 notes. *"There are those who have money but act poor, and those who don't want to trouble their children for money."* In a remarkable demonstration of resident agency and solidarity, five residents at the institution established a medical policy for staff welfare, under which 70 percent of treatment costs for staff or their families are reimbursed an act that complicates any simplistic framing of the relationship between residents and their careers.

P2 expresses general satisfaction with professional conditions. The workload is described as manageable, with regular hours from 9 AM to 6 PM and overtime occurring only during events, for which compensatory leave is provided. The institution provides free food, accommodation, Provident Fund, and ESI benefits. P2's salary has grown from a starting point of twelve thousand rupees to approximately twenty-one to twenty-five thousand rupees. Recognition is provided through staff meetings and monthly evaluations. The interpersonal environment is described positively: *"Emotionally, there are no issues like groupism. Professionally, we work 9 to 6, and after that, we are a group of friends."* P2 supervises four cases and a residential block, and the team actively collaborates with MSW colleges, hosting seminars and utilising internship students for programmes.

However, P2's narrative reveals a significant tension around professional identity and career growth. Within the institution, P2 is known by the designation of the Relations Department

not as a *"Social Worker." "This is a bit difficult,"* P2 admits, *"because we might want the Social Worker designation for our next job."* The work is therapeutic and valued by residents *"Residents believe only MSW staff can solve their problems, so we feel valued"* but the formal absence of the social work title creates an invisible professional erasure. P2 also acknowledges the limitations of the role: *"We can't apply everything we studied; we can't do much community-related work."* The question of career growth is a recurring undercurrent: *"For a career, we use our maximum skills here, but sometimes we feel like moving to a better field for growth. However, it is a comfort zone with free food and stay, PF, and ESI. But for growth, one must go outside."* This tension between institutional comfort and professional ambition, between being valued by residents and being invisible as social workers in the formal organisational structure, represents one of the most significant findings in P2's narrative.

Ethical dilemmas in P2's experience are not dramatic but are persistent in subtle ways. The most common involves the management of guest access for residents with dementia, where the family's wishes may conflict with the resident's desire to receive visitors. *"The hardest is when guests come for dementia residents against the family's wishes,"* P2 explains. *"We have to check with the children or spouses before letting them in. Sometimes the resident is waiting for the guest, and we have to say no, which leads to anger."* Confidentiality is strictly maintained, including restrictions on social media. Financial considerations do not affect care quality: even if residents wish to leave because of fee increases, the institution does not obstruct their departure. There is no formal ethics committee, but a board exists, and daily briefings are used to discuss concerns openly. P2 notes the availability of a feedback system using scan codes, indicating a degree of institutional transparency.

Looking towards the future, P2 identifies a strong need for additional therapeutic training, particularly in psychology and psychiatry, to work more effectively with dementia residents. *"We would like more training sessions on psychology and psychiatry,"* P2 says. *"Nursing and HR get training, but MSW graduates don't get much."* P2 advocates for gerontological specialisation in social work education and for the regulation of starting salaries to at least twenty-five thousand rupees. P2 recommends the field of elder care to future social workers but notes honestly that career growth within these institutions is limited and that professionals may need to move on after gaining experience. *"You can't come here saying 'I will only do social work'; you have to support all departments, including the reception,"* P2 advises a statement that encapsulates both the breadth of opportunity and the ambiguity

of professional identity that characterises social work practice in Kerala's private paid elder care sector.

P2's case, taken as a whole, presents a distinctive portrait of social work practice within a large, corporately structured retirement community. The presence of eight MSW-qualified social workers, the implementation of evidence-based therapeutic interventions, and the structured approach to documentation and assessment mark this institution as comparatively advanced in its integration of social work. Yet the narrative also reveals the structural contradictions of the setting: the therapeutic work is sophisticated but the professional title is absent; the residents value the social workers profoundly but the organisational designation erases their professional identity; the institutional environment is comfortable but career growth is constrained. P2's experience illustrates that in the corporatisation of elder care social work may be functionally central yet organisationally invisible a paradox that has significant implications for the professionalisation of gerontological social work in India.

### 4.4 CASE C: PARTICIPANT 3 (P3)

This case presents the professional narrative of Participant 3 (P3), a social worker employed for one year and eight months at a well-established private paid elder care institution in Kerala operating under the same organisational foundation as Participant 1, though at a different facility. P3 holds a Master of Social Work degree and was recruited directly through a campus interview upon completing the postgraduate programme. What distinguishes P3's case from the other participants is the nature of the role occupied: rather than working in direct social work or resident relations, P3 was posted to the institution's Education and Research wing, serving as Programme Coordinator for diploma programmes in gerontology and paediatrics, and as Field Supervisor for MSW internship students from colleges across Kerala. P3 is currently on a career break due to pregnancy but has continued professional development through online diploma programmes in gerontology and counselling. P3's narrative thus offers a distinctive insider-outsider perspective deeply embedded within the institutional structure yet positioned at one remove from the daily pressures of direct resident care, allowing for an unusually reflective and systemic account of how social work functions within private paid elder care.

The institution in which P3 worked is described as highly systematic in its departmental organisation. P3 provides a detailed account of the institutional structure: the nursing

department provides 24-hour care and health coordination; the social work department monitors residents from admission to departure, handling psychological well-being and care plan preparation; the operations department encompasses housekeeping, laundry, food and beverages, and gardening; and the education and research wing manages academic programmes and intern supervision. Social workers within the institution occupy two distinct functional roles: Resident Relations and Social Work. Resident Relations, as P3 explains, *"is like a hotel, from the time an elderly person arrives until they leave,"* encompassing the collection of personal details, room setup, departmental introductions, grievance management, daily and monthly family updates via email, and coordination of all communication between management, family, and resident. The social work function focuses on care plan preparation, psychological monitoring, counselling, and coordination of psychiatric medications. P3 emphasises that the institution operates as a teamwork effort requiring a holistic approach across departments: *"For a generic function to run smoothly, this institution runs as a teamwork effort. To provide good care, a holistic approach involving these departments is needed."*

P3's account of the admission and care planning process is the most detailed of all participants. Before a resident is admitted, the Business Development team receives enquiries, and a multi-disciplinary team comprising social workers, nurses, dieticians, and physiotherapists conducts a home evaluation. The institution does not accept all applicants: *"We don't take everyone because it's a community living space; we don't take troublemakers so that others can live in peace. We don't take those with criminal behaviour or addictions."* Each department assesses the prospective resident from its own perspective nurses examine biological and medical conditions, social workers assess psychological and psychiatric history using tools akin to the Mental Status Examination, physiotherapists evaluate mobility, and dieticians assess nutritional needs. Once admitted, the resident undergoes an initial 24-hour assessment, a 7-day assessment, and by the 21st day, a comprehensive individualised care plan is prepared. The care plan is renewed every three months, with each department contributing its observations and recommendations. Social workers take the initiative to inform families, conducting meetings with departmental representatives and family members via video call, with all communication documented through email to ensure transparency. *"We don't even see a doctor without the family's consent,"* P3 notes. *"All communication goes via email to ensure transparency. Even for a small procedure, we need consent."*

P3's own daily work centred on the education and research wing. Monthly cohorts of MSW interns from prominent Kerala colleges were supervised by P3, who was responsible for building awareness about geriatric social work, monitoring day-to-day activities, preparing schedules, and rotating interns across departments to understand the full scope of institutional operations. P3 also coordinated online diploma programmes in gerontology, managing admissions, attendance, marks, and certification. Beyond academic duties, P3 was involved in Quality Assurance studying existing systems, identifying gaps, and proposing solutions through committees and projects. P3 also engaged directly with residents who had dementia, conducting activity sessions to slow cognitive decline. This combination of academic, supervisory, and direct engagement roles gave P3 a panoramic understanding of how the institution functions, even though the primary designation was not in frontline social work.

On the question of role boundaries, P3's experience is notably different from other participants. P3 reports that non-social-work tasks were not assigned: *"In our institution, social work is a respected job and a respected position. There are specific roles for everyone. There was no need for role negotiation with the management."* However, P3 acknowledges that this clarity applied to the more systematic facility where P3 was posted. P3 draws a sharp contrast with a colleague's experience at a newer, developing facility under the same foundation, where a single social worker was responsible for the front office, social work, and resident relations simultaneously: *"She was under immense pressure because she had to manage the front office, social work, and resident relations all by herself. She eventually left."* This variation within the same organisational foundation reveals that the quality of professional experience in private paid elder care is not determined solely by the parent organisation but by the specific facility's staffing levels, maturity, and operational structure.

Regarding resident well-being, P3 describes a rich programme of social engagement designed to prevent cognitive decline and combat loneliness. The institution runs multiple clubs a Movie Club, a Games Club with evening sessions of carroms and board games, and technology orientation sessions where active residents present videos and lead discussions. Before the COVID-19 pandemic, residents were taken on outings to beaches, cinemas, and family visits. P3 articulates the underlying philosophy clearly: *"Our aim is to prevent dementia through social engagement. That's why we host programmes to engage them daily."* The resident profile shapes these interactions distinctly. Monthly fees at the

institution range from fifty thousand to one lakh rupees, and P3 observes that residents are demanding precisely because they are paying substantial fees: *"Residents here are demanding because they are paying a high amount. Unlike in a free home where they might eat whatever is given without complaint, here, they question any gap in service."* Monthly meetings between management and residents serve as a structured forum for addressing grievances.

P3's reflections on professional conditions are candid and revealing. P3's own role in the academic department was cognitively demanding but relatively structured, with regular 9-to-5 hours. However, P3 is acutely aware that direct social workers in the same institution face a fundamentally different reality. At the facility, which housed approximately 71 residents, social workers operated under immense pressure. I think social workers there face burnout because it's a job with high responsibility. She mentioned *"waking up at 6 AM and returning to the room at 9 PM."* Initially, social workers had night duties as well, which disrupted sleep and personal life. Two social workers were responsible for approximately 70 residents, and when one was absent, the load on the remaining worker was overwhelming. P3 argues that reducing such conflicts requires management to provide motivation, welfare support, and clarity in roles from the time of the offer letter: *"If management respects our psychological aspects and motivates us, the work feels worthy. If the field offers opportunities to learn, it's interesting; otherwise, it's tiring."*

P3's account of ethical dilemmas is the most critically reflective among the participants. While acknowledging that the institution has systematic measures to prevent ethical breaches including quarterly quality studies where staff are divided into groups to assess different departments P3 is unusually forthright about the limitations. On the question of moral distress, P3 identifies the commercial nature of care as a source of inner tension: *"Frankly, a care institution is a business, right? When payments increase, it's a concern for the resident and family, but we can only inform them as instructed by management. We can't influence management to reduce the pay. Our core is service for the vulnerable, right? So we feel it in such situations."* This is one of the most candid acknowledgements among all participants of the structural tension between the social work ethic of service and the market logic of commercial elder care.

P3 also raises a critical point about the integrity of individual practitioners: *"I've seen that not all social workers have the same integrity and transparency. Some get lazy and avoid*

*checking on a resident if they are called after duty hours. Others go immediately. That's a question we must ask ourselves are we following ethical principles?"* This reflexive turn directing the ethical gaze inward towards the profession rather than solely outward towards the institution is rare among the participants and adds depth to the understanding of ethical practice in these settings. P3 identifies a significant structural gap: the absence of written ethical guidelines. *"That is a drawback; there's a gap in written documents and rules. They exist in practice but not as written guidelines. We learn what to do and who to inform through verbal training, not certain guidelines."* P3 also notes the absence of a dedicated supervisory structure for social workers, who report directly to management without an intermediary professional supervisor. *"For a fresh graduate, a supervisory role would be a good recommendation,"* P3 suggests. When asked directly whether the institution fully operates with ethics, P3 responds with measured honesty: *"I doubt if the institution fully operates with ethics. I say this from my work experience."*

P3 recounts one concrete ethical incident: an elderly couple without children had their money stolen by a care worker. The institution responded decisively, informing the police and dismissing the worker. *"We always stand up for the resident's well-being,"* P3 states. Confidentiality is maintained rigorously care plans and resident details are not shared with interns or third parties, and all information is restricted to the family and relevant staff. When conflicts arise between residents' wishes and family directives, P3 notes that decisions are made according to *"what is best for the resident,"* though family members are integral to decision-making as they placed the resident in the institution.

Looking towards the future, P3 is articulate about the competencies that the field demands: communication skills, decision-making, problem-solving, management and leadership skills, technology proficiency for presentations and documentation, and research skills. P3 is particularly emphatic about the need for lifelong learning: *"The MSW syllabus alone isn't enough for the job. We need life-long learning."* P3 argues that social work education should be more job-oriented and that gerontological specialisation should be expanded significantly. P3 identifies a critical governance gap: unlike colleges which have NAAC accreditation, private old age homes in Kerala have no systematic accreditation body or external monitoring framework. *"There are associations like the Association of Senior Living India, but no governing bodies,"* P3 observes. P3 advocates for the strengthening of professional associations such as the Kerala Association of Professional Social Workers (KAPS), the legal mandating of social work roles, and the regulation of minimum salaries

to at least eighteen to twenty thousand rupees. P3 recommends the field of geriatric social work for those with patience, empathy, and strong communication skills, predicting that demand will grow substantially as Kerala's elderly population increases and more private paid institutions emerge.

P3's case, taken as a whole, offers a perspective that is both complementary to and critically distinct from the direct practice accounts of other participants. By virtue of occupying a role in education and research rather than frontline care, P3 is able to observe the institutional system with a degree of analytical distance that produces some of the study's most penetrating insights: the gap between verbal training and written guidelines, the variability in professional experience across facilities within the same foundation, the moral distress generated by the intersection of service ethics and commercial imperatives, and the honest acknowledgement that not all practitioners maintain the same level of ethical commitment. P3's narrative demonstrates that the professionalisation of social work in private paid elder care requires not only better salaries and clearer roles but also stronger accountability structures, written ethical frameworks, and a culture of reflexive professional practice.

### 4.5 CASE D: PARTICIPANT 4 (P4)

This case presents the professional narrative of Participant 4 (P4), a social worker employed at a newly established private paid retirement home in Kerala that is currently in its first phase of operations. P4 holds a Master of Social Work degree and has been working at the institution for approximately ten months. P4 serves as Executive Resident Relations and is, at present, the sole social worker performing direct practice functions at the facility, though a second social worker occupies the managerial role. The institution currently houses approximately 10 to 15 residents, with the number fluctuating as some residents travel to visit their children or continue working. P4's narrative is distinctive among the participants because it captures the experience of building a social work practice from the ground up within a nascent institution, where structures are still evolving, protocols are being created rather than inherited, and the social worker's role is being shaped in real time rather than fitted into a pre-existing organisational template.

P4 describes the primary role as conducting activities that keep residents engaged, performing daily resident visits to identify complaints, difficulties, or areas needing improvement, and functioning as a mediator between residents and the institutional authority. *"A social worker acts as a mediator among the residents because my position is*

*in Resident Relations,"* P4 explains. "The authority here learns about any problems the residents have through me; I function as a mediator between the authority and the residents." Beyond these social work functions, P4 also handles inquiry calls and performs tasks related to the sales department, reflecting the reality that in a small, developing institution, role boundaries are necessarily fluid. P4's official title is Executive Resident Relations not Social Worker continuing the pattern observed across all participants of professional identity being absorbed into institutional designations. However, P4 reports that the work performed is strictly within the domain of social work training: *"I only perform work related to the profession I studied, specifically tasks based on MSW."*

The institutional context of P4's practice differs markedly from the larger, more established facilities described by other participants. The decision-making structure is described as still developing: *"Initially, it wasn't very organized, but after I joined, I developed activities based on my internship experience."* The appointment of a new manager who is also a qualified social worker has been a positive turning point, enabling the implementation of structured programmes. P4 reports a high degree of professional freedom: suggestions are accepted with a friendly and open attitude, professional judgement is respected, and there is no experience of being overburdened or overruled. Financial considerations do not influence institutional decisions. This picture of a supportive, still-forming institutional culture contrasts with the more complex power dynamics and commercial pressures described by participants in larger, more established facilities.

P4's contributions to resident well-being are built primarily around activity programming and relational engagement. The therapeutic approach centres on what P4 describes *as "talk therapy and validation therapy."* Validation therapy is identified as the primary method used, especially for residents with dementia: *"Making them feel understood is a significant positive factor."* P4 does not employ more specialised therapeutic modalities such as CBT, noting that no residents currently require it, but provides emotional support through daily visits, conversations, and careful observation of residents' emotional states. P4 describes an intuitive, relationship-based approach to identifying distress: *"I can tell from their faces if they are struggling with family issues, and we focus more on those who seem distracted during activities."* The importance of initial rapport-building is emphasised, particularly given the profile of the residents: *"Building an initial rapport is essential because these residents are often financially well-off and may be reserved; they will only cooperate if they feel understood."*

Spiritual and social needs are addressed through the celebration of festivals such as Vishu, Christmas, and Onam, as well as observance days including Environment Day, Teachers' Day, and Mother's Day. P4 notes that in this mixed-religion community, residents participate in each other's festivals, fostering a sense of shared belonging. External spiritual programmes are not organised to avoid potential conflict, though residents are free to visit nearby places of worship. P4 offers a perceptive observation about the social dynamics of private paid institutional living: while some residents view living in the retirement home as a privilege, a persistent social stigma exists *"because many people cannot distinguish between a retirement home and an old age home."* This observation about stigma the conflation of paid retirement living with charitable institutional care in public perception adds an important contextual dimension to understanding how residents and their families experience institutional elder care.

P4 expresses very high job satisfaction, having specifically sought out a role in a retirement home after completing the postgraduate programme. *"I enjoy being active and interacting with everyone,"* P4 says. The daily routine involves resident visits, creating activity posters using Canva, conducting activities, and handling inquiries. P4 describes the work as more therapeutic than administrative a characterisation that distinguishes this experience from participants in larger institutions where administrative functions tend to dominate. P4 takes visible pride in having implemented programmes such as Chair Yoga, Brain Gym, and craft sessions, and in witnessing the community grow from its initial residents. The starting salary of fifteen thousand rupees increased to twenty thousand after a six-month probation period. P4 receives accommodation within the institution. Supervision is provided by the manager, who is also a social worker, creating a rare instance among the participants of professional social work supervision by a qualified colleague. P4 acknowledges initial stress in adapting to tasks such as creating digital content but describes this as a manageable learning curve rather than a systemic problem.

Ethical dilemmas in P4's experience are minimal, which P4 attributes to the small scale of the institution and the supportive management culture. P4 maintains clear professional boundaries, notably refusing to accept financial gifts or tokens from residents: *"It is against company rules and professional ethics."* Most complaints are minor and practical food preferences, requests for specific cleaning staff rather than structural or ethical in nature. All decisions are discussed with the manager. There is no external monitoring of the institution,

and while the facility is registered as a Private Limited company and follows professional standards, the governance framework remains informal and evolving.

Looking towards the future, P4 identifies acceptance, patience, and empathy as essential competencies, with communication singled out as the most critical skill: *"It is about how we speak and behave with the residents."* P4 notes that while geriatrics is covered in the MSW curriculum, specific conditions such as dementia are not studied in sufficient depth, and more specialised training would be beneficial. P4 believes that the minimum starting salary for a fresh MSW graduate should be at least fifteen thousand rupees and sees significant scope for social workers in retirement homes both in India and abroad. P4 identifies a persistent challenge in the field: the difficulty of retaining staff, with many workers leaving within six months. This observation about workforce instability echoes the brain drain concern raised by P1 and has direct implications for the sustainability and quality of social work practice in elder care.

P4's case, taken as a whole, offers a counterpoint to the narratives of participants working in large, established institutions. In a small, developing facility with a supportive social-work-trained manager, P4 experiences a degree of professional autonomy, role clarity, and therapeutic focus that the other participants describe as aspirational but often unattainable in their more complex institutional environments. The absence of significant ethical conflict, the manageable workload, and the direct therapeutic engagement with residents paint a picture of what social work in elder care might look like under optimal conditions of scale and institutional culture. Yet the case also reveals the fragility of this model: P4 is the sole practitioner, the institution is in its earliest phase, and the governance structures remain informal. As the institution grows and the resident population increases, the conditions that currently enable P4's positive experience may come under pressure a trajectory that the experiences of participants in larger, more mature institutions suggest is likely.

### 4.6 CASE E: PARTICIPANT 5 (P5)

This case explores the professional journey of Participant 5 (P5), a social worker who served for approximately one year at one of the most established private paid elder care institutions in Kerala a Trust-registered assisted living space operating across multiple branches in the Kottayam and Ernakulam districts. P5 holds a Master of Social Work degree and was posted at the institution's Kottayam branch, a facility housing approximately 80 residents across a spectrum of dependency levels from fully independent individuals living a post-retirement

life to those who are wheelchair-bound, bedridden, or living with advanced dementia. Monthly fees at this institution range from sixty thousand to one lakh fifty thousand rupees, placing it among the higher-fee private paid institutions in Kerala's elder care market. P5 has since relocated abroad, and this interview captures reflections shaped by both the immediacy of lived practice and the analytical distance that comes from having stepped outside the institutional context. P5's narrative is distinctive among the participants for several reasons: it offers the most articulate account of the insider-outsider tension that defines social work in commercial elder care; it is the only case where the participant's formal designation was explicitly *"Social Worker"*; and it provides the most nuanced account of how institutional culture, professional autonomy, and ethical practice intersect in a well-established, values-driven institution.

P5's role within the institution was structured across two interconnected departments: Resident Relations and Social Work. Understanding the architecture of this dual role is essential to grasping P5's professional experience. As a Resident Relation Officer, P5 functioned as the primary communication bridge between management, families, and residents a role that P5 describes as fundamentally about *"bridging."* As a Social Worker, P5 focused on the psychosocial well-being of residents, conducting primary-level psychological interventions, monitoring cognitive and social orientation, documenting changes in care plans, and serving as a member of the Multi-Disciplinary Team (MDT). Only two social workers held the authority to initiate changes within these departments P5 and one colleague making them, as P5 puts it, *"the heads of a department right at the starting phase."* This level of responsibility, conferred on freshly graduated professionals, speaks to an institutional culture that simultaneously trusts and burdens its young social workers. *"Job satisfaction was always at its peak because we were the heads of a department right at the starting phase,"* P5 recalls. *"Also, we had full freedom; the management gave us full authority to bring any changes to that department."* Yet this freedom existed within the constraints of a residential posting where emergencies falls, hospital rushes, deaths could and did arise at any hour. *"Since we are residential social workers, I or the other girl will generally be at the workplace 24/7,"* P5 explains matter-of-factly.

The admission process described by P5 is the most detailed and methodologically rigorous account among all five participants, revealing a sophisticated institutional system that belies the common perception of old age homes as informal or ad hoc. When a prospective resident's family contacts the Business Development team, the MDT comprising social

workers, nurses, a nursing manager, a physiotherapist, and an activity coordinator conducts a home assessment. P5's explanation of why this home visit matters reveals a depth of professional reasoning that distinguishes experienced practitioners from textbook knowledge: *"We mostly prefer a home visit so we can understand the surroundings because there is a chance the family might act or pretend to get the elderly person accommodated. Doing these home assessments in the environment they grew up in provides a secondary cue for us to understand."* This awareness that families may conceal difficult behavioural histories or exaggerate care needs to secure admission reflects a professional vigilance that is born from practice, not from curricula. Following admission, a 7-day observation report is prepared, after which an online meeting with the family presents the care plan. The plan is renewed every three months, and if significant changes occur in three or more areas, the existing care plan is entirely dismissed and a new one is formulated. Every step is documented via email to ensure transparency: *"We don't even see a doctor without the family's consent. All communication goes via email."* The rigour of this system stands in notable contrast to P3's observation that written ethical guidelines are absent suggesting that in this institution, operational protocols are formalised but ethical frameworks remain verbal and implicit.

P5's contributions to resident well-being span physical, psychological, social, and spiritual dimensions, but what distinguishes this account is the attention to the holistic and investigative nature of the work. When a fall occurs, it is not treated as a simple incident but triggers a full MDT investigation: the nurse manager interviews the caregiver, the physiotherapist analyses mobility, and the social worker assesses whether the fall has affected the resident's orientation or emotional state. *"We focus on holistic development when doing these things,"* P5 explains. *"For senior citizens, physical well-being is highly important. If a person can't hear, their social skills will gradually decrease."* This understanding of the cascading relationship between physical and social functioning where a hearing deficit leads to social withdrawal, which leads to cognitive decline reflects a systems-level clinical thinking that aligns with Bronfenbrenner's ecological framework without P5 ever naming it. The social dimensions of care are addressed through group activities, celebrations of festivals and birthdays, and crucially, resident meetings where residents voice their concerns directly to management. *"When they realize their point of view reaches us and we incorporate it, they get a sense of empowerment,"* P5 observes. *"It's a reminder that they aren't living at our expense."* This framing of resident meetings as

instruments of empowerment rather than mere complaint forums reflects a strengths-based orientation embedded in institutional practice.

P5's account of navigating the demands of residents and their families is candid and layered with professional maturity. The fees sixty thousand to one lakh fifty thousand rupees monthly create a dynamic where families feel entitled to demand anything. *"Because families are paying money, they have an attitude that we should do anything; those are the challenges we basically face,"* P5 states. When a resident fell and the family was informed, *"without knowing the facts, they raised their voice and there were big arguments."* The institution's response was firm: management communicated to the family that *"you don't have to yell. Just because they pay doesn't mean we are there only for their money; every resident is valued."* This institutional backbone the willingness to push back against paying clients when professional standards are at stake is a critical finding, as it demonstrates that commercial elder care need not automatically capitulate to market pressures. Yet P5 is equally honest about the emotional cost: financial comfort does mask emotional vulnerability, particularly for residents whose children fund their care. When bills include extra charges for personalised meals, *"some children call and tell the parents, 'Why are you making all this?' Because from the family's perspective, it might be an unnecessary burden. So they sometimes get frustrated."* The emotional economy of paid elder care where love, money, guilt, and entitlement circulate between resident, family, and institution is captured in P5's account with a clarity that none of the other participants achieve.

The spiritual dimension of P5's experience adds a layer absent from other accounts. The institution is founded on Christian values, and P5 comes from a Hindu cultural background. *"I don't know much about biblical references beyond a point,"* P5 acknowledges. *"Although I faced some challenges, the organization never forcefully pressured me to set aside my religious perspective."* Tasks related to Christian religious observances were handled primarily by P5's colleague, while P5 contributed to interfaith spiritual care by recognising that *"spiritual aspects are very important for senior citizens because we can influence them a lot that way. Even residents who have fully lost their orientation sometimes respond when hearing certain songs especially religious songs."* This observation that deeply cognitively impaired residents may respond to familiar spiritual stimuli when other forms of communication fail has significant clinical implications and demonstrates how practice wisdom often outpaces formal training.

On the terrain of professional identity and ethical practice, P5's narrative is uniquely positioned among the five participants. P5 is the only participant whose formal title was *"Social Worker"* not Resident Officer, not Senior Executive, not Programme Coordinator. *"My title was Social Worker itself, never any other title. So I am happy,"* P5 states. This stands in sharp contrast to the professional identity erasure documented across the other four cases. Yet P5 is also clear-eyed about the limits of this recognition: *"In India, I still don't feel Social Work is a celebrated profession. I realized that especially after coming to another country. Here [abroad], it's done more."* The transition from feeling *"very valued"* within the institution to recognising the broader societal devaluation of the profession upon moving abroad provides a powerful micro-to-macro perspective on the structural positioning of social work in India.

P5's reflections on ethical dilemmas reveal a mature understanding of the insider-outsider tension that shapes practice in any institution. *"When first joining, I thought 'if this was done like this, or that like that, it would be super,"* P5 recalls. *"But when dissecting the situation, an organization has its own criteria and developmental plans to run. The insider-outsider perspective is very different."* This acknowledgment that idealistic expectations must be tempered by institutional realities is not a capitulation but a mark of professional growth: the recognition that ethical practice within organisations requires negotiation, not just assertion. Regarding confidentiality, P5 draws an important distinction: within the MDT, *"there isn't confidentiality we keep a bit of transparency. It's when outsiders come that we look to strengthen the principle of confidentiality."* This nuanced, context-dependent approach to confidentiality transparent internally for effective teamwork, strict externally for client protection is more sophisticated than the absolute confidentiality typically taught in classrooms. When asked directly about written ethical guidelines, P5 confirms their absence: *"Not written. You are informed, verbally informed, but there is no written ethical guideline as an institution."* The institution has crisis protocols what to do in the first second after a demise or fall but not a comprehensive ethical framework. P5 suggests that having a social worker as the supervisory head would make practice *"more professional,"* but also values the autonomy that came from being the department head: *"Since we ourselves were the heads, we had the opportunity to grow and let grow."*

The emotional dimensions of P5's experience are woven throughout the narrative rather than confined to a single response. Counter-transference the transfer of the professional's own emotions onto the client relationship was a significant early challenge: *"Initially, we used to*

*get hit with counter-transference. Especially with senior citizens, demise can happen anytime. People might die anytime, or someone who was independent might suddenly become bedridden due to a fall."* The residential nature of the posting intensified this emotional exposure: living within the same building as residents meant there was no physical boundary between the world of work and the world of rest. Burnout was managed through weekend rotation between the two social workers and the flexibility of a supportive management. But P5 is frank that overtime was never compensated financially: *"Obviously, in an Indian, especially Kerala-based organization, overtime payments are always questionable. I haven't received payment."* This candid acknowledgment of unpaid overtime framed not as a grievance but as an accepted reality of the Indian professional landscape reveals the structural conditions under which social workers in elder care operate.

Looking forward, P5 emphasises communication as the paramount competency for geriatric social workers, alongside rapport-building, knowledge of mood disorders, and an empathetic rather than sympathetic approach. *"They don't need sympathy 'Oh, they are poor, so I will love them' it's not like that. They need proper, factual things. Especially as they come from an affluent section, they have no lack of money; they don't need our sympathy."* This distinction between empathy and sympathy, applied specifically to private paid elder care, is one of the most practically useful insights across all five cases. P5 advocates for salary increases for social workers, recognition of the profession as distinct from psychology and psychiatry, and the need for new graduates to approach the field with openness rather than rigid expectations. P5's parting advice to future social workers is characteristically direct: *"Only those with interest should take Social Work. Take it only if you have an interest in being socially relevant. Don't take it just because it's a professional degree."*

P5's case, taken as a whole, offers perhaps the most integrated and reflective account among the five participants. Working in a well-established, values-driven institution where the social work title was formally recognised, P5 experienced the highest degree of professional legitimacy of any participant. Yet this positive experience exists alongside the same structural gaps documented across all cases: the absence of written ethical guidelines, the lack of formal social work supervision, the unpaid overtime of residential postings, and the emotional weight of working with ageing, decline, and death. What distinguishes P5's narrative is the reflective capacity to hold these contradictions together to appreciate the institution's strengths while honestly naming its gaps, to value the autonomy of being a department head while recognising the need for professional supervision, and to feel proud

of the work while acknowledging that Indian society does not yet celebrate the profession that makes this work possible. The transition from Kerala to abroad has given P5 a comparative lens that none of the other participants possess, and through that lens, the structural positioning of social work in India's private paid elder care sector comes into sharp relief: respected within the walls of progressive institutions, invisible beyond them.

# CHAPTER V
# ANALYSIS AND DISCUSSION

# CHAPTER V

# ANALYSIS AND DISCUSSION

## 5.1 INTRODUCTION

Qualitative data analysis involves moving from the primary data gathered through fieldwork towards explanation, understanding, and interpretation of the phenomenon under investigation. Thematic analysis, as proposed by Braun and Clarke (2006), is concerned with identifying, analysing, and reporting meaningful patterns or themes within qualitative data. This chapter presents and discusses the professional experiences of the five social workers (P1 to P5) employed in private paid homes for the elderly in Kerala, based on the semi-structured in-depth interviews conducted in Malayalam and translated into English by the researcher.

The analysis is organised into five major themes and twenty-four subthemes, which were developed through the thematic analysis of the interview data. These themes correspond directly to the five research questions of the study and collectively explore the various dimensions of social work practice in private paid institutional elder care. The five themes examine (1) professional roles and institutional positioning, (2) gerontological social work practice and contribution to resident well-being, (3) professional identity, working conditions and emotional labour, (4) ethical conflicts, power and institutional pressures, and (5) policy, regulation and future directions.

The first theme, *Professional Roles and Institutional Positioning*, comprises five subthemes: Formal Job Description, Informal and Expanded Roles, Role Negotiation, Decision Hierarchy, and Power Dynamics and Professional Identity. The second theme, *Gerontological Social Work Practice and Contribution to Well-being*, includes four subthemes: Physical Well-being, Psychological Well-being, Social and Spiritual Engagement, and the Private Paid Context and Care Expectations. The third theme, *Professional Identity, Conditions and Emotional Labour*, consists of six subthemes: Decision-Making Autonomy, Salary and Benefits, Workload, Emotional Labour, Professional Recognition, and Supervision Systems. The fourth theme, *Ethical Conflicts, Power and Institutional Pressures*, contains five subthemes: Autonomy versus Safety, Family Dominance, Confidentiality, the Care-Commerce Tension, and Moral Distress and Reflexivity. The fifth theme, *Policy, Regulation and Future Directions*, comprises four

subthemes: Education and Specialisation Gaps, Regulatory and Policy Gaps, Institutional Governance, and Workforce Sustainability. Each theme concludes with a discussion that relates the findings to the existing literature and the theoretical framework.

For each theme, the analysis proceeds in three stages. First, the findings are presented through the identified subthemes and supported with verbatim quotations from the participants. Second, the researcher interprets the patterns emerging within and across the cases. Third, the findings are discussed in relation to the literature reviewed in Chapter II and interpreted through the study's theoretical framework, comprising Ecological Systems Theory (Bronfenbrenner, 1979), the Strengths Perspective (Saleebey, 2006) and the Ethics of Care (Tronto, 1993). This approach enables the findings to be situated within broader theoretical and empirical debates, highlighting the ways in which the study confirms, extends, or challenges the existing body of knowledge. The chapter concludes by synthesising the key findings across all five themes.

## 5.2 PROFILE OF THE RESPONDENTS

Five social workers, designated as **P1 to P5**, participated in the study. Each participant was employed in a different private paid home for the elderly in Kerala and held a **Master of Social Work (MSW)** degree. The participants represented diverse institutional settings, ranging from small and newly established facilities to large corporate retirement communities. Their varied roles, experience, and organisational contexts provided a rich and diverse dataset for understanding the professional experiences of social workers in private paid institutional elder care.

**Table 5.1: Profile of the Respondents**

| Participant | Designation | Type of Institution | Approximate Number of Residents | Work Experience | Key Institutional Characteristics |
|---|---|---|---|---|---|
| **P1** | Resident Officer & Institution In-charge | Platinum-accredited independent living facility | 31 | 3 years | Independent living model |

| Participant | Designation | Type of Institution | Approximate Number of Residents | Work Experience | Key Institutional Characteristics |
|---|---|---|---|---|---|
| **P2** | Senior Executive, Relations Department | Corporate retirement community | 57+ | 3 years | Employs eight MSW-qualified social workers |
| **P3** | Programme Coordinator (Education & Research) | Multi-facility elder care foundation | Multiple facilities | 1 year 8 months | Education and research wing |
| **P4** | Executive, Resident Relations | Newly established private paid elder care facility | 10-15 | 10 months | First phase of operation |
| **P5** | Social Worker | Trust-registered assisted living facility | Approximately 80 | 1 year | Assisted living model; participant has since relocated abroad |

Across the five institutions, the monthly fee ranged from approximately ₹30,000 to ₹1,50,000, reflecting the premium nature of the institutions included in the study. The diversity of organisational structures, institutional size, and participant roles enhanced the richness of the data and strengthened the transferability of the study findings.

### 5.3 THEME 1: PROFESSIONAL ROLES AND INSTITUTIONAL POSITIONING

***Research Question 1: What roles and responsibilities do social workers perform in private paid homes for the elderly, and how are these roles negotiated within the institutional structure and decision-making hierarchy?***

Across all five cases, the professional roles of social workers in private paid elder care resist neat categorisation. The participants enter their institutions with a professional identity grounded in their MSW training, but the institutional reality rapidly expands, reshapes, and in several cases obscures the boundaries of that identity. The narratives describe professionals functioning simultaneously as care planners, family mediators, administrators, activity coordinators, and institutional representatives frequently without the formal title of "Social Worker."

### 5.3.1 Formal Job Description

*"My scope of work within social work mainly involves communication with residents and their families, meeting the needs of residents, and providing whatever assistance is assigned be it documentation, paperwork, or clarifying doubts. I am a member of the IDT regarding care plan formulation."* P1

*"Formally, we carry out two departments: Resident Relations and Social Work. Resident Relations basically means communication between the management, family, and residents; we mostly perform a bridging role. As Resident Relation Officers, we also carry out our discipline, which is Social Work, focusing on psychosocial well-being."* P5

*"What we mainly do here is provide therapies for dementia care, case work, and things like that. Our core area is Residency. We address psychological needs, support the residents' families, and look after their quality of life."* P2

Across the participants, the formal responsibilities of social workers clustered around four major areas: **care planning and monitoring, family communication and mediation, psychosocial assessment and intervention, and documentation**. Although the specific responsibilities varied across institutions depending on their size, organisational structure, and service model, these four functions formed the core of professional social work practice.

**Care planning and monitoring** involved participating in interdisciplinary team (IDT) meetings, assessing residents' individual needs, contributing to the preparation of personalised care plans, and regularly reviewing residents' progress. Social workers worked collaboratively with nurses, physiotherapists, dieticians, psychologists, activity coordinators, and medical professionals to ensure that residents received holistic and coordinated care. Their role extended beyond developing care plans to continuously

monitoring residents' physical, psychological, social, and emotional well-being and recommending modifications whenever residents' conditions or needs changed.

**Family communication and mediation** emerged as one of the most prominent responsibilities across all institutions. Participants consistently described themselves as the primary communication link between residents, families, management, and the multidisciplinary team. Their responsibilities included updating families about residents' health and psychosocial status, explaining institutional policies and care plans, clarifying doubts, addressing complaints, facilitating family meetings, supporting decision-making, and mediating disagreements between residents, family members, and institutional management. This bridging role helped maintain transparency, strengthen relationships, and ensure continuity of care while balancing the expectations of multiple stakeholders.

**Psychosocial assessment and intervention** formed another central aspect of practice. Participants reported assessing residents' emotional well-being, behavioural changes, cognitive functioning, adjustment to institutional life, interpersonal relationships, coping abilities, social support systems, and overall quality of life. Based on these assessments, they implemented a range of psychosocial interventions, including individual counselling, casework, supportive counselling, crisis intervention, family counselling, behavioural observation, dementia care interventions, reminiscence therapy, validation therapy, cognitive stimulation activities, group programmes, recreational and therapeutic activities, and referrals to psychologists, psychiatrists, or other professionals whenever specialised services were required. These interventions were aimed at promoting psychological well-being, reducing loneliness, enhancing social participation, preserving dignity, and improving residents' overall quality of life.

**Documentation** was an equally important professional responsibility. Social workers maintained comprehensive records related to resident care, including psychosocial assessments, case histories, care plans, progress notes, counselling records, family interaction records, interdisciplinary meeting notes, incident reports, admission and discharge documentation, consent forms, referral records, activity reports, and other institutional documentation. Participants highlighted that systematic documentation ensured continuity of care, facilitated communication among members of the multidisciplinary team, supported informed decision-making, and promoted accountability within the institution.

In the larger institutions (P1, P2, P3, and P5), these responsibilities were integrated within an interdisciplinary or multidisciplinary team consisting of nurses, physiotherapists, dieticians, psychologists, activity coordinators, and administrative personnel. The social worker contributed a psychosocial perspective while collaborating closely with other professionals to address residents' multidimensional needs. This collaborative approach enabled comprehensive care planning and facilitated coordinated service delivery.

Across all institutions, the social worker occupied a central position in institutional communication and coordination. As P5 described, the social worker functioned as a "bridging role" connecting residents, families, management, and other professionals. This position provided opportunities to influence care planning and decision-making, but it also placed considerable responsibility on social workers, as complaints, expectations, emotional concerns, requests, and institutional information were frequently channelled through them. Thus, the formal job description extended beyond administrative responsibilities to encompass coordination, advocacy, psychosocial intervention, and relationship management, highlighting the multidimensional nature of professional social work practice within private paid homes for the elderly.

### 5.3.2 Informal and Expanded Roles

*"This is a service sector. When someone from the admin team is off or needs a replacement, we take on that individual's role. That could be front desk duty, activities, or even minor accounting tasks."* P1

*"My job involves both social work and the sales department. My official job title is Executive Resident Relations."* P4

*"We have been part of the upliftment and promotions of all these in a non-social work perspective. If Business Development representatives aren't there and someone walks in, we provide a facility tour."* P5

The expansion of roles beyond formal social work functions is universal, though it manifests differently with institutional size and maturity. In smaller or newer facilities (P4), the social worker handles sales enquiries alongside therapeutic work; in larger institutions (P1, P5), the expansion takes the form of administrative duties such as conducting staff interviews, providing orientation, handling accounts, and representing the institution externally. The consistent finding is that social workers neither do, nor can, confine themselves to textbook

roles: the service-sector logic of private paid elder care demands a flexible, multi-functional professional who fills gaps wherever they appear.

### 5.3.3 Role Negotiation

*"There was no need for role negotiation with the management. Everyone has their own set of roles, and that's enough."* P3

*"Role negotiation as such hasn't happened. But we have carried out non-social work roles as part of the institution's well-being and promotion."* P5

*"I haven't needed to negotiate my role with the management yet."* P4

A striking anomaly emerges here. All five participants report that role negotiation has not been necessary yet the preceding subtheme shows that each performs significant non-social-work tasks. The resolution lies in how the participants frame role expansion: not as an imposition to be negotiated away, but as a natural feature of the environment. P5 reframes expanded duties as "exposure"; P1 accepts them as inherent to the "service sector"; P4, as the newest practitioner, has not yet met the conditions that would prompt negotiation. The perceived clarity of roles thus coexists with actual role diffusion.

### 5.3.4 Decision Hierarchy

*"The final authority is the head of each location. Major decisions are taken by them, but we can make day-to-day operational decisions."* P1

*"When it comes to social work matters, we are the final yes or no. What we write is what stands. But for decisions regarding institutional upliftment, management includes our point of view."* P5

*"We cannot make independent decisions; we make decisions as an organization. We must ask the authority."* P3

Decision-making authority forms a gradient rather than a uniform pattern. At one end, P5 reports final authority on social work matters; at the other, P3 describes a system in which organisational approval is always required, with P1 and P2 occupying intermediate positions. The gradient appears to correlate with institutional maturity, the worker's tenure, and management disposition. What is consistent, however, is that social workers are included in institutional decision-making rather than excluded from it; the hierarchy is collaborative but not egalitarian.

### 5.3.5 Power Dynamics and Professional Identity

*"We are known by our post Member Relations not necessarily as Social Workers. This is a bit difficult because we might want the Social Worker designation for our next job."* P2

*"My title was Social Worker itself, never any other title. So I am happy."* P5

*"Even when the company starts a new project, we are included in discussions with planning engineers. This is a place that gives that level of respect to social workers."* P1

This subtheme produces the most consequential finding of the theme: a fundamental paradox of professional identity. P2 is designated "Member Relations," P1 "Resident Officer," P3 "Programme Coordinator," and P4 "Executive Resident Relations"; only P5 held the title "Social Worker." Yet all five perform core social work functions. The profession is therefore functionally central to the institutional machinery but organisationally invisible in four of the five cases. P2 articulates the practical consequence most clearly: without the title, career mobility is compromised. P5's experience demonstrates that this erasure is not inherent to the sector it depends on the institutional will to name and recognise the profession, and only one institution among five chose to do so.

### 5.3.6 Discussion of Theme 1

The findings both confirm and extend the international evidence. Elices Acero et al. (2024), in their systematic review of long-term-care social work in Europe and North America, found service and case management, direct support, personalisation of care, and community engagement to be the leading roles, while identifying lack of specialisation, paperwork burden, and work overload as persistent limitations. The present study confirms each of these roles and limitations in the Kerala private paid context, but extends the picture in an important way: whereas the Western literature frames the central problem as role ambiguity and fragmentation of tasks (Miller et al., 2021), in Kerala the fragmentation reaches beyond tasks to professional identity itself. The recurring substitution of administrative or relational titles for the designation "social worker" constitutes what may be termed professional identity erasure a process whereby the discipline is performed in full but named only partially, with direct consequences for recognition, career mobility, and the accumulation of professional legitimacy.

Read through Bronfenbrenner's (1979) ecological framework, the social worker's "bridging role" is precisely a mesosystem function: the practitioner is the connective link between the

resident's microsystem (daily care relationships) and the family and institutional systems that surround it. The data show that this mesosystem position carries influence but also strain, because the worker becomes the single channel through which demands and distress are routed. The paradox whereby participants describe their roles as "clear" while listing five to seven overlapping functions suggests that role ambiguity in this setting is not experienced as confusion, as much of the Western literature assumes, but as normalised adaptation  a culturally specific inflection that the Indian evidence base adds to the global conversation. Miller et al. (2021) observed that the literature on nursing-home social work is limited and that the role is ambiguous even where regulation exists; the present findings indicate that in the comparatively unregulated Indian private sector, the worker's mandate is sustained almost entirely by informal institutional culture rather than by any formal definition of scope.

## 5.4 THEME 2: GERONTOLOGICAL SOCIAL WORK PRACTICE AND CONTRIBUTION TO WELL-BEING

***Research Question 2: How do social workers contribute to the physical, psychological, social, spiritual, and economic well-being of residents, and how does the private paid institutional context shape these practices?***

The contributions of social workers to resident well-being extend across the physical, psychological, social, and spiritual dimensions. What distinguishes these contributions from care delivered in charitable or government-run homes is the institutional context: residents pay substantial fees, families hold elevated expectations, and a market logic of service satisfaction permeates the care relationship. Within this terrain, social workers pursue a double imperative  to provide genuine, person-centred psychosocial care while simultaneously meeting the service expectations attached to fee-paying residence.

### 5.4.1 Physical Well-being

*"We provide one hour of exercise daily. For residents with dementia, we have a one-hour morning activity to improve their cognitive levels  writing names, puzzles, reading."* P1

*"If a fall happens, instead of just saying it's this person's mistake, we conduct an investigation. The nurse manager interviews the caregiver, the physiotherapist analyses mobility, and social workers check if the fall caused any impact on orientation."* P5

Contributions to physical well-being are primarily coordinative rather than clinical. Social workers do not prescribe medication or conduct medical examinations; they serve as the connective tissue of the interdisciplinary team, ensuring that physical health concerns are identified, communicated, and addressed across departments. P5's fall-investigation protocol illustrates how each profession contributes its specific lens, with the social worker assessing whether a physical incident has psychological or social consequences. P5 articulates the underlying logic plainly: "If a person can't hear, their social skills will gradually decrease."

### 5.4.2 Psychological Well-being

*"We introduced Reminiscence Therapy ourselves after studying it. We collect life history materials and photographs with family support. PMR was also a social work initiative."* P2

*"Validation therapy is the primary method used, especially for those with dementia, as making them feel understood is a significant positive factor."* P4

*"We do many primary-level psychological interventions, but we don't do medications in that way. We focus more on social well-being because in an assisted living space, every resident is a community."* P5

This subtheme yields one of the study's significant findings: social workers in the larger institutions independently initiate evidence-based therapeutic interventions without external clinical direction. P2's team introduced Reminiscence Therapy, Progressive Muscle Relaxation, and Brain Gym by studying these modalities themselves, and conducts MOCA and MMSE assessments to categorise cognitive impairment; P4 uses validation therapy as the primary approach for residents with dementia. These are structured, assessment-driven interventions that, in many Western systems, would be delivered by clinical psychologists or occupational therapists. P5 simultaneously draws a clear professional boundary "we don't do medications" reflecting a mature understanding of scope.

### 5.4.3 Social and Spiritual Engagement

*"We try to keep them out of their rooms so they don't feel lonely. We recently did a three-day exhibition called Still Blooming featuring paintings from the residents."* P2

*"Spiritual aspects are very important for senior citizens because we can influence them a lot that way. Even residents who have fully lost their orientation sometimes respond when hearing certain songs especially religious songs."* P5

*"We can spend up to an hour talking to them. But if we do it continuously, they become dependent. So we keep a distance."* P2

Social and spiritual well-being emerged as important components of social work practice in private paid elder care institutions. Participants described organising a range of activities such as exhibitions, group programmes, celebrations, outings, recreational sessions, and regular interactions to reduce loneliness, encourage social participation, and improve residents' overall quality of life. These activities created opportunities for residents to remain socially connected, express themselves creatively, and maintain a sense of purpose within the institutional environment.

Alongside these social interventions, participants also recognised the importance of addressing residents' spiritual needs. Spiritual support was provided by respecting residents' religious beliefs, facilitating participation in religious practices, and using devotional music as a source of comfort. P5 explained that even residents with advanced dementia who had lost much of their orientation often responded positively to familiar religious songs. This suggests that spiritual engagement can become an effective means of emotional connection when verbal communication and cognitive functioning are significantly impaired.

The findings also highlight that social workers consciously maintain professional boundaries while building meaningful relationships with residents. Although spending time listening to residents and providing emotional support was considered essential, P2 pointed out that prolonged one-to-one interaction could lead to emotional dependency. Consequently, participants described balancing empathy with professional distance to ensure that supportive relationships remained therapeutic rather than dependent.

Overall, the findings indicate that social workers contribute to residents' well-being not only by organising programmes and facilitating social interaction but also by recognising the emotional and spiritual dimensions of ageing. Their practice reflects a holistic approach that addresses residents' psychosocial needs while preserving dignity, emotional security, social connectedness, and professional boundaries.

### 5.4.4 The Private Paid Context and Care Expectations

*"They are demanding. Their voices and opinions are loud. Since it is a paid facility, they will demand. Consistency in service is the hardest part. If the food quality drops once, all the good work we did previously is forgotten."* P1

*"We must view them with equal respect, not just through the lens of mercy. While they have financial comfort, they also have the mental strength gained from living to 85."* P1

*"They don't need sympathy Oh, they are poor, so I will love them it's not like that. They need proper, factual things. Especially as they come from an affluent section, they have no lack of money; they don't need our sympathy. An empathetic approach is needed."* P5

*"A stigma still exists because many people cannot distinguish between a retirement home and an old age home."* P4

This subtheme captures the most distinctive dimension of practice in private paid elder care the intersection of payment, care, and expectation. P1's use of the term "Customer Delight" shows how the market logic of service provision is absorbed into institutional vocabulary, reframing care as customer satisfaction measured by consistency. The residents' profiles former CEOs, politicians, scientists, returned Non-Resident Indians create a dynamic in which the care recipient may hold more social and financial capital than the care provider. Yet both P1 and P5 resist reducing residents to consumers: P1's insistence on "equal respect, not mercy" and P5's distinction between empathy and sympathy reflect a deliberate professional stance that recognises residents' strengths and dignity. P4's observation about stigma adds a further layer: even fee-paying institutional living carries, in Indian society, the cultural weight of filial failure.

### 5.4.5 Discussion of Theme 2

The findings confirm and substantially extend the Indian and international literature. Gurrapu et al. (2024) and Kumar et al. (2016) documented loneliness, depression, and a markedly lower social-domain quality of life among elderly residents of Indian institutions, but neither examined who addresses these needs. The present study identifies the social worker as the professional who fills that gap and, strikingly, often with self-taught, evidence-informed tools. This independent initiation of structured interventions both demonstrates professional initiative and exposes a structural absence of other clinical specialists in the staffing model, a configuration not reported in the Western reviews of

Elices Acero et al. (2024) or Miller et al. (2021), where such interventions are typically delivered by dedicated clinicians.

The participants' orientation aligns closely with Saleebey's (2006) strengths perspective: the deliberate refusal to view residents through a deficit lens of decline, the reframing of resident meetings as instruments of empowerment, and the insistence on respect over pity all enact strengths-based principles within a commodified setting. P5's reasoning that a hearing deficit erodes social skills, which in turn accelerates cognitive decline, mirrors Bronfenbrenner's (1979) ecological insight that functioning is shaped across interacting systems rather than within isolated domains practice wisdom arriving at theory without naming it. At the same time, the data illustrate the tension that the political economy of ageing (Estes, 2001; Phillipson, 2013) predicts: care is structured by the capacity to pay, and the language of "customer" satisfaction sits uneasily beside the therapeutic relationship. The finding that material security coexists with significant emotional vulnerability qualifies any assumption that the residents of fee-paying homes have fewer psychosocial needs; rather, those needs are masked by comfort, and social workers are uniquely positioned to identify and address them.

## 5.5 THEME 3: PROFESSIONAL IDENTITY, CONDITIONS AND EMOTIONAL LABOUR

***Research Question 3: How do social workers perceive their professional autonomy, job satisfaction, workload, compensation, emotional labour, and institutional support within these settings?***

The conditions under which social workers practise in private paid elder care are not uniform; they vary considerably across institutions, and even within the same organisational foundation. This theme examines the autonomy practitioners possess, the compensation they receive, the emotional weight they carry, the recognition they earn, and the supervision or its absence that shapes their development. The picture is one in which high job satisfaction coexists with structural vulnerability.

### 5.5.1 Decision-Making Autonomy

*"The attitude of the MD is: You make the decision; even if it's a mistake, it's okay."* P2

*"When it comes to social work matters, we are the final yes or no. What we write is what stands."* P5

*"We cannot make independent decisions; we make decisions as an organization. We must ask the authority."* P3

Autonomy exists on a spectrum: P5 reports the highest, with social work decisions final; P2 describes a culture that actively encourages independent judgement; P3 describes a system requiring organisational approval throughout. The variation correlates with institutional culture and management philosophy rather than with formal policy a structural vulnerability, since autonomy granted by a supportive manager can be withdrawn by a different one.

### 5.5.2 Salary and Benefits

*"Compared to other social work salaries in Kerala, this is very good, with a starting salary of 25,000. I now receive free food and accommodation as well."* P1

*"I started at 12,000 INR; now it's around 21,000 to 25,000 INR."* P2

*"Compensation was correct. Obviously, in an Indian, especially Kerala-based organization, overtime payments are always questionable. I haven't received payment."* P5

Salaries range from twelve thousand to twenty-five thousand rupees, supplemented by non-monetary benefits such as food, accommodation, Provident Fund, and ESI. P1 describes the compensation as "very good" relative to other social work posts in Kerala a framing that reveals how low the baseline expectation is. P5 is the only participant to address overtime directly, and the answer is stark: there is none, despite the round-the-clock demands of a residential posting. The non-monetary benefits create what P2 elsewhere calls a "comfort zone" that paradoxically constrains career growth.

### 5.5.3 Workload

*"A friend of mine who worked at the developing Presidency Home was under immense pressure because she had to manage the front office, social work, and resident relations all by herself. She eventually left."* P3

*"The workload was manageable because there were two of us."* P5

*"Overtime only happens during events. Otherwise, there is no extra work after duty time."* P2

Workload is the variable most strongly determined by staffing levels. P5 and P3's former facility operated with two social workers for seventy to eighty residents manageable when both are present, overwhelming when one is absent. The colleague at a developing facility, working alone across three functions, resigned: a data point that represents a systemic rather than individual failure. P2's facility, with eight social workers for over 157 residents, represents the opposite end of the spectrum. The wide variation reveals that staffing norms are entirely ad hoc, set by each facility's budget rather than by any professional or regulatory standard.

### 5.5.4 Emotional Labour

*"Working in these homes has changed me as a human. I've seen residents who were once head nurses or in elite positions now dealing with dementia. It made me realize we must be humble because we all reach a stage of weakness. We see death at least every three months because most are over 85."* P1

*"Initially, we used to get hit with counter-transference. Especially with senior citizens, demise can happen anytime. People might die anytime, or someone who was independent might suddenly become bedridden due to a fall."* P5

*"The blessings we get from residents are worth more than the salary."* P1

Emotional labour in geriatric social work is qualitatively distinct because it involves sustained engagement with ageing, cognitive decline, dependency, and death P1 reports encountering death at least every three months. P5 names counter-transference explicitly, demonstrating a clinical self-awareness likely acquired through practice rather than training. The labour also transforms identity: P1 describes being "changed as a human" and locates the reward in residents' "blessings" rather than in salary. This meaning-making is sustaining, but it also carries a risk when professional meaning is drawn chiefly from relational and spiritual rewards, it can mask the need for structural improvement in pay and conditions.

### 5.5.5 Professional Recognition

*"We arrived as basic social workers with only academic learning, but within two years they recognized us and gave us higher posts."* P1

*"Residents believe only MSW staff can solve their problems, so we feel valued."* P2

*"In India, I still don't feel Social Work is a celebrated profession. I realized that especially after coming to another country."* P5

Recognition operates at two levels. Within their institutions, all five participants feel valued P1 was promoted within two years; P2's residents believe only MSW staff can resolve their concerns. Yet P5's comparative reflection, sharpened by living abroad, exposes the gap between institutional micro-recognition and societal macro-invisibility. Social workers are valued within the walls of their institutions but remain professionally invisible in the broader Indian landscape.

### 5.5.6 Supervision Systems

*"Social workers here don't have a head; they report directly to management. They listen when we voice concerns, but there's no separate supervision."* P3

*"There isn't a formal supervisory post for social work specifically, but management is approachable as mentors."* P1

*"I receive good supervision and support from my manager."* P4

The absence of formal social work supervision is the most consistent finding across all five cases. No institution has a designated social work supervisor whose role is to provide professional guidance, reflective-practice support, and clinical oversight. P3 and P1 report to management personnel who are supportive but not qualified in social work; P5 served as departmental head; only P4 receives genuine professional supervision, and that is because the manager happens to be a social worker a fortunate accident rather than a structural design. The implications are serious: practitioners who independently conduct cognitive assessments and deliver therapeutic interventions do so without clinical oversight or a structured space for reflective practice.

### 5.5.7 Discussion of Theme 3

These findings map closely onto Silarova et al.'s (2022) six components of work-related quality of life organisational characteristics, job characteristics, mental well-being, physical well-being, work-to-home spillover, and professional identity but reveal that, in the Kerala context, these components are distributed unevenly. Professional identity is strong within institutions yet weak beyond them; mental well-being is sustained by meaning but threatened by unstructured emotional exposure; and work-to-home spillover is built into the residential-posting model, since living and working in the same building dissolves the boundary

between duty and rest. The pattern whereby practitioners construct positive meaning from demanding, externally undervalued work echoes Yau et al.'s (2024) finding that care workers frame their labour as a "helping career" that buffers adverse conditions  a psychological resource clearly visible in P1's account.

The data also corroborate Takeda and Fukuzaki's (2024) finding that workplace interpersonal relationships are a meaningful determinant of care workers' psychological distress: where collegial support exists (P2's "group of friends," P5's two-person team), workload and emotional strain are more manageable, whereas the isolated practitioner at the developing facility burned out and left. Timonen and Lolich's (2019) thesis that the care worker is socially constructed with fundamental ambivalence  simultaneously valued and devalued  finds a specific Indian inflection here: the social worker is institutionally respected yet societally unrecognised. Finally, the universal absence of professional supervision represents a critical structural gap that the international literature treats as a basic safeguard; its absence in a sector where social workers independently assess cognition and deliver interventions is among the most consequential findings of this study, and one with direct implications for both practitioner well-being and resident safety.

## 5.6 THEME 4: ETHICAL CONFLICTS, POWER AND INSTITUTIONAL PRESSURES

***Research Question 4: What ethical dilemmas and professional challenges do social workers encounter while balancing residents' autonomy, institutional policies, family expectations, and market-driven pressures in private paid homes for the elderly?***

Ethical dilemmas in private paid elder care rarely present as dramatic confrontations between right and wrong. Instead, they simmer beneath daily practice, embedded in the structural tension between care and commerce, between family expectations and resident autonomy, and between professional values and institutional realities. The participants navigate an ethical terrain shaped fundamentally by money  by who pays, who demands, and who decides.

### 5.6.1 Autonomy versus Safety

*"We don't take everyone because it's a community living space; we don't take troublemakers so that others can live in peace. We don't take those with criminal behaviour or addictions."* P3

*"The hardest is when guests come for dementia residents against the family's wishes. We have to check with the children or spouses before letting them in. Sometimes the resident is waiting for the guest, and we have to say no, which leads to anger."* P2

The tension between resident autonomy and institutional safety appears in two forms. First, admission screening restricts access by excluding applicants with behavioural issues, criminal histories, or addictions protecting the community while raising questions about exclusion and access. Second, the management of dementia residents' social contact creates daily friction: P2 describes the distress of denying a visitor to a resident who is waiting expectantly, because the family has restricted access. The social worker is caught between the resident's expressed wish and the family's directive a classic autonomy-versus-beneficence dilemma.

### 5.6.2 Family Dominance

*"When the family pressures us, we face a dilemma in decision-making. It depends on how cleverly and logically you handle the matter."* P3

*"Because families are paying money, they have an attitude that we should do anything. Without knowing the facts, they raised their voice and there were big arguments."* P5

*"We constantly communicate with families and update them. At the end of the day, the family decides what should be given to the resident."* P5

Family dynamics are fundamentally shaped by the financial relationship. When families pay substantial monthly fees, they may feel entitled to influence, and sometimes to dictate, care decisions. P5 describes families who argue without knowing the facts of an incident, and P3 the "dilemma in decision-making" that arises when family pressure conflicts with professional judgement. Yet P5 also acknowledges that "the family decides what should be given to the resident," revealing how deeply family authority is embedded in the institutional structure. The social worker functions less as an autonomous decision-maker than as a mediator among resident, family, and institution.

### 5.6.3 Confidentiality

*"Family issues aren't tea table talk and are only handled by the social worker, nurse, and admin team."* P1

*"On the basis of management and the MDT, there isn't confidentiality, we keep a bit of transparency. It's when outsiders come that we look to strengthen the principle of confidentiality."* P5

Confidentiality is practised rigorously, but through institutional culture rather than written protocol. P1's phrase "family issues aren't tea table talk" captures the informal but firm norm restricting sensitive information to the social worker, nurse, and administrative team. P5 offers a more nuanced position, distinguishing internal transparency within the team, necessary for effective collaboration, from strict external confidentiality with outsiders. This context-dependent approach is more sophisticated than the absolute confidentiality often taught in the classroom; its weakness is that it exists verbally, not structurally, and is therefore vulnerable to erosion if institutional culture changes.

### 5.6.4 The Care-Commerce Tension

*"Frankly, a care institution is a business, right? When payments increase, it's a concern for the resident and family, but we can only inform them as instructed by management. We can't influence management to reduce the pay. Our core is service for the vulnerable, right? So we feel it in such situations."* P3

*"We don't put forward a regulation that we must listen to everything just because we take money. Management communicated to the family: you don't have to yell. Just because they pay doesn't mean we are there only for their money; every resident is valued."* P5

*"We use the money from those who can pay to provide service, and we have a charity wing that helps with children's education and medicine for the needy."* P1

This subtheme produces the study's central ethical finding. P3 names the tension with unusual candour: a care institution is, frankly, a business, and when that logic conflicts with the service ethic, social workers "feel it." This is the moral distress of commodified care not dramatic violation but the persistent, low-grade strain of working in a system where care is purchased and commercial viability determines what care is possible. P1's rationalisation through the charity wing and P5's account of management refusing to capitulate to an aggressive family ("you don't have to yell") show that institutions respond to this tension in different ways, and that commercial elder care need not automatically yield to market pressure.

### 5.6.5 Moral Distress and Reflexivity

*"I doubt if the institution fully operates with ethics. I say this from my work experience."* P3

*"I've seen that not all social workers have the same integrity and transparency. Some get lazy and avoid checking on a resident if they are called after duty hours. That's a question we must ask ourselves are we following ethical principles?"* P3

*"I have never had to compromise my conscience. We do not take an attacking mode even if someone is harsh; we are patient, calm, and polite, but also firm."* P1

A revealing divergence emerges here: P1 reports never having compromised conscience and P5 found moral distress not significant, yet P3 who worked under the same organisational foundation openly doubts whether the institution fully operates ethically, and turns the ethical gaze inward to question the integrity of practitioners themselves. Because these participants share a foundation, the divergence cannot be attributed to different institutions. The most plausible explanation is that ethical awareness is shaped by role proximity and reflective capacity: P1, embedded in daily care within a supportive culture, is buffered from structural contradictions that P3, positioned in education and research with analytical distance, is able to observe and name.

### 5.6.6 Discussion of Theme 4

Tronto's (1993) ethics of care provides the most illuminating lens for these findings. Her four ethical elements attentiveness, responsibility, competence, and responsiveness are visible in the participants' daily practice, but the framework's deeper demand, that the conditions under which care is provided be subjected to scrutiny, is met most fully by P3, whose reflexive doubt about institutional ethics exemplifies the political dimension of care that Tronto insists upon. The autonomy-versus-beneficence dilemmas around dementia residents' social contact, and the recurring subordination of the worker's judgement to family directives, show that the "care-receiver"'s voice is frequently overridden by those who pay a distortion of the care relationship that Tronto's account anticipates.

The findings strongly corroborate Banerjee et al.'s (2012) demonstration that structural conditions, not individual temperament, generate ethical harm in long-term care: in the present study the ethical terrain is shaped by the market structure of care, the financial leverage of families, and the absence of professional infrastructure, rather than by the moral

failings of individual practitioners. The care-commerce tension itself is precisely what the political economy of ageing (Estes, 2001; Phillipson, 2013) predicts of commodified "elderscapes," where economic power structures the distribution and quality of care. The family power imbalance echoes Ayalon et al.'s (2008) account of social workers' concerns in paid care for affluent elders in Israel, here compounded by Indian cultural norms of filial authority. Finally, the universal absence of written ethical guidelines, ethics committees, and professional supervision means that ethical practice rests entirely on institutional culture fragile, variable, and uncodified a gap that the standards literature on social work ethics (Banks, 2012; Reamer, 2006) would regard as a fundamental deficiency.

## 5.7 THEME 5: POLICY, REGULATION AND FUTURE DIRECTIONS

***Research Question 5: How do social workers envision the future scope of social work practice in these institutions, and what policy reforms, governance mechanisms, and training requirements are necessary to strengthen professional practice?***

The final theme moves from documentation to prescription from what social workers experience to what they envision. Across all five cases the participants converge on a set of systemic needs that transcend individual institutions and speak to the structural foundations of gerontological social work in India.

### 5.7.1 Education and Specialisation Gaps

*"We need more focus on gerontology in education; we only had one chapter on it. The volume of this subject needs to increase because the aging population is growing."* P1

*"The MSW syllabus alone isn't enough for the job. We need life-long learning. While I was on a career break, I did two diplomas to stay updated."* P3

*"We would like more training sessions on psychology and psychiatry to work better with dementia residents. Nursing and HR get training, but MSW graduates don't get much."* P2

The convergence across all five participants on this subtheme is the strongest single finding of the study. Every participant identifies a severe gap between academic preparation and field demands: P1 had "one chapter" on gerontology in the entire programme; P3 pursued additional diplomas because the syllabus "isn't enough"; P2 notes that MSW graduates are deprioritised relative to nursing and HR staff for in-service training; P4 identifies dementia-specific training as a critical gap; and P5 locates the primary source of competence in experience rather than education. This unanimity across different institutions points directly

to the conclusion that the MSW curriculum does not prepare graduates for the realities of geriatric practice.

### 5.7.2 Regulatory and Policy Gaps

*"The elderly are often neglected because they aren't a vote bank. There isn't even a regulatory body for institutions like ours; we only have associations like ASLI."* P1

*"There's no systematic accreditation body or monitoring for old age homes like there is for colleges with NAAC. There are associations like the Association of Senior Living India, but no governing bodies."* P3

*"Recognition of our own profession that's the most important. Everyone should realize we are neither psychologists nor psychiatrists."* P5

The regulatory vacuum is exposed most clearly through P3's comparison with the accreditation framework that governs educational institutions: no equivalent exists for the elder care homes. P1 links this vacuum to political neglect the elderly are not a "vote bank." The practical consequences are visible throughout the study: no mandated staffing ratios, no required qualifications for care workers, no standardised social work roles, no minimum-salary norms, and no external quality monitoring. The participants advocate legally mandating social work roles, regulating salaries, strengthening professional associations such as the Kerala Association of Professional Social Workers, and establishing an accreditation body; P5 adds the crucial identity claim that social work must be recognised as distinct from psychology and psychiatry.

### 5.7.3 Institutional Governance

*"Everything we do is documented in software or Google Sheets and is visible to all departments. External monitoring includes auditors, social justice officers, and food and fire safety inspectors."* P2

*"Management included our point of view the point of view of the MDT. Being one of the major team members is a huge acceptance in itself."* P5

Institutional governance ranges from highly systematic in the established institutions to still-evolving in the newest. In the more developed facilities, governance includes team-based decision-making, daily departmental meetings, comprehensive documentation, surveillance systems, and external oversight from auditors and government inspectors, with social

workers actively included in planning. Crucially, however, this governance is operational rather than professional: it ensures that the institution runs smoothly, but it does not ensure that social work is practised according to codified professional standards. As established in Theme 4, even well-governed institutions lack written ethical frameworks P5's suggestion that a social worker as supervisory head would make practice "more professional" captures exactly this distinction between operational and professional governance.

### 5.7.4 Workforce Sustainability

*"Brain drain is also a crisis. Many people come here just for the experience certificate to go abroad. We invest time in training them, but they leave after a year or so."* P1

*"For a career, we use our maximum skills here, but sometimes we feel like moving to a better field for growth. However, it is a comfort zone. But for growth, one must go outside."* P2

*"One challenge in this field is the difficulty of finding staff who remain in the role for more than six months."* P4

Workforce sustainability is threatened by two interrelated forces: brain drain and the comfort–growth paradox. P1 describes staff recruited and trained at institutional expense who then depart within a year for opportunities abroad; P4 identifies retention as a primary challenge. P2 captures the paradox precisely: the institutional benefits create comfort, but limited advancement drives talented professionals away. Despite this, the participants are optimistic about the field's future, grounded in the demographic certainty that Kerala's ageing population will drive sustained demand for professional elder care.

### 5.7.5 Discussion of Theme 5

The participants' unanimous diagnosis directly substantiates Siva Raju and Singh's (2021) characterisation of gerontological social work in India as an emerging rather than established field. Their argument that the discipline receives inadequate scholarly and curricular attention is borne out by every participant's account of a curriculum offering only token gerontological content. The workforce findings align with Morrow et al. (2024), who identified structured career pathways as a strategy for retaining the elder-care workforce precisely what Kerala's sector lacks, and the absence of which underlies the brain drain and comfort–growth paradox the participants describe. The call for integrated, professionally

governed models resonates with Dadich et al.'s (2025) scoping review advocating coordinated, person-centred models of care for older people.

At the level of policy, the participants' prescriptions converge with the direction set by the NITI Aayog (2024) position paper on senior care reforms, which calls for recognising care work and care workers, strengthening the regulation of senior living, and promoting public–private partnerships. The regulatory vacuum the participants describe the absence of any accreditation or monitoring body for private elder care indicates how far implementation lags behind this policy intent. The central implication is that the future of the profession will not be secured by individual institutions acting alone: it requires coordinated action across social work education, professional bodies, and state regulation. Demand without infrastructure, as the data make clear, produces not professionalisation but the conditions for exploitation and attrition.

## 5.8 CONCLUSION OF THE CHAPTER

This chapter has presented and discussed a thematic analysis of the professional experiences of five social workers across five private paid elder care institutions in Kerala, organised around five themes and twenty-four subthemes corresponding to the study's research questions, and read throughout against the literature and the theoretical framework. The analysis reveals a profession that is simultaneously indispensable and invisible, valued within institutional walls yet structurally unrecognised beyond them.

Theme 1 established that social workers perform expansive, multi-functional roles while four of five work under non-social-work titles, producing a professional identity erasure that extends the role-fragmentation documented in the Western literature to the level of professional identity itself. Theme 2 showed that social workers contribute across every dimension of resident well-being and independently initiate evidence-based interventions, resisting the reduction of residents to consumers through a strengths-based, empathy-driven orientation even within a commodified setting. Theme 3 revealed a paradox of comfort and vulnerability: high satisfaction and genuine institutional recognition coexisting with unregulated salaries, uncompensated overtime, staffing-dependent workloads, and a universal absence of professional supervision. Theme 4 identified the care-commerce tension as the central, structurally embedded ethical challenge, with confidentiality practised culturally but codified nowhere, and ethical experience shown to vary with role proximity and reflective capacity rather than with institutional policy alone. Theme 5 produced the

study's strongest convergence: a unanimous call for expanded gerontological education, a regulatory and accreditation framework, salary regulation, and formal supervision.

Taken together, the five themes portray a profession at a crossroads. Social workers in Kerala's private paid elder care possess the skills, the commitment, and the institutional trust to deliver high-quality psychosocial care, but they do so without the professional infrastructure that would sustain, protect, and advance their practice. The detailed findings, their implications for social work practice, policy, and education, and the study's specific recommendations and directions for future research are presented in Chapter VI.

# CHAPTER VI
# ANALYSIS AND DISCUSSION

# CHAPTER VI

# FINDINGS, SUGGESTIONS, AND RECOMMENDATIONS

## 6.1 INTRODUCTION

This chapter presents the major findings of the study, derived from the thematic analysis of the semi-structured in-depth interviews with five social workers employed in private paid homes for the elderlyin Kerala. The findings are organised according to the five objectives of the study, each summarising the key patterns identified across the five cases. Following the findings, suggestions and recommendations are presented, each derived directly from the corresponding finding and addressed to four stakeholder groups: social work educational institutions, private paid elder care institutions, policy-makers and regulatory bodies, and professional associations. The chapter concludes with directions for future research and the overall conclusion of the study.

## 6.2 MAJOR FINDINGS

### Objective 1: Roles and Institutional Positioning

**Finding 1:** Social workers perform dual, and sometimes triple, roles, combining care planning, family communication, and administrative management across all five institutions. Their formal social work functions include care plan formulation, membership of the multidisciplinary team, psychosocial assessment, family mediation, and documentation. However, all participants also perform significant non-social-work tasks, including front-desk duties, sales enquiries, staff recruitment, event management, and facility tours.

**Finding 2:** Four of the five participants work under non-social-work designations: Resident Officer (P1), Senior Executive in the Relations Department (P2), Programme Coordinator (P3), and Executive Resident Relations (P4). Only P5 held the formal title of "Social Worker." The profession is thus functionally central to institutional operations but organisationally invisible in terms of professional identity.

**Finding 3:** Role negotiation is absent across all five cases. Participants describe their roles as clearly defined, yet the data reveal five to seven overlapping functions per participant. This anomaly  perceived role clarity coexisting with actual role diffusion  suggests that role expansion has been normalised within the institutional culture of private paid elder care.

**Finding 4:** Decision-making autonomy exists on a gradient, from P5 ("what we write is what stands") to P3 ("we must ask the authority"). Social workers are included in institutional planning across all cases but do not hold final authority over institutional decisions.

**Objective 2: Contribution to Multidimensional Well-being**

**Finding 5:** Social workers contribute most actively to the physical, psychological, social, and spiritual dimensions of resident well-being, with more limited engagement in the economic dimension. Their contributions are primarily coordinative in the physical domain, independently therapeutic in the psychological domain, creatively programmatic in the social and spiritual domains, and navigational in relation to the class dynamics of fee-paying residence.

**Finding 6:** In the larger institutions, social workers independently initiate evidence-based therapeutic interventions Reminiscence Therapy, MOCA assessments, MMSE evaluations, Progressive Muscle Relaxation, Brain Gym, validation therapy, and art therapy without external clinical direction. This represents a notable level of therapeutic autonomy that fills the gap left by the absence of clinical psychologists or occupational therapists in the institutional staffing structure.

**Finding 7:** Financial comfort does not eliminate psychosocial need. All participants report that residents in these fee-paying homes carry significant emotional vulnerabilities loneliness, family estrangement, grief, and dependency anxiety masked by material security. Social workers are uniquely positioned to identify and address these hidden needs, and P1's framing of "equal respect, not mercy" reflects a strengths-based orientation applied to this population.

**Finding 8:** The "Customer Delight" framing (P1) reveals how the market logic of paid care reshapes the therapeutic relationship into a service-delivery relationship. Residents are simultaneously clients, consumers, and vulnerable persons, and social workers navigate this triple identity daily, sustaining empathic care while meeting service-delivery expectations.

**Objective 3: Professional Conditions and Job Satisfaction**

**Finding 9:** Job satisfaction is generally high in supportive, well-staffed institutions but varies considerably across facilities even within the same organisational foundation. P1

and P5 report high satisfaction, while P3 describes a colleague at a different facility under the same foundation who resigned owing to an unmanageable workload. Professional experience is therefore determined by the specific facility's staffing levels and management culture rather than by the parent organisation.

**Finding 10:** Salaries range from approximately twelve thousand to twenty-five thousand rupees across the five cases, with non-monetary benefits including free food, accommodation, Provident Fund, and ESI. Overtime is not compensated in any institution. The non-monetary benefits create what P2 describes as a "comfort zone" that paradoxically constrains professionals: security without career advancement.

**Finding 11:** No institution has formal social work supervision. Social workers report to management personnel who may be supportive but are not qualified in social work. P4 is the only participant with a social-work-qualified manager, and this is a coincidence rather than a structural design. This systemic absence means social workers independently conduct cognitive assessments, deliver therapeutic interventions, and manage complex family dynamics without professional clinical oversight.

**Finding 12:** The emotional labour of geriatric social work produces personal transformation, not merely burnout. P1 describes being "changed as a human" by witnessing ageing, dementia, and death, and P5 names counter-transference as a significant early challenge. The emotional rewards residents' blessings, relational meaning, and the privilege of witnessing dignity in decline are located outside financial compensation, which may mask the need for structural improvements in pay and conditions.

**Objective 4: Ethical Dilemmas and Structural Challenges**

**Finding 13:** The care-commerce tension is the central ethical challenge of private paid elder care. P3 articulates it most clearly: a care institution is a business, yet the core of the work is service for the vulnerable, "so we feel it." This tension is structurally embedded rather than episodically encountered, and creates a persistent undercurrent of moral unease.

**Finding 14:** No institution has written ethical guidelines or a formal ethics committee. Confidentiality is maintained through institutional culture rather than codified protocol. Ethical practice therefore depends entirely on the goodwill and values of individual institutions and practitioners a dependency that is inherently fragile.

**Finding 15:** Ethical experience is not uniform even within the same organisation. P1 reports never having compromised personal conscience, whereas P3 doubts whether the institution fully operates with ethics. This divergence reflects different role positions (direct care versus education and research) and different levels of critical reflexivity, suggesting that proximity to direct care may buffer awareness of structural ethical tensions.

**Finding 16:** Family dominance in decision-making is fuelled by financial investment. Families who pay high fees may feel entitled to influence care decisions, sometimes overriding professional judgement. Social workers function as mediators among resident autonomy, family demands, and institutional policy  a triangulation for which no formal protocol exists.

**Objective 5: Future Scope, Policy, and Professional Development**

**Finding 17:** All five participants identify a severe gap between the MSW curriculum and the demands of geriatric practice. P1 had "one chapter" on gerontology; P3 calls the syllabus "not enough"; P5 says "most of my learning was from experience." This is the study's strongest convergent finding, unanimously confirmed across all cases.

**Finding 18:** Private paid elder care in Kerala operates in a regulatory vacuum. No accreditation body exists for the elder care homes, in contrast to the framework governing educational institutions, and only voluntary associations such as the Association of Senior Living India are present. Professional regulation is absent: there are no mandated social work roles, no standardised qualifications, and no minimum-salary requirements.

**Finding 19:** Workforce sustainability is threatened by brain drain  staff who join chiefly to obtain an experience certificate before moving abroad (P1)  and by the comfort–growth paradox, in which institutional benefits create comfort while limited advancement drives professionals away (P2). Retention beyond six months is a challenge identified by P4. Without career pathways, the sector will continue to lose trained professionals.

**Finding 20:** Despite these challenges, all five participants are optimistic about the future of geriatric social work. The demographic trajectory  Kerala's elderly population set to grow substantially in the coming decades  guarantees rising demand. P1 notes that doctors are only recently recognising the need for social workers, signalling an evolving interprofessional landscape, and all participants recommend the field to future social workers.

## 6.3 SUGGESTIONS AND RECOMMENDATIONS

The following suggestions are derived directly from the findings of each objective. They are addressed to four stakeholder groups: social work educational institutions, private paid elder care institutions, policy-makers and regulatory bodies, and professional associations.

**From Objective 1 (Roles and Institutional Positioning)**

1. Private paid elder care institutions should formally adopt the designation "Social Worker" for MSW- or BSW-qualified professionals, so that the professional title is not subsumed under institutional designations such as "Resident Relations" or "Executive."

2. Institutions should establish dedicated Social Work Departments with a defined scope of practice, clear role boundaries, and a departmental head who is a qualified social work professional.

3. Job descriptions for social workers in elder care should explicitly distinguish social work functions from administrative and commercial functions, while acknowledging the multifunctional reality of practice in smaller institutions.

**From Objective 2 (Contribution to Well-being)**

4. Institutions should develop formal protocols for evidence-based, social-worker-led interventions (Reminiscence Therapy, cognitive stimulation, validation therapy), with documentation standards and outcome monitoring.

5. Social work educational institutions should integrate practical training in dementia care, cognitive assessment tools (MOCA, MMSE), and therapeutic modalities (Progressive Muscle Relaxation, art therapy) into the MSW curriculum as core rather than elective components.

6. Institutions should develop guidelines for managing therapeutic boundaries with fee-paying residents, addressing the distinctive dynamics of care relationships in which the client is simultaneously a consumer.

7. Training programmes should address the distinction between empathy and sympathy in working with residents of private paid homes, equipping social workers to recognise the emotional vulnerabilities that financial security can mask.

**From Objective 3 (Professional Conditions)**

8. The minimum starting salary for social workers in elder care should be regulated at twenty thousand to twenty-five thousand rupees, with provisions for annual increments, overtime compensation, and performance-linked advancement.

9. Institutions should formalise supervision systems with qualified social work supervisors not administrative managers who provide reflective-practice support, clinical oversight, and professional development guidance.

10. Staffing ratios should be standardised to prevent the workload imbalances documented in this study, in which some social workers manage seventy to eighty residents alone while others share the load with colleagues.

11. Institutions with residential postings should establish clear policies for rest periods, compensatory leave for overnight emergencies, and structured breaks, in order to prevent burnout.

**From Objective 4 (Ethical Dilemmas)**

12. Every private paid elder care institution should develop written ethical guidelines covering confidentiality protocols, family-management boundaries, conflict-resolution procedures, and resident-autonomy protections and provide them to all staff on joining.

13. Institutions should establish Ethics Committees comprising social workers, nursing staff, management representatives, and, where possible, resident representatives, to provide structured forums for discussing ethical dilemmas collectively.

14. Professional associations should develop a Code of Ethics specific to gerontological social work in institutional settings, addressing the distinctive care-commerce tensions of private paid elder care.

**From Objective 5 (Future Scope and Policy)**

15. MSW curricula should substantially expand gerontological content from the current single chapter to a full-semester course covering dementia care, cognitive assessment, end-of-life practice, family mediation, and the ethics of commercialised care.

16. Field placements in elder care institutions should be a core component of MSW programmes rather than an optional or rare elective.

17. The Government of Kerala, through the Department of Social Justice, should establish an accreditation body for private paid elder care institutions, with standards for professional staffing, psychosocial services, and quality monitoring.

18. Social work roles should be legally mandated in registered elder care institutions, through amendment to the Maintenance and Welfare of Parents and Senior Citizens Act, 2007, or through state-level legislation.

19. Professional associations, particularly the Kerala Association of Professional Social Workers, should be strengthened to advocate for licensing, professional standards, salary regulation, and the formal recognition of gerontological social work as a specialisation.

20. Institutions should develop structured career pathways for social workers including mentorship, specialisation opportunities, and leadership development to address the brain drain and the comfort–growth paradox that currently undermine workforce sustainability.

## 6.4 DIRECTIONS FOR FUTURE RESEARCH

Building on the findings and limitations of this study, the following directions for future research are recommended:

1. A larger, multi-district or multi-state study with a greater number of participants, to test the transferability of these findings across different geographical, cultural, and institutional contexts in India.

2. Research incorporating the perspectives of elderly residents, their families, and institutional management, to provide a multi-stakeholder understanding of social work practice in private paid elder care.

3. A comparative study of social workers in private paid institutions and those in government-run or charitable homes, to illuminate how institutional context shapes professional experience.

4. Longitudinal research tracking how social workers' professional experiences evolve over time particularly as institutions grow and the sector matures, to address the cross-sectional limitation of this study.

5. A quantitative study developing and validating a standardised instrument for measuring social workers' professional experience in elder care, to enable larger-scale assessment across the sector.

6. Research examining the impact of social work interventions on measurable resident outcomes, such as cognitive function, depression scores, and quality-of-life indices, to strengthen the evidence base for mandating social work services in elder care.

## 6.5 CONCLUSION

This study set out to explore the professional experiences of social workers in private paid homes for the elderly in Kerala, a topic that had not previously been examined empirically in India. Through a qualitative multiple-case study design, semi-structured in-depth interviews with five social workers from five different institutions, and thematic analysis following Braun and Clarke's (2006) framework, the study has produced twenty major findings organised across five objectives.

The central finding of this study is a paradox: social workers in Kerala's private paid elder care are functionally central yet organisationally invisible. They deliver holistic care across the physical, psychological, social, and spiritual dimensions of residents' lives. They independently initiate evidence-based therapeutic interventions. They mediate between residents, families, and management. They navigate the ethical complexities of a care system structured by market logic, and they are personally transformed by the work of accompanying elderly persons through ageing, decline, and death. Yet four of the five work under non-social-work titles; none has access to formal professional supervision; none operates under written ethical guidelines; and their salaries are unregulated, their overtime unpaid, and their professional identity largely unrecognised beyond the walls of their institutions.

The care-commerce tension, where the ethic of service meets the logic of the market, is the defining challenge of this practice context. It does not produce dramatic ethical crises but a persistent, structural moral unease that some practitioners name openly and others absorb silently. Financial comfort does not eliminate the psychosocial needs of residents in these homes; if anything, it masks vulnerabilities that only trained social workers are equipped to identify and address.

All five participants converge on a vision for reform: expanded gerontological education, salary regulation, professional supervision, written ethical guidelines, a regulatory body for private elder care, and career pathways that retain talented professionals in the field. These are not aspirational wishes but evidence-based recommendations grounded in the lived realities of practice.

Kerala's demographic trajectory  the highest proportion of elderly persons of any Indian state and the most advanced ageing profile in the country  ensures that the demand for professional social work in elder care will grow substantially in the coming decades. This study provides an early empirical foundation for ensuring that this demand is met not by institutional improvisation but by professional infrastructure: trained practitioners, regulated standards, written guidelines, formal supervision, and a profession that is named, recognised, and valued both within the institutions it serves and in the wider society it seeks to strengthen.

## REFERENCES


1. Ayalon, L., Kaniel, M., & Rosenberg, L. (2008). Social workers' perspectives on care arrangements between vulnerable elders and foreign home care workers: Lessons from Israeli/Filipino caregiving arrangements. *Home Health Care Services Quarterly, 27*(2), 121–142. https://doi.org/10.1080/01621420802022563
2. Banerjee, A., Daly, T., Armstrong, P., Szebehely, M., Armstrong, H., & Lafrance, S. (2012). Structural violence in long-term residential care for older people: Comparing Canada and Scandinavia. *Social Science & Medicine, 74*(3), 390–398. https://doi.org/10.1016/j.socscimed.2011.10.037
3. Banks, S. (2012). *Ethics and values in social work* (4th ed.). Palgrave Macmillan.
4. Behrendt, D., Spieker, S., Sumngern, C., & Wendschuh, V. (2023). Integrating social support into interventions among the elderly in nursing homes: A scoping review. *BMJ Open, 13*(4), Article e071962. https://doi.org/10.1136/bmjopen-2023-071962
5. Bolster-Foucault, C., Vedel, I., Busa, G., Hacker, G., Sourial, N., & Quesnel-Vallée, A. (2024). Social inequity in ageing in place among older adults in OECD countries: A mixed studies systematic review. *Age and Ageing, 53*(8), afae166. https://doi.org/10.1093/ageing/afae166
6. Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa
7. Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by nature and design*. Harvard University Press.
8. Bronfenbrenner, U., & Morris, P. A. (2006). The bioecological model of human development. In W. Damon & R. M. Lerner (Eds.), *Handbook of child psychology* (6th ed., Vol. 1, pp. 793–828). John Wiley & Sons.
9. Creswell, J. W., & Poth, C. N. (2018). *Qualitative inquiry and research design: Choosing among five approaches* (4th ed.). Sage.
10. Dadich, A., Lan, A., Shanmugarajan, S., Childs, S., Alford, J., & Ní Chróinín, D. (2025). Models of care for older people: A scoping review. *Journal of the American Geriatrics Society, 73*(5), 1588–1597. https://doi.org/10.1111/jgs.19371

11. Dev, P. S., & Eljo, J. G. (2024). Addressing the ethical and legal complexities in elderly care: A study from India. *Nusantara Journal of Behavioral and Social Science, 3*(3), 111–118. https://doi.org/10.47679/njbss.202456
12. Ebrahimi, Z., Patel, H., Wijk, H., Ekman, I., & Olaya-Contreras, P. (2021). A systematic review on implementation of person-centered care interventions for older people in out-of-hospital settings. *Geriatric Nursing, 42*(1), 213–224. https://doi.org/10.1016/j.gerinurse.2020.08.004
13. Elices Acero, Á., Prieto-Lobato, J. M., & Rodríguez-Sumaza, C. (2024). The role of social workers in long-term care for older adults: A mixed-methods systematic review in Europe and North America from 2000 to 2022. *International Social Work, 68*(1), 7–21. https://doi.org/10.1177/00208728241269670
14. Estes, C. L. (2001). *Social policy and aging: A critical perspective*. Sage.
15. Fernandez, S., Zacharias, L., & Harikrishnan, U. (2018). Case studies on elderly and institutionalization in the southern region of Kerala. *Journal of Social Work Education and Practice, 3*(3), 54–58.
16. Gilligan, C. (1982). *In a different voice: Psychological theory and women's development*. Harvard University Press.
17. Government of India. (2007). *The Maintenance and Welfare of Parents and Senior Citizens Act, 2007* (Act No. 56 of 2007). Ministry of Law and Justice.
18. Government of Kerala. (2025). *Economic review 2024* (Vol. 1). Kerala State Planning Board.
19. Gupta, M., Goel, S., & Bhargava, V. (2025). Bridging the gap between actual and desired quality of life: A study of older adults in institutional care settings in India. *Journal of Gerontological Social Work*. Advance online publication. https://doi.org/10.1080/01634372.2025.2477575
20. Gurrapu, R., Ammapattian, T., & Antony, S. (2024). Perceived social support, loneliness, and depression among elderly living in old-age homes. *Journal of Family Medicine and Primary Care, 13*(3), 864–868. https://doi.org/10.4103/jfmpc.jfmpc_799_23
21. International Federation of Social Workers. (2014). *Global definition of social work*. https://www.ifsw.org/what-is-social-work/global-definition-of-social-work/
22. Irudaya Rajan, S. (2002). Home away from home: A survey of old age homes and inmates in Kerala, India. *Journal of Housing for the Elderly, 16*(1–2), 125–150. https://doi.org/10.1300/J081v16n01_09

23. Irudaya Rajan, S., Shajan, A., & Sunitha, S. (2020). Ageing and elderly care in Kerala. *China Report, 56*(3), 354–373. https://doi.org/10.1177/0009445520930393
24. Jiang, H., & Liu, Z. (2023). Community home elderly care services, multidimensional health and social participation of chronically ill elderly. *Frontiers in Public Health, 11*, Article 1121909. https://doi.org/10.3389/fpubh.2023.1121909
25. Kumar, P. B. A., Udyar, S. E., Arun, D., & Sai, S. (2016). Quality of life of elderly people in institutional and non-institutional setting: A cross-sectional comparative study. *National Journal of Community Medicine, 7*(7), 546–550.
26. Lam, J., & Baxter, J. (2023). "Friend-ish": Home care workers, "social labor" and managing the boundaries of the carer relationship. *Journal of Applied Gerontology, 42*(4), 581–588. https://doi.org/10.1177/07334648221144026
27. Lobanov-Rostovsky, S., He, Q., Chen, Y., Liu, Y., Wu, Y., Liu, Y., Venkatraman, T., French, E., Curry, N., Hemmings, N., Bandosz, P., Chan, W. K., Liao, J., & Brunner, E. J. (2023). Growing old in China in socioeconomic and epidemiological context: Systematic review of social care policy for older people. *BMC Public Health, 23*(1), Article 1272. https://doi.org/10.1186/s12889-023-15583-1
28. Mayer, A. (2017). *Old-age home? Middle-class senior citizens and new elderscapes in urban India* (Doctoral dissertation, Heidelberg University). http://archiv.ub.uni-heidelberg.de/volltextserver/23346/
29. Miller, V. J., Hamler, T., Beltran, S. J., & Burns, J. (2021). Nursing home social services: A systematic review of the literature from 2010 to 2020. *Social Work in Health Care, 60*(4), 387–409. https://doi.org/10.1080/00981389.2021.1908482
30. Ministry of Social Justice and Empowerment. (1999). *National policy on older persons*. Government of India.
31. Ministry of Social Justice and Empowerment. (2011). *National policy for senior citizens*. Government of India.
32. Moreno, G., Mangione, C. M., Tseng, C.-H., Weir, M., Loza, R., Desai, L., Grotts, J., & Gelb, E. (2021). Connecting Provider to Home: A home-based social intervention program for older adults. *Journal of the American Geriatrics Society, 69*(6), 1627–1637. https://doi.org/10.1111/jgs.17071
33. Morrow, E., Kelly, C., Killeen, C., Naessens, E., & Lynch, M. (2024). Exploring a career pathway for home support workers in Ireland: A systematic scoping review of the international evidence. *Frontiers in Health Services, 4*, Article 1360920. https://doi.org/10.3389/frhs.2024.1360920

34. NITI Aayog. (2024). *Senior care reforms in India: Reimagining the senior care paradigm: A position paper*. Government of India.
35. Philip, A. J., & Johns, F. (2024). Prevalence of cognitive defects among senior inmates of old-age homes in a district of South Kerala. *Cureus, 16*(7), e65082. https://doi.org/10.7759/cureus.65082
36. Phillipson, C. (2013). *Ageing*. Polity Press.
37. Reamer, F. G. (2006). *Social work values and ethics* (3rd ed.). Columbia University Press.
38. Saleebey, D. (2006). *The strengths perspective in social work practice* (4th ed.). Pearson.
39. Silarova, B., Brookes, N., Palmer, S., Towers, A.-M., & Hussein, S. (2022). Understanding and measuring the work-related quality of life among those working in adult social care: A scoping review. *Health & Social Care in the Community, 30*(5), 1637–1664. https://doi.org/10.1111/hsc.13718
40. Siva Raju, S., & Singh, V. (2021). Gerontological social work in India: The emerging trends. In M. K. Shankardass (Ed.), *Gerontological concerns and responses in India* (pp. 71–88). Springer.
41. Takeda, S., & Fukuzaki, T. (2024). Association between workplace interpersonal relationships and psychological distress among care workers at elder care facilities. *Psychogeriatrics, 24*(4), 847–853. https://doi.org/10.1111/psyg.13130
42. Timonen, V., & Lolich, L. (2019). "The poor carer": Ambivalent social construction of the home care worker in elder care services. *Journal of Gerontological Social Work, 62*(7), 728–748. https://doi.org/10.1080/01634372.2019.1640334
43. Tronto, J. C. (1993). *Moral boundaries: A political argument for an ethic of care*. Routledge.
44. United Nations Population Fund, & International Institute for Population Sciences. (2023). *India ageing report 2023: Caring for our elders: Institutional responses*. UNFPA India.
45. Wang, J., & Wu, B. (2017). Domestic helpers as frontline workers in China's home-based elder care: A systematic review. *Journal of Women & Aging, 29*(4), 294–305. https://doi.org/10.1080/08952841.2016.1187536
46. Yau, S. Y., Lee, Y. K. L., Li, S. Y. B., Law, S. P. S., Lai, S. K. V., & Huang, S. (2024). Health care workers' self-perceived meaning of residential care work. *BMC*

*Health Services Research, 24*(1), Article 766. https://doi.org/10.1186/s12913-024-11218-2

47. Yin, R. K. (2018). *Case study research and applications: Design and methods* (6th ed.). Sage.

# APPENDIX

# TOOL

## GENERAL RESEARCH QUESTION

How do social workers in private paid homes for the elderly interpret and experience their professional roles, contributions to wellbeing, job conditions, ethical dilemmas, and future scope within institutional elder care?

## SPECIFIC RESEARCH QUESTION 1

**Roles, Responsibilities and Role Negotiation**

**Theme 1: Professional Roles and Institutional Positioning**

**Subthemes:**

• Formal job description

• Informal/expanded roles

• Role negotiation

• Decision hierarchy

• Power dynamics

***Main Question 1***

**Can you describe your formal and informal roles in this institution?**

***Probing:***

– What is officially written in your job description?

– Have your responsibilities evolved over time?

– Are you assigned non-social work tasks?

– How do you negotiate your role with management?

***Main Question 2***

**How is decision-making structured here?**

***Probing:***

– Who has final authority?

– Are your professional judgments respected?

– Have your decisions ever been overridden?

– Does financial contribution influence decisions?

***Suggestion Question***

*What changes would improve clarity and recognition of the social worker's role?*

**SPECIFIC RESEARCH QUESTION 2**

**Contribution to Multidimensional Wellbeing**

**Theme 2: Gerontological Social Work Practice**

**Subthemes (Revised):**

• Physical wellbeing

• Psychological wellbeing

• Social and spiritual engagement (merged: social integration + spiritual needs)

• Class dynamics and socio-economic expectations (merged: economic/legal support + class-based expectations)

***Main Question 3***

**How do you contribute to residents' physical and psychological wellbeing?**

***Probing:***

– Do you coordinate medical or therapeutic services?

– How do you address loneliness or depression?

– How do you handle crisis situations?

***Main Question 4***

**How do you address social and spiritual needs?**

***Probing:***

– Do you facilitate social engagement?

– Are spiritual concerns common?

– How do affluent residents express emotional distress?

***Main Question 5***

**Do residents from private paid homes have unique expectations?**

***Probing:***

– Are their demands different?

– Do family relationships differ?

– Does financial comfort mask emotional vulnerability?

***Suggestion Question***

*What additional supports are required for holistic wellbeing?*

**SPECIFIC RESEARCH QUESTION 3**

**Job Satisfaction and Professional Conditions**

**Theme 3: Professional Identity, Conditions and Emotional Labour**

**Subthemes:**

• Decision-making autonomy

• Salary and benefits

• Workload

• Emotional labour

• Professional recognition

• Supervision systems

***Main Question 6***

**How would you describe your job satisfaction?**

***Probing:***

– Do you feel professionally fulfilled?

– Is your compensation appropriate?

– Is workload manageable?

– Do you receive recognition?

***Main Question 7***

**What emotional demands does this work place on you?**

***Probing:***

– Do you experience burnout?

– How do you manage emotional boundaries?

– Do you receive supervision?

– Is there institutional support for stress?

***Main Question 8***

**How has working in this setting shaped your professional identity?**

***Probing:***

– Do you feel more administrative than therapeutic?

– Has your understanding of social work values changed?

– Do you feel valued or marginalized?

***Suggestion Question***

*What improvements would enhance professional satisfaction?*

**SPECIFIC RESEARCH QUESTION 4**

**Ethical Dilemmas and Structural Challenges**

**Theme 4: Ethical Conflicts, Power and Institutional Pressures**

**Subthemes (Revised):**

• Autonomy vs safety

• Family dominance

• Confidentiality

• Care-commerce tension and institutional pressures (merged: profit orientation + institutional image pressure)

• Moral distress

***Main Question 9***

**What ethical dilemmas do you commonly face?**

***Probing:***

– Conflict between resident and family?

– Policy vs professional ethics?

– Confidentiality breaches?

– Financial influence on care?

***Main Question 10***

**How does working in a private paid setting affect ethical decision-making?**

***Probing:***

– Do affluent families exert pressure?

– Is institutional reputation prioritized?

– Are complaints handled sensitively due to status?

– Do you feel moral distress?

***Main Question 11***

**How are ethical decisions discussed or supervised?**

***Probing:***

– Are there written ethical guidelines?

– Is there a supervision or ethics committee?

– Are dilemmas discussed collectively?

***Suggestion Question***

*What structural reforms could reduce ethical conflicts?*

**SPECIFIC RESEARCH QUESTION 5**

**Future Scope, Governance and Professional Development**

**Theme 5: Policy, Regulation and Future Directions**

**Subthemes (Revised):**

• Education and specialisation gaps (merged: training needs + gerontological specialisation)

• Regulatory and policy gaps (merged: policy gaps in Kerala + professional regulation)

• Institutional governance

• Workforce sustainability

***Main Question 12***

**What competencies are essential for social workers in such institutions?**

***Probing:***

– Should gerontological specialisation be mandatory?

– Is ethical decision-making training needed?

– What skills are most lacking?

***Main Question 13***

**How is this institution governed or regulated?**

***Probing:***

– Is there external monitoring?

– Are social workers involved in institutional planning?

– Are there professional standards followed?

***Main Question 14***

**What policy-level changes are needed to strengthen social work practice?**

***Probing:***

– Should roles be legally mandated?

– Should salary standards be regulated?

– Should supervision systems be formalized?

***Main Question 15***

**How do you see the future scope of social work in private paid homes for the elderly?**

***Probing:***

– Will demand increase?

– Will specialisation expand?

– Would you recommend this field to future social workers?

***Final Reflective Question***

***Is there anything important about your professional experience in this setting that we have not discussed?***