<u>ACADEMIA EUROPAEA</u>

Relationships in Old Age: how does the Community Care?

This paper focuses on those elderly people who have a degree of frailty which means that they cannot continue life as they have lived it without an increase in support or care. It is also about those who care for them. It is not about those millions of fit 'young elderly' people who are defined as 'elderly' simply because they retire and draw a pension. This is not to deny that there are important issues to be addressed in relation to this group, many centring upon the changes in life style and roles consequent upon retirement. But that is another paper.

It may be at the end of this paper that you will feel I have overemphasised problems and yet again 'pathologised' old age, despite plenty of evidence to the contrary. However, those whom I call the 'anti depressant' gerontologists often fail to distinguish between the young old and the old old in their analysis of old age and they often focus upon those (a large number) whose financial and material circumstances facilitate fuller lives. Rather than pathologising old age itself, I am drawing attention to social pathology, to the many ways in which society stigmatises and further disables old people at the end of their lives.

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problems besetting old people. Indeed, academics have tended to polarise in the stance which they adopt. This may reflect a continuing social and individual ambivalence towards the issue, bound up, of course, with our own feelings and fears about becoming old. The fact of the matter is that however smooth a passage 'young old' people may have in those early years, everyone in this room knows of the struggle which many old old people have to sustain creative, hopeful relationships. This paper attempts to deal honestly with that fact. It suggests that there needs to be a social transformation of attitudes towards old people and their relationships which would in turn affect social policies and service provision in a host of ways. It suggests that we all have a responsibility in this matter, as much in our private as in our professional lives.

We are all now familiar with the term 'agism' - one of the 'isms' by which we diminish the human value of certain groups by process of stereotyping and denigration. Agism can manifest itself in peculiarly offensive assumptions about relationships in old age - that they are in some ways less significant for the very old than for younger people. In its grossest form, one can still see callous separation of couples in residential care. A few years ago, when I was on the British Registered Homes Tribunal, we upheld the wish of the local authority to close a private home, in which, inter alia, twin sisters had been placed on different floors of a home with no lift and saw each other at Easter and Christmas when carried by staff. When challenged, the proprietor claimed that they quarrelled when together. So? They presumably always had! From such examples, we move to slightly more subtle manifestations of agism; notably with regard to sexuality in old age, a topic which frequently gives rises to nervous titters or even to manifestations of disgust in younger people. Yet it is an area in which many old people

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need help and advice as physical disability or illness arise.

In short, the nature of the required social transformation is quite simple to articulate and immensely difficult to achieve. We are asking for old people to be treated as full human beings with the same needs, feelings, wishes, loves and hates as the rest of us. This leads to the question - why have they not been so treated?

It is commonplace to remark upon the marginalised status of old people in developed societies. The literature on the structured dependency of old age created by processes of retirement and 'pensioning off' is extensive. (See, for example, Phillipson & Walker 1986). It is suggested that in societies subject to less technological and industrial change it was and is easier for old people to make a contribution to society which is recognised and valued. (However, I sometimes wonder whether we need more evidence on this point - is there some romanticisation going on?). However that may be, it seems that a critical factor is successful relationships in old age is a sense of being needed by others as well as needing them. There can, of course, be many different manifestations of being needed, from active participation to 'being there', offering emotional support. The sense of being connected to society, whether the family or the wider community and of having something to offer is for most old people (as for any one else) a vital element in well being. In fact, this is problematic and we do old people no service if we ignore or deny it. It is problematic for a number of reasons.

- First, demographic, social and familial trends have dislocated the structures within which people interact. Take, for example, one issue illustrated by this OHP.

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(OHP here).

The numbers of old women living alone speaks for itself but does not tell us that many of them do not have surviving younger kith and kin. We have not yet seen the full impact of a later cohort of divorced and remarried persons with its effects on the older as well as the younger generation.

Secondly, limitations are often placed on what can be offered because of physical disability and diminishing energy. The O.P.C.S. Survey of Disability shows this very clearly.

(OHP here)

Thirdly, and this is complex, a vicious circle may be at work whereby diminishing activity and responsibilities exaggerate self preoccupation. There is literally, 'not enough to worry about' and this may disable people from engaging in ways which they would have taken for granted before.

Fourthly, it is only to be expected that over this period of life the balance between giving and taking shifts. What is so unsatisfactory is that this balance is often determined not by the wishes and capacities of the old person but by a lack of appreciation by others of their feelings and a lack of attention to the practical details which might make it possible for them to contribute more fully in the social exchange which is part of relationships.

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Not all this is about 'doing'; it is about sharing in experience fully and others giving to others. There is a particular form of agism which is sub-titled 'we didn't want to worry you'; the oft repeated cry of the generation in the middle. To exclude old people from the sorrows, anxieties and fears of others, just because they are old, is a fundamental denial of their humanity. There may be other reasons, long standing personality or relationship difficulties for example. (If you were never able to talk freely to mother, there is no obligation on you to do so in old age!) In general, however, old people are well able to sense strain and concern in those round them, possibly more so if the bustle of daily preoccupations is less; also, from a lifetime of coping they are usually more resilient than the younger generations acknowledges. Exclusion does not save them worry - it just goes on privately and in loneliness. To put it crudely, it is an emotional cop-out.

This is not to say that intergenerational sharing of this kind is easy; it is bound up with earlier relationships, with the younger generations' sense of the expectations which their parents and other kith and kin have of them. Success and failure in education, employment, sexual relationships - these are the stuff of the 'worries' which confront ordinary families and which resonate with earlier family experiences. Changing values and norms play a part in creating difficulties in communicating openly. Yet if these are not faced, the process of marginalisation of the old is exacerbated. The less old people are involved in the process of daily living which surround them, the more marked the characteristics which irritate become - repetitiveness, self preoccupation etc.

This, then, is the first challenge which awaits us - how to confront agism at its most

blatant which gives to very old people the message - 'you have nothing to give us any more'. I do not deny that that may sometimes be the case, notably and tragically, in cases of dementia, or that technological advances play a part in that marginalisation. I am, however, suggesting that there are many millions of old people whose capacities to give are undervalued and disregarded. In a very real sense, the community is <u>not</u> caring enough to find out what they have to give.

Bound up with this is another manifestation of agism - a denial of the capacity to change and adapt which so many very old people show to a remarkable degree. Let us take the typical case of our generation; the woman in her late 70s, whose husband has died. Married from her own home, she may never have lived alone, or slept alone in the house until she is bereaved. Raised in an era in which gender roles are very clearly distinguished, she may never have handled aspects of the financial affairs, undertaken 'do it yourself' repairs and so on. She is not, therefore, dealing only with the complex processes of brief and mourning. She is required to adapt to a different way of life, to assume a different roles or find new ways of reascribing them. In many ways the changes are even more radical than others in the life cycle and they have to be achieved at a time when there is quite a high probability of physical disability is, even if minor. The fact that most old women achieve these changes with courage and dignity should give the lie to talk about 'less adaptability'. Furthermore, a proportion of such old women will have to make a decision about their future living arrangements, for example to enter residential care. Could any decision be more fundamental, any choice more important?

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There is in Britain much disquieting evidence that professionals give little attention to the trauma of such life cycle events. There is little bereavement counselling for the very old. (Scrutton's work (1989) is an honourable exception. The influential work of Murray Parkes (1986) dealt with a younger group of widows.) In fact, counselling with old people could offer particularly interesting opportunities for facilitating role change as well as in the conventional work on loss, which in itself may differ because of the stage in life in which the loss is experienced. There is also evidence (Weaver et al; 1985) from studies of private residential care that a significant number of old people are 'hustled' by doctors and relatives from hospital to residential care without even lip service to 'choice'. In social work, residential care applications are often investigated by unqualified workers, whose appreciation of the complex processes involved in deciding whether or not to go into care or 'soldier on' alone may be limited.

More generally, we in Britain are hardly at the beginning of sensitive and skilled interpersonal work in the field of very old age. A few (but increasing number of) family therapists are taking it forward but their scarcity epitomises the fundamental problem, that of cynicism about the need for, and possibility of, change in the quality and nature of interactions in the later years of life. Yet, as we have seen, change and adaption is demonstrated over and over again in the daily lives of countless individuals. There may be those here today who are sceptical about the value of psycho-therapy and related work for anyone at any age. I do not propose to take them on! What I would assert is that <u>if</u> it is perceived as of value to younger people, it should be available to those who are older.

are older.

Even more important than formal psycho-therapy is the need to incorporate a counselling approach into the repertoire of a number of professionals engaged in the health and social care of old people. I have a sense that short term and focussed psycho-therapeutic intervention on particular difficulties as they arise would often pay dividends. There are various commonly occurring periods of difficulty, which, if happening to younger people, would be generally agreed to merit consideration for such intervention - such as the onset of disability in the patient or partner, the prospect of death, bereavement, and the eruption, or increase in, tensions between carer and cared for. I confess to a certain sadness when I see these matters openly raised in relation to HIV and AIDS sufferers and still largely ignored in relation to old people. It is not suggested for a moment that all old people need such forms of interventions - that would be absurd. It is a plea to keep this option as open for the old as anyone else.

Probably the most frequent and useful occasions for this type of intervention lie in the interaction between carer and cared for. In Britain, as in the USA, the last 15 years or so have seen a great increase in, and understanding of, the position of informal carers of frail elderly people. There is now a burgeoning literature, (see refs), a good deal of which is written from a feminist perspective. There is also, similarly, a growing literature on the issue of elder abuse. (See refs). There are certain key issues for debate which time does not permit me to develop here but which I have explored elsewhere (Stevenson 1989). Three of these are:

- The majority of those who provide informal care are women - where both sexes are involved, women provide much more. Formal community care plans all assume continued availability of women to provide informal care, yet, in Britain, the increased

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demand for women in the labour force and their wish to be so involved seems set to continue, sharpening dilemmas and increasing ambivalence about the combining of those roles, which have implications for financial security as well as demands on time and energy.

- A significant proportion of women carers are those who are on the edge of or at the beginning of retirement. For a number, these demands are unwelcome, coming at a time when greater freedom to enjoy life might reasonably have been expected.
- More recently, attention has been drawn to the significant number of male carers in households where both partners are old. Thus, whilst assumptions continue to be made that caring is 'womens work' and the bulk of care both in the household and between households is carried out by women, old men have shown themselves able and willing to assume major share of caring for partners in the same household. Gender roles are not irreversible but these reversals are restricted to specific situations.

Such findings raise moral and social questions concerning the role of carers which go beyond the scope of this paper. One must however stress that any initiatives on psycho-therapeutic interventions, in whatever context, should not accept uncritically the status quo. As has been pointed out in other areas of activity, psycho-therapeutic activity should not be used to help people tolerate the intolerable, to adjust to circumstances in which their quality of life is impoverished, for whatever reason. I have in mind, in particular, the position of women caring for parents with dementia, when it is commonplace for them to say that they have in effect 'lost' their relative already; they have, in a sense, died. In some such situations, the goal of therapeutic intervention may be to release them from the guilt which continues to bind them in ways which are self

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destructive.

Research on gender differences (Braithwaite 1990) suggests that women experience 'the burden' of care more intensely than men who do the same amount and same kind of caring. The suggestion, which seems most plausible, is that women have so internalised assumptions that it is right and proper for them to provide informal care that they are constantly dissatisfied with what they provide - they have not done 'enough'. And it is much more difficult to be reassured by the care of the old than by care of children whether the eventual visible proof a healthy independent adult is profoundly reassuring. The implications of this for therapeutic intervention are considerable.

Concern for carers, an acknowledgement of the value of their contribution and of the stress which they endure, has led to a proliferation of carers' support groups often initiated by professionals or by voluntary agencies. In one sense, it could be said that professionals have identified more with relationships from the carer's point of view than with that of the old people themselves. One suspects that this is another instance of subtle agism.

The issue of carers is a sensitive one; let me try to be very clear. The growth of action for and by carers and by professionals who support them is very welcome, as is the greater appreciation of their feelings about their role. I have, however, some concern that this has not been accompanied by a comparable attempt to understand the feelings of those who find themselves in positions of dependency which they themselves do not always welcome and in which they too experience strain.

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