‘What can you expect, my dear, at my age?’

Recognising the need for counselling in a residential unit

Steve Scrutton

Steve Scrutton, *MA, CQSW, BSc (Econ)*
Unit Manager, Northamptonshire Social Services Department, Northampton, UK

Ageism, simply defined as the discounting of the needs and aspirations of older people, is inbred in our social attitudes. It is as rampant as sexism and racism – but much less discussed and understood. There is a tendency for all of us to believe that bereavement in older people is a natural concomitant of the ageing process, and something that does not require help. Such an acceptance of loss in old age has led to a neglect of the support and counselling required by older people and their carers in situations that would clearly warrant such assistance with younger people.

DISCOUNTING THE LOSSES OF OLDER PEOPLE

As I write this from my office in a residential home for older people, I am conscious that outside are residents and day care clients, their care staff, and visiting relatives and friends. Staff from my Home Care team are visiting older people in their own homes. Surrounding us are the common features of old age – the process of gradual decline, ill-health, loss of function and mobility, and death. My staff are, of course, entirely used to dealing with this. It is part of their job.

The people we work with, a few in their 60's, some in their 70's, but most in their 80's and 90's, are resigned to the ageing process. After all, we all die and, as we grow older, there is an increasing acceptance of declining function, mobility and the imminence of death. As the years pass, more of our friends and relatives, with whom we have shared our lives and experiences for many decades, die. But of course this is all quite normal – or is it?

Well, perhaps in part it is. But there is a crucial need to distinguish between the physiological and the psychological, the body from the mind. The longer I work with older people, the more important this distinction seems to me. The older we become, the more ill-health, disability and death seem to be discounted. It is too easy to accept this process as an inevitable, naturally occurring part of life, and therefore as something that is somehow more ‘acceptable’ than it is. We tend to forget the pervasiveness of loss in old age, not brought about by death alone, but through the loss of health, mobility, social role and status, and the ability to live independently. In making these remarks, I am not seeking to criticise ‘you’ – we are all to some degree guilty.

> **EDITOR'S NOTE**
>
> The practical implications of the problems described in the foregoing paper by Miriam and Sydney Moss are well described in this account, by Steve Scrutton, of bereavement in a residential home for older people. His paper also hints at the special stresses that these may cause for caring staff. To ignore such issues provides no lasting solution and may, in the long run, undermine morale in residents and staff.

IN A RESIDENTIAL UNIT

Let us examine life within the residential part of this unit. Here, managers, social workers, and a variety of carers, kitchen and domestic staff are employed. Doctors, district nurses, and a variety of other heath staff are regular callers. We ensure that residents are well fed and clothed, and live in warm, comfortable and hygienic surroundings. We seek to treat each resident as an individual with full rights, comply with their need for dignity, privacy and confidentiality, and ensure that they have as much choice and independence in their lives as possible.

We try (and generally succeed) in maintaining a happy and accepting atmosphere within the home. Yet inevitably loss is a regular visitor to the unit, and we have no counsellors, or even access to counselling provision.

Loss of independence

Some years ago, when I was new to work with older people, a member of staff who had been assaulted by a new resident came to talk to me (she had been kicked whilst toileting her). It became apparent that she was not aware of the indignity the lady felt at requiring assistance in this, the most private of all functions, and the grief and anger that such dependence caused her. We eventually agreed that we needed to counsel the lady about her loss of independence, to reach an agreement about her need for assistance in this and other matters of personal care, and what help she was prepared to accept.

The incident was instructive. The carer thought she was doing no more than fulfilling her caring task, for which she normally received appreciation rather than violence. The resident, on the other hand, was conscious of the indignity of requiring help, and lashed out in anger. How easy it is for such cross-communication to occur when we forget that people, regardless of age, maintain

the same need for privacy and dignity, for understanding generally, as everyone else. The outcome was that we were able to maintain as much privacy and dignity for the resident as possible, whilst avoiding further violence to members of staff. Most important, we did not fall into the trap of seeing her as a bad-tempered, unreasonable and ungrateful old woman.

Depression after three deaths

Until recently this unit did not formally recognise that there was a problem. Then, around Christmas, three popular, long-standing residents died in quick succession, including our centenarian. The atmospheres amongst both staff and residents became restrained. The weather was unceasingly miserable. We went through a period of high levels of staff and resident sickness. There had been an expression of sadness, but life within the unit had to continue. The familiar routines could not stop. Everyone was busy. Soon new residents replaced those who had died. Everyone knew and accepted this. Yet the depression within the unit continued for many weeks.

Eventually, I engineered some discussions with key residents and staff – a series of 'bereavement' meetings, and many interesting facts and feelings began to emerge. Several residents expressed their feelings vividly.

- They felt empty and alone. They had got on well with the dead residents, and their age did not minimise, in any way, their sense of loss.
- Within a few days of the funerals, the rooms had been cleared of personal belongings, new residents had arrived, and by that time every trace of the dead residents had been expunged. It was as if they had never existed within the unit.
- They reasoned that when they died they would be forgotten with similar rapidity.
- And had they discussed their feelings with staff? Well, no. Staff were busy, and did not have time to spend discussing their sadness.

Staff – the price of 'coping'

I spoke to several members of staff too. One resident had died on Christmas day evening, and carers had at one moment to care for the dying resident, then, in the next, move out to join the seasonal celebrations going on elsewhere. They had felt cut in two. They welcomed the opportunity to talk about their feelings. Despite having cared for these residents, often for many years, no-one had previously spent time with them to discuss their feelings of loss. The routine work of clearing the vacant rooms to get them ready for a new resident, and continuing to look after the other residents, had to go on. Yet they had feelings about this, which they had never been able to express before. For them, as sensitive human beings, it was not routine. They were not automatons.

The personal price can be high. The husband of one experienced member of staff died. She seemed to cope very well during the early weeks and months, and soon returned to work. But then grief struck her, delayed and violent. She had dealt with the loss of her husband as she had learnt to deal with the loss of her residents. She had helped and supported everyone else, sons, daughters, relatives, friends. Everyone had marvelled at how well she was coping. But now, she felt guilty at her failure to cry, her failure to recognise at the time the significance of her loss. Her way of coping with death was really no way at all. The price she paid for her 'learned behaviour' was high indeed.

Relatives and friends

You might expect that relatives and friends would have accepted that disability, ill-health and death awaited the older people they loved? Not so! One daughter of a resident suffering from advanced dementia discussed her mother's condition. This ageing, dementing woman was her mother, yet not the mother she had known – that person had already gone, leaving someone who was hostile to her and who upset her. The daughter was doing her best and received only abuse from her mother. She confided that other members of her family had suffered dementia, and she feared that she might in time suffer the same fate. We discussed this briefly, and she said that it was the first time she had ever talked to anyone about it.

AGEISM IN OLDER PEOPLE

It is surely strange that within establishments such as this one, devised to meet the needs of older people, bereavement should be so neglected and it is surely sad that I, an experienced unit manager, should not have picked up these feelings before. Yet the situation I have described probably accurately reflects the low status of older people within our social structure. We should all be more aware, and take matters less for granted, when we consider our elders, and their needs.

Yet we also need to recognise another feature of ageism. Perhaps the most ageist group, those most likely to discount the needs and aspirations of older people, are older people themselves. They do not complain. They say they have had their lives and that they are content with their lot, even when they are not. 'What can you expect, my dear, at my age?'

Too often, older people do not insist that they have a problem and it is important that their carers become as aware of what they are *not* admitting as what they are admitting. It is easier for them to complain of aches and pains than psychological distress. People of all ages are full of fears and self-doubt, and old age does not diminish these feelings. The experience of loss in older age is statistically more common, and we should indeed expect it, but we should never discount it. Each single statistic is a human experience which has to be borne, faced, and dealt with as positively as possible.

Responding to the needs

We must also be careful not underestimate the ability of older people to adapt to loss, however devastating it might appear. The fact that they have become 'older people' means that they have survived many personal losses, and done so successfully. They have, in many cases, proven their ability to survive the blows that life has dealt them. There is no reason to assume that these abilities decline with age. Certainly, older people who attended our meetings, low key events as they were, and talked about their feelings, felt better for having done so. In many ways, the meetings broke new ground. We now plan to start a picture gallery, a hall of fame, featuring both current and former residents – thus ensuring that there is 'life after death' within the home.

The author has published three books: *Bereavement and Grief: supporting older people through loss** (London, UK: Edward Arnold and Age Concern, 1995); *Counselling Older People: a creative response to ageing* (London UK: Edward Arnold, 1989); and *Ageing, Healthy and in Control* (Andover, Hants, UK: Chapman Hall, 1992).

*Available from Cruse Bereavement Care, 126 Sheen Road, Richmond, Surrey TW9 1UR, UK.