Considerations in Planning Services for The Elderly

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"On dusty benches in the park
I see them sit from noon to dark,
Infirm and dull, or glum and dry,
And think, as I stepping by:
"There – but for the grace of God – sit I!"
Yet cannot blink and cannot bless
God's manifest graciousness"[1]

A walk along Lummus Park running from the southern tip of Miami Beach for almost a mile shows a hundred scenes similar to that described in Ms. Deutsch's poem. As medical technology improves, increasingly the proportion of aged in our society becomes greater and greater. Over 20 million of our citizens are over the age 65. Yet the misconceptions about the aged process and our elderly citizens run rampant in this youth-oriented society. We know that the typical elderly person is not a senile patient in an institution. Only five percent of the aged are in any type of institution. The remaining 95 percent live independently in their own communities and engage in active and productive life-styles.

Contemporary American thought is currently perplexed by a fascinating contradiction. On one hand we are increasingly concerned with society becoming youth-oriented. Youth cults have inundated all aspects of our society and are representative of a new way of thinking that has emerged since World War II. At the same time, however, we can begin to see the subtle changes in the recognition that aging no longer has to be defined as "over-the hill."

The changing attitudes toward the aged have begun to be expressed in numerous governmental and societal circles. As one traces the history of the elderly in Simone De Beauvoir, *The Coming of Age,*[2] one sees that just as technological progress has greatly speeded in the twentieth century, so has the knowledge of the aging process been better understood.

Yet the status of research in biomedical, behavioral, and social sciences as they affect and are effected by the aging population is not commensurate with the increasing proportion and role that this population plays in society as a whole. While society is beginning to attempt to provide necessary services for the aging, the nature, scope, and validity of these services must be seriously questioned. Familial relationships over the past half century have drastically changed the life expectation of the senior citizen. The nature of governmental and other benefits that are utilized by the aging have additionally changed their location in society. Elderly people in general, do not overwhelmingly live with their families and die with their families as they did some years ago. The effect of this form of family breakdown no doubt has a significant impact on the planning of health and social services to meet the needs of the elderly.

What do we know about the elderly?

We know that there is a direct relationship between the youthfulness of older people and the kinds of society in which they live. The numerous examples of the contributions by aged persons need not be mentioned at this time.

[1] Babette Deutsch, "Reflections On A Little Park," in R. Humphries, (ed.), *New Poems,* New York, 1953.

[2] Simone de Beauvoir, *The Coming of Age,* New York, 1972 (especially pp. 27-418).

We know that the ability to learn does not innately deteriorate with age. As long as we do not over emphasize speed of response, older people can continuously and readily acquire new skills and knowledge.

We know that chronological age is not a reliable index of people's capacity. Individuals age at different rates and organs within individuals age differently. Often, a person at 70 may in fact be younger than another at 50.

We know that many symptoms associated with aging are actually the end results of processes that began many years earlier. We know in essence that the aging suffer most from Merton's concept of the "self fulfilling prophecy." We as a society tend to isolate the elderly and not treat them the way we do other facets of society. It is the last period of segregation in life for our fellow Americans. As we isolate and as we treat them this way, we then watch how many of the pathological influences we believe to be there emerge. If the older individual is to be a creative, active personality in his old age, he must maintain an affective personal relationship with his environment and must adapt to the danger within himself.[3]

"Basic personality significantly determines the individual's style of adjustment to aging. Those who grow old successfully do so in different ways. Some find happiness in remaining active: others like to take it easy. There is no single formula for successful aging; each individual must find the formula that best fits his need."[4]

Adequate adjustment of the elderly is largely determined by the strengths and weaknesses acquired in earlier life. The aged person is nothing more or less than he/she was in any other life cycle period except that this is his/her last life-cycle period. One of the problems in the recognition that it is the last period is that it creates a societal mystique to which we all tend to react in one or another way. The thinking of Doctors Thomas Szasz and R.D. Laing among others, who have spoken in general about mental illness as a societal definitional problem, should be adapted to the overall category of the elderly and their societal perceptions thereof. Society has thus a definitional problem with the elderly. Does "oldness" represent a pathological stream hitting 10% of the population of the United States?

To achieve the development of a client-oriented social service system, one must look at this very question. There are three basic models within which the helping professionals seek to work. The first is the medical model which states that the cause of illness may be found within the patient himself. Therefore, the removal of the illness can be achieved by destroying the source within the sick patient. The growth model says that behavioral change can occur through process and process is represented by transactions with other people. It states that illness is believed to be an inappropriate communicative responsive to a dysfunctional system or context. Therefore illness goes away when the individual is removed from the maladaptive system or the system itself is changed to permit healthy responses and communications. Growth occurs where the system permits it. A third model occasionally used is the sin model which suggests that something is wrong with the patient's thinking, values and attitudes — of values. It is a system in which the therapist has the "right" answers.

[3] Clark Tibbets, (ed.), *Handbook of Aging and the Individual,* Chicago, 1960.

[4] Suzanne Reichard, "Personality and Adjustment to Aging," *Social and Psychological Aspects of Aging,* Proceedings of the Fifth Congress of the International Association of Gerontology, New York, 1960, p. 669.

Any approach toward developing a system of services must be based on the designer's beliefs about the cause and cure of the "illness." It is this writer's first contention that the model must be related to the growth of the individual and the essential search for personal fulfillment. To demonstrate this, this writer believes the basic premise that the elderly can achieve personal fulfillment. He maintains that the works of Adler, Maslow, Shostrom and others regarding self-actualizing processes may be as readily available to the aged as it is to anyone else in any other life cycle.

> Self-actualization does not mean a transcendence of all human problems. Conflict, anxiety, frustration, sadness, hurt, and guilt can all be found in healthy human beings. In general, the movement, with increasing maturity, is from neurotic pseudo-problems, inherent in the nature of man (even at his best) living in a particular kind of world. Even though he is not neurotic he may be troubled by real desirable and necessary guilt rather than neurotic guilt (which isn't desirable or necessary), by an intrinsic conscience (rather than the Freudian superego). Even though he has transcended the problems of becoming (self-actualized), there remains the problem of Being. To be untroubled when one *should* be troubled can be a sign of sickness. Sometimes, smug people have to be scared "into their wits." (italics added)[5]

The main thrust for the elderly should be to gain attention, respect, and some restitution of self-esteem. Dr. Stanley H. Cath stated, "that isolated living without the stimulating input of meaningful and repeated human interaction results in psychologically regressive and physiologically degenerative processes. Failure to restore meaningful object relationships is often followed by ego disorganization, with loosening of the chain of retrospective thought and fantasy. Connections to the present seem lost."[6]

As Kierkegaard stated, "To venture causes anxiety, but not to venture is to lose one's self.... And to venture in the highest sense is precisely to become conscious of one's self."

To engage in rational social planning for the elderly, one must first attempt to develop a total needs assessment of the elderly population in terms of the definitions presented. Second, a social service delivery system for this population must utilize client-oriented, on-call services designed for meeting those specific needs outlined in the assessment. The rationale for such a study is simple. While numerous writers have developed materials relating to the dynamics of aging, the needs of aging, and programs for the aging, little work has been done in the way of integrating the material in order to provide a specific community with a blueprint for a comprehensive service system for the elderly.

The obvious concentration of planning efforts must be for the 95 percent of the elderly population that does not require institutionalization. These persons must be able to receive services aimed at assuring their personal self-fulfillment. Many of such services are of a concrete nature aimed at relieving the client of burdensome physical difficulties. These would include homemakers, housekeepers, companions, etc. Others seek to ward off potential isolation when physical mobility is limited. Friendly visitors, telephone reassurance programs illustrate same. Leisure-time activities are critical in the planning for the elderly. Activities centers, social, recreational and vocational programs are badly needed. Libraries, friendship corners,

[5] Abraham H. Maslow, *Toward A Psychology of Being*, New York, 1968, p. 210.

[6] Stanley H. Cath, "Some Dynamics of the Middle and Later Years," *Smith College Studies In Social Work*, Vol. XXXIII, Nov. 1963.

and other "gathering spots" are indicated. Opportunities for personal counseling must be available. One forgets the severity of personal and family problems faced by the elderly. Grief from numerous losses of spouse, siblings, and often children, tends to facilitate degenerating processes. Often these emotional factors begin a final downward whirlpool in which the physical and the psychological synergistically interact toward severe pathology. Furthermore, counseling agencies are increasingly finding elderly people seeking their services to prevent separation and divorce of long term marriages, alienation from families, and adjustment to life cycle changes.

"A person who is actualizing trusts his feelings, communicates his needs and preferences, admits to desires and misbehavior, enjoys a worthy foe, offers real help when needed, and is, among other things, honestly and constructively aggressive."[7] "While a mere one percent of mankind has been selected as fully self-actualized by Maslow's estimate, it should encourage the rest of us to note that an ever-increasing number ... today can become self-actualizing — can be *on the way*, even though they haven't arrived."[8] (italics added)

Careful consideration of physical factors such as architectural barriers is essential in all planning. Sophisticated communities are able to plan housing for their elderly which builds in all of the above. The work of the Jewish Association for Services to the Aged of New York illustrates this potentially critical variable.

Planning for the future is the only way of changing the conditions of old age for the better. It must include the formation of goals.

[7] Everett Shostrom, *Man The Manipulator*, New York 1967, Page XII.

[8] *Ibid.*, p. 23.

Traditionally, planning for the aged has been on a short range basis: involving a variety of piecemeal techniques. However, this pattern must change as we begin to recognize the explosiveness of demographic projections such as within twenty-five years, one in four of our population will be aged. Albeit, certain limitations of planning are inevitable. The design cannot relate to national income maintenance program such as Social Security. Yet this very program has tremendous relevance in the nature of achieving personal self-fulfillment. For example, the Social Security benefit for a married couple, regardless of the couple's level within the benefit system, is considerably less than the sum of the benefits received by the man and the woman if not locked in matrimony. Consequently, we find an increasing number of elderly people who wish to be married, avoiding legal marriage because of the economic disincentive provided in the Social Security system. This enormous taxing of marriage results in aging people cohabitating: a lifestyle running counter to the mores with which they've grown over many decades. Considerable pain and suffering occurs in the decision to cohabitate by an elderly couple. Familial and society pressures create a burden totally caused by a short-sighted legal definition related to economic benefits.

An example serving to summarize the basic benchmark upon which the social service delivery system may be developed, relates to changing pathological concepts. Historically, when a child or adolescent engaged in serious acting-out or dysfunctional behavior, the human services were quick to find psychological and sociological labels. In the past five years, increased sophistication in neurological testing has resulted in a new awareness of the affect of brain damage and other physiological pathology on this dysfunction. In the

gerontological field exactly the opposite is occurring. Prior concepts of dysfunctional behavior in the aged were related to lay terms such as senility and belief in major physiological brain and central nervous system disorder. Just as with the children, we are finding that our prophecies were self-fulfilling. Much of the dysfunction in the aged is psychological and sociological, and often reversible. This reversibility is the essence for which a client-oriented social service system must be designed. "Looked at realistically, then, and with the stereotypes dispelled, aging is not a leveler of individual differences. For most people it brings no sudden and drastic transformation of personality. This being so, aging will not separate the individual's present from his future self. Just as every person changes as he grows up, he will continue to change as he grows old."[9]

"There can be no doubt that man is most likely to endure by becoming more and more individualized; freedom to think and act as an individual is still one of the best ways of postponing the onset of incurable senility."[10]

Perhaps the Recommendation XII of the Section on Planning of the 1971 White House Conference on Aging states it best: "in the final analysis, planning on behalf of aging stems from the basic values of society. Those values are translated into goals, objectives, and priorities. As planning for aging proceeds, it will be necessary to address these values and priorities. In planning the allocation of resources, we urge the aging receive a fair share of national wealth. This should be accomplished through a re-ordering of priorities at all levels to increase the commitment of national resource to meet human needs."[11]

Grow old along with me!
The best is yet to be,
The last of life, for which the
first was made,
Our times are in His hand.[12]

[9] Bernice L. Neugarten, "Grow Old With Me! The Best Is Yet To Be," *Psychology Today,* December 1973, page 81.

[10] Jacques Guillerme, "Longevity" as quoted in Burnside, Irene Mortenson, *Psychosocial Nursing Care of the Aged,* New York, 1973. Page XII.

[11] *Toward A National Policy On Aging, Final Report,* Volume 2, 1971 White House Conference on Aging, Washington, D.C. 1972, Page 90.

[12] Robert Browning, *Rabbi Ben Ezra,* 1864, St. 1.