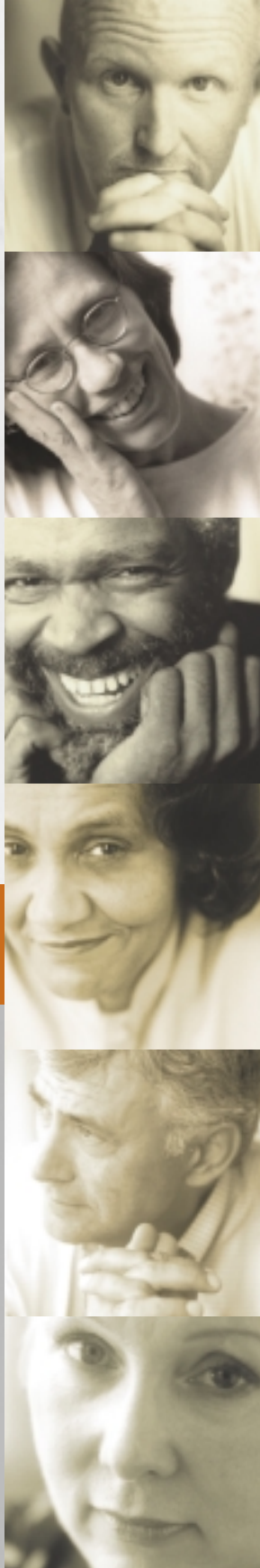
Counselling Older People

Ann Orbach



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SAGE Publications
London • Thousand Oaks • New Delhi

First published 2003

SAGE Publications Ltd
6 Bonhill Street
London EC2A 4PU

SAGE Publications Inc.
2455 Teller Road
Thousand Oaks, California 91320

SAGE Publications India Pvt Ltd
B-42, Panchsheel Enclave
Post Box 4109
New Delhi 100 017

British Library Cataloguing in Publication data

A catalogue record for this book is available from the British Library

ISBN 0 7619 6405 3
ISBN 0 7619 6406 1 (pbk)

Library of Congress Control Number: 2003102952

Typeset by C&M Digitals (P) Ltd., Chennai, India
Printed and bound in Great Britain by Athenaeum Press, Gateshead

‘Old age hath yet his honour and his toil’
Tennyson

Contents

Introduction

My interest in working with older people began quite by chance, when I was in my 50s and a colleague asked me if I would see an 'old lady' of 79. I never thought of refusing though I was full of doubts, having assumed that people of her age could not benefit from what I had to offer. Up till then my clients had all been middle-aged or young, many of them students. I see now that I had been imbued, quite unknowingly, with most of the ageist attitudes that I vehemently attack in this book. But there was also humility. How could I hope to help people of my parents' generation, whose experiences of the world and of themselves were so far ahead of mine?

During our first session, my client and I were both equally nervous. She sat on the edge of her chair and looked up at me expectantly. I felt as though I was with a shy schoolgirl, eager to learn. Very soon, as we began to feel at home with each other, we seemed to become ageless, and the sessions timeless. She was looking for a mother-figure, and we were neither of us surprised by this reversal of roles. We worked together for several years. There was no reason to limit the time, and, although I have since then taken on people for an agreed shorter period, I will always be grateful to that first older client for all she taught me, and all that both of us were able to explore about growing old.

It has been my involvement since 1996 in founding SAGE (Senior Age) Counselling Service in my locality that has heightened my interest and expanded my experience in working with this age group. The original idea was not mine but I found myself called on to implement it, and the opportunity arose when I was asked to run a workshop at a Diocesan Conference on Old Age and Death. A group of counsellors attended and this included at least two who had already done some work counselling older people. One of these, Chrystabelle Brotherton, has given me permission to publish the case history which you will find in Chapter 3 of this book. After the conference, a group of us started meeting to discuss the idea and, the following autumn, SAGE was launched. It took a long time getting off the ground, and longer still for people to believe in it as a viable project, but we have made ourselves known through various forms of publicity and twice-yearly study days, and last year we achieved charitable status. So the work goes ahead and we learn from each other, both in a counselling and supervisory capacity.

You will find, in reading what follows, that I use the words counselling and psychotherapy more or less interchangeably. When, more than ten years ago, I used to tutor students at Chichester Counselling Services, I would have seen a gap between the two. Counselling training in those

days was squeezed into two years, and I had to fit the psychodynamic input into year two and also include seminars on transactional analysis (TA), gestalt and sex therapy, given by invited seminar leaders. These days, with the enormous growth of trainings, many of them up to degree standard, counselling is a profession in its own right. Although some of my former students have subsequently trained as psychotherapists, this is no longer seen as a necessary progression to superior status. In a publication on counselling and psychotherapy in primary health care, the authors state:

> The task of differentiating between counselling and psychotherapy is almost impossible, given the many different meanings that are attributed to both terms, as well as the overlap between them … Struggling to make distinctions in meaning between terms takes us into stormy waters, where the rivalries and status positions among different training organisations can seriously interfere with clarity of thinking. (Wiener and Sher, 1993: xxiii)

The case histories I have included, though based on real people, with real people's problems, have, for the sake of confidentiality, been so radically altered as to make them fictitious. There are two exceptions, as shown clearly in the text, where counsellors have offered me exact scripts of their counsellor/client interactions.

It has been easier to find a group of counsellors to form a specialised service such as SAGE than I imagine it would have been to choose a group of psychotherapists. My impression is that counsellors tend to be more pragmatic in how they are prepared to work, and generally more eclectic in using the various models they have learnt, in order to suit particular client needs. Humanistic and psychodynamic counsellors work well together in discussing client problems, enriching each other and also the supervisor. I hope some of their easy eclecticism comes over in the text of this book. I hope also that what I have written may prove helpful to any counsellors and counselling students who are interested in exploring what it is like to be old and how we can creatively be of help to people who have lived much longer than ourselves.

My aim is to expand the counselling field by including the whole spectrum of human development from youth to old age and showing that it is never too late for growth and change. This is borne out by experience as I illustrate in the following chapters. I explore some of the assumptions that have, in the past, written off the over 60s as unsuitable clients, and the generalisations that continue to work against accepting them as still developing individuals with specific problems. I go on to discuss suitable counsellors and whether their ways of working will need adjustment to address an older person's needs. There is a chapter on relationships and on sex in later life. Another chapter discusses the problems of older people from ethnic minorities, those who are disabled and those who are gay. I look at the importance of older people's life stories and how we can help make sense of them. How people cope with loss will be found to overshadow each chapter, particularly loss through retirement, bereavement, disability and the approach of death. Suggestions for reflection and discussion are included at the end of each chapter.

The book may be of interest to anyone caring for older people, both professionally and in a family context, but it is particularly aimed at counsellors and student counsellors, who are interested in exploring what it is like to be old and how we can creatively be of help to people who have lived longer than ourselves.

My background is analytical psychotherapy. I qualified with the Guild of Psychotherapists in the 1970s, having studied Freud, Jung and object relations theory – all psychodynamic – with a smattering of existentialism thrown in. Probably this early bias still shows in my writing, even though, for many years, I have supervised therapists and counsellors from humanistic and integrative backgrounds.

I would like to dedicate this book to past and present members of SAGE Counselling Service.

1
Age Affirmative Practice

How can counsellors develop a positive approach to older clients in an age-unfriendly world? In this chapter, I shall attempt to answer that question.

We need to challenge ageism in all its forms, not least that which has been internalised by the people whom we are hoping to affirm. We need to help our clients in distingishing between problems which have been projected on to them by younger people's expectations and those that are intrinsic to the stages of development they are passing through. Counselling is not about control but empowerment. A weakened body does not necessarily mean a weakened mind, and our treatment will only be affirmative if we are able to show respect for our clients as having survived a century of extraordinarily fast change, and as having gained enough wisdom to promote a balance of power between themselves and us. We need to be open and humble enough to learn from them as much as they can learn from us.

Living longer

Our population is ageing at an unprecedented pace. 'By the year 2030, if the gerontologist, Tom Kirkwood is right, there will be 35,000 people in this country over the age of 100' (Vaughan, 2002). The Government Actuary's Department (GAD) is cautious in its predictions but highlights the fact that the ratio of old to young is undergoing considerable change:

> … in 1998 there were nearly 1.4 million (13 per cent) more children under 16 than people of pensionable age. However by 2008 the population of pensionable age is projected to exceed the number of children. (GAD, 1998)

Longer-term predictions suggest that the number of people over pensionable age will peak at 16 million by 2040. We are also moving later into middle age, which has traditionally been estimated as about 36 (with or without a mid-life crisis) but projected to rise to 41 by 2021 and reach a stable 44 in about 40 years time.

Individuals age at different rates and it would be senseless to lump all pensioners together and write them off as old. There are two generations spanning the time between retirement and death – 30 years from 60 to 90. The terms 'young old' and 'old old' are useful in describing two different stages of the ageing process, though I prefer not to designate a particular

age at which people pass into old old-age. We often meet people who are old at 40 and others in their 80s and 90s with continuing youthful attitudes.

Discrimination

Although we live in a society where considerable attention is being paid to human rights and the removal of restrictive labels, it seems that we still inhabit a prejudiced environment.

Research by Age Concern uncovered evidence of age discrimination at all levels of the NHS. A Gallup poll in 1999 showed that 1 in 20 people over 65 had been refused treatment, while 1 in 10 had been treated differently after the age of 50. This included 40 per cent of coronary care units attaching age restrictions to the use of clot-bursting drug therapy, the refusal of kidney dialysis or transplants to 66 per cent of kidney patients aged 70–79 and no invitations to breast screening for women of 65 and over. There were also delays in hip replacements, the withdrawal of chiropody services and inappropriate use of anti-psychotic drugs in care homes. Despite government asurances of equal treatment, the evidence from patients and their relatives showed that discrimination was widespread and, in many cases, hospitals were failing to provide essential care. Although many patients in the survey spoke when invited to, others suffered in silence. 'Many people of my generation see doctors as gods and would never contradict them. Or they're frightened' (Gilchrist, 1999: 3). Old people come to feel that they are expendable. Treatments that are available to younger patients are withheld because of shorter life expectancy. Decisions are made on the basis of productivity. Whereas the young have something to contribute to society, the old are seen as a burden and a drain.

Things have had to go from bad to worse before a turning point could be hoped for. An 88 year-old, rushed to hospital after a stroke, was left on a trolley in a corridor for several hours, then moved to a mixed ward and eventually to a geriatric ward, where her relatives found her in much distress, lying in her own faeces. The stroke had taken away her voice, so she had no way of complaining except by writing notes which no one read. 'What she didn't know was that doctors had written "Do not resuscitate" on her file' (*The Observer*, 1/4/2001). This was not unusual, but the fate of many like her. When *The Observer* published details of her case, there was a response from hundreds of readers with stories of their elderly relatives receiving similar treatment. What followed was the 'Dignity of the Ward' campaign and a pledge by the Government to end ageism in hospitals. The NHS is now committed to providing care 'regardless of age and on the basis of clinical need alone'. This is a welcome step in the right direction but:

> Many specialists now believe ageism is so entrenched that it will take more than a blueprint, however radical, and a set of targets, however ambitious to transform the culture of a lack of respect for the elderly. (Ibid.)

The word 'ageism' is comparatively new (Butler, 1975) but the prejudice has earlier roots and seems to be a phenomenon of Western culture, with its emphasis on a person's usefulness and productivity. Here, in the West, we have all but lost sight of some of the spiritual values that still hold sway in less materialistic cultures. Those psychologists concerned with studying human development might benefit from the insights of Confucian philosophy in which each stage of life has meaning.

> At 40, I was free from doubt. At 50, I understood the laws of Heaven. At 60, my ear was docile. At 70, I could follow the desire of my heart without transgressing the right. (Soothill, 1910 quoted in Featherstone and Wernick, 1985: 149–50)

The following quote looks like a caricature, yet contains some uncomfortable grains of truth about how the young look at the old.

> He or she is white-haired, inactive, unemployed, making no demands on anyone, docile in putting up with loneliness, rip-offs of every kind and boredom, and able to live on a pittance. He or she … is slightly deficient in intellect and tiresome to talk to … asexual, because old people are incapable of sexual activity, and it is unseemly if they are not. He or she is unemployable because old age is second childhood and everyone knows that the old make a mess of simple work. Some credit points can be gained by meeting or being nice to these subhuman individuals, but most of them prefer their own company and the company of other aged unfortunates. Their main occupations are religion, grumbling, reminiscing and attending the funerals of friends. (Comfort, 1977: 2)

Ageism associates growing old with unstoppable physical decline, and views any evidence of vitality in older people as exceptional rather than the norm. Not only joints and muscles, but also mental capacities, are expected to fail. Old people's pain tends to be treated with palliative drugs instead of probing for causes, while those who suffer from depression are given anti-depressants and are unlikely to be referred for counselling.

Individuals working with old people may have consciously overcome their own prejudices but are likely to be affected by those of the organisations for which they work, where ageism may be endemic within the general ethos of the care-giving work-place, often without any of those concerned being aware that this is so. Ageism, as already mentioned, seems to pervade the NHS, not only in medical treatments but also in the way old people are nursed and spoken to. Being hard of hearing or in shock is too often interpreted as senility. 'You mean your mother isn't senile', said a young doctor to the daughter of a 90 year-old, who had been trying for some time to protect her mother from humiliation. 'You never bothered to find out', was the reply. In homes for old people, whether NHS or private, dependency is too often taken for granted, and efforts on the part of residents to hold on to their self-respect are seen as stubborn or 'naughty'. The carers tend to be brisk and lack the patience to watch people slowly doing tasks for themselves which could be more quickly got through by those in charge.