

Love in the Time of Old Age

By Dr. Sarah Egger

Love is a fundamental aspect of spirituality. There is so much one could say about Spirituality and Ageing and indeed, so much one could say about love. Where to begin? Most health settings now have guidelines for whole person care in which spiritual needs are acknowledged. However these are focused in specific ways for older people.

Spirituality

I will start with two definitions of spirituality to put the work done in old age psychiatry into context.

One brief but pithy definition is, *'The rediscovery of lost humanity'*.

The American National Interfaith Coalition on Ageing describes it as an *'affirmation of life in relationship with God, self, community and environment that nurtures and celebrates wholeness'*.

Values, relationships and the discovery of meaning and purpose in life - all these intangibles are of vital importance to us as human beings. This is what Spirituality is to do with.

Love

As healthcare professionals we may feel uncomfortable with the word, or the idea of, love. Maybe we feel easier describing 'love in action' - in other words, the effect of love in the kind of work we do – care, compassion, consideration, kindness, mercy, empathy and sympathy.

I have in the past been moved and inspired by the writings of Stephanie Dowrick (2000) and I would like to précis a passage from her book *'The Universal Heart'*.

'It's clear that at the beginning of a human life and again at the end, love - expressed through delight, gratitude, constancy, interest, good humour, kindness - is what matters most to us. The absence of love is something that countless people experience on a daily basis. They may call it loneliness, isolation, dissatisfaction or emptiness. Often they have become strangers to love and strangers to themselves. Love joins us to others - we need that - the longing to care for others and be cared for is fundamental to our shared human nature. We are social beings, using our relationships throughout our lives to find out not only what we are capable of giving, but also to discover whom we are; what makes sense to us, what insight we can achieve, what kind of life we are in the process of creating. Love connects us and inspires us. Our well being as a society depends absolutely on whether we, as individuals, are willing to care about how life is for other people. A safe society is one where trust exists and concern for others is readily expressed. If we are cut off from our capacity to give and receive love, we go beyond loneliness, we become dangerous to others as well as ourselves. A life worth living is a life of love. And anything worth discovering about love will deepen not just one but every one of our relationships. Just as crucially, though, love joins us to the deepest part of ourselves. It allows us to know that our own life has legitimacy, that from our own inner world we can reach out to give willingly to other people and receive what they can give us.

Another publication that has inspired me is the *'Living Values'* guide from the Brahma Kumaris World Spiritual University (BKSU 1995).

'Love is the principle which creates and sustains human relations with dignity and depth. It's the bedrock for the belief in equality of spirit and personhood. The basis of real love between people is spiritual. To see another as a spiritual being, a soul, is to see the reality of the other. To be conscious of that reality is to have spiritual love; each person, complete from within, independent yet totally interconnected, recognizes that state in the other. Love is not simply a desire, a passion, an intense feeling for one person or object, but a consciousness, which is simultaneously selfless and self-fulfilling. Love can be for one's country, for a cherished aim, for truth, for justice, for people, for nature, for service, and for God. Spiritual love takes one into silence and that silence has the power to unite, guide and free people.'

Love as a Value

In 1994 the British Medical Association held a summit on 'Core values for the medical profession'. The summit called for a re-evaluation, redefinition and restatement of core values, which it defined as 'ancient virtues distilled over time'. Those at the meeting recognised these values - derived from the doctor-patient relationship and based on love, caring and sharing - as the profession's greatest asset, greater even than scientific knowledge and sophisticated technology.

The core values of the medical profession identified by that summit were *caring, compassion, integrity, competence, confidentiality, responsibility, advocacy and the spirit of enquiry.*

McWhinney (1998) writes that responding to suffering is a moral obligation, that compassion is not just conditional upon evidence of its effectiveness. The relationship between doctor and patient is a covenant, an undertaking to do what is needed, beyond the terms of the contract. Sticking with a person through thick and thin is hard work, an act of love - active love, tenacity - a whole science (or a whole art). The healing relationship between practitioner and patient carries strong moral obligations and mutual commitments. McWhinney feels we have forgotten the importance in medicine of *presence* and the continuity of responsibility.

Dr. Kieran Sweeney (2000) maintains that the relief of suffering is central to the responsibility with which we are entrusted. He believes trust and self-discipline are vital to this. Trust in others is one of the central human solutions to the unbearable uncertainty of being ill, and, indeed, for some the unbearable uncertainty of existence. Self-discipline implies a degree of self-knowledge. This helps us to recognise what the patient is experiencing and to have insight into the meaning of that experience for them as unique individuals.

Challenges of Old Age

As night follows day, so old age brings change and loss and with it dependency, isolation, loneliness and depression. But it can also be a time of great spiritual growth and awareness and for some, a celebration of wisdom borne of experience. People of all ages share basic human needs; love, faith, hope, peace and worship. Older people are no different and certainly these needs can take on a particular poignancy in old age.

It is normal to view old age with some apprehension. The depletions of ageing multiply with the loss of role, bereavement and domicile. Undoubtedly they have an impact on 'personhood' in ways that we can but barely imagine when we are younger - our self-image and identity slowly drain away and ultimately we face death. Our society tends to be ageist and marginalizes older people, making them feel a burden. In western culture there is such an emphasis on achievement and the work ethic that there simply isn't the appreciation of wisdom of old age as an essential and significant ingredient of society. It would appear that in eastern societies it is more customary to respect and honour one's elders.

Yet, as the pastoral director of Methodist Homes for the Aged, Jewel (1999) reminds us, in the book *Spirituality and Ageing*, this is a time when the elderly have a real need for the affirmation of their continuing value as unique and socially connected human beings and their wisdom as a resource for others.

I recall here Erickson's eighth stage of psychosocial development – Integrity versus Despair (1982). According to Martindale (1998), integrity in old age is the capacity to assimilate (integrate) the value of one's full life experience, to be and to continue to be - through having been - able to hold onto the worthwhile aspects of one's life. These include conscious and unconscious memories of having been valued and loved. It implies being sufficiently free of persecutory guilt as a result of having been able to love.

Facing death also shapes the spirituality of many older people. The unfinished business of human relationships and the need to become reconciled with significant others becomes a high priority; the deepest desire is to die at peace. To try to heal painful memories and perhaps even the basic need to be at one with God (whom, or whatever, he, she or it might be) as death approaches is a legitimate focus. Towards the end of life there is the search for integration (a sense of wholeness in a spiritual sense), to pull life together and make sense of it as a whole.

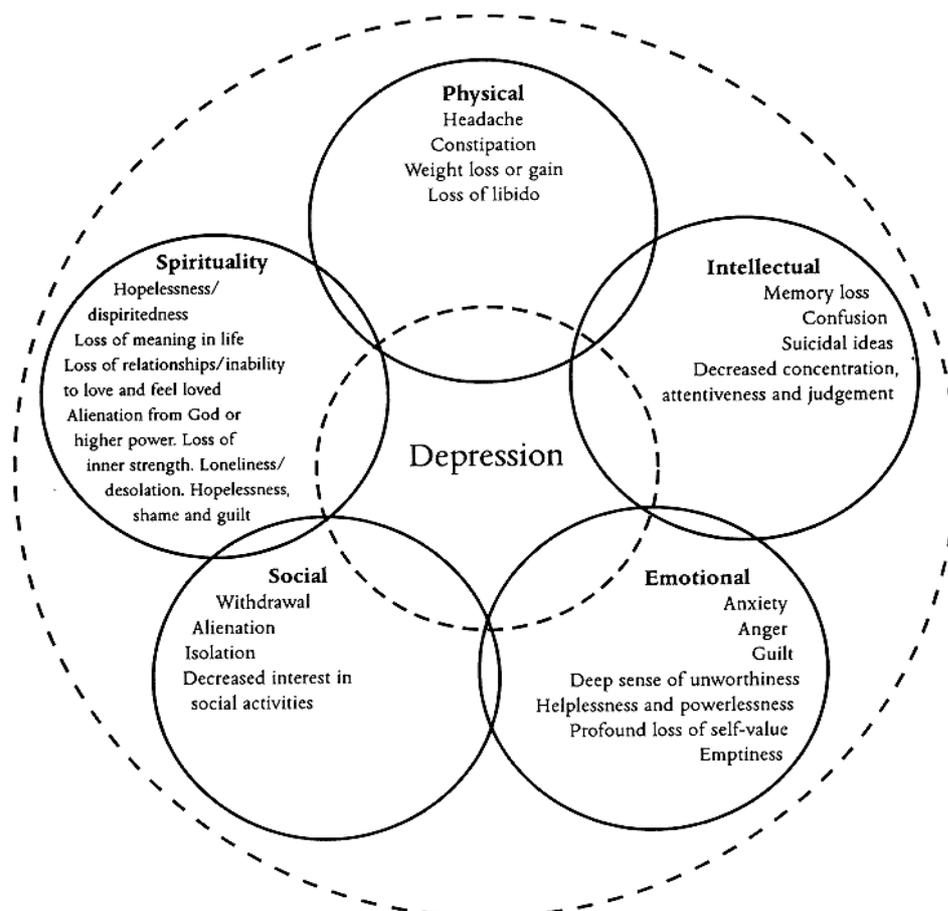
Old Age Psychiatry

In Old Age Psychiatry we deal with much co-morbidity. The elderly with mental health problems often have the triple disadvantage of problems associated with ageing, physical illness and mental ill health - depression, paranoia and dementia.

What of those who have 'turned their face to the wall' and feel there is nothing for them to live for anymore? Is this an illness requiring electro convulsive treatment, or a justifiable response to the end of life?

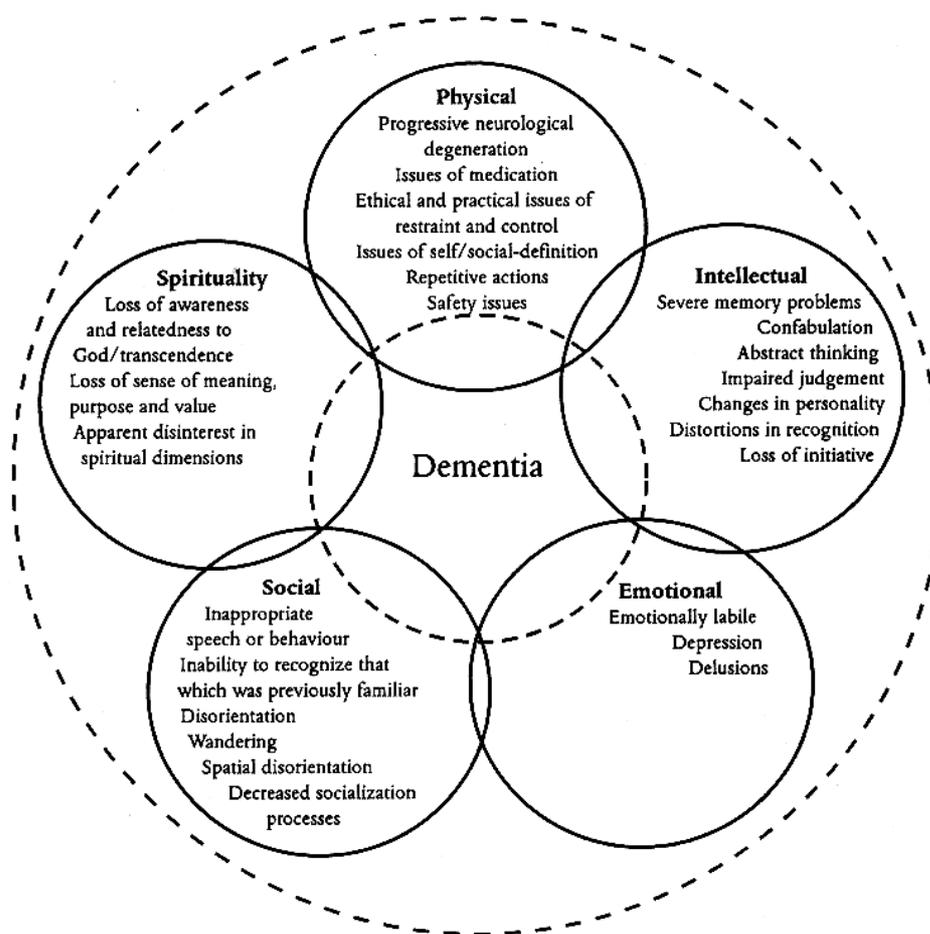
Swinton (2001), in his book *Spirituality and Mental Healthcare*, gives us a holistic model of the major disorders that incorporates spirituality.

'Spirituality and depression' (Swinton page 167).



Swinton describes depression as a profoundly spiritual illness that digs to the heart of a person's spirit and forces people to face experiences of meaninglessness and hopelessness. We know that this can be devastating in its consequences. Swinton believes the spiritual dimension has the potential to reframe experiences and enable people to reinterpret them in ways that are therapeutically helpful. He also believes that dementia provides us with the possibility of reframing from a spiritual perspective.

'Spirituality and dementia' (Swinton page 166)



When we ask the question 'what does it *feel* like to have dementia?' rather than simply 'what *is* dementia?' we begin to see this particular condition in a very different light. Swinton highlights work that has shown clearly the importance of recognising the continuing personhood of people with dementia, even in the midst of neurological degeneration. When viewed from the sufferer's perspective, dementia is found to have hidden psychological and spiritual dimensions that are masked by the dominance of the medico-biological discourse. Focusing on the former offers new possibilities of re-humanisation for people with this illness. Swinton encourages

interventions such as a therapeutic presence that helps to *reconnect* those, who are by definition, becoming *disconnected* from self, others and God.

Certainly we are challenged to find spirituality capable of embracing dementia, a condition in which so much is stripped away that only the essence may seem to remain. This confronts our usual notions of personhood. I was extremely gratified to find that the late Tom Kitwood, a psychologist and leader in dementia care from Bradford, had put love at the centre of his circle of the main psychological needs of people with dementia in his book *Dementia Reconsidered* (Kitwood 1997).

Kitwood also quotes a carer who described persons with dementia as showing 'an undisguised and almost child-like yearning for love'. By love is meant a generous, forgiving and unconditional acceptance, a wholehearted emotional giving without any expectation of direct reward. The presence of dementia, it is suggested, may provoke a psycho-spiritual crisis in carers. *'If we do not deal with our own issues of love, and grief around the failures of love, we cannot live with Alzheimer's disease'*.

How we Love

I know that in our daily practice we reveal aspects of love in a myriad of ways. It is often the kind word, a touch or loving look that has the most significance for the patient. As Martindale describes (1998), we have an 'everlasting connection' with those who may have... nothing. At times we are the *only* human connection our patients have. We become their family, their world and, even immodest though it may sound, their reason to live. The rules of standard psychiatry seem to change, to become more flexible and respond in a humane way to the situations we face. We are there to affirm, validate, acknowledge, listen, witness, to hear confession, to hear their story, to love and allow ourselves to be loved. We help with the tasks of resolution and integration.

I recall a patient who was finding it difficult to come to terms with his loss of skills as a builder and I related the Daoist idea of the increasing value of quiet and reflection in old age. I told him that Daoists regarded it as one of the tasks of old age to sit beside running water and contemplate! He then realised how much time he spent sitting by his fishpond and how much he enjoyed it and was delighted.

We talk about facing death. The disclosure of hitherto well-guarded concerns will only occur if the therapist creates a climate of trust and is non-judgemental. What enables trust and the unspoken to be spoken?

My colleague Dr. Mark Ardern (2001) in his chapter on 'Dynamic psychotherapy in the setting of the old age psychiatry department', states that such therapy is most likely to be supportive. He goes on to describe how a basic premise is that the patient's ego is insufficient to allow personality change and the prospect of insight is limited. One aim of supportive psychotherapy is to locate weaknesses in the patient's defensive structure and bolster these by the therapist's active encouragement. The therapist still constructs a psychodynamic formulation to avoid alienating the patient or precipitating psychiatric illness. Therapists observe the transference and counter-transference but by and large keeps these ideas to themselves.

It is assumed that the major factors in the success of supportive psychotherapy are the therapists' reliability and empathy. As the patient's unconscious preoccupation is with impending dependence, the dependability of the therapist is especially crucial for the elderly. Patients may not need to be seen frequently, but for the internalisation of the good object will have to be sure that the therapist is psychically available. For some patients the therapist may conclude that weaning away is not possible. In these cases the patient's dependence is actively cultivated. The notion of encouraging dependence can seem alien to other branches of psychiatry. In these situations, we also try to foster a dependence on 'the team', so

that a *community* is available, rather than the burden having to be placed on a single individual. Patients can experience a new kind of parenting that provides containment.

In group therapy for older people, they are also able to show concern for each other. In these groups the process of pairing does not have to suggest destructive sub-grouping but can be of self-restorative value. There are also potential benefits in extra - group socialisation and it is often unavoidable. Group psychotherapy with older people is likely to require a greater tolerance of behaviours. In a mature group some patients will act as co-therapists, not necessarily a defensive manoeuvre.

Generally speaking, the emphasis of our work moves from one of change to acceptance. We are co-workers in the task of rearranging the bricks that make up the architecture of character, rather than replacing them.

In his book *Spirituality and Ageing*, Jewell (1999) remarks that we so often hear old people say 'Why don't I die? I don't want to be a burden to others'. He feels we should never allow this to go unanswered as it signifies hopelessness. Instead, he tells old people *'you are never a burden if people love you. Those who do, have the joy and privilege of looking with tenderness, concern and intelligence at someone they love. But in return you must be able to receive graciously and make it as easy as possible for them to love you. If you receive with a cramped heart you are saying 'I would prefer to receive nothing from you but I am a victim''*.

We all depend on one another's love and must learn at all ages how to receive it with gratitude and grace.

All patients are vulnerable, ours especially so. They often can't communicate in the conventional sense, yet really respond to our loving attitude. I don't have to tell you that this is not easy to sustain, day in day out, with the sheer intensity of the work. I continuously see how much love is reflected in work we do in dementia care.

I would like to relate a further passage from Stephanie Dowrick's book 'The Universal Heart' that illustrates this point.

'I was told a quite exceptional story about two people I have observed together on several occasions. The younger man Geoff is profoundly intellectually and physically disabled. He has no speech. His movements are limited and out of control. He is also deaf and blind. The older man Bill is the volunteer, who comes unfailingly each day to see Geoff, to talk to him, hold his hand, share news with him and let him know he is loved. Nothing too remarkable in that you may think. But what about this? When Bill enters the large building where Geoff lives, Geoff starts moving, smiling, and making the noises that are for him the nearest approximation to speech. He cannot hear Bill coming, but through his senses he knows that Bill is in the building, even when Bill is still several rooms away. Geoff is someone whose powers of comprehension would seem to be minimal. Yet the sense that he has of Bill's presence, and the comfort and delight he draws from that, is unfailingly acute.'

This really does demonstrate the mysterious power of love and it's central role in caring. I see this on the wards every day.

The team

A team with high morale and a clear sense of purpose is inherently of benefit to patients. One that is split, and at war with itself, will lead to patients being caught in the middle. Our ability to care depends to a large extent on our own experience of being cared for and valued. As well as being loving practitioners, we need loving institutions. This could also go some way towards protecting patients from practitioners acting out their own needs in the healthcare setting, for instance, the need for power, control, to be liked, wanted and cared for. These needs can be more healthily contained in an atmosphere of good staff support.

We need to care for and love each other. A very touching experience for me in our unit was after the death of a staff member's young child. The staff group held a

spiritual service where each contributed a ritual and spoke to support the mother and acknowledge their own grief.

It may be easy to talk about love but a relevant question for all of us is how to be compassionate in caring for our patients without personally becoming emotionally drained, compassion-fatigued or 'burned-out'. By burnout, I mean a state of physical, emotional and mental exhaustion caused by long-term involvement in situations that are emotionally demanding.

Learning to be compassionate without suffering burnout is a skill. Compassion is something that we all innately possess, yet we need to practise and refine its use. It is learning to be alongside patients in their suffering by seeing them as souls like ourselves and yet at the same time not to identify personally with all their physical, mental and emotional issues. It is remaining emotionally detached from patients, yet keeping a spiritual, loving connection.

Finally, we can only be compassionate towards others if we have the same compassion towards ourselves. This means nourishing ourselves at all levels, physical, mental and spiritual. How do we do this - how can we allow compassion to flow in from others, and from the universe, to replenish ourselves from a spiritual filling station, as it were? How can we tap into a source of love and mercy and keep ourselves topped up? Surely this is what spiritual practices offer, such as prayer, devotion, meditation and contemplation.

What patients say

A patient told me 'Love from you means not to be shunned, that you listen to me, I'm not cut off, that you are concerned about me and kind - it may even be physical, such as touching me on the arm in a reassuring way, or holding me in your mind.'

I've come to realise many aspects of love through my own work running a support group for people in the early stages of dementia. When asked whether patients in the group ever think about God, their quick replies reveal their preoccupations. 'What I want to know,' asks one, 'is not whether we think about God but does God think about us?' Another patient said, 'No one asks you how you are going to prepare to meet your God'.

In groups we have the privilege of hearing the anxieties and frustrations of older people that would not normally be discussed in a social setting. Some of our patients in the day hospital requested that we acknowledge the passing on of some of the patients. We assisted them in their own plan of having a small service on All Souls Day, having a book of condolences and a bench in the day hospital garden to commemorate those that had passed on. It was not just a memorial to those departed or reassurance that they too would be remembered when their turn came. This acknowledgement of their spiritual needs was also an act of love.

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Discussion on Love in the Time of Old Age. Reported by Dr. Daphne Wallace

It was voiced that there is a danger of 'compassion burnout' and the need for refreshment for the self, which may be through various means including prayer or meditation. It was suggested that in Old Age Psychiatry we are privileged to be able to respond to neediness and dependency. It was noted, however, that recruitment into work with older people is not good, especially in nursing. Possibly the professionalisation of nursing has made the situation worse by increasing the distance between nurse and patient.

In the discussion that followed, the assessment of spiritual needs was discussed at length with reference to the work of Michael King and to the Handbook of Religion and Health, edited by Koenig, Larsson and McCulloch. It was suggested that measurement scales were useful, as a door opener to introducing spiritual needs into mental health curricula. It is hard to offer love when faced with rejection and criticism, not least from colleagues. In particular, there is the danger of collusion with the patient's view of self as a failure with nothing to give. Each person has it in them to love but we find that difficult to communicate. Equally, it's important not to feel guilty at what we can't do.