PART I

Context

Older People and Society

> From the available evidence, old age would appear to be a stigmatized social identity. Even those who are chronologically old may disassociate themselves from 'old age'. (Pilcher, 1995: 102)

This chapter focuses on the place of older people in British society. Any capable social worker must understand the nature of ageing in order to work successfully with this group of people. This implies an understanding of the physical, biological and psychological manifestations of the ageing process; however, it also requires a grasp of two elements that are perhaps less well understood, as the experience of living as an older person cannot be fully comprehended by reference to the above three factors alone. The first of these is the political, social and cultural status of older people in contemporary society. As we will see later in this chapter, there are a number of ways in which older people are perceived as problematic, and a range of reasons that have been advanced to explain this. The chapter will argue that the theory of 'ageism' (Bytheway, 1995) can help to explain how many views that are prejudicial to the well-being of older people are perpetuated within society. The second are the subjective experiences of older people – what Thompson (1998) has termed the 'ontology' of ageing. As Biggs (1993) has explained, we cannot reach an understanding of subjective experiences of ageing if we are incapable of penetrating the inner lives of people who have become old. In addition, we need to understand how the impact of structural and cultural factors can create individual problems and difficulties for older people. The chapter will argue that an effective social work practice with older people cannot be developed unless we first understand the way in which all of the above factors can combine to affect an individual older person and her/his life.

The need to examine social work with older people will be made more pressing by demographic changes in the twenty-first century. For example, there will be an increase in the numbers of older people, both in absolute terms and as a proportion of the overall population (Shaw, 2004). There will also be a higher proportion of people categorised as dependent – both children and older people – within the

population. However, the 'dependency ratio' – the proportion of people defined as economically unproductive and hence 'dependent' expressed as a proportion of those of working age in society – is likely still to remain within the boundaries that had been considered normal through the twentieth century (Tinker, 1997). It is interesting that the increase in longevity which characterises modern British society is not treated as 'one of the great successes of modern times' (Wilson, 2001: 1). Instead, there has been a focus on the problems that this could create in terms of the increased burden on the rest of society, particularly health and social care services. A crude determinism dominates the debate, where the subtleties of demographic change are underestimated or simply ignored (Pilcher, 1995). While it is clear that there will be a gradual increase in the numbers of older people requiring some level of support and assistance from health and social care services into the middle of the twenty-first century, the increased amount of need may well not reach the levels that some have forecast. In addition, no account is taken of the positive contributions that older people make to society in a range of different ways (Wilson, 2001). However, on the basis of current knowledge, it is reasonable to assume that social work services for older people will be even more required in the future than they are at present.

The chapter commences with an analysis of the nature of ageism, as it is a concept that informs the rest of the content of both the chapter and the overall book. It then considers the various ways in which ageing can be understood, moving from individual to structural considerations. Having surveyed the subject in broad terms, the chapter then summarises the range of needs that all older people experience, before considering the specific circumstances that are liable to require the assistance of a social worker. The chapter emphasises that only a minority of older people will require this level of support. This is an important corrective to the tendency of professionals to fix their understanding of ageing on the examples of the most disadvantaged and distressed people as if they represent the totality of the ageing experience (Biggs, 1993). In conclusion, the chapter notes the deficits of current services in responding to need, setting up links between this chapter and the remainder of the book.

A word on terminology is important here. Over time, the language that refers to older people has undergone a gradual transformation. For example, the phrase 'the elderly' was used in health and social care for many years in an unreflective way, without consideration of the fact that it depersonalised the people to whom it referred. As a result, an alternative conception was long overdue – but agreeing what such a term might be was problematic, given the contested nature of language. In many ways, the changes in terminology reflect a similar shift that has occurred in relation to other groups, notably people with physical or learning disabilities. While it is in the nature of language to have a certain measure of elasticity, these changes came about largely because the terminology deployed by professionals was challenged by the people to whom it referred. This has

encouraged a greater degree of caution about language, and a wider understanding about the impact of previously unchallenged constructions. As a result, in line with most authors in the social work/social policy field, I have fixed on the term 'older people' as being the most accepted current usage. For example, two standard texts in this area (Marshall and Dixon, 1996; Tinker, 1997) have changed their titles as successive editions have been produced, both (currently) deploying the phrase 'older people' that is suggested here. The use of 'older people' may well prove unacceptable in future, reflecting the continuing growth of language; however, it seems sensible to deploy similar terminology to that which is most current both in academic and practice circles.

AGEISM

Ageism has been simply defined as the unwarranted application of stereotypes to older people (Bytheway, 1995). In the way it is used in this book it is different from a more generalised form of age-related discrimination, which could affect people at all ages. The distinctive quality of ageism, in British and other western societies at least, is that it is a process whereby older people are systematically disadvantaged by the place that they occupy within society. Thompson (1995) has argued that the discrimination faced by older people can be manifested at three levels, the 'structural', 'cultural' and 'personal' (Thompson, 1995; see also Thompson, 2001, for a more general application of this analysis).

While this position does have considerable analytical clarity, it fails to engage satisfactorily with the fact that these levels are interconnected in terms of an individual's actual lived experience. For example, the way in which an older person could be treated when raising a question about her/his pension may easily contain aspects of all three of Thompson's levels. The way in which the pensions system operates is part of the overall 'structural' oppression of older people; the fact that their demands for a decent standard of living are seen as representing a burden on the state is indicative of the way in which the presence of older people is seen as problematic. The idea that we are living with a 'demographic time bomb', further explored below, is an example of an ageist construction of older people, as it completely ignores the positive contribution that older people can make within society in favour of seeing them as creating a forthcoming crisis (Pilcher, 1995; Wilson, 2001) through their continued existence. At the 'cultural' level the people charged with responding to the individual's question may carry stereotypes about older people that inform the way in which they act. If the stereotype is that older people become unable to deal with relatively simple matters, the behaviour at the 'personal' level is likely to be patronising; if a contrasting stereotype is held that older people are awkward and cranky, the behaviour might shift to be more defensive and obstructive. In such a case, the three levels at which ageism might be manifest continually reinforce each other and can become indistinguishable in practice.

The following bullet points give an indication of the more common and insidious ways in which ageism can be made manifest, with particular reference to the provision of health and social care services.

- *In the policies of government, both at national and local levels*. As an example of this, it has been argued (Grimley Evans and Tallis, 2001) that the *National Service Framework for Older People* is inherently ageist because it works on the assumption that older people do not merit expensive hospital care. (This is particularly ironic given that the reduction of age-related discrimination is a key aim of the framework!) Similarly, given that the primary motivation for community care was to curb the social security budget (Lewis and Glennerster, 1996; see also Chapter 3), this can be seen as a policy constructed on the ageist basis that cost considerations have precedence over the quality of lives of older people, the majority of people affected by the policy. At the local level, it is worth noting that while the bulk of a social services department's budget is spent on the care of older people, this amounts to the smallest amount *per capita* of all the main service user groups.
- *In the way in which services for older people are organised and staffed*. As Chapter 3 will argue, the development of health and social care policy for older people has often been poorly organised and developed, with ageist assumptions at its heart (Means and Smith, 1998). The scandalous treatment of older people in institutional care in the immediate post-war years, highlighted by Townsend (1962), was a particularly striking example of this. The development of social work for older people, addressed more fully in Chapter 6, is another example of how policy and practice have had an ageist underpinning, as it has long been the least professionally developed of the various forms of social work practice (Lymbery, 1998a). Much day-to-day practice with older people is in fact carried out by staff without professional qualifications, often paid on an hourly basis, many of whom work in the independent sector where the pressure to carry out tasks within a defined time period is intense. These sorts of arrangement are scarcely in the best interests of older people, and attest to the fact that they are treated in a way that reinforces their relatively low social value.
- *In the differential development of understandings about the abuse of older people as opposed to the abuse of other groups, particularly children*. While the abuse of children has become a preoccupation within social services, the abuse of adults and older people has never been given the same level of priority. Although the publication of *No Secrets* (DoH, 2000a) has ensured that policies have been put in place the better to manage issues related to adult protection, their impact has been variable (Mathew et al., 2002). The 'discovery' of the abuse of older people occurred many years after the equivalent

discovery of the abuse of children, and yet was trivialised by the ageist terms ('granny-bashing'!) by which it was originally described. Even now, it does not have the shock value of child abuse; there are fewer headlines if an older person dies as a result of abuse or neglect that if the same fate befalls a child.

- *In the attitudes and values of those staff employed to work with older people.* As noted above, a wide range of staff are employed to work with older people, both in residential and nursing homes and in the community. The fact that many of these staff do not have professional qualifications renders them more susceptible to stereotyped and demeaning impressions of older people.
- *In the language deployed to describe older people*. This issue ranges from the casual stereotyping in everyday parlance (variations on the themes of 'silly old fool' and 'old dear') to the more insidious and dehumanising references to older people by professionals. There is also a tendency, particular in health care settings, to refer to people by their condition rather than their names, another depersonalising and essentially dehumanising act.

It is particularly important that practitioners are enabled to understand the ways in which older people's lives are affected by factors at the structural and organisational levels, hence avoiding a reductive biologically-based view of ageing. Social workers have an occupational tendency to focus first on the needs of the individual, and can easily allow themselves to ignore wider structural issues. Practitioners must also identify other forms of power and oppression to which older people could be subject. Ageism does not operate in a vacuum and hence in isolation from other forms of oppression. Instead, these forms of oppression can combine to create even more difficulties for the older person. As a result, it is important for social work practitioners to be able to recognise and challenge multiple forms of oppression, of which ageism will be a major element.

SECTION SUMMARY

This section has explored the issue of ageism and its impact on older people. It has discussed the following issues:

- The nature of ageism and its centrality as a concept in respect of the needs of older people.
- Drawing on Thompson (1995) the various 'structural', 'cultural' and 'personal' aspects of ageism.
- The connections between ageism and other forms of oppression that older people might experience.
- The various ways in which ageism can be made manifest.

WAYS OF UNDERSTANDING THE AGEING PROCESS

This section will summarise different approaches to understanding the ageing process. It will start at the individual level, working outwards from this to focus on older people in the context of society. The content of this section is a necessarily condensed version of material that can be found in standard texts on gerontology and social gerontology (see, for example, Bond et al., 1993a). Its purpose is to examine the experiences of ageing through a variety of theoretical prisms. The overall intention is to present the issues of which social workers need to be aware if they are to pursue their roles successfully.

A note of caution is appropriate at this point: while the chapter does start its survey with the impact of biological ageing it is imperative not to perceive older people only in terms of what happens to them physically as they age. Such an attitude can lead to what has been termed 'biological reductionism' (Biggs, 1993), where the complexity of an individual's life and experiences is reduced to the apparent verities of what will inevitably occur to the physical body. Of course, there are observable physical changes when one ages; it is important to know what these are and to understand the impact that these might have on the individual and others. Although ageing is a physical fact, it is not inherently problematic. The vast majority of people are quite able to manage the process of ageing without requiring the support of social workers. It is therefore important to see older people in a more rounded light, not simply as the collection of problems that a purely physical/biological approach might seem to encourage.

PHYSICAL/BIOLOGICAL CHANGES

The process of human ageing is affected to a large measure by certain universal truths, which have their basis in biological fact (Briggs, 1993). For example, there are four facets of ageing that have been generally accepted:

- That it is *universal*, in that it will inevitably affect all people.
- That it is *progressive*, a continuous process throughout life.
- That ageing is *intrinsic* to the human organism.
- That it is *degenerative* in a biological sense (Strehler, 1962; in Bond et al., 1993b).

However, while particular diseases may be associated with the process of ageing, ageing is not in itself a disease, although Briggs (1993) points out that the distinction between 'ageing' and 'disease' is often quite narrow and arbitrary. For the sake of clarity, this sub-section will focus on those processes that can clearly be accounted as part of the 'normal' process of ageing, not all of which

will necessarily involve the intervention of health and social care services. Indeed: 'Decline in physiological function may be of little consequence to an older person until they cross some threshold so that they are no longer able to carry out necessary activities' (Briggs, 1993: 56). However, some aspects of biological ageing – for example, recovery from a stroke, the onset of dementia – will almost certainly require this form of assistance.

The first sub-group of issues is concerned with decline in sensory functioning. For example, many older people – approximately one in three people over the age of 65 (Briggs, 1993) – experience some measure of hearing loss. While there are numerous ways in which this loss can be compensated, it can also create some practical and psychological problems, particularly when the loss of hearing has an impact on day-to-day living. An even higher proportion of older people experience some impairment of vision: indeed, practically all older people need spectacles to assist them in some aspect of their lives (Briggs, 1993). For the majority, the difficulties that the impairment creates can be managed relatively easily; however, approximately one in four older people have continuing difficulties that the use of spectacles alone cannot resolve. In particular, older people are much more likely to develop *cataracts* (a compression of the lens in the eye, leading to reduced vision) or to experience problems due to the onset of *glaucoma*, raised pressure of the fluid in the eyeball, usually leading to a gradual loss of peripheral and later central vision.

Similarly, there are a number of ways in which changes to our biological makeup affect the bodily appearance as we age. Two of these represent the most obvious physical signs of ageing. The first of these is wrinkling of the skin, due to a gradual degeneration in its elastic tissues. This is more severe where an individual has been extensively exposed to strong sunlight, and also varies according to ethnicity. The second of these is that the skin and (most noticeably) the hair tend to lose their pigment with age. Neither of these observably common experiences of ageing are usually, in themselves, problematic. Similarly, an inevitable decline in muscle power is associated with ageing, although this can be compensated to some extent by maintaining physical activity. Weight-bearing exercise can also help to preserve bone density, the reduction of which is a significant feature of ageing, especially for women. Many women experience *osteoporosis* – an extreme thinning of bone density – following the menopause, due to changes in the hormonal balance. This renders the individual more prone to fractures and is also the cause of skeletal and postural problems, which can – in more severe cases – affect the functioning of internal organs such as the heart and lungs. Many people also experience a form of arthritis as they age. The more commonly experienced is *osteoarthritis*, which is usually caused by wear and tear on the major weight-bearing joints such as hips and knees. In the worst cases affected joints can be replaced, although the replacements only have a limited lifespan. The less common form is *rheumatoid*

arthritis, which usually affects the smaller joints such as hands and wrists, but is often experienced as more painful.

The internal functioning of the body also alters with age in a variety of ways. For example, changes in kidney and bladder function are commonly experienced. The operation of the kidneys generally starts to deteriorate from the age of about 30 years, without necessarily creating a problem in later life. There is often a weakening of bladder function associated with ageing, with older men experiencing problems with the prostate gland and women being particularly susceptible to stress incontinence. In both of these cases effective medical intervention can help to maintain bladder function; however, more serious and irreversible bladder problems can also be created by a range of diseases: for example, incontinence is strongly associated with recovery from a stroke and also with dementia.

Changes are also generally experienced in respect of the heart and lungs during the ageing process. For example, heart muscles degenerate with age, thereby becoming less effective and often requiring additional support to regulate the rhythm of the heart. In serious cases, this can lead to heart failure, where the heart is no longer sufficiently effective to pump blood around the body. Similarly, the lungs become less efficient with age, creating problems with breathing. A combination of the above two occurrences can render it difficult for an older person to maintain the healthy level of exercise that can help to control the rate of physical decline in respect of muscle tone and bone density, noted above. Problems with circulation can be exacerbated by *atherosclerosis*, the 'furring up' of arteries. This is particularly prevalent in developed societies, aggravated by a number of factors including high fat and salt diets, high blood pressure, smoking, etc. which are characteristic of countries such as Britain and the United States. The range of problems that can be created by this process include one of the largest causes of death in industrialised societies, coronary heart disease.

Older people are more likely than younger people to be affected by various forms of hormonal imbalance, such as diabetes and disorders of the thyroid gland. In addition, as noted above, older women are particularly susceptible to *osteoporosis*. As well as the difficulties that this can create deriving from reductions in bone density, noted above, it can also create physical changes – for example, thinning of vaginal walls and vaginal dryness – that can adversely affect sexual functioning. Similar physiologically-based sexual problems can also afflict men in later life, due to reductions in the production of testosterone.

Finally, a number of physiological effects can result from disorders to the brain and nervous system. The process of *atherosclerosis*, noted above, can affect the blood supply to part of the brain causing a stroke. As we shall see, this is a major cause of death and illness amongst older people. This process can also lead to one of the two main forms of dementia. Perhaps the most commonly feared disease affecting older people is *Alzheimer's disease*, a degenerative condition of the

brain's nerve cells. This affects around 2–3% of those aged over 65, rising to around 20% of those aged over 80. The prognosis for people with *Alzheimer's disease* is poor, with a gradual loss of memory leading to increasing levels of behavioural difficulties over a number of years. There are also other sorts of disease that can affect the brain's ability to function. For example, *Parkinson's disease* causes selective degeneration in the nerve cells that release the chemical transmitter 'dopamine'. While this disease can affect people in their middle years, it is particularly associated with old age.

This sub-section has indicated the main physical and biological changes that are likely to occur for older people. Although some of these may precipitate the involvement of health and social care services, most such involvement will be brought about by 'abnormal' as opposed to 'normal' ageing – the presence of illness and/or disease. There are also other aspects of ageing that affect this; the following sub-section considers one of these, the psychological impact of ageing.

PSYCHOLOGICAL CHANGES

Unlike the picture created by the examination of biological changes that occur during the ageing process, a study of the psychological impact of ageing presents a more varied set of outcomes. As Coleman (1993a) has observed, psychological ageing is not necessarily negative; however, the dominance of biologically derived understandings of the ageing process has ensured that the negative effects are emphasised over the positive. This is not aided by the 'folk' conceptions we often hold of older people being forgetful and not quite 'with it'. In reality, there are psychological gains as well as losses in the ageing process; often the two balance each other out.

There are two main areas in which the popular belief is that older people experience a considerable decline in their ability to function. The first of these is in respect of intellectual ability. However, the evidence suggests that there is minimal decline in intellectual functioning up to 70 years, with some people showing no decline at all, although there is an increased likelihood of some decline in intellectual functioning in very old age (Coleman, 1993a). As with physical activity, it has been suggested that the maintenance of mental 'exercise' can help the brain to function as well as it can. Further research has shown that there may be changes in the nature of one's intelligence with age. For example, while there may be a decline in what has been termed 'fluid' intelligence (that is, the ability to solve new and unfamiliar problems quickly) this may be balanced by the stability (and possibly even increase) in 'crystallised' intelligence (that is, the way an individual can bring her/his experience to bear on a problem). This also links to the 'common-sense' attribution of wisdom to older people, a perspective that is particularly common in societies that value, even venerate, age and experience (Slater, 1995). Of course, as with many issues that affect the experience of

ageing, intellectual functioning may be affected by biological events, such as Alzheimer's disease.

Memory loss is popularly believed to be the other key aspect of decline in psychological functioning in old age. While there are changes in memory function, they cannot all simply be labelled as indicative of deterioration and decline. However, there are some areas of decline that do appear to affect most older people. For example, as Coleman (1993a: 75) points out: 'difficulties occur for older people when they have to process novel information . . . especially if they have to deal with other problems and distractions'. This could relate to older people's reduced capacity for 'fluid' intelligence, noted above. Despite this, it can be concluded that the reduction in the efficiency of an older person's memory is less sharp than might popularly be understood. Of course, if an older person is affected by conditions such as dementia, memory functioning will deteriorate markedly; even here, as Jones (2004) has argued, the nature of memory loss is more complex than has hitherto been acknowledged. However, the general points about memory loss do relate to 'normal' as opposed to 'abnormal processes of ageing. In addition, there will be a wide variety of experiences within the broad category of 'older people', just as there are within the wider population.

As Coleman (1993a) has indicated, older people retain a considerable ability to learn new tasks and skills – with the possible *caveat* that not all older people have the *desire* to learn a repertoire of new skills and abilities. In addition, many older people tend to underestimate their abilities, perhaps believing that speed of recall (the exercise of 'fluid' intelligence where they may experience difficulties) is a better proxy for the ability to assimilate new knowledge, rather than the more sophisticated act of making sense of complex information (the exercise of 'crystallised' intelligence) (Slater, 1995). Indeed, as reported by Coleman (1993a) older people can often make good sense of a mass of apparently contradictory information. On balance, therefore, during the course of 'normal' ageing older people retain much of the capacity for learning and memory that they possessed as adults. While there are age-related changes, these do not constitute a major obstacle to the ability to function effectively in later life.

Another key element of psychological change amongst older people concerns the extent to which their personality alters as they age. While a range of research has been carried out on the response of older people to their changed circumstances, the findings do not all point in one direction (Coleman, 1993b). For example, there is a body of research that suggests that people have enduring personality characteristics that endure into old age (Slater, 1995), although this is often accompanied by suggestions that older people do change some facets of their behaviour and interests (Coleman, 1993b). By contrast, the influential research by Cumming and Henry (1961) hypothesised that older people undergo a process of disengagement with the external world, preferring to withdraw into themselves. While the general theory of disengagement has been criticised for

its apparent justification of policies that actively exclude older people (Estes et al., 2001a; Pilcher, 1995), at the psychological level it does accord with other research that suggests that people tend to become more introverted and inward-looking as they age (Coleman, 1993a).

A possible corollary of this is that older people are more likely to experience depression than younger people (Slater, 1995). However, some caution about this conclusion is warranted on two counts. First, it does not appear that older people are any more likely to become seriously clinically depressed (Coleman, 1993b). Secondly, it is difficult to be entirely accurate about the incidence of depression since the basis for diagnosis varies from clinician to clinician (Coleman, 1993b) and the suspicion exists that older people are more likely to confuse the symptoms of depression with the symptoms of an illness with a physical cause (Slater, 1995). Given that the older one gets, the more one is likely to experience a range of losses and other negative life events, it is perhaps not surprising that older people can become depressed. Indeed, in the light of this Slater (1995) suggests that it is remarkable that depression is not more common amongst older people.

This partial survey of the psychological impact of ageing reveals a similar picture to that of the previous sub-section: that although older people experience some psychological changes regarding issues such as intellectual functioning, cognitive ability, memory and learning, the impact of these changes is less dramatic than might be popularly believed. There is nothing about the process of ageing that leaves older people inherently less able to cope with the psychological demands of everyday life. Indeed, older people seem to be remarkably resilient in the face of these pressures. In the face of this evidence, combined with the fact that biologically driven theories of ageing also fail to explain the place of older people in society, we need to consider wider structural issues that affect ageing – particularly the way in which the experience of ageing is socially constructed, and the place of older people in the political and economic context of society.

SOCIAL CONSTRUCTIONIST PERSPECTIVES

As Thompson (1995) suggests, the process of ageing can be understood in more ways than simply focusing on the biological and psychological. He argues that various elements that make up our understandings of old age are socially constructed. Indeed, whereas the physical signs of ageing are slow to accumulate, the various social constructions of ageing are applied suddenly, and are experienced as particularly problematic as a result (Biggs, 1993). The first of these is the construction of 'retirement', which has become central to the experience of older people and which defines most clearly the point at which one officially becomes an 'older person'. As Phillipson (1982) has argued, the concept of 'retirement' was primarily

created to meet the needs of the capitalist economy, ensuring that work would be redistributed from older to younger people. This has been particularly important in times of high unemployment – the 1930s being a classic example – when defining people as surplus to economic requirements was helpful in appearing to reduce the numbers of people defined as 'unemployed'. The construction of the concept of 'retirement' was also assisted by passage of pensions legislation in the first part of the twentieth century; although this was heralded as a socially beneficial event for older people, it also created a safety net for older workers, meaning that employers no longer needed to accept any sort of responsibility for their longer-term welfare (Phillipson, 1982). While retirement can have beneficial consequences for individuals and their families, it is a fact that the older one becomes the more likely one is to join the ranks of the poorest people; for example, 37% of pensioner couples over the age of 85 are in the bottom quintile of net income, as opposed to 24% of those aged between 60 and 74 (ONS, 2001).

By the early years of the twenty-first century, retirement has become something that practically all older people will experience. Indeed, in the 1980s, the growth of unemployment heralded a rapid growth in the experience of early retirement, prompted by the politically unacceptable reality of mass unemployment (Phillipson, 1993). Concerns about the impact of demographic change, particularly the projected shortage of people of working age in the middle of the twenty-first century (Shaw, 2004), have lead to an ongoing debate about the need to harmonise retirement ages and to 'allow' older people to work longer. Both of these moves will potentially increase the numbers of people available for work, thereby helping to reduce some of the projected difficulties in respect of the dependency ratio.

The experience of retirement from paid employment is therefore a major part of the way in which society constructs old age. However, the experiences of older people are also mediated by various other socially constructed artefacts – for example, 'class', 'gender' and 'race' (Thompson, 1995). Older people from the 'working class' experience ageing in a qualitatively different manner than people from the middle and upper classes, as the effects of earlier disadvantage and inequality are magnified by getting older. Therefore, while not all older people are at an increased likelihood of experiencing poverty, those people so afflicted are disproportionately from the working classes, who were more likely to be in poorly paid employment without the benefits of an occupational pension, and hence reliant on the state pension as their primary source of income. At the same time, these same people are more likely to experience poor health (Townsend et al., 1992), while their housing quality is also significantly worse than for the population at large. For example, 13.9% of people over the age of 85 live without central heating as opposed to 7.0% of those people between the ages of 50 and 64 (ONS, 2001). Similarly, 39.2% of those over 85 live in rented accommodation, which often provides the worst form of housing available, as

opposed to 19.8% of those people aged between 50 and 64 (ONS, 2001). At the same time, increasing numbers of the very oldest people (i.e. those over the age of 85) live alone (ONS, 2001). The financial hardship of many working class older people also has an impact on their leisure activities, as they are more likely to be reliant on public transport, which is often inadequate – particularly in rural areas. At the same time, they are likely not to have sufficient disposable income to engage in a number of leisure pursuits. A combination of all of these factors means that older people of working class background are far more likely to come to the attention of social services than others. In particular, economic strength in old age means that an individual does not have to approach social services for assistance, given that this can be purchased direct.

As far as 'gender' is concerned, it is vital to recognise the impact that this has on the lives of older women, who greatly outnumber men amongst older people, particularly at 75 years and beyond. In 2002, there were almost 4.2 m people over the age of 75 in Britain, 61.35% of whom were women and 38.65% of whom were men (adapted from ONS, 2001). With the increased numbers of women in the workplace they are likely to experience all the issues that relate to retirement in the same way as men. In addition to this, women are significantly more likely than men to have caring responsibilities that will continue into old age (Evandrou, 1997), as women have long been assigned the role as 'carers' within British society. As Hughes and Mtezuka (1992) have observed, when older women require care themselves this 'natural' order is in fact overturned. The gendered assignation of caring roles to older women is mirrored by other assumptions about the nature of older women. Within a society fixated on the physical attractiveness of women, the loss of this commodity renders older women 'invisible'. Indeed, the cultural references to older women tend to portray them as crones, harpies and witches (Hughes and Mtezuka, 1992), hardly the most positive of points of reference. It should also be added that gendered expectations of behaviour can also affect older men, who may be given little opportunity to express their emotional responses to the losses of old age.

'Race' is another important variable in considering ageing in British society (Blakemore and Boneham, 1994). While the majority of post-war immigrants were predominantly adults and younger people, the first generations of immigrants are progressively ageing, ensuring that they are now a larger proportion of the older population as a whole (Blakemore and Boneham, 1994). In addition, there are many 'invisible' minorities – from Irish and eastern European backgrounds – who also have needs that are particular to their group, which may not be adequately met. As a way of conceptualising the experience of older people from ethnic minorities, Norman (1985) has suggested they are subjected to a form of 'triple jeopardy', often experiencing forms of discrimination based on class and race, in addition to oppression based on age. It is the interlocking nature of these forms of oppression that create particular problems for such older people.

There are also numerous culturally bound images of ageing that are common within society. It is rare, for example, that any action by an older person – other than the Queen or Rupert Murdoch! – is deemed to be worthy of news coverage. When older people do appear in the news the coverage is likely to be patronising and hence demeaning (Aldridge, 1994). Similarly, there are relatively few positive images of older people to be found in the visual media – in films, television and advertising. Indeed, despite the numbers of older people in society, advertising directed specifically at them is 'ghettoised' into specialist publications and daytime television. Although older people do inhabit the pages of quality literature (see Johnson, 2004) their presence in the more popular forms of media are few and far between. Although most television 'soaps' contain older characters, often portrayed by highly skilled actors, the story-lines that they tend to be given are more limited in their scope than the younger characters. In general, forms of popular culture seek to play commonly accepted attitudes and forms of behaviour back to its audience, rather than seeking to challenge and change perceptions: in this way the inherent 'conservatism' of much of its coverage can be readily explained.

THE POLITICAL ECONOMY OF AGEING

The development of the above concept is particularly associated with the writings of Estes (1979) in the United States and Phillipson (1982) in Britain. An essential element of their argument is that mainstream thinking has constructed age as exclusively an individual problem, ignoring the impact of broader social structures on the way in which each individual experiences her/his ageing (Estes et al., 2001a). By contrast, Estes (1979) and Phillipson (1982) have argued that it is also important to understand the ageing process in western societies. They have suggested that older people are seen as inherently problematic primarily because they represent a drain on resources, to which they no longer contribute actively either as tax-payers or as parents raising the next generation of tax-payers. Because of this, older people are accorded a lower status in a capitalist society than other 'productive' citizens.

Estes (2001) has suggested that there are three ways in which this dominant view is perpetuated:

- Through the creation of cultural images and representations of ageing (which was addressed in the previous sub-section).
- Through an appeal to the requirements of the economic system.
- Through focusing on ageing as a 'rational' problem amenable to 'technical' problem-solving, without consideration of the conflicts and disagreements that might underpin the debate.

The latter two points have been well exemplified in the debate concerning the supposed 'demographic time bomb', where the essential 'problem' is defined as the fact that the economy cannot sustain increasing numbers of older people. If one

were to accept this economic argument, it follows that some form of technical 'solution' might be proposed. Two of these have already been trailed in Britain. The first is a 'harmonisation' of retirement ages for men and women, to take place between 2010 and 2020 (Shaw, 2004), which is in fact an increase in the pensionable age for women from 60 to 65. The second is the outline proposal that all people should be allowed to work beyond the retirement age should they and their employers so desire. Both of these changes would have the result of reducing the numbers of people claiming their pensions and hence allaying the fears about the unproductive numbers of older people in society. While there are rational arguments in favour of both proposals, the fact remains that they are both driven by economic calculations. To be more credible, they need to be placed within the context of a fundamental debate about the most appropriate way to structure society in order to ensure the best quality of life for older people.

The essential tenets of the political economy approach to the study of ageing are usefully summarised in the following quotation:

> In the political economy perspective, social policies pertaining to retirement income, health and social benefits and entitlements are seen as products of economic, political and sociocultural processes and forces that interact in any given socio-cultural period. (Estes et al., 2001a: 40)

Estes and colleagues (2001b) are particularly critical of those theories of ageing that do not take these factors into account. In their view, this has resulted in policies that treat old age as a 'disease' and older people as primarily therefore a medical problem; these policies are reinforced by the various forms of practice – in health and social care services in particular – which only treat older people in relation to their presumed medical problem, failing to respond to them as individual citizens. They suggest that the dominance of the medical paradigm for understanding ageing has acted to suppress the development of alternative forms of understanding, and effectively ignores the influence of four critical factors on ageing:

- Income and education;
- Safe and supportive housing environments;
- Opportunities for meaningful human interactions;
- Public financing for rehabilitation (Estes et al., 2001b).

The effects of inequality on health outcomes have become more widely recognised (Townsend et al., 1992), but public policy has not been widely constructed on this knowledge. In fact, although there has been increased public finance available for rehabilitation and intermediate care – an extra £900m was promised in the *NHS Plan* (DoH, 2000b) – this is less about the inherent benefits to older people of enhanced rehabilitation than it is an economically driven attempt to free up beds in hospitals. Therefore, in a number of ways, the political economy approach

reminds us of the marginal status of most older people in society. However, this too can only provide a partial understanding for social workers, as it fails to engage with the areas of difference between the experiences and outlook of people from similar economic and social circumstances. An examination of the nature of identity in old age is therefore a necessary element in our overall understanding.

IDENTITY AND AGEING

With the changes that will inevitably affect the ageing body, combined with the acknowledgement that the organisation of society profoundly affects the experience of ageing, it is important to establish a sense of how each older person experiences her/his personal encounter with old age. For example, Nolan et al. (2001a: 9) have suggested that the increased frailty of extreme old age creates an 'existential challenge' for older people. Thompson (1998) has discussed the need to establish a different way of looking at the individual older person, suggesting that more work is needed to establish an understanding of what he has termed the 'ontology' of ageing. Indeed, models of ageing that derive from the biological, social constructionist and political economy perspectives have relatively little to say about the way in which the process of ageing may be experienced by the individual.

In examining what effect ageing might have on the identity of the older person, Biggs (1999) has suggested that three critical factors – drawn from a combination of sociological and psycho-dynamic theory – should be considered:

- Ageing takes place in a potentially hostile environment which over-emphasises productivity and consumption.
- Societal changes occur very rapidly, necessarily impacting on the identity of the individual older person.
- Despite all the changes to which an ageing person is subject, an 'inner self' will tend to continue.

Although the self-confidence and self-image of older people may well be more fragile than for younger people, which can lead to the internalisation of negative societal attitudes, he suggests that the essential characteristics of an individual's identity will remain, despite being subjected to numerous challenges and assaults. Taking this insight into account, it would seem that a vital role for a social worker is to contribute to the maintenance of an older person's sense of identity under circumstances where events will conspire to threaten it. In addition, while the individual identity will be affected by social and economic factors, it will not be predetermined by such factors. Each individual will respond differently to identical sets of occurrence; in working to assist somebody at a time of change or transition in her/his life the uniqueness of this response needs to be recognised and form the basis of future work. It will be difficult to help a person

through fundamental changes in her/his life without grasping how those changes are perceived by the individual.

The theory of the 'life course' (Hockey and James, 2003) has been advanced to link the individual experience of ageing with the structural factors that have a major influence on this. Here, it is argued that a fuller understanding of the process of ageing can be gained through connecting a number of factors that combine to construct each individual's experience. For example, each person belongs to a 'cohort' (Pilcher, 1995) of people, who share similar experiences due to their membership of a group of people comprised of people of similar age. In addition to this, people can claim memberships of other groups that are not dependent on their age – their gender, class, race, etc. These factors will create other sets of experiences which will differ from the first. An understanding of the individual experience of ageing is generated from an understanding of these influences, together with the specific psychological makeup of the individual, her/his family background and experiences, etc. Identity, therefore, is a complex entity moulded from these various elements.

THE NEEDS OF OLDER PEOPLE AND THE SOCIAL WORK ROLE

As the preceding section makes clear, there are numerous issues that could lead to a reduction in the quality of life experienced by older people. While this section will not attempt to itemise all the eventualities that could precipitate changes in an older person's circumstances that might call for the involvement of health and social care services, it will identify some key general themes. In so doing, it will draw directly on the insights generated through the previous section.

ILLNESS, DISABILITY AND PHYSICAL FRAILTY

Undoubtedly the single event that is most likely to promote the involvement of health and social care services is the onset of physical illness, a growth in the level of disability experienced by an individual, or an increased level of physical frailty. As the previous section indicated, older people are more likely to be subject to various manifestations of any one of the three above. For example, 67% of men, and 74% of women, over the age of 85 have a long-term illness or disability that limits their activities (ONS, 2001). Given the expressed policy intention is for care services to be designed to maintain people in their own homes for as long as possible – an aspiration expressed in both *Caring for People* (DoH, 1989) and the *NHS Plan* (DoH, 2000b) – there is an urgent role for services to function in such a way as to allow that policy aspiration to be met. The fact that there has been a reduction in the proportion of people in long-stay institutional

care (ONS, 2001) is some evidence that there have been genuine moves in that direction. Problems that would previously have caused the automatic admission of an older person into long-stay care – hip fractures, strokes, heart disease, etc. – are now increasingly managed within the person's own home. Social workers are an integral part in the process by which assessments are made concerning an older person's ability to manage at home, the nature and extent of care support that is required, as well as the contributions from family and other care-givers (see Chapter 7). They also have a key role in the continuing management of care packages (see Chapter 8). In addition, the proliferation of 'intermediate care' services that enable older people to maintain their independence and autonomy also creates a potential role for the social worker (see Chapter 9), although this has been relatively little developed as yet.

Where problems stem from deterioration in the physical health of an older person, the social worker needs to have a general understanding of the causes and effects of the conditions that have caused the problems. For example, it is important for a social worker to understand that the nature of life-threatening conditions for older people changes with age. While cancer is the main cause of death for those people between the ages of 50 and 64 years, other factors predominate for older people. There is an increased likelihood of heart disease or related problems of the circulatory system, as well as an increased likelihood of respiratory problems (ONS, 2001). However, they also need to recognise where specialist knowledge about specific aspects of a person's condition is required. For medical matters that require the knowledge of a doctor this may appear self-evident; however, there are also other aspects of health and life-style where other forms of expertise will be needed. For example, the area of diet and nutrition is a vital factor in the maintenance of good health (Copeman and Hyland, 2000) while physiotherapy can play an active role in the recovery of an older person's independence (Randall and Glasgow, 2000). In neither case would a social worker be expected to have the specialist knowledge to carry out these tasks, but they do need to understand how important they may be for an older person's overall welfare. Similarly, the contributions of nursing, occupational therapy and podiatry will also be an essential component of a co-ordinated response to the changing physical needs of older people. This argues for a multi-disciplinary approach to the organisation of the response to the needs of older people. However, as explored in Chapters 4 and 5, there does need to be some caution about the potential for collaborative working to resolve some of these historical problems.

DEMENTIA, DEPRESSION AND OTHER COGNITIVE IMPAIRMENTS

Social workers will almost certainly become involved where there are significant levels of cognitive impairment in an older person. For example, where there is progressive dementia it will become increasingly difficult for an individual to

maintain her/his level of independence – creating problems both for the person concerned and also for any carers that are involved. The disruption caused to normal, everyday patterns of living will become so intense that additional levels of support will almost certainly be required.

One of the key practical problems lies in understanding the various forms of dementia and their effects. In addition, social workers often confront difficulties in securing accurate information on which to base care plans, as many people are broadly characterised as having 'dementia' or being 'senile', without any detail about the nature of the condition being communicated. This creates a particular problem because, as noted with respect to physical illness and disease, there are many aspects of the various cognitive impairments where the social worker will be reliant upon others for detailed information. The aetiology of dementia is a complex subject, on which specialist medical guidance is required. This chapter can only give general guidance about the most commonly encountered forms of dementia, their likely prognosis and possible options for the provision of care services.

As Goldsmith (1996) has pointed out, dementia is not in itself an illness, but a syndrome that is caused by a number of other illnesses. Of these, the numerically most significant is *Alzheimer's disease*. Indeed, in many people's minds, there is an automatic connection between the two. However, there are numerous other causes of dementia that can afflict older people. The second most common is *multi-infarct dementia*, caused by a succession of small 'strokes', in which parts of the brain are starved of a blood supply. In addition, much less commonly, a number of other conditions can cause dementia, illustrating the complexity of diagnosis and treatment. It is therefore vital to establish the nature of dementia in each circumstance, as this will necessarily affect the nature of the treatment provided. The importance of social workers possessing this general level of understanding of dementia cannot be underestimated. Certainly, it would be impossible to construct a viable care plan without clarity about the likely progress and effects of Alzheimer's disease, for example.

Similarly, a social worker is well advised to encourage a service user who appears to be depressed – or that person's carer – to seek specialist advice and support, as this is likely to reap benefits that are beyond the individual social worker's capabilities. In all such circumstances, the social worker has to recognise the limits of her/his knowledge and professional role. However, within these limits the social worker still has an important role to play and her/his skills will be of the utmost importance. The experience of any cognitive impairment – particularly dementia – is acutely distressing for all concerned, requiring a high level of skill on the part of all practitioners involved.

WORKING WITH CARERS

While many of those defined as 'carers' provide care for a range of people, it is in respect of older people that their numbers are particularly significant. It was

estimated that approximately 3.4 m people were providing significant levels (in excess of 20 hours per week) of care for people in the 1990s, roughly half of which were living in the same house as the person cared-for (usually a spouse) with the other half living elsewhere (Evandrou, 1997). While the gender composition of the former group was broadly even, the latter group comprised significantly more women than men, reflecting the gendered nature of caring (Arber and Ginn, 1991). While people have many motivations for carrying out a caring role – reciprocity, obligation, expectation, lack of alternatives, etc. – there is little doubt that some of the conditions that can affect older people have a profoundly distressing impact on carers as well. In addition, the sheer volume of work undertaken by informal carers is a vital component of the entire system of care, without which it could barely function.

In recognition of this the 'new' Labour government instigated a *National Strategy for Carers* (DoH, 1999) to co-ordinate policy in relation to carers. While the concept of a 'carer's assessment' has long been a feature of community care, its impact was constrained by the fact that no resources were allocated to meet the needs that could be identified. Although the Carers (Recognition and Services) Act 1996 obliged local authorities to provide an assessment for each carer who requested one, an obligation that was reinforced by the passage of the Carers and Disabled Children Act 2000 (DoH, 2001b), practice was still heavily circumscribed by a lack of resources. Even the additional resources promised in the *National Strategy for Carers* (DoH, 1999) only scratched the surface of the problem. In fact, the guarantee that carers could receive an extra £50 a week by 2050 (!) was faintly risible (DoH, 1999), an archetypal promise of 'jam tomorrow'.

In practice, social workers involved with older people are particularly well aware of the needs of carers, especially the fact that support for the carer is often a prerequisite for enabling an individual to remain at home. At the same time, social workers are also aware that there may be problems and tensions in the caring relationship – the needs of the service user and carer should not be presumed to be identical, and conflict may be anticipated in many cases. Negotiating, and potentially mediating, between the potential conflicts is a key role for social workers, as Chapter 6 will explore in more detail.

TRANSITION AND CHANGE

This sub-section is closely connected to the one that follows. Older people experience numerous transitions in later life, many of which are concerned with various aspects of loss. Social workers are likely to become involved with older people at precisely such a point – when they are no longer capable of managing their lives independently and require the support of paid carers, or when they can no longer live in their own home, needing to transfer to sheltered accommodation

or some form of institutional care. By the nature of social work's role with older people, practitioners will normally become involved with older people at precisely the points at which some form of transition is needed.

Two examples of this are the process of discharge from hospital (see Chapter 7) and admission into long-term care. Both of these events occur when people are at their most vulnerable, feeling powerless to affect their lives in a positive way, and often subjected to well-meaning but destructive guidance from family members. The balance between autonomy and protection – at the root of much contemporary social work with adults in general, and older people in particular – looms particularly large here. Many family members understandably emphasise the need for safety in decision-making, often believing that residential or nursing homes will be 'safer' places than the home. By contrast, many older people are loath to give up their independence and are desperate to remain in their own homes. As one older person who had experienced some weeks away from home put it: 'more than anything in the world I want to go home, back to *my* home' (in Hart et al., 2005). Here the identity of the older person is clearly bound up in being able to return to live independently in what she was clear was *her* space. A key role for the social worker is being able to manage and negotiate the conflicts that may arise in such a situation.

BEREAVEMENT AND LOSS

While bereavement and loss are an inevitable part of life, they are experienced most by older people. The older one becomes, the more likely it is that many of the people to whom you have been close in life – spouse, friends, relatives – will die. While many people will be profoundly affected by any one of these events, other older people are able to take even multiple bereavements in their stride. Therefore, a social worker must not assume that the experiences and emotions of every older person will be identical – s/he must start from the specific experiences of each person and work alongside her/him in accordance with this.

In addition, it is likely that each transition experienced by an older person will be accompanied by some form of loss. For example, if an older person requires assistance with many activities of daily living – bathing, cleaning, shopping, etc. – s/he may also experience a sense of loss of those abilities that had previously been taken for granted. If the person becomes unable easily to leave the house, there may also be a sense of loss regarding social activities. In addition, any admission to sheltered housing or institutional care implies a loss of home and/or independence. As we shall observe in Chapter 6, the nature of social work with older people has historically provided limited opportunities for practitioners to engage with these issues, leaving a number of emotional and psychological needs unaddressed.

ABUSE AND PROTECTION

As noted earlier in this chapter, the publication of *No Secrets* (DoH, 2000a) has ensured that the issue of the protection of adults from abuse and harm has assumed a higher priority in the provision of services for older people. The establishment of Adult Protection Coordinators in many locations has meant that more allegations of abuse are being addressed within Social Services Departments (SSDs) (Cambridge and Parkes, 2004). However, the establishment of procedures does not define the appropriate course of social work action; rather they provide a framework within which effective practice can take place. This must be directed by what the social worker uncovers in the process of working through the issues. For example, in some cases, abuse may have taken place within the context of a long-standing abusive relationship. In others, it may have only developed later in life, and be exacerbated by the disinhibiting effects of dementia. Yet again, the abuse could involve other family members, or be aggravated by alcohol dependence. It may be of markedly different types, ranging from direct physical or sexual abuse, to more indirect forms such as financial abuse (see Bennett et al., 1997).

Given the range of possible circumstances within which the abuse has taken place, and the complexity of relationship dynamics that may underpin it, the social worker's task is replete with complexity. Clearly, the first priority will be to seek to maintain the abused person's personal safety, but the number of possible ways in which this could be achieved are legion. As in much of social work practice, the core dynamic underpinning abuse is the balance between protecting the individual from harm while simultaneously seeking to maximise her/his autonomy. Social workers have a pivotal role in ensuring that older people are able to live safely, in managing the investigation processes in cases where their safety is threatened, and in ensuring that their autonomy is maintained.

CONFRONTING AND CHALLENGING OPPRESSION

Social work has a clear commitment to challenging and confronting injustice (see Chapter 2 for more on this theme). However, as delineated in this chapter, older people experience some forms of oppression which derive from deep-seated attitudes and social policies which social workers cannot directly affect. This is not to suggest that practitioners can therefore have no role in seeking to combat wider forms of injustice, but rather to point out the (perhaps obvious) fact that change at such a level is not liable to come about quickly. It is politic for social workers to be patient and take a 'long view', where the detail of their own practice might help to improve the general status of older people. If older

people and their families are able to experience their involvement with social workers as an empowering process this can potentially have beneficial wider consequences.

Although this chapter has foregrounded specific aspects of disadvantage that older people will experience – with particular emphasis on ageism – it should be remembered that there are many other forms of oppression that could be encountered. The chapter has already focused upon issues around race, class and gender, but these do not represent the only forms of oppression that older people might encounter. As Pugh (2002) has highlighted, for example, there are a number of relatively unexamined issues relating to social work undertaken within rural settings. For older people, the likely increase in social isolation that often accompanies old age can be exacerbated by the physical isolation of many isolated rural communities. Similarly, there is an increasing need to consider the needs of older people with intellectual disabilities, as an increasing number of such people are living into old age, with particular difficulties generated by a combination of their age and their intellectual disabilities.

As I shall argue later in the book, there are forms of practice that can be developed which can have a more direct impact on the oppression of older people. Many of these derive from the 'collectivist' traditions within social work outlined in Chapter 2, moving beyond the administrative responsibilities of most statutory social workers. In reality, simply carrying out statutory duties, as transformed into agency policies and procedures, is unlikely to challenge the forces of injustice and oppression that confront older people, even where these duties are carried out with exemplary consideration for the principles of empowerment. Therefore, this book will argue that a broader conception of the social work role is needed – which clearly has implications for the organisation of social work, as well as for social work practice itself. However, if one accepts that the range of older people's needs encompasses the wider structural and societal issues elaborated above, it becomes incumbent on social work to organise itself so as to ensure that they also can be addressed. Simply defining social work in a restricted way as the commission of statutorily defined duties will not go far enough to meet older people's needs.

CONCLUSION

This chapter has outlined the place of older people within the context of British society, and the nature of the problems that might be encountered when people age. The perception of ageing on which this chapter has drawn is strongly influenced by Riley (1986), who argued that in the study of age it is vital to retain a 'dynamic emphasis', where several different levels of analysis – for example,

structural, organisational, familial, group and individual – are seen as intersecting and interconnecting. In her view, the appropriate study of ageing requires the integration of several academic disciplines, as it is from these disciplines that specific knowledge can be generated. For example, an understanding of biology and psychology forms an essential base for the study of ageing, but these understandings are insufficient unless supplemented with knowledge from a range of other disciplines, of which sociology and social policy are particularly important, and to which anthropology, economics and history also contribute.

What has been outlined represents an 'ideal' response to the needs of older people; as Chapter 6 will outline, the current practice of social work within the statutory sector does not necessarily address all of the areas of difficulty emphasised here. A more complete reaction to the needs of older people requires social workers to exercise a wider repertoire of responses, drawing on a level of creativity that has not always characterised social work practice with older people. However, before being able to accomplish this task, it is important to understand the different elements of what social work actually is, which is the task of Chapter 2. Chapter 6 will then apply this understanding specifically to social work with older people.

CHAPTER SUMMARY

This chapter has addressed the following issues:

- Demographic changes to the population at large, commenting that concern about the effects of the 'demographic time bomb' may be over-stated, given current population projections.
- The importance of the concept of ageism in seeking to understand the treatment received by older people, individually and collectively.
- A number of ways in which the ageing process can be understood, touching upon physical and biological changes, psychological changes, social constructionist and political economy perspectives, with consideration given to the combined impact of these on the identify of an older person.
- The areas of need that older people have that might call for the involvement of social work, relating these areas of need back to the various ways in which the problems of older people can be understood.