Social problems in geriatric rehabilitation

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Rehabilitation, like truth, has many facets. Unfortunately it has become a rather 'with it' term, but it is not a new concept, St Paul writing to the Hebrews said 'Lift up the hands that hang down and the feeble knees', which I think is rather apt. You have heard how my colleagues here, in their various fields, try to put this precept into practice. Where does the social worker come into all this? Medical social workers or almoners as we used to be called, are concerned both with the social problems that cause illness and the social problems that are caused by illness. In geriatrics there is plenty of both—isolation, bereavement, self neglect, bad housing, inadequate food, cold, misery, apathy, all contribute to illness among the elderly. I am sure you have all seen plenty of this in your practice, and it is often these factors as much as the patient's medical condition which lead to hospital admission.

Once an old person is admitted to hospital it is all too easy for the community to close up behind him leaving him homeless. This does not happen with younger people except possibly in mental hospitals, but with the old, the usual pattern is that the family decide (with the best will in the world) that granny will never be fit to live alone again. So they give notice to the landlord, share out the furniture and have the cat destroyed, quite often without telling the patient, much less the hospital staff. It is a function of the medical social worker to stop this happening.

Any geriatric unit sees a great many patients with strokes. The psychological and social problems of these patients and their families depend on many personal and environmental factors apart from the old person's physical and mental state. Social workers are often involved with the difficulties of geriatric patients following a stroke; their emotional adjustment to their handicap, the family stress, maintaining their home while they are ill, their reintegration into the community when they are fit to leave hospital, and the possibility of future employment if they are young enough. We tackle these problems basically as we would those of any other patient.

The approach to a case

Usually we start with a fairly bald statement of the problem, made by the doctor or by the nurse who is asking us for help. Right from the beginning we need to know the medical position; the diagnosis, what treatment is planned, what stage in rehabilitation the patient has reached, and what sort of recovery is likely. The next step is to talk to the patient, and even more important to listen to him. To find out what his plans are, if any, what help he thinks he may expect from his family—even in the days of the welfare state the family is the first line of defence. The problems of a previously active man in his 60's whose self-image before his stroke was of a vigorous, successful man are going to be quite different from those of the old lady who has had several strokes previously, who some time ago fractured her femur and who also has diabetes, poor sight and a failing memory. This latter patient is more typical of the geriatric unit, for as you know one of the characteristics of a geriatric patient is what doctors call multiple pathology and what Shakespeare described rather more colourfully as "the wreckful siege of battering days". However, call it what you will, from the point of view of the social worker it probably means that the old person has made some adjustment towards accepting increasing infirmity, and there is seldom the same degree of shock and

disbelief followed perhaps by depression and resentment that one finds in previously healthy people suddenly struck by accident or illness.

This question of resentment is a very real one. It is odd that we all believe we are personally immune to the troubles of the world; we pick up the papers and read of economic depression, floods in India and famine somewhere else, then we pick up the local paper and read of our neighbour who fell off a ladder, or got run over by a bus, or dropped down dead in the street and yet we all persist in this completely illogical illusion that we personally should be immune from those tragedies. When we find we are not, resentment can be a real factor and a great bar to rehabilitation. Whatever the background, the patient will be encouraged to talk widely around the problem. As he talks the social worker will form some impression of him, what sort of person he is as well as what sort of a problem he has got. Is he resourceful in overcoming his difficulties or does he use them as an excuse for everything he cannot or does not want to do? Attitude to the disability is often as important to rehabilitation as the handicap itself. I am talking now of patients who are not grossly confused and who are in touch with their surroundings. If the social worker is skilful, the patient in talking to her will express some of his anxiety and perhaps resentment at what has happened to him. In so doing he will release some of his tension and relax a bit and the problem will present itself as less of a nightmare and more of an obstacle. This is the social worker's first objective, to get the patient to see the problem, not as a nightmare beyond his control, but as an obstacle which he can tackle and at least modify even if not overcome. This nightmare versus obstacle process is the technique which social workers call casework. The change doesn't happen in a single ten minute interview; it usually needs a series of interviews, perhaps spread over weeks or even months, I find that with old people repeated short interviews are much more profitable than less frequent but prolonged ones.

The decision is the patient's

Possible courses of action are discussed with the patient and his family so that they all know the alternatives, but the patient must decide for himself. His life is his to plan and not mine or anybody else's. This I think is where the approach of a social worker differs from the approach of a doctor, a nurse or a physiotherapist. Your approach is essentially authoritarian, mine is essentially permissive. This difference is fertile ground for misunderstanding between us. Your method is entirely appropriate to your profession and my method to my profession. I think patients know this although very few of them are articulate enough to say so. When we are ill most of us expect definite statements from our doctor about the nature of our illness, and we put up with treatment however inconvenient or uncomfortable in the hope of a quick cure. We should, however, bitterly resent authoritative instructions concerning the management of our personal affairs or domestic problems.

To get back to the social problems of geriatric patients, in geriatrics as in paediatrics it is vital to consider not only the patient but the whole family. Few geriatric patients are entirely independent after discharge. Nearly all need some help from relatives, neighbours or the community services such as home helps, meals on wheels and so on. In hospital the relatives are our greatest allies. They should be made to feel welcome on the wards, made to feel that we appreciate their problems and welcome their interest and concern. There are various ways of doing this. Open visiting is one, short term admission to give the family a holiday is another. But by far the most important is that all grades of staff should deliberately cultivate a sense of partnership with the family. They may not be all that we would wish, or indeed all that the patient would wish, but they are all that we and he have got and if we neglect them we do so at our peril. Families vary as do patients. The relatives of old people who have had strokes often have a lot to put up with; a patient with brain damage from multiple strokes may become forgetful,

irresponsible, irritable, he may write cheques merrily, spending money he does not possess or alternatively he may hoard; goods, money, old papers, he may stop bothering about his personal appearance, forget to wash or shave, leave his buttons undone, eat messily.

Rôle reversal in marriage

In hospital these patients usually behave perfectly well, and the nursing staff would be indignant if they were described as confused. Undoubtedly, though they have lost the edge a bit and the frustration and emotional exhaustion that these old people can create among their relatives has to be experienced to be believed. Other people have to take over the running of the house and doing the cooking and the shopping, or if the positions are reversed the wife may have to take over the household finances. Apart from the actual physical work this reversal of rôles creates tremendous emotional stress. I well remember a retired professional man like this whose wife came to see me so that I could show her what to do with a cheque book. In 60 years of married life she had never written a cheque or paid a bill and she was too ashamed to ask the bank staff or her very competent son to show her. I must say I did wonder how many sleepless nights she had had before she hit on the idea of coming to me. For 60 years she had depended on her husband for financial support and he had made all the family decisions. They were a rather Victorian old couple and this does not happen so often with younger married people these days, but she had no wish to take over what they both conceived to be his rôle in their marriage partnership and she had no confidence in her ability to do so. That old couple had been very happily married and they were still devoted to each other. They needed a great deal of help and support for a long time but the old lady made a good job of caring for her husband until his death a year or so later and incidentally she was much better equipped to face widowhood than otherwise she would have been. For other couples the onset of confusion in one of them can be the last straw in the breakdown of a marriage.

Help from relatives

Old people are usually admitted to a geriatric unit for social as well as medical reasons, and so we get a high proportion of social problems among our patients. It is often said that families used to look after their old people and now they expect the State to do so. I do not think that is true at all; it is amazing how much help many old people *do* get from their families and their neighbours. It is, however, true that in hospital and to a certain extent in general practice, we do not see a fair cross-section; we see an undue proportion of those who have no families or who are estranged from them. We are still dealing with the generation of old women who lost their husbands, fiances or boy friends in the First World War. These are the patients who, if frail or disabled, are likely to need either propping up in their own homes by home helps, meals on wheels, district nurses and any other domiciliary service that is available locally, or they may require admission to an old people's home. Other patients have relatives who have other responsibilities. If, for example, your patient's only relative is a daughter with six children under seven-years old, it is not usually in anybody's interest to expect her to look after her confused hemiplegic mother as well. There are exceptional daughters who will manage it, but in most cases it is simply setting the stage for divorce, nervous breakdown, emotional troubles in the children or all three.

To revert for a moment to the problem of patients without close relatives, during one year I arranged for 67 patients from the Hastings geriatric unit to go into old people's homes. These were all patients who had not lived in homes before and for whom it was intended that they should live permanently in the home. Of these 67 old people, 37, that is 32 women and five men, were either single or widowed without children. Others had children but they were not available to help. One widow's only son was in New

Zealand, another widow's only son lived in lodgings in London, coming home at the weekend. One old man was admitted as a social emergency after his daughter had attempted suicide and was taken to a mental hospital. Only one daughter of this group felt no responsibility and only a lukewarm interest in her mother's future. This girl was illegitimate, fostered as a baby and had had no contact with her mother until she was ten-years old when the foster mother died and the child went to live with her mother and stepfather. There did not seem ever to have been any affection between mother and daughter, although the daughter by this time of course was grown up and married with a family of her own. She did agree rather half heartedly that if I could get the old lady into a convenient nearby home she would visit.

This case illustrates what we repeatedly find, that children brought up away from their parents for whatever reason are not likely to feel much responsibility for them in their old age. We hear an awful lot about the illegitimacy rates among young people now, but it surprised me how many of our geriatric patients had illegitimate children, because we do not really associate it with that age group. The reason is that when people have grown up, established in jobs or married they are not always ready to admit that they were illegitimate or that they were brought up away from their parents. Mother probably married someone else subsequently or else assumed the courtesy title 'Mrs'. If you look for illegitimacy among younger relatives who, you think, could but will not look after their old people, you will probably find it much more frequently than you might imagine. There is no easy answer to these problems. What is right for one patient is wrong for another. But undoubtedly social policies that enable parents to bring up their own children in conditions that encourage decent family life will contribute indirectly towards better care of the elderly and the handicapped. Some patients need a miracle not a social worker. For others there seems to be no answer, at least not in this world. Social work is a bit like medicine. You cannot cure everybody but most people can be helped to some extent.

Discussion

Dr Robert Hardwick (*Maidstone*): The Hastings team has set a pattern in the hospital rehabilitation of disabled patients, and I am sure you will have caught the air of enthusiasm which plays an essential part in their success. But two other members of the team ought to be included, one is the family doctor and the other the relatives. A vital factor in successful rehabilitation is the mental approach of the patients and their contacts; here the family doctor has a very important educative rôle. I constantly come across patients undergoing rehabilitation who say that when they are at home they are advised to take it easy and have a rest. This is a dreadful approach, one which medicine as a whole overfavoured in years gone by but which in most departments is now being altered.

Everywhere you find people being made to get up earlier, being encouraged to do more, and this enthusiastic, somewhat aggressive approach is essential in old people. They must be encouraged all the time to try a little bit more, whereas advising them to take it easy is simply accepting defeat. I am a great believer in this aggressive approach. There may be an occasional tragedy, but most of us would prefer to go out with our boots on rather than finish up in some rather gloomy long-stay ward.

One other point. Minor ailments that you or I would hardly notice become very important in elderly people. The early detection and treatment of minor degrees of anaemia, urinary infection, upper respiratory infection and so on are important in keeping these people going.