ELDERLY LIFE: ITS CHARACTERISTICS, NEEDS AND PHILOSOPHY

J. W. BEATTIE, M.D., M.R.C.P.
Consultant Physician in Geriatrics, United Norwich Hospitals

Elderly life or the period of ageing has many important aspects—especially its relationship to life, to itself, that is, its particular attributes, and to society, and its attractiveness or otherwise as a subject for scientific study and practice.

Certain quotations emphasize these aspects:

SOCRATES:

From the day your baby is born you must teach him to do without things. Children to-day love luxury too much. They have execrable manners, flaunt authority, have no respect for their elders. They no longer rise when their parents and teachers enter the room. What kind of awful creatures will they be when they grow up?

BOSWELL:

Boswell: What I admire in Ramsay is his continuing to be so young.

Johnson: Why yes sir, it is to be admired. I value myself upon this, that there is nothing of the old man in my conversation. I am now sixty-eight and I have no more of it than at twenty-eight.

Boswell: But sir, would you not wish to know old age? He who is never an old man does not know the whole of human life; for old age is one of the divisions of it.

Johnson: Nay sir, what talk is this?

Boswell: I mean sir, the sphinx's description of it: morning, noon and night. I would know night as well as morning and noon.

Johnson: What, sir, would you know what it is to feel the evils of old age? Would you have the gout? Would you have decrepitude?

Seeing him heated—I would not argue any further, but I was confident I was in the right.

MARGERY FRY (herself an octogenarian):

Intellectually you alter your opinion of yourself as adolescence, maturity, and old age follow each other, but the knowledge "I am middle-aged, I am elderly, I am old" has to be recalled into consciousness again and again. . . . We certainly do not feel that it (old age) belongs to us in anything like the way in which outside people classify us by it. . . . The surprises which most

people have to confront on reaching old age are of two kinds: " So what we all said is true, but I never quite believed it could happen to me "—this of the effects of age visible from without. . . . Beyond the physical characteristics there are others, of which we have been well forewarned by the unsparing frankness of youth. . . . There is no one point upon which I feel stress needs to be more constantly laid than this, that the external stigmata of old age must not be allowed to obscure the lasting divergencies of character; individuality must be respected. . . .

The doctors (and they exist) who are ever ready with " What can you expect at your age? " throw away some useful odds and ends of human life.

And finally a medical quotation:

Mental deterioration in the elderly was now a problem of great medical and social importance, yet it had excited comparatively little psychiatric interest. There were many reasons for that, mainly based on the tradition of unacceptability of old age to our general hospitals, and on the beliefs that all medical problems of the elderly were uninteresting, that diagnosis and prognosis were uniformly dull and gloomy and that therapy was doomed to failure. Reflection would show that that was the attitude and outlook towards the elderly in general medicine twenty years ago.

These four aspects of elderly life merit further examination and comment.

Its Relation to Life

Senescence or the state and period of ageing is an essential, integral, physiological, or normal period of life. Following the first period of childhood and youth when growth and development predominate over degeneration, there follows maturity or adulthood when relative stability exists between growth and degeneration and finally the period of senescence when degeneration predominates over growth.

Senescence will therefore be experienced by many people. It must be regarded as inevitable and normal. It must not be considered as a pathological or abnormal state of maturity. It must not be feared as being synonymous with decrepitude or mental infirmity. In other words senescence is not synonymous with senility, the latter in modern scientific thought implying a condition of abnormality. Explanation of the characteristics of senescence and preparation for it however are necessary.

Its Relationship to Itself

Examination of the relationship of ageing to itself implies investigation and clarification of its attributes.

Incidentally it is preferable never to speak of old age, for in this mechanical era things old carry the implication of being useless. Moreover, too many people still refuse to call themselves old, even

when the most tolerant adults cannot possibly adorn them with any other description. On the other hand, things elderly still have uses and, indeed, may have added lustre. It is better therefore, to think of people being elderly and ageing.

Senescence can be defined and is different biologically, psychologically, sociologically, and clinically from the period of maturity. If senescence is a normal period of life, different from the preceding period of maturity or adulthood, then it must have certain distinguishing characteristics. Being different implies either the possession of qualities not found in others, or the absence of qualities found in others, or a marked difference in the nature of the qualities or characteristics already present in others.

There are certain well recognized biological criteria of ageing or senescence; for example, morbidity or invalidism increases markedly in senescence, survival curves show a rapid decline and accident proneness increases. More important individually is the fact that marked alterations in functions must be expected; for example, increasing difficulty in the dark, increasing liability to falls, increasing deaths from falls, and increasing reduction of mobility long before any real infirmity may arise. Alterations in the environment, whether external or internal, are badly withstood. On the other hand, disturbances of physiological functions are easily produced, the range of permissible variation is narrowed and minor changes may produce serious damage.

A whole range of psychological performance tests shows evidence of deterioration; for example, in accuracy of judgment, in speed of judgment, in reaction time, in performance time, in the ability to select from multiple choice situations, in the ability to retrain without previous allied experience, and in the ability to learn new material of various kinds. Paced tasks are extremely difficult for the elderly, especially when the pacing is combined with continuous bodily activity or movement or muscular work. There is slowing of sensory processes and central control, of psychological and somatic adjustment reactions, and of the perceptual organization of incoming stimuli within the central nervous system.

There is a lack of flexibility of outlook, an increasing inability to meet and deal with new situations, a resistance to change and a sacrifice of speed in activity and thought.

Intelligence tests also show declining scores with senescence, when comparison is made with younger groups, i.e., people of later

generations. It has been found that less deterioration occurs with the tests of more frequently used abilities, such as vocabulary, general information, and verbal comprehension, than with the abstract tests.

When can these changes be found? They can be demonstrated quite easily and clearly in people 60 plus years of age. They are the effects of alterations in function; some deteriorate steadily from early adulthood, some deteriorate slowly throughout adult life and then more rapidly in senescence, and others remain nearly unchanged throughout adulthood until they show marked deterioration in senescence.

The personality in the elderly is in a way peculiar to senescence. It is a natural and inevitable development of all that has already taken place in the individual's life. Character becomes fixed and intensified, dependencies and inadequacies camouflaged in earlier life by supporting social factors become obvious, rigidity in thinking and action sets in, special fears arise, the immaturity of earlier years is revealed, and the poor relationship with the grown up children is seen to be part of a lifetime of immature or neurotic behaviour. There may occur intellectual, emotional, and creative impoverishment. It will be obvious that careful preparation must be made before entry into this period of life in order to minimize the deficiencies and increase its potentialities. Such preparation must be made early in middle age.

The result then is that the elderly person is markedly different from the adult or mature person, a fact still not universally appreciated. These functional changes are associated with morphological alterations—predominance of degenerative rather than reparative processes, reduction in parenchymatous tissue as compared with connective or supporting tissue, and intrinsic alteration in the supporting tissue and vasculature.

Clinically, senescence is also demarcated. Diseases represent disharmony or imbalance between the biological unit and its environment, external, or internal; or an inability of the individual to meet the demands made upon him by his life; or a disproportion between a person's abilities and his requirements. Clinical differences regarding diseases in the elderly are of course to be expected since the manifestations of diseases or indeed, the diseases themselves, are the product of the host and the causative factors (predisposing, precipitating, and prolonging) and not merely due to the causative

factors. Whatever the disease may be named, because of its causative factors, that disease cannot be the same throughout all physiological periods of life, if the subjects of these periods, the patients, are in fact different. Names do not make a disease. Moreover, in the elderly duplicity, multiplicity, and chronicity tend to be the characteristics of the symptomatology, the pathological lesions, and the diseases.

There is a precarious balance of health in the elderly. This is well realized even by those who have previously refused to recognize that they were ageing once they have sustained an illness, even when such illness has been apparently well overcome. Important basic clinical features are the capacity of minor upsets to produce apparently grave illness, severe physical or mental infirmity, the unfortunate inability to stand change well, the ease and frequency with which minor disturbances of physiological functions may produce severe damage to the organism and the detrimental effects of recumbency and bed-rest. Characteristic of disease processes in the elderly are the tendency for locomotory functions in the elderly to be lost or seriously diminished, the frequency of acute symptomatic confusional states, the paucity of reactive processes and the non-specific nature of many initial manifestations, e.g., malaise, falls, syncopal, or cerebral attacks. Differences in diseases such as alterations in acuteness, in symptomatology, in severity, and in course, and the importance of a régime of management appropriate to the elderly are gradually becoming more widely recognized.

Despite the defects of the personality and the decreases in efficiency of various psychological functions, mental deterioration is not an inevitable result of ageing. Preservation of the personality and mental integrity is compatible with advancing age. Unwise attribution of a casual relationship on the basis of certain mental or behaviour characteristics or symptoms and a presumed morphological alteration, especially of a vascular nature, in the brain has brought about great confusion and obscured certain facts. Several authorities have clearly stated that there is no clear relationship between behavioural changes in senescence and anatomical and physiological alterations in the central nervous system. " It appears that older people are able to tolerate extensive degenerative change in the central nervous system without serious effect upon their behaviour provided that their cultural environments continue to support them."

Mental disturbances thus require brief mention. Acute symptomatic confusional states occur with great frequency in somatic conditions in the elderly. Their great characteristic is their recent onset—they represent a rapidly developing change in the personality —and they are due to internal (disease) or external environmental changes. They are, therefore, essentially a medical as distinct from a psychiatric problem. The same is true of the secondary or terminal mental confusion, deterioration, or dementia produced by gross cerebral or somatic damage in conditions which already will have required ordinary medical and nursing care.

Other mental disturbances would appear to be more properly regarded as psychiatric problems. These include the occurrence of one of the already known, more usual psychiatric syndromes, the diagnosis of which, however, may be difficult in senescence, the common but inadequately understood senile psychosis (or true senile dementia) representing a *gradual* disintegration of the personality, or the comparatively uncommon but too often diagnosed arteriosclerotic dementia with its interrupted stair-case, downhill course. It must be emphasized that senile psychosis is not simply an organic brain illness but a multifactorial condition of varying mental patterns encountered with and without organic disease, that is, rather a concept of accumulated emotional traumata from without and within with reactive mental changes.

Sociologically, the interests of the elderly tend to narrow, especially with retirement. Three main interests usually predominate—economic security, health, and the presence or absence of a sense of purpose in life. The sociological characteristics of senescence have been carefully analysed. It has been found that increase in age is associated with: a higher percentage of widows and widowers; a higher percentage living in dependent relationships; a decrease in amount of close companionship; a decrease in participation through attendance at meetings, offices held, number of hobbies, and plans for the future; a decline in the gainful employment of males; greater dependence on pensions, old age assistance, and children for support; increase in physical handicaps, illness and nervousness, and a decrease in feeling of satisfaction with health; increase in religious activities and in dependence upon religion; decrease in feelings of happiness, usefulness, zest for living, and a corresponding increase in lack of interest in life; and lower median attitude score, indicating poor adjustment. While it has been alleged that the withdrawal of the elderly from occupation, from

community affairs and family life is largely involuntary yet it must be appreciated that—

... " there is one test of senescence that almost all men must meet—the consciousness that they can no longer carry out in their normal ways the work to which they had grown accustomed. It is often the first sign for them that organic or mental changes are taking place. Occasionally the signs are more evident to their workmates or their supervisors ". Thus " there is nowadays a fundamental distinction for an older man between being fit for industrial employment and being fit to live a healthy retired life."

Personal adjustment therefore is necessary for the elderly. Personal adjustment has been described as the restructuring of attitudes and behaviour to enable the person in response to a new situation to achieve the integrated expression of his wishes and aspirations in a form that also satisfies the expectations and demands of society.

However, the environment is important and here society as a whole is faced with its responsibilities in the challenge.

Its Relationship to Society

Ageing undoubtedly presents certain challenges. Retirement must come about because of decreased performance, psychologically, physically, and socially, in the elderly, the increased working span of life of the productive section of the population and the decreased working time in the week through automation. One of the critical problems of senescence, therefore, is the discovery of some status-giving roles to replace those of the essentially productive years of life. This problem involves not only the elderly person, but also the community in which he lives and indeed society as a whole. In addition to personal adjustment on the part of the elderly person, social or society adjustment and social integration are of great importance. Only under these conditions will it be possible to hope for the attainment of happiness and the prevention of feelings of loneliness, inferiority, or frustration.

Throughout life existence in isolation independent of the community is impossible. There must at all stages of life be a co-operative relationship between any person and his neighbours and the community as a whole, involving the participation in whatever mutually provided services exist. The contribution of something by everyone is important for then the receipt of help does not mean humiliation.

Happiness for the elderly is a society obligation. It is not only morally, but socially, economically, and politically desirable. Happiness lies essentially in the feeling of being needed, of being

useful, of being secure, and in not being lonely. The needs of older people " in relation to the theory of the fundamental wishes " as set forth by W. I. Thomas have been formulated as:

Security—physically, economically, mentally, and emotionally; new experience —to stimulate the body and mind; response—in terms of affection and the expression of intimate appreciation; and recognition—a role in society that has status and function. But our senescence is, to a large extent, governed by what has gone before. Our attitudes, our interests, and our characteristics in senescence are a natural and inevitable development of all that has gone before. The best senescence belongs to those who have had the best adjusted youth and the best adjusted and fullest maturity and have made the most sensible preparation and provision for their new period of life. A happy senescence thus has to be earned, prepared for, provided for, and maintained. Interests must be developed earlier in life of such a kind that they can be maintained and prosecuted during senescence with the facilities that will be available then. Moreover, these interests should be pursued, for preference, in familiar surroundings at all times. Recreational activities and stimulating interests, while of great importance to the elderly in the maintenance of health, cannot substitute for occupation unless they have social value or status. Furthermore it must be appreciated that the most rewarding activities in which we engage are those " in which we express our most intimate self in some organized kind of way ".

An elderly person cannot by himself provide a successful senescence. Society as a whole has a part to play—in its attitude to the elderly, its willingness to make provision for them and to participate in common organized activities, and its recognition of the importance of the conditions under which people age.

In considering society's responsibility to the elderly it must be remembered that every elderly person today has given more to the community in terms of working life span alone than his predecessors of 60 years ago and may well have given more than this generation will give because of the continuing reduction in hours in the length of the working week. The elderly person of today has already invested his life in the community.

Its Scientific Study and Practice

The scientific study of human ageing has not so far been very popular, especially from its medical aspects. Even today the need to consider the elderly person as representing a definite physiological being has not yet received universal recognition. Elderly people were not welcome in the voluntary hospitals of pre-war days, but were diverted into the public assistance institutions, and today their admission into, and reception by some hospital departments might seem an act of tolerance rather than of right, which may be withdrawn should other more acceptable patients appear. Nevertheless a large and growing body of medical knowledge concerning

the elderly is being accumulated. Indeed in this country where such a high proportion of the illness is found amongst the elderly population, the practice of medicine among the elderly is inevitable. The development of geriatrics, as the whole medical care of elderly people is known, therefore must be encouraged.

The benefit to the elderly, which has accrued from the organization and development of hospital departments devoted to acute or active treatment, geriatric medicine, or medical geriatrics, as the non-operative or medical aspect of geriatrics is known, is being gradually acknowledged. It has demonstrated how much there has been to learn about illness in the elderly, how much of the illness and disease in the elderly is remediable or at least capable of alleviation, and how rewarding special management and courageous therapy can be. Nevertheless there is still a need for more " acute " or active-treatment medical beds specifically allocated for the elderly sick population and not necessarily nor simply for more chronic sick beds for permanent hospital nursing accommodation of the irremediable and nursing dependent. There is strong suggestion that with the provision of the former, the containment within reasonable limits of the chronic (or true irremediable) sick problem is possible. Such active treatment beds must have the usual full ancillary services (diagnostic and therapeutic) *to provide from the beginning and in one place*, complete and comprehensive investigation, diagnosis, and treatment including simultaneous rehabilitation. Moreover such active treatment beds should be direct admission beds, able to deal with all medical (non-operative) problems in the elderly, including medical emergencies. A collection of beds which cannot provide such services cannot logically be a geriatric medical unit and cannot, without further qualification of the title, be so described. The official Ministry of Health (notes on Form S.H.3) definition of a department of geriatrics demands facilities for diagnosis, treatment, and rehabilitation. Irrespective of whoever looks after the elderly patients, there would seem to be an undoubted need to make special provision for their medical care and management in the general hospital. Separate accommodation from the beginning either in units, wards, or ward-annexes would surely be the most satisfactory solution, in view of the attributes of the elderly previously described.

In providing for long term or permanent hospital nursing for the elderly, accommodation separate from the young chronic sick and the adult chronic sick is necessary. The chronic sick, as distinct

from those with a chronic disease or illness, are the irremediable bed-fast or chair-fast or otherwise dependent who require nursing which could only reasonably be provided in a hospital.

Separate accommodation emphasizes the need for new and distinct management techniques, prepares and provides for different clinical manifestations, shows concrete belief in the difference that exists between the elderly and other patients and provides better opportunities for research. Separate accommodation seems the easiest and most efficient way of achieving what is best for elderly patients, what is best for the development of geriatrics as a whole, and what is best for the staff tending the elderly. Such separation under the appropriate consultant staff should ideally apply to surgical orthopaedic and other specialist management as has occurred already in paediatrics. In the future then there will surely be geriatric surgical, geriatric accident, and other geriatric sections.

Much of what was prophesied for geriatrics—which is a patient-orientated discipline like paediatrics and not merely an anatomical or technical specialty—is being gradually fulfilled, as has already happened with paediatrics.

It is unfortunate that the formation of this separate discipline, concerned with the study of health and disease in the elderly, has arisen through the failure of those preoccupied chiefly with the adult or mature population to appreciate the special characteristics and needs of the elderly, just as happened years ago with children and led to the development of paediatrics.

The provision of special mental health services for the elderly is now of immediate concern. There can be no doubt of the medical and social importance of mental deterioration and disease, yet it is receiving comparatively little expert psychiatric attention. It would seem that psychiatry is now in the same position as general, or really mesiatric, medicine twenty odd years ago in regard to the elderly with the view—that all their medical problems are uninteresting, untreatable, and unsatisfying. It cannot be denied that the problem is of such a size as to warrant attention; that there is a need for more knowledge of psychological processes in the elderly, of disease reactions, of the aetiology and course of dementia, and of the requirements for maintenance of the integrity of the personality and mental health; and that there is an unsatisfactory attitude to the whole problem in regard to the desire to provide for intensive investigation, to explore the intricacies of diagnosis, and to experiment with

methods of treatment, management, and accommodation.

It is possible that there might be a different psychiatric outlook if there were satsfactory methods of disposal following treatment, if the accommodation of the elderly did not prevent the admission of the adult, if there were a decline in the need for inpatient accommodation for the adult population and if there were some encouraging reports from pioneer units.

Not only the medical and psychiatric aspects of human ageing require greater investigation. Sociological studies of ageing are being pursued but there is insufficient knowledge as yet from longitudinal studies, socio-psychologically orientated. Moreover, social service for the elderly, both in a professional as well as in a voluntary capacity, still lacks and still fails to attract personnel in all spheres.

The Needs of Elderly Life

There are eight factors of importance for the well-being of the elderly. They are health, housing with its important associates heating, lighting and sanitation, health giving foods, home services and aids, happiness, activities, health and welfare " retirement " clinics, and hygiene of the mind (mental health). Certain comments may be made on some of these factors.

When special housing is being provided, attention should be paid to the deficiencies of the elderly, for instance, failing eyesight, difficulty in the dark, tendency to falls, declining muscular power.

Housing for the elderly must be considered in three categories:

(1) For the fit or fairly fit, which might be special extra ground-floor rooms or ground-floor flats in family houses, or maisonettes or flats in property specially adapted and converted for the needs of the elderly, e.g. with lifts, safe and easy heating, illumination which can be operated immediately on entering darkened rooms or corridors or before getting out of bed, non-slip flooring, wall-rails, and several easily accessible call or alarm signals.

(2) For the semi-fit, possibly consisting of grouped bungalows, with a supervisory warden or in association with hostels, with certain communal services provided, e.g., recreation, feeding, heating, laundry; and

(3) For the infirm, mentally and physically, unable to provide for themselves but able to live a community life, where the varying needs of privacy, segregation, companionship, and supervision have to be satisfied.

There is a great need for two new developments. In the first place it is essential to consider the provision of communal services as indicated above, almost routinely, either within the grouped bungalow schemes or through the associated hostel where present. Under no circumstances should the provision of the bungalows alone be considered sufficient; the occupants must also be provided for as much in social and cultural companionship as in material help. Furthermore, it might well be considered desirable to arrange always for the adjacent association of the hostel and the grouped bungalows. So much of mutual assistance is bound to result from such an arrangement, to the residents of both types of dwellings.

Too often there is excessive preoccupation with the bodies of the elderly and too little respect for or attention to their minds and personalities and their social needs. The provision of a special hostel for social rehabilitation and reintegration is the second need. Too frequently one hears of elderly people struggling in lonely despair amid declining powers towards decrepitude, supported in this unfortunate situation with desperation by those without statutory welfare accommodation available, when a short period in the warm, comfortable surroundings of a special hostel supplying good food, good companionship, and good hope, might well provide invigoration, revitalization, and reintegration within the community. How much statutory accommodation might be unnecessary if it were not the case of " once in, never out ".

The home or domiciliary services provided by the local authorities and voluntary organizations require no emphasis. Attention should be directed however towards a new aspect—providing services designed for short term emergencies—such as night sitters, day sitters, night nurses—as well as continuing the adequate provision of the long term services, e.g. home help, district nurse, chiropody, home bathing personnel, the supply of linen and other sick room requirements, disability gadgets and aids, provision for structural alterations, adaptations and home gadgets, and the provision of meals-on-wheels and laundry services. So much good-will exists to help the elderly that it is essential that there should be a voluntary co-ordinating committee with representatives from the hospital services, the local authority services, and the voluntary organizations in order that no avoidable duplication of services or unnecessary dissipation of energy takes place, amidst the general desire to provide assistance.

A few years ago attention was drawn to the need for health and

welfare retirement clinics. It was envisaged that these clinics should have a dual purpose:

(1) To provide the mature or middle-aged members of the community with pre-retirement advice and information regarding the meaning and implication of senescence, the possible effects of retirement, and the means of suitable preparation for elderly life in order that it might be a satisfying and satisfactory period of life, and

(2) To offer to the elderly, whether retired or not, a clinic, specially concerned to maintain health and to detect the early manifestations of disease, to undertake research regarding health and disease, and to provide advice about services available to the elderly for various purposes, and, for both classes of people, to provide education regarding all the measures designed to promote full health, both before and during elderly life.

Such a health and welfare retirement clinic and a social rehabilitation hostel would undoubtedly make great contributions to the maintenance of full health and the prevention of unnecessary deterioration and disease.

It would seem that many difficulties would be overcome by inaugurating special geriatric psychiatric services based on the threefold pattern of the geriatric medical services:

(1) An acute or active treatment unit, with full facilities for investigation, diagnosis, and treatment, including rehabilitation of *all* psychiatric conditions and not solely the unattractive ones, from which patients would be discharged to their own homes or one of the institutions mentioned below.

(2) The chronic annexe where custodial care of the irremediable, anti-social, mentally disordered would be provided, and

(3) The local authority home or hostel or similar institution designed for the mentally sick or senile who were fit to live a community life.

It would seem essential that the geriatric psychiatric service should be under the primary control of the psychiatrists: the problems are those of disorders of the personality, expressed in behaviour and mental activity; the discipline best fitted to investigate, explore and undertake research upon these problems would undoubtedly be psychiatry; the personality which develops throughout life and is indivisable in its growth or degeneration should surely likewise be indivisable in its management; and, finally, since it is

possible that preventive measures may have to be applied as early as the mid-adult period of life, it would seem desirable and suitable for preventive treatment and curative or custodial treatment to be the responsibility of the same service.

The need to remove or prevent the causes of unhappiness in elderly life has already been mentioned. Elderly people desire and require (1) to engage in meaningful activities, (2) to enjoy a feeling of security, economic, social, and psychological, (3) to take part in the exchange of affection and sociability, (4) to have the feeling of identification and participation with others in common organized activities, and (5) to have their individuality respected. Education concerning these needs must be impressed upon both the elderly and society as a whole. It must be appreciated that expression of all four wishes and activities (1 to 4) above is necessary, otherwise unadjustment and maladjustment may occur, and that it is not possible to substitute an activity in another field for an unexpressed or unsatisfied wish, though sublimation by another activity in the same field is satisfactory.

Improvements in the mental health of the elderly will only come about through increasing knowledge and action based upon this knowledge. Reference to this need has already been made. In particular, prospective studies of the middle aged and retrospective studies of the elderly ought to help in indicating the factors which are of importance for mental health in elderly life. But of great importance is the removal of the general apathy concerning geriatric psychiatry and mental hygiene.

As man is composed, at least, of body, mind and emotions, and needs to live within the community of other human beings, that is, should be regarded as a psychosomatosocial entity, and as living implies activity, then the needs of elderly life may be summarized as requiring provision of all the factors necessary to maintain ability and performance in these three aspects.

A Philosophy for Senescence

A philosophy for senescence must take cognizance of the various factors discussed above. Calmness of mind toward ageing must be based on the realization and acceptance of certain concepts, and the rejection of others.

It is necessary to accept the inevitability and normality of ageing and senescence, its attributes or, in a way, its deficiences, and the inevitability of some restriction in activity and work or retirement.

Senescence has a definite place in the inescapable and probably unmodifiable pattern of life which over the centuries has evolved and proved most successful for the perpetuation of the species.

It is equally important to reject the ideas that impairment of function means infirmity or decrepitude, that " old age " is to be equated (especially with other people's) decrepitude or senility, or that " old age " is only to be considered (and thus unprepared for) as some vague period about 10 years beyond one's present age. The fear of inevitable increasing infirmity and senility as a consequence of indefinitely increasing life expectancy must be allayed. Recognition of the difference between life expectancy and ultimate life limit is necessary. The expectation of life has been subject to extension in the earlier (*but not in the later*) decades, especially in this century so that it is approaching the ultimate life limit, which is unlikely to be appreciably increased.

It must be appreciated that besides personal adjustment, social adjustment to, and social reintegration in, senescence are necessary, and call for the development, at the latest, in early middle age of interests and activities which can be carried over into and maintained during senescence on the one hand and a sympathetic and co-operative society on the other.

Continued activity in all aspects of the fundamental wishes and needs, the acquisition and use of knowledge, such as education throughout life, the practice of obligations towards the community and the use of sociability and intercourse, are essential for a satisfactory, satisfying, and successful senescence. Not only must the individual play his part in formulating the philosophy for senescence, but society as a whole must realize that the conditions in which people age may determine whether they are going to regress or improve. The ultimate responsibility for preventing or postponing regression lies with society. There must thus be an acceptance of the necessity for status-giving roles in senescence to replace those of the productive period of life. There must be full exploration of the sociological problems of the correct location of the elderly in the community and of the contributions which they can and should be asked to make to the community. There must be the determination that nothing should be allowed to obscure the lasting divergencies of character in the elderly, and that their individuality should be respected. Finally, it should be remembered that social reform has been defined as the process of creating the social problems of tomorrow by measures designed to solve those of today.