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mocking took the place of sadness and loss until the feelings could be worked through in the group discussions.

I have tried to demonstrate how important it is for staff involved in painful and stressful work to be given space to think about the anxieties stirred up by the work and the effects of these anxieties on them. The cost of not having this is considerable, both to clients and to workers. As well as offering much needed support, consultation can offer the opportunity for insight and change in the group and wider institution, *if* the pains and difficulties can be tolerated.

Chapter 8

Till death us do part

Caring and uncaring in work with the elderly

Vega Zagier Roberts

Caring for elderly people brings with it particular stresses, insofar as ageing is the fate of all who live long enough. It inevitably stirs up anxieties about our own future physical and mental decay, and loss of independence. It also stirs up memories and fears about our relationships with older generations, especially parents, but also grandparents, teachers and others, towards whom we have felt and shown a mixture of caring and uncaring. This chapter discusses how these anxieties were dealt with in one geriatric hospital. However, the processes described exist to some extent in all caring work.

THE INSTITUTION

Shady Glen was a specialized hospital for severely impaired elderly people who, without being particularly ill, required intensive, long-term nursing care. It had two wings: the smaller North Wing had three rehabilitation wards for those patients who were thought likely to be able to leave the hospital eventually; South Wing had four 'continuing-care' wards for those who were not expected ever to be able to live outside the hospital again.

The four wards of South Wing were particularly bleak and depressing. The beds were arranged in a circle around the edge of each ward, pointing towards the centre, from where the nurse in charge could keep a watchful eye on everyone. Squeezed between each bed and the next one stood a small wardrobe and chest of drawers; there was little space for personal possessions, and virtually no privacy. A few patients could move about with walkers, but the others spent most of their time in bed or sitting immobile in chairs. Most were totally dependent on the nursing staff for all their physical needs, and were fed, toileted and bathed on a fixed schedule.

The nurses maintained a high standard of physical care. There were few bedsores or accidents, little illness, and the patients were clean and well nourished. However, the managers of Shady Glen were concerned about the poor quality of life for the patients in South Wing, and asked the senior nurses of the South Wing wards to form a working party to explore what could be done to improve the situation. It quickly became apparent that patients' quality of life

could be examined meaningfully only in conjunction with the quality of life for the staff working on the wards, and also that other significant hospital staff could not be left out of the project if real change were to take place. The working party was therefore expanded to include the heads of other departments providing patient treatment. Two external consultants were brought in to assist the working party in thinking about the stresses in the continuing-care wards, and considering how these might be coped with better. They were then to present their findings and recommendations in a report to the senior managers of Shady Glen.

STRESS AND INTERPROFESSIONAL CONFLICT

Morale among the nurses was very low, and relations between them and the other professional groups involved in the treatment of patients were antagonistic and competitive rather than collaborative. The nurses felt, not without some justification, that they were left to bear the brunt of the strenuous but thankless routine of physical care, unsupported and unappreciated. This kind of work has low status within the nursing profession – just as the patients on these wards could be said to have low status in society – and many of the older nurses at Shady Glen lacked the training and technical expertise needed for jobs elsewhere. They felt their wards were used as a dumping-ground for people that everyone else – doctors, families, society – had given up on and wanted kept out of the way, but well enough looked after that no one would have to feel too guilty about having rejected them. Not only did the nurses get little positive feedback from colleagues, patients or patients' families, but they got little inner satisfaction from the sense of a job well done. None of them felt these wards were a place where they would wish themselves or their loved ones to spend their last years.

The division of the hospital into two parts, one for patients who would improve, and another for those who would not, exacerbated the problem for both patients and staff. Many patients died soon after being transferred from North Wing to South Wing, as if they had received a death sentence. Staff on the continuing-care wards were deprived both of hope and of the satisfaction of seeing at least some of their patients improve and move back into the community. The alleged rationale for this division was that the two kinds of patients required different treatment approaches, and that the presence of 'incurables' would retard the progress of the less impaired patients, as if their condition were contagious, though there was little evidence for this.

At the same time, the nurses were not in the business of helping patients to die, as in a hospice, since most deteriorated only very slowly and remained on the wards for many years. It was as if the patients were 'on hold', the nurses just struggling against the gradual encroachment of decay. In the face of all this, any idealism or enthusiasm in newly arrived nurses was rapidly extinguished. New ideas they offered were rejected as impractical, or even sabotaged. As a result, those with ideas and choices rarely stayed long, and the staff from departments

other than nursing tended to focus most of their efforts on the rehabilitation wards, adding to the continuing-care nurses' sense of being abandoned.

In the absence of the usual nursing goal of assisting patients to get well, the nurses did the best they could to keep patients as well as possible, which translated into keeping them safe: preventing accidents by keeping mobility to a minimum, discouraging the keeping of personal possessions which might get lost or stolen, keeping patients out of the kitchen in case they burned themselves. This policy, while depriving the patients of individuality and dignity, added to the quantity of work to be done by the nurses, so there were rigid schedules for meals, drinks, toileting and dressing in order to get it all done. Furthermore, since other professionals, like occupational therapists and physiotherapists, were mainly oriented towards increasing patients' mobility and independence, and since the services they offered tended to clash with ward routine, friction between the various disciplines was inevitable.

THE CONSULTATION

The antagonism between the nurses and staff from other departments was so great that the two consultants initially worked separately, one consulting to the senior nurses on South Wing and the other to the heads of the departments providing specialist inputs to the wards: speech, occupational therapy and physiotherapy. The plan was that the two groups would each first explore their own concerns and develop their own ideas for improving the quality of life on South Wing, and later come together to work on joint recommendations to make to management.

The nurses were at first apathetic and resistant to the whole project. They had worked on the continuing-care wards for a long time, were cynical about managers' implementing any of their suggestions, and were in any case sure that very little could be done, given the extent of the patients' disabilities. Everyone found their attitude very frustrating; even the senior nursing officer, who usually defended 'her' nurses from criticism from outsiders, chided them for undermining the project.

In contrast, the members of the other group were young, enthusiastic and full of ideas. As heads of their own departments, they were accustomed to making decisions fairly autonomously, and for many weeks they worked eagerly at coming up with new programmes and plans for improving the quality of life on the wards. But the initial excitement gradually gave way to discouragement, as they anticipated – or actually encountered – the nurses' resistance to their ideas. Finally, the group became listless and work ground to a halt, everyone complaining, 'What's the point when they just won't co-operate?' The project had reached an impasse.

A chance occurrence some months into the consultancy changed this. Someone interrupted a meeting to ask for a patient's record, and it was revealed that many speech, occupational and physiotherapy records were months behind. This was the first time that any deficiency in the work of these departments was

recognized. The group now began to work at reviewing their own services and improving them, rather than blaming everything on the nurses and focusing on how to make *them* change. They worked without the earlier excitement, but with more effect. At the same time, without there having been any formal contact between the two groups, the nurses became livelier in their meetings with their consultant, coming up with ideas of their own to contribute to the project. Within a few weeks, the two groups started joint work on what could now be experienced genuinely as a shared task, rather than a vehicle for apportioning blame. They drafted proposals for a new approach to continuing care, and these became the core of the consultants' report to management of their findings and recommendations (Millar and Zagier Roberts 1986).

THE REPORT

The central recommendation was to re-define the primary task (see Chapter 3) of the wards. Up to this point this seemed to have been to prolong physical life, keeping the patients in as good physical condition as possible for as long as possible. The proposal was that it should be 'to enable patients to live out the remainder of their lives in as full, dignified and satisfying a way as possible', which might or might not include their moving out of the hospital. This definition would mean that all the various professionals involved in patient care could see their particular work as contributing to a common purpose, rather than having conflicting and competing aims.

This change in task definition had major implications. It invited re-examination of practices previously taken for granted, such as the nurses' emphasis on safety as a priority, with its consequent depersonalization and loss of dignity for patients. Instead, the new aim required considering how to encourage such independence and autonomy as were possible, identifying differences between patients, so that some could make their own tea or leave the ward unescorted, even if others could not, and even if some moderate risk were involved (provided the patient wished to do so). This not only gave patients more self-respect and choices, but lightened the workload for staff and restored some meaning to their work. The greater dignity and sense of personal identity for patients if they wore their own clothes, no longer had wristband identification and had their personal possessions around them came to be regarded as outweighing the risks involved.

The new primary task definition also had implications for how the hospital was structured, that is, where boundaries needed to be redrawn. Boundaries delimit task-systems (see Chapter 3). Whereas before each discipline or department had had its own discrete task, and was therefore managed as a separate system, the new definition of a shared task required a new boundary around all those involved in patient care. (This is described in more detail in Chapter 20.) Furthermore, the separation of rehabilitation from continuing-care wards no longer had any rationale, since their previously different aims were now

subsumed under a single task definition. By doing away with this, some hopefulness could be restored to the work.

Finally, the report recommended developing improved support systems for staff, particularly during the period of transition from the old way of working to the new. This is discussed further near the end of this chapter.

ANXIETIES AND DEFENCES IN INSTITUTIONS FOR INCURABLES¹

The situation of severely disabled people who are neither dying nor likely ever to improve enough to leave an institution produces particular anxieties both in the residents and in those caring for them. Miller and Gwynne (1972) made a study of institutions caring for people with incurable, mostly deteriorating, physically disabling illnesses, but much of what they described is very similar to what was happening on South Wing. For the residents, entering this kind of institution is inevitably accompanied by a sense of having been rejected – by family, employers and society generally. Those inside such institutions are not necessarily more handicapped than those outside, but they have actually been rejected, if only by having no family to look after them, or no money to pay for care at home. Crossing the boundary into such institutions means joining the category of non-contributing non-participants in society: they lose any productive role they may have had, and with this, often, all opportunity to continue making decisions for themselves. Being treated differently from self-caring and able-bodied people, they experience great loss: 'I am no longer what (who) I was.' It is as if they are already socially dead, although they may be years away from physical death. The staff of such institutions can also have feelings of having been rejected and abandoned. Projective identification processes (see Chapter 5) can contribute to their over-protectiveness of the patients and their anger at patients' relatives and their own colleagues.

These were not the only difficult feelings which emerged during the consultation to Shady Glen. Others included staff members' anger at uncooperative patients and hatred of their failure to improve; discomfort with being still relatively young and healthy; anxieties about their relationships with the ageing members of their own families, and about their own ageing; and guilt for preferring some of their charges and treating them differently, while wishing they could be rid of some of the others, which could happen only through death.

Defences by the staff against becoming too aware of these disturbing feelings included depersonalizing relations with patients by treating them as objects, and by sticking to rigid routines; avoiding seeing common elements between themselves and the patients; illness, absenteeism and exhausting themselves to avoid feeling guilty. There was also an enormous anxiety throughout the care

¹ Readers who have struggled to promote the personalization and dignity of clients and patients in institutions like those described here may object to the use of words like 'incurables' and 'inmates'. However, these stark terms, used by Miller and Gwynne in 1972, have been retained here not only for historical reasons but also to underline the harshness of the experiences being discussed, which can be glossed over by using more modern and politically correct language.

staff about being blamed. This probably arose largely from their internal and unconscious conflicts, but was attributed to their being held responsible for keeping patients safe and well. It produced a preoccupation with patients' safety, rigid routines designed to minimize the chance of making mistakes, and a hostile defensiveness towards colleagues and patients' relatives. The widely felt, but largely denied, doubts about the adequacy of the service contributed to the pervasive tendency towards blaming others.

TWO MODELS OF CARE

The anxieties inherent in any work give rise to institutional defences in the form of structures and practices which serve primarily to defend staff from anxiety, rather than to promote task performance. Miller and Gwynne (1972) identified two models of care in institutions for incurables, each involving a different central defence. The first, the *medical* or *humanitarian defence*, was based on the principle that prolongation of life is a good thing. This tends to be accompanied by denial of the inmates' unhappiness, lack of fulfilment and sense of futility. Inmates' ingratitude is an affront to these values. This defence produced what the researchers called the *warehousing model* of care, that is, encouraging dependence, and depersonalizing inmate-staff relations and care. A 'good' inmate is one who passively and gratefully accepts being looked after.

The second, the *anti-medical* or *liberal defence*, was based on the view that inmates were really normal, 'just like everyone else', and could have as full a life as before, if only they could develop all their potential. This defence produced what Miller and Gwynne called the *horticultural model* of care, defining the aim of the institution in terms of providing opportunities for the growth of abilities, while denying disabilities. There tends to be excessive praise for minor achievements, like the praise adults give for a small child's first drawings, and denial of inmates' failure to achieve social status. A 'good' inmate here is one who is happy and fulfilled, active and independent. Eventually, of course, nearly all of them fail.

It is easier to see the inadequacies of the warehousing model, but the other is also inadequate: the demand for independence may be distressing to some people whose physical and mental strength is declining. In many cases, they have been struggling for years against increasing infirmity, and some may give up this struggle with relief upon entering a nursing institution. Others want to continue to fight. These two types need different kinds of care and different attitudes in their carers. When models of treatment are based on defensive needs in the staff, however, these kinds of distinctions among different clients' needs may not be made, since they require thought and facing reality. Instead, one model is likely to be applied indiscriminately to all, on the basis of being the 'right' way to work, rather than as appropriate for the needs of a given individual at a particular time.

Both models represent unconscious psychological defences against unbearable anxieties aroused by the work, and by the very meaning of the inmates' having entered the institution. There is guilt about the social

death-sentence that has been passed, and ambivalence about whether at least some of the patients might not be better off dead than alive. Similar splits occur in other institutions, for example, between cure and care in work with the mentally ill (see Chapter 13) or with the dying (see Chapter 10). In all these cases, care tends to be unjustly devalued, while cure is pursued against all odds.

MOVING TOWARDS INTEGRATION

Both the medical and the liberal defences were operating at Shady Glen, the first among the nurses, the second among the specialist therapists. Each group was unquestioningly committed to its own model. The therapists blamed the poor quality of life for patients at Shady Glen on the nurses' being unco-operative and too set in their ways to entertain new ideas. The nurses agreed they were resistant to the quality-of-life project, but insisted this was for good reason: no one else was placed as they were to realize the full extent of the patients' disabilities. They also felt hostile towards the more privileged staff who could leave work at 5 p.m. and did not have to dirty their hands with the 'real' work: easy for them to have these airy-fairy ideas! Only they behaved realistically and responsibly; it was thanks only to their disciplined care and unswerving routines that the patients had any quality of life, free of the bedsores, illnesses and injuries so prevalent in other geriatric care settings.

Each group had split off and disowned unacceptable parts of themselves, projecting these into the other group, who were identified with the projections (see Chapter 5). The therapists unconsciously counted on the nurses to attend to details, and so did not take responsibility for these, which led to the nurses' being all the more weighed down and having to stick to routine all the more rigidly. Similarly, liveliness and hopefulness were split off in the nurses and projected, defending them against guilt and disappointment, while the therapists became virtually manic in their planning. As a result of these intergroup projections, the nurses actually were rigid, and the therapists were inclined to be careless.

In the first phase of the consultation, members of the specialist group were excited and hyperactive in producing ideas and plans, the impracticality of which they blamed on the nurses – and the nurses accepted this blame. Over time, the euphoria associated with this kind of manic defence – that everything was possible, if only others would not stand in the way – gave way to angry helplessness and a listless feeling of being stuck. The recognition by the therapists of a shortcoming in themselves – small enough not to have to be immediately denied, but significant enough to provoke self-examination – led to their beginning to re-introject split-off parts of themselves, including responsibility for routine, and recognition of their own and also their patients' limitations. Taking back these projections not only increased their capacity for realistic work, but permitted them to value more the actual and potential contribution by nurses to patient care. Freed of the projections, the nurses were enabled to re-own hopeful parts of themselves, previously split off to defend against disappointment and

depressive concerns, and to begin to relinquish some of their own obsessive preoccupation with routine. As each group became more able to value the other, less anxious about being blamed and therefore less prone to blaming the other, it became possible for them to think together about how to bring about improvements in the patients' quality of life, and thus also in their own.

THE NEED FOR SUPPORT

The recommendations to the management, to re-define the primary task and redraw the defensive boundaries between professional departments (see Chapter 20) and between rehabilitation and continuing-care wards, were designed to reduce the institutional splits which were impairing rather than supporting the quality of life at Shady Glen. However, since institutional defences arise in response to the anxieties inherent in the work, dismantling defensive structures requires providing alternative structures to contain these anxieties. The final part of the report, therefore, focused on ways of developing new kinds of support systems. These were of three kinds.

In the first instance, because of the stressfulness and strenuousness of their work, the staff needed their efforts to be recognized and valued, with explicit acknowledgement of work well done. They also needed more face-to-face contact with the hospital management to counteract their sense of being marginalized, rejected and of low status. This might be achieved through regular visits to the wards by senior managers, to review staff needs and the development of their new practices.

Second, staff needed a time and place where it would be possible – and actively encouraged – to reflect together on their work and how it was carried out. In small groups with continuity of membership, and with positive support from management, staff might then begin to acknowledge some of the unacceptable feelings aroused by their work: the fear, dislike and even hatred they sometimes felt towards their work and the patients, and the anxieties stirred up by the constant proximity to human decay. Otherwise, they could only defend themselves in the kinds of counterproductive ways we have seen. Often, just being able to face these feelings with colleagues can reduce the need for such defences. This, in turn, can lead to more effective task performance, which produces more work satisfaction, which further reduces anxiety: a benign cycle. (For further examples of this process, see Chapters 7 and 10.)

Finally, there needed to be mechanisms for inviting, considering and implementing ideas for change from everyone in the system, whatever their status (including patients and their relatives), so that everyone could participate in joint problem-solving and feel a sense of contributing towards a shared purpose. Such a forum could serve to support thoughtful institutional self-review and development, as described towards the end of the next chapter, in place of the rigid, stagnant working practices and entrenched intergroup conflicts which had previously characterized Shady Glen.

CONCLUSION

Dictionary definitions of care range from affection and solicitude, to caution, responsibility, oppression of the mind, anxiety and grief. Care staff can experience their work in all of these ways. Containing such a spectrum of emotions is psychologically stressful. Since ageing is the inevitable fate of all who live long enough, personal anxieties and primitive fantasies about death and decay add to the strains of looking after the elderly. The pressures to split positive from negative feelings are likely to be particularly acute. We have seen how at Shady Glen this splitting was exacerbated by the way the hospital was organized, with its divisions among the disciplines and between rehabilitation and continuing care.

In all caring work there are elements of uncaring. To be 'weighed down by responsibility' invites flight from the caring task, which can at times be hateful. Obsessional routines of care can serve to protect patients from carers' unconscious hate, from what staff fear they might do to those in their charges if not controlled by rigid discipline. At the same time, these routines can provide organizationally sanctioned ways of expressing hate of patients who exhaust, disgust or disappoint staff. Alternatively, all hate is projected, and the patients' hatefulness denied by seeing them as totally curable.

In his short but seminal paper, 'Hate in the Countertransference', Winnicott (1947) discussed the hate inevitably felt by psychoanalysts for their patients, and by mothers for their babies. He stressed that the capacity to tolerate hating 'without doing anything about it' depends on one's being thoroughly aware of one's hate. Otherwise, he warned, one is at risk of falling back on masochism. Alternatively, hate – or, in less dramatic terms, uncaring – will be split off and projected, with impoverishment of the capacity to offer good-enough care.

Winnicott's paper has given 'permission' to generations of psychotherapists to face previously unacceptable – and therefore denied and projected – negative feelings towards their patients. Indeed, to become conscious of such feelings has become a fundamental part of their training. Such permission – from within ourselves and from the environment – to acknowledge and own the uncaring elements in ourselves and our 'caring' institutions is crucial, both for individual well-being, and for the provision of effective services.