Western Michigan University

The Journal of Sociology & Social Welfare

Volume 5
Issue 6 *November*

Article 8

November 1978

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DIFFERENTIAL ASPECTS OF ASSESSMENT AND INTERVENTION IN SOCIAL WORK PRACTICE WITH THE ELDERLY AND THEIR FAMILIES

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So much in our society separates the rest of us from the old that a discussion of the differential aspects of practice with the elderly and their families (many of whom are aging) runs the risk of being redundant as well as a concealed endorsement of the professional biases which afflict us all. The truth of the matter is that important differences do exist between social work practice with the old and with younger generations, differentials which emanate from a sound gerontological knowledge base. Although the similarities far out-weigh the discrepancies, failure to recognize or delineate these differences has resulted in frustration and disillusionment and qualitative limitations on our work.

Our quantitative efforts have also suffered. Morris has noted that the under-representation of older persons as recipients of all types of social services is attributed to the fact that social work has overlooked scientific knowledge, failed to recognize the potential of the elderly for personal growth and successful adaptation and therefore has set low priorities to their needs.[1]

For the most part those developments, which have taken place over the past 25 years, have reflected changes on the macro-level of social work intervention. With a view toward broad social, economic and health policies which affect the elderly, social workers have supported efforts to liberalize Social Security, humanize S.S.I., provide broader options to the chronically ill other than institutionalization, and most recently highlight the importance of enhancing the informal support systems of the frail elderly. While efforts on the macro-level have been outweighed by an even greater professional interest in the child and family, welfare and civil liberty issues, the interest is far from insignificant and has resulted today in the establishment of an operation NASW Committee on Aging on the national level.

The author wishes to acknowledge the very helpful consultation and case materials contributed by Ann Burack-Weiss, Assistant Professor of Social Work, Columbia University School of Social Work and Faculty Field Instructor, Jewish Home and Hospital for Aged. This article is based upon a paper presented at the National Association of Social Workers National Professional Symposium, San Diego, California, November, 1977.

Developments on the level of direct practice and intervention lag far behind, and skilled, knowledgeable practice with the elderly and their families has yet to be legitimized and promulgated. The symptoms of this malaise are widespread. The majority of social work school curricula offer little in terms of the skills needed in working with the elderly and their families.[2] Clinical social workers have largely ignored the older age groups.[3] For those elderly in institutions, often the neediest of all, the skills of an MSW social worker are no longer mandated by federal law.[4] Most family service agencies were found ten years ago to offer meager casework services to the elderly and their families and the picture has only improved slightly today.[5] The vast majority of practitioners in government social service programs are not professionally trained.[6]

This condition exists in spite of creative efforts within the profession. Over ten years ago Margaret Bleckner, in her controversial protective services study, raised meaningful questions about social work practice which failed to stabilize or arrest the deterioration of the frail elderly in the community.[7] Edna Wasser drew on the cream of social work practice in family service agencies, and the excellent programs of such agencies as the Community Service Society and The Benjamin Rose Institute, to articulate the skills needed in working with the elderly. She stressed similarities in practice: the application of developmental/life cycle concepts, the necessity for assessing ego and coping strengths as well as the effects of stress and loss.[8] Other practitioners have pointed to the importance of recognizing the plight of the families of the old.[9] Innovative techniques such as reminiscence and multigenerational family group theory have been tested and recommended.[10]

Yet, practice with the elderly and their families continues to suffer. What is there that discourages professional interest and investment? What makes direct practice with the elderly so special? The differentials listed are not inclusive but suggest directions for continued investigation.

DIFFERENTIALS IN ASSESSMENT

Assessment and intervention cannot be separated from one another. Assessment is an intervention in and of itself, and any intervention must be interwoven with an ongoing evaluation. It is useful to separate the two in order to make explicit the important inherent properties of each process, and to insure that the skills required for each are indeed utilized.

An important, if subtle, differential factor in making a psychosocial assessment of an elderly client and his family is the greater degree of complexity involved. Unfortunately, the opposite view prevails, and a psychosocial assessment of the elderly and their families is viewed rather simplistically. We tend to cling to overly-generalized abstractions,

such as reaction to loss, feelings of guilt, or fear of growing old to explain behavior, without enriching or validating them with knowledge based on specific life histories of the elderly and their families.

Of course, any psychosocial assessment is a complex undertaking. The point to be made here is that in the case of the elderly and their families it is often much more involved than an assessment of younger age groups. Both a wider range of variables and a greater diversity of processes must be taken into consideration in sizing up a client's ego strengths and weaknesses, adaptive capacities and his social situation. The following are some of the theoretical underpinnings which account for this greater degree of complexity.

Systems theory, which provides social work with a useful theoretical framework, indicates that an important characteristic of living organisms is their capacity for growth and differentiation as well as the fact that biological, psychological, and social subsystems interact and are interdependent. One needs to look at the development of a baby to understand this truism. The interaction of internal growth processes and environmental input enables the infant through a process of differentiation to move from a state of biological dependency to increased independence and the acquisition of a social identity.

As the organism declines or ages in later life a process of de-growth or de-differentiation takes place culminating in death. Observations of the very old or sick before death corroborate this systems formulation. While biologists still debate the molecular components of the aging process, there is little doubt that at some point in the later years (with great chronological variation) the integrity of subsystem boundaries begin to fail and various physical as well as psychological problems blend into one another. A heart attack in a very old person is seldom unaccompanied by other physical ailments or severe emotional reactions. Furthermore, these intersystemic changes are rapid. An old person can quickly lapse into a confused episode if his nutrition is poor. By the same token, his confused state of mind will often clear if placed without too much delay on a nutritious diet. The depressive episodes which follow rapidly on the heels of physical illness, and vice-versa are another case in point.

Unique processes, therefore, are in motion in the very old which in combination with the increased incidence of chronic disease demand that biological variables be part of any psychosocial assessment. An assessment becomes even more complex when we consider the fact that in contrast to the biological de-differentiation which takes place, a process of individuation is also pronounced. Man is not only a biological organism. He is a thinking, learning, social being. In defiance of his biological time clock, he is able (if relatively free of disease) to learn and change until death, although perhaps more slowly than when he was younger. By virtue of living many years and being exposed to a variety of influences a process of differentiation also takes place.

Beattie has noted: "The great differentiation through life experiences of older persons of the same categorical age means they are more individualized and more unique than persons of earlier age groups."[11] This process of individuation does not necessarily imply growth or improvement. It may involve a repeated reinforcement of lifelong neurotic, psychotic, or character defenses often acted out with the extended family.

Social variables which characterize the lives of the elderly only complicate the assessment further. In an age-structured society, the old and their families live by different social norms than younger persons, age norms which are rapidly changing. The position of the aged in society brings into play conflicting sets of role expectations and socioeconomic opportunities.

Human beings bring a wide array of behaviors to old age. This results from numerous biological and psychological variables and processes which, in interaction with our age-structured social situations, produce a complexity which can confound the most astute diagnostician. The task facing the social work profession is to develop the necessary assessment skills on an interdisciplinary and one-to-one basis. For example, the frustrating sparseness which often characterizes the contributions of an elderly client in initial interviews is the result of complex, interrelated factors. He comes to the professional anxious, depressed, seeking help with concrete problems. The mental and physical stresses of his situation can impair memory and cause confusion. Rather than feel hopeless or probe prematurely we can pursue the clues given us.

> Mr. K., aged 92, was referred for admission by a daughter tearful at the breakup of her parents marriage of 60 years. Since a recent hip fracture, Mr. K. was increasingly homebound and demanding of his 80 year old wife. Although physically able to care for him, she wished more time for herself and could not tolerate his constant presence or needs. All home care possibilities were rejected. She repeatedly called her children begging that they find a place for him. As they were unable to take him into their homes, admission plans were initiated. The intake social worker recognized the history that should be explored and the family issues resolved prior to placement. However, Mr. K. could not remain where he was. A short cut assessment was needed.
>
> Mr. and Mrs. K. were seen together once to discuss the immediate situation and complete the application. Mr. K denied any feelings of anger or loss at the separation, focusing only on his hopes that the Home's care would rehabilitate him. One application question asked the date of arrival to the U. S. A. Mr. K. volunteered the following story.

It was in a village in Russia in 1905. He was 17 and had crossed town to say goodbye to an aunt and her family who were leaving for America the next day. On the kitchen table was a family passport. Never having seen one he looked it over and noted with surprise that his cousin (a year older with the same name) was listed. But the cousin was already in America! Mr. K. decided on the spot to go in his place. He returned to his home that night to pack and say goodbye to parents and siblings who he never saw again. When asked about the sort of work he did, Mr. K. briefly told of learning the cap making industry from the ground floor, eventually running his own successful business. He went bankrupt during the Crash, and sought employment again as a worker. By the time of retirement, he was a partner in another small business.

Mr. K. was admitted within a week and adjusted quickly. Six months afterward, a student social worker knocked on his door to invite him to a newly formed resident group. He was expecting an orderly, and freely expressed his anger at being three days overdue for his bath. Not listening, the student continued to point out the merits of joining the group. In exasperation, Mr. K. concluded the interview. "If you get me a bath, I'll go to your group." She did and he went.

This piece of history offered by the client indicated how the elderly, frail, rejected gentleman sitting in the admission office would respond to placement with a capacity for imaginative coping and adaptation shown earlier in life. Although seemingly simplistic, the social worker's assessment reflected a broad knowledge of the complexities of later life and a readiness to learn from older clients.

DIFFERENTIALS IN INTERVENTION

The most important differential in intervention with the elderly and their families lies within the framework of the worker/client relationship. Needless to say, there are other differentials ranging from the necessity for a long term approach to the special skills needed in communicating with the hard-of-hearing, confused, and sightless. These differentials, however, overlap with the care of the chronically ill and disabled and are not specific to the frail aged alone.

The special characteristics of the worker-elderly client relationship have not been ignored. Attention in the literature has been given to the older person's potential difficulties in perceiving a youthful therapist as a source of help. Hollander noted "although the relationship of a psychiatrist or social worker to an older person has some superficial aspects that are different from that of a therapist to a younger person, basically it is still rooted in the early parent-child relationship. The aged individual

feels toward the therapist as we feel toward an adult son or daughter - but a son or daughter who would be like a parent to him."[12] More recent theorists have criticized the concept of role reversal which has crept into worker-client relationship and see the major task as developing a system of mutual aid and filial responsibility. Rhodes notes that the concept of mutual aid between generations also transcends the pitfalls of role reversal which breeds feelings of helplessness and resentment. "...Mutual aid can be achieved without the loss of dignity; roles may be initially redefined based on the exchange of services, and thus provide a structure of respect and cooperation."[13] Wasser noted that the older person often needs to be somewhat personal in manner, to touch and be touched, to be comforted, and to receive and give affection to people, having outlived probably those who provided him with these kinds of personal warmth.[14]

The difficulties faced by the older person in entering into a helping relationship and his special needs have been emphasized and appropriately updated. The difficulties faced by the social worker and his special needs, however, have yet to be expanded upon. Wasser notes that "caseworkers are generally younger and healthier than their elderly clients, they need to 'climb inside' the client's skin to understand empathically his feelings of psychological needs and to form a relationship with him."[15] Other practitioners have noted the reluctance of social workers and other therapists to work with the elderly because of their own negative stereotypes about aging.[16]

Social workers have failed to identify the narcissistic needs and subjective feelings which they bring to the helping relationship. An important and very valid narcissistic need is the boost to self-esteem derived from doing a good job. A stereotyped view of the later years, however, can lead to a belief that there is not much to be done other than provide concrete services for an age group who, if anything, will probably only deteriorate. Ergo, there is little gratification in working with the elderly.

A lack of knowledge about the later years further reinforces the fear that there is little to be done. As noted before, a gerontological knowledge base is sorely lacking effective skills in assessment. Another essential ingredient of knowledge, life experience, is absent for many. The elderly and their families are traversing a life terrain which many professionals have yet to travel. Young social workers are usually acutely aware of the differences in life experiences which separate them from their elderly clients. They often attempt to bridge this span by seizing surface similarities in their situations and present them as indications that they understand. They will sometimes tell an institutionalized client that they too have had to get along with a roommate or have suffered indigestion from dormitory cooking or also live away from family.

Mrs. L. went on about the fact that her children had all moved away. They call and say, "Hello Mom. Are you all right?" She asked the worker "what's that?" The worker said "It's not the same as really seeing them." She then went on to say that its harder to keep in touch when families move away. She volunteered that she herself had no family in New York, that she had moved away from them and it was hard on them and her. Mrs. L. responded "But you have your husband to talk to." The worker then heard and said "that's true."

The worker's experience is voluntary, time-limited and reversible, and can only heighten the client's despair of ever being heard. It is more honest and effective to admit that we do not know how it feels, but would like to, and urge the client to tell us. In doing so, the client may assume a teaching role with the younger worker, passing on his life experience with the hopes that the worker will be instructed and thus spared pain, or given hope, for his own life.

There are, of course, wide variations among social workers in terms of their narcissistic needs. To the extent that a worker needs to see dramatic changes in clients, in order to validate a sense of personal worth, one is less likely to work with the elderly and their families.

Narcissistic strivings do not alone account for discomfort in working with the old. The close proximity to aged persons, particularly if they are sick or dying, can continually remind one of the inevitable facts of aging and death. A worker may avoid the aged, both in his personal and professional lives if the need to deny the inevitable death and dying is a strong one. By the same token, this same need can drive others into work with the aged in an attempt to "save" them from illness and pain and their inevitable death. The social worker who "experiences" the client largely in terms of what personally lies ahead may need to "help" the client to reassure oneself about one's own future and quite miss the point of the client's actual predicament.

From an object relations perspective, the aging client further frustrates professional needs. Contrary to Hollander's thesis, the older person who is being helped is much more likely to reactivate the worker's relationship with parents rather than the reverse, simply because the client is old enough to be the worker's parent or even a grandparent. Because of the aging person's advanced years and proximity to death, the meaning of the relationship on an object level, therefore, can be one of bereavement, abandonment, and loss. The relationship can also activate unresolved feelings toward the worker's own parents. It is particularly difficult for younger workers to handle the libidinal aspects of clients who are old enough to be their parents.

The lack of gratification on narcissistic and object levels can deter or motivate interest in older client groups. In the latter case, distortion

of perceptions and can lead only to frustration. The failure to recognize the genesis of negative feelings toward older clients is responsible for the infantilization, so common in social work practice with older people. Under the guise of meeting dependency and affectional needs of the aged, workers often tend to treat them as children, thus diminishing the compelling transference to them as potential parents or grandparents. This infantilization also enables workers to relate to the "child in them." This deludes workers into feeling more powerful and helpful.

The current preoccupation on the part of the profession with death and dying issues represents a move toward resolving some of these problems discussed. To some extent, however, it is an intellectual exercise focusing on the death of the young and does not deal with the intimacy of the worker-elderly client relationship. The more professionals can share feelings with peers, and within the context of supervisory and therapeutic relationships, the more they shall be able to face fears of abandonment and death and overcome reluctance to work with the elderly and their families.

Lynn Morris eloquently summarizes the feelings of a social worker whose client was a dying 85 year old woman:

> Mrs. F. evoked in me a great respect. It was easy to identify with her need for control and independence and difficult to admit that her method of coping was no longer adequate. I can remember vividly my reaction to my supervisor's questions about Mrs. F.'s application; I felt anxious and angry that I was being pushed too fast. I was able to be realistic in Mrs. F.'s presence, yet I had a great need for her to complete the preparatory stage before placement. At the time of her death, I felt I was mourning on two levels. The first is the obvious-loss of a person with whom I had spent considerable time and had known well. The second is one I feel is peculiar to professionals. I had invested a great deal in the treatment of Mrs. F., and although my approach was professional, I had made attachments to the healthy side of her that had enabled her to adjust, as well as to that part of her personality that changed during my contact with her. A process not unlike mourning was facilitated by my own customary review of the case material for the purpose of arriving at concepts and generalizations that might be useful in treating other clients. ...Those of us who work with dying clients not only must examine our feelings about death in general, but also must prepare for the loss of the client, particularly that part of the client's ego that enables both client and worker to feel there was accomplishment. It seems to me that the threat of such a loss could prevent some workers from making investments unless they are helped with their own preparation beforehand and receive support from co-workers at the time of the client's death.[17]

SUMMARY

The various differentials in practice with the elderly and their family which have been explored are closely interrelated. If and when the social work knowledge base in gerontology expands, the professional shall witness a vast improvement in assessment skills. Armed with these skills, realistic individualized goals with our clients can be set with resulting meaningfully intervention. This enhancement to professional self-esteem could, in turn, serve as a springboard for transcending personal feelings about aging, death and the older generations.

The challenge to the profession is compelling. Society is looking more and more to the professional community for effective means of caring for and helping the ever increasing number of very old Americans. One of the key recommendations of the Federal Council on Aging, in its policy statement relating to the frail aged, is for the establishment of universal social work services for all Americans over the age of 75.[18] A key provision of these services is a professional psychosocial assessment and plan. It is questionable whether the profession has the skilled manpower willing to provide this universalized service. On the other hand, it is believed that social work is the only profession with the potential to do so. Social work practice with the elderly and their families will and can come into its own if it can recognize and face its unique features, challenges and opportunities.

FOOTNOTES

[1]Robert Morris, "Aging and the Field of Social Work." Matilde Riley, John W. Riley, Jr. and Marilyn E. Johnson, eds. Aging and Society, Vol. 2, Aging and the Professions, New York: Russell Sage Foundation, 1969, Chapter 2.

[2]Elaine Brody, "Aging," Encyclopedia of Social Work, National Association of Social Workers, Inc. New York, 1971, p. 69.

[3]The reader is referred here to the various training programs offered to clinical social workers, some of them interdisciplinary. An example here is the very fine advanced program in clinical soical work being offered by the Hunter College School of Social Work in New York City.

[4]The 1972 Social Security Law Amendment (92-603) withdrew the requirement for a qualified (MSW) social worker in long term care facilities.

[5]Dorothy Fash Beck, Patterns in Use of Family Agency Service, Family Service Association of America, New York, 1962.

[6]For example, the New York City Department of Social Services, Human Resources Administration which operates senior centers throughout the city to provide information, referral, counseling, and activity programs for older persons.

[7]Margaret Bleckner, Martin Bloom, and Margaret Nielsen, "A Research and Demonstration Project of Protective Services," Social Casework, Vol. 52, No. 8, October 1971, p. 483.

[8]Edna Wasser, Creative Approaches in Casework with the Elderly Aging, Family Service Association of America, New York, 1961.

[9]Helen Lokshin and George Tucker, "Mr. and Mrs. Johnson, Social Services and the Aging," Arthur E. Fink, C. Wilson Anderson, and Merrell B. Conover, The Field of Social Work, Holt, Rinehart and Winston, Inc., New York: 1968.

[10]Sarah Olstein and Judith Liton, "Therapeutic Aspects of Reminiscence," Social Casework, Vol. 50, No. 5, May, 1969, pp. 263-268.

Alida G. Silverman, Beatrice H. Kahn, and Gary Anderson, "A Model for Working with Multigenerational Families," Social Casework, Vol. 58, No. 3, March, 1977, pp. 131-135.

[11]Walter M. Beattie, Jr., "Matching Services to Individual Needs of the Aging," in Working with Older People, A Guide to Practice, Vol. III - The Aging Person: Needs and Services. U. S. Department of Health, Education, and Welfare, Health Resources Administration, 1974, p. 2.

[12]Marc H. Hollender, "Individualizing the Aged," Social Casework, Vol. XXXIII, October, 1952, p. 342.

[13]Sonya L. Rhodes, "A Developmental Approach to the Life Cycle of the Family," Social Casework, May, 1977, Vol. 58, No. 5, p. 310.

Margaret Bleckner, "Social Work and Family Relationships in Late Life with Some Thoughts on Filial Maturity," in Social Structure and the Family, Ethel Shanas and Gordon Streib (eds.) Prentice-Hall, Englewood Cliffs, New Jersey, 1965.

[14]Edna Wasser, op. cit., p. 43.

[15]Edna Wasser, Ibid.

[16]Elaine Brody, op. cit.

[17]Lynne L. Morris, "To Die Young, To Die Old, Management of Terminal Illness at Age 20 and at Age 85," Journal of Geriatric Psychiatry, Vol. VIII, No. 2, 1975.

[18]Federal Council on Aging 1975 Annual Report to the President, Washington, D. C., DHEW Publication [illegible] (OHD), 76-20955, pp. 45-49.