The Ellard Collection

Growing old

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'Growing old' is an essay by the late Dr John Ellard reproduced from the book The Anatomy of Mirages: a Psychiatrist Reflects on Life and the Mind.*

Dr Ellard, revered former Editor of *Modern Medicine of Australia* and *Medicine Today* and a distinguished psychiatrist, wrote many essays in the 1970s, 1980s and 1990s on society's most controversial and vexing issues. These were published in various journals including *Modern Medicine of Australia*, and also collected together and published as books. The essay 'Growing old' originally appeared in the February 1988 issue of *Modern Medicine of Australia*.

Growing old is a luxury which was not available to mankind until recently. Even now one needs to be cautious about the country of one's birth and the choice of one's parents. Popular beliefs about old age have not kept pace with the change, and unhappy misconceptions abound. Sooner or later we must think about it, and I am doing so now.
'Old age is the most unexpected of all things that happen to a man.'
– Leon Trotsky, 'Diary in Exile', 1935

In most Western cultures to become old is to run the risk of being seen as redundant, and few of us view the prospect with much enthusiasm. Demographers, in describing the swelling proportion of those aged more than 65 years, are troubled by the burden that the elderly will place upon the young. Few refer to the burdens that the young have already placed upon the elderly.

A common way of avoiding acknowledgement of one's own ageing is to develop a stereotype of the elderly as a group of people, deaf, shrivelled of body, whose teeth do not always follow the excursions of their jaw and who are much given to forgetting everything except a limited range of anecdotes, which they repeat tirelessly. They are constipated and sexually inactive – except when they are dirty old men – and they can view the world only with the aid of spectacles, which they lose repetitively. They have one foot in the grave: in short they are totally unlike oneself.

The reluctance to contemplate ageing is to be found in unlikely places. For example, an authoritative and widely read textbook of psychiatry (that of Kaplan and Sadock) devotes 269 pages to child psychiatry, seven of which are concerned with enuresis and encopresis. The psychiatry of the elderly is likewise covered in seven pages.

Again, in an address on the 'Fixed Period' given at Johns Hopkins in 1905, William Osler said 'My second fixed idea is the uselessness of men above 60 years of age, and the incalculable benefit it would be in commercial, political and professional life if, as a matter of course, men stopped working at this age.' He then went on to discuss a suggestion made in one of Trollope's novels to the effect that at 60 men should retire into a college for a year's peaceful contemplation before being despatched by chloroform. There is a touch of irony in the address, but only a touch.

The tragedy is that attitudes of this kind are widespread and have much force, and it becomes easy to neglect and denigrate people if one can see them as a little less than human. Who has not seen a long row of elderly people firmly embedded in their chairs with nothing to do except look at a television set, or each other. And how often, when they are roused from the torpor which boredom – and, too often, sedatives – has induced, are they addressed in terms suitable for children, or the demented. It is deplorable when such a thing happens at all; it is shameful when it happens in a medical environment. My own confession must come too: when first I thought of writing this article, my mind turned directly to the differential diagnosis of dementia.

The psychological changes of ageing

It is obvious that, slowly, people lose some of their physical strength and agility; few septuagenarians are to be found playing football. One should not forget the positive aspect, for most of them will have gained enough wisdom not to want to. The psychological changes of ageing are not as straightforward as they may seem to be.

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* Ellard J. The anatomy of mirages: a psychiatrist reflects on life and the mind. Sydney: University of New South Wales Press; 1994. p. 106-116.

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Intelligence

Inspection of the age-related norms of a standard intelligence test such as the Wechsler Adult Intelligence Scale (WAIS) would seem to demonstrate that there is a substantial decline in intelligence with age. Thus, if one is aged between 20 and 34, one needs to obtain a scaled score of 110 to be credited with an IQ of 100, but at the age of 75 a scaled score of 68 will suffice. It is easy to assume that something like a quarter of the average person's intelligence has departed by the time the seventies are reached, but the situation is not quite like that.

The sub-tests of the WAIS sample many facets of performance, a prominent one being motor speed, which certainly declines with age, pulling the whole score down with it. Many of them also depend upon previous experience. The age curves were not derived by testing the one generation sequentially as it aged, but testing different age-groups simultaneously. The older people were much further removed from their schooling, which may well have been less extensive in any case. They are likely to have been less motivated and less vigorous than the young, and to have had a background which was significantly different. The younger group was likely to have done similar tests before. These considerations suggest that comparing total scores may be misleading and that, as ever, the concept of intelligence needs very careful examination and dissection before generalisations can be made safely. It may be, for example, that intelligence which is partly dependent on accumulated experience continues to rise for many years, where intelligence defined as ability to deal with totally unfamiliar tasks peaks early. In life there are very few totally unfamiliar situations.

Memory

It is obvious that remembering a telephone number heard a minute ago, an event which happened decades ago, and how to ride a bicycle are rather different processes. It is impossible to write clearly about memory because there is little agreement about how many such processes there are, and little knowledge about the neural pathways and the intracellular mechanisms involved. Furthermore, all is not as it seems to be. For example, it has been shown that structural lesions, such as head injury, Alzheimer's disease and Korsakoff's disorder do not produce accelerated forgetting, but rather an inability to absorb new information in the first place.

Outside the laboratory, other factors become relevant. It is likely that as we grow older we become selectively disinterested in many things – we learn to switch off in certain circumstances. We have other preoccupations – I may be thinking about my income tax or my arthritis while being told the details of a film I have resolved never to see. Nothing sinks in, and an admission of forgetfulness is as good a refuge as any other.

It seems likely that immediate memory declines with the years, but a small notebook in the pocket and a noticeboard at home can compensate for that. The fate of intermediate and long-term memory (if I may use these terms loosely) is more obscure, but in the healthy aged there is no significant disability.

Learning

It is often said that 'Old dogs cannot be taught new tricks'. I know of no study in which adequately motivated and properly rewarded old dogs failed to learn new tricks perceived by them as being interesting, amusing or relevant to their daily lives. Over the years, I have learnt a vast amount of material which has turned out to be useless, incorrect, muddled or irrelevant to getting on with my life. Mercifully I have forgotten most of it, and I have learned to think twice before putting aside the time to memorise new things when I might be enjoying myself otherwise.

Many elderly people have had little experience in receiving instruction, and others have been away from it for so long that anxiety diminishes their capacity. If one attends to such difficulties, then surprising results may be achieved. In a study conducted at the University of Queensland some years ago, 55 persons over the age of 60 were given a six-month course in German. Thirty-eight of them passed German at the Senior School examination and seven obtained As.

Such research evidence as there is would suggest that any loss of learning capacity which occurs with normal ageing is small, and that the well-motivated elderly person who is not unduly anxious and is prepared to take his or her time has a capacity to learn little changed from what it was at its best.

Personality

It is very difficult to distinguish the changes due to ageing *per se* from others due to such things as the continuing presence of lifelong personality disorders, and the consequences of being regarded by oneself and others as old and therefore over the hill. Many measures of personality have been used in an attempt to clear the air but they have not been very useful. People age differently, and in any case those who are young in this less inhibited and restrictive society may age into people different from those who were young half a century ago.

Generally, those who are old now seem to be more controlled, less energetic and less flexible than those who are young now. It is anyone's guess how much this represents a change in the elderly and how much a difference between generations. The point is that there is no such thing as a characteristic and inescapable personality disorder of the aged, and one should not sit about waiting for it to manifest itself.

The problems of ageing

If psychological deterioration is not a significant factor in ageing, what then are the substantial problems? It is important to eliminate disease from our consideration, for here we are concerned with examining the changes which occur if we are fortunate enough to escape disease, not if we encounter it. It is obvious enough that as life progresses, so too does our morbidity, and the consequences of cerebral vascular disease, Alzheimer's disease, osteoporosis, arthritis, respiratory failure and a thousand other disorders may descend upon us. Each has its own story to be told, but here our consideration is limited to those events which are now thought to be part of the normal process.

Loss of people

If one is fortunate enough to stay alive as the years pass, sooner or later it becomes plain that all others are not equally fortunate. I had had the one teledex for many years: recently I had to buy a new one, not only because the old one was full, but also because about half the people listed in it are now dead. Put shortly, not only do we lose those who are obviously important to us – spouses, lovers, close friends – but many other companions as well.

Loss of identity

Our place in the world and in our estimation revolves around what we do, where we live, whom we know and the emotions intrinsic in those relationships. A rational approach to ageing would be to preserve as many of these things as we can, but as we shall see both social pressure and personal choices often combine to remove almost all of them quite suddenly.

Loss of money

Most people retire at a particular age and mostly their income becomes much reduced at the same time. Moreover, inflation has been with us for many years now, and the accumulated nest-egg which once seemed adequate soon becomes a source of anxiety rather than of comfort. The remembered threepenny bus fare is now a dollar: the pence, carefully saved, do not amount to much today.

Loss of independence

The principal problem here is the effect of the degenerative physical diseases which, although not part of normal ageing, are its frequent accompaniments. Steps become taller, the garbage bin heavier, failed light globes more inaccessible and the multitudinous controls on the panels of domestic appliances more confusing than ever – especially without one's spectacles. A significant number of elderly people are housebound, not only by physical problems, but by anxiety.

One could labour the point, but essentially, because nothing is permanent, old age is a time of loss – loss of loved people, loss of status and loss of important bits of oneself. The result is bereavement, a major topic in itself.

A case history may illustrate the point. Quite recently, a gentleman in his seventies was admitted under my care. His history included an undoubted biological depression several years ago and some recent changes in his behaviour, following the death of his wife. I looked carefully for a recurrence of his depression, but could not find it. Rather he seemed impoverished, quiet and emotionally flat, unable to say much about himself. Discussion of the death of his wife, and other significant events, produced conventional, shallow responses. I thought him empty, rather than depressed, then speculated about decline rather than depression. Since he had alimentary symptoms appropriate investigations were done, but no neoplasm was discovered. To confess again, I decided that I was seeing the withering and disengagement of old age, and that he should go home in the near future, unrelieved.

A few days later, he bounded into my room, talkative and full of life. My registrar had been more tenacious than I had been: she had pursued the question of loss, touched upon the right spot and he had begun to talk feelingly about what had happened to him, and how much it meant. I wondered how often I had made the same error before, and how often it is made every day.

What is being done about ageing

In Western communities people tend to be valued for what they own, how much they earn, how famous they are or what they look like. Most elderly people do not own much, earn little, are not famous at all and have lost such conventional beauty as they may have had in the first place. It is not difficult to put them out of mind and turn to someone more rewarding if that is one's scale of values. Equally, if one is elderly, and accepts the stereotype with which this article began, there is little more to be said and one is reduced to reading nursing home advertisements.

There is much social reinforcement of this position. Compulsory retirement is becoming more widely enforced: the Commonwealth Department of Health would like to see it introduced for our profession right now. The situation is complex: there is a correlation between age and disease, and as a result more people become incompetent because of illness as the years pass. It is necessary to stand down the unfit, but unreasonable to dismiss everyone at, say, the age of 60 because of the possibility that they may have become or are about to become unfit. It is worth remembering that in 1716 Leibniz set a difficult problem for the mathematicians of Europe to grapple with – to find the orthogonal trajectories of any one parameter family of curves. Newton was then 74 and fully employed as Master of the Mint. He came home tired at five o'clock one afternoon and resolved the problem that evening. No one thought of retiring him.

As the proportion of the elderly in the general population increases and as the number of jobs decreases because of automation, the young find it hard to get work and difficult to be promoted. They have the numbers and the drive: it is easy to see why they would like their seniors to step aside as soon as they can be made to.

Those retired suffer a number of fates. Some of them find themselves suddenly deprived of their income, their companions, their status, and of the work which gave meaning to their lives, perhaps at a time when they had mastered it and were enjoying it. Their lives lose their purpose, and they dwindle away into nothing.

There are other less obvious processes at work. The retired very wealthy move from continent to continent as they have always done. They lack neither money nor power, and we do not need to be uneasy about them. Those of the middle income group are likely to retire to where they used to take their holidays, or to a more expensive suburb. They leave behind their friends and their familiar routines, hoping for a new and satisfying existence. If they detested their work and disliked their neighbours they may get it; often they do not. The aged poor tend to live in cheap accommodation near the centres of cities because the shops and transport are closer to hand. There are parks to sit in, people to meet and shop windows to inspect. Developers buy such buildings to demolish them and build larger ones, so the aged poor are dispersed further afie1d, further from each other and from the services they need. Loneliness is endemic.

What can be done

The first principle in the management of the ageing and the aged is a firm recognition that normal ageing is not what it is commonly supposed to be. This may seem obvious enough, but a long observation of what goes on in medical practice persuades me that it is worth emphasising. The same recognition may be useful for oneself in due course.

The vital distinction to be made is between physiological ageing, as discussed above, and the pathological processes which may become attached to the ageing person as time progresses. It is much more important to discover a treatable minor disorder than an untreatable major one. More than at any other time in life the care of the elderly is not merely an exercise in differential diagnosis, but the consideration of a range of problems of many kinds. Some of them are listed below.

- If the patient is not functioning well, and there is no obvious cause, than one must think of depression. If there is a doubt, then the patient should be treated for depression. The example given above should make it clear that this does not always translate into the prescription of antidepressants. An unrecognised depression is a medical catastrophe; unrecognised dementia is an error of a much lesser order which time will correct.
- Is the patient drinking too much? Estimates vary, but perhaps 10% of the elderly drink more than is wise at a time when their tolerance is waning.
- Are there simple physical problems leading to larger ones? Constipation can lead to confusion, painful feet to isolation, poor teeth to malnutrition and anaemia, deafness to being run over and so on. Snoring can be the only sign of a respiratory obstruction sufficient to cause nocturnal hypoxaemia, producing not only cerebral damage but also dangerous cardiac arrhythmias.
- Are there illnesses which would be more likely to produce specific symptoms in a young person but no more than a general regression in the elderly person? Respiratory and urinary infections are the common ones, with heart failure not far behind. Disorders of thyroid function, anaemias of various kinds and diabetes mellitus are also worth a special mention; the list is very long.
- Is medication the problem? In 1983, Family Medical Programme trainees attached to 31 practices in New South Wale interviewed 348 patients aged 65 or more. Three per cent of them were taking eight or more medications regularly. Fourteen per cent were taking sedatives and 14% were taking anxiolytics: the degree of overlap is not stated. One wonders how many of them were given hypnotics for the consequent broken sleep.

It is true that some elderly people have been taking their sleeping pill for the past three or four decades, and will not be parted from it. So be it. But the continuing use of sedatives in the elderly is almost never indicated, partly because they are likely to become confused and regarded as demented, and partly because they are more likely to fall over and break their bones. Many elderly people take hypnotics which have half-lives so long that they are disorganised all the next day.

It is necessary to explain to patients that as we age we sleep less, most reaching a stage when five or six hours each night is the norm. To take drugs to achieve an arbitrary eight hours sleep is both illogical and dangerous.

The subject of other medications is too large to be pursued here, but it is worth mentioning that the too vigorous treatment of diabetes, or hypertension, may lead to hypoglycaemia or hypotension which can have serious consequences.

- Is the immediate environment safe? It is a tragedy when a loose mat on a slippery floor brings an active life to a rapid close. The importance of ferreting out and remedying hazards such as dark steps, absent handrails and the use of the wrong floor polish needs no emphasis.
- Is the problem social rather than medical? Being isolated, housebound, lonely and bored is a sad way to be at any time of one's life, more so when one is very aware that there is not much of it left and no reason to expect an improvement. There is a limit to what the doctor can do, and here the community agencies will be important. Governments talk a great deal about the excellence of community care; it is our duty on our patient's behalf to harass them unmercifully if the reality does not match the rhetoric.

Conclusion

As we age, we are likely to accumulate diseases which bring burdens with them. Even more burdens may be imposed by the consequences of enforced retirement, and by the way in which the healthy aged are perceived as failing and a little ridiculous. Our patients need to be prepared, not for a retreat, but for a regrouping of their forces. They need accurate information about the changes to expect, and – more importantly – the changes not to expect. It is likely that their doctor's attitude to his or her own ageing will be an important determinant of how they face theirs. MT