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An Introduction to Life and Care in Aging

Four faces leaning forward into a card game: At a dining room table, they tease and laugh. Hands hold cards—fanned out and propped up by elbows on the table. Someone chides, "We're gonna be here all night at this rate. Play your hand already!"

The taunted player winks and asks, "Oh, is it *my* turn?" And the other players chuckle.

We live our lives by trying to make meaning. Time with friends or family; a vacation to a beautiful destination; workdays devoted to a professional life: They are the minutes, hours, days, and years of our construction. We make plans and we try to build a meaningful life.

Sitting down to supper conversation about what everyone did that day can be an opportunity to connect. Sometimes, the day's tasks are still going on and dinner is missed—because of a piano lesson, a basketball game, or an evening meeting. When we give our time: to sit down and enjoy our loved ones; to console a friend in tears; to play with a child or a grandchild; to take a walk

with a neighbor; to consult a confidant by phone; or to eat a delicious meal—with interesting talk about sports, politics, our kids' report cards, or an upcoming celebration—we are making meaning. *When we donate energy, time, and personal resources in ways that are valued by us and by others, then we can work to improve the quality of human life.*

On a Friday night, my husband and I played cards with my brother and his wife. We laughed and carried on with silly chatter about this-and-that. We munched snacks, dealt cards, and teased each other. We were having fun, and as we did so, it struck me that we are just like the "bridge ladies". They are four women I know who meet each Tuesday evening (and sometimes other nights) to play cards after supper. They tease and laugh. They chitchat about food, the weather, their families, and anything else that comes to mind. They do all of this and more at the long-term care facility where they live.

Their actions are the same as mine: playing a game with friends/family on a pleasant evening. Nevertheless, the bridge ladies' game of cards might seem less important. I can hop into my car and run to the store for more pop and chips. They cannot. My card game is a diversion of leisure from stress. It rejuvenates me for the next week of work, family crises, driving here

and there, and meal preparation. Theirs is not. Or is it? What purpose does the card game play in the life of a bridge lady?

We all seem to suffer from the same delusion that *our own days* mean something more than other people's do.¹ We are validated by our racing around, our shuffling papers, our drawing-up plans, our bathing children, and our folding laundry. We have decided which activities mean something and which ones do not. Like Raskolnikov in Dostoyevsky's famous novel,² we engage in a perpetual game of judgment about the relative values of ourselves and others. When we drive too fast, it is because *we must* get to an appointment on time. When others drive too fast and cut us off in traffic, it is because *they are* rude and obnoxious. If I talk too loudly at a movie, it's because I'm having fun with friends, but when a stranger does the same thing, it's because s/he is inconsiderate and idiotic.

How do we arrive at the assessment that values our card game but considers theirs trivial? Why is it so easy to dismiss their behaviors and elevate our own to significance? An individual's sense of meaning is, in part, tied to his/her *attributions*. These are the judgments we make about the causes of people's behavior. In the examples I gave above—of rambunctious road-running and movie mayhem—the common theme is a tendency

to excuse one's own bad behaviors, while holding others personally accountable for theirs. *We attribute our own misbehavior to circumstances, but for others we assume a personality flaw is the cause.* These are the foundation of what scientists call "fundamental attribution errors".³

A centuries-old expression goes something like: "Whatever you believe, it is so." In the field of sociology, it is called the Thomas Theorem (or the "Thomas Dictum"; Thomas & Thomas, 1928) and paraphrased: whatever one believes, it is 'real in all its consequences'. So it goes that people attribute more meaning to one thing than to another. They believe one thing, but not another, and their actions reflect their beliefs. This reality of belief is played out in fundamental attribution errors every day. Our attribution errors become crystallized when we enact the Thomas Dictum: that is, when we treat our attributions as reality.

We make personal judgments and then proceed to treat them as facts. When we believe, in one moment, that we are worth more than everyone else, then we act as if it were true. If I am late for an appointment, it is because I am over-worked and, after all, I'm doing the best I can—considering all I have to juggle in my hectic life. But when someone is late to meet with me, then s/he is ill-mannered and uncaring. I have turned my internal reality (that my day is worth more) into an error

in judgment about someone else. I excuse my own behavior and expect others to do so, because: "I'm a decent person and I didn't mean to make a mess out of everything!" At the same time, I refuse to forgive others for their mistakes, because my attributions tell me that: "They did it on purpose, and they are stupid!"

You can arm yourself with an array of derogatory adjectives to suit all your needs for "rationalized dislike" of another person, e.g., rude, conniving, thoughtless, careless, ignorant. Given the specific circumstances, you can swipe out one adjective and replace it with just about any unflattering descriptor. After a while, the adjectives seem to justify your dislike of the person. You tell yourself, "I don't like him/her. After all, I have seen how *rude* s/he is!!!!!"

Misattribution of meaninglessness is our human folly. We assume that other people's lives are less meaningful. We believe our time is more valuable. We assume their goals are worth less. And we judge our accomplishments as worth more. Our teenagers do it when they ignore our advice in favor of advice from their friends or when they ignore their younger siblings in favor of same-age peers. We do it when we call Mom, Aunt Angie, or Aunt Ida at a moment's notice to baby-sit for us, because—after all—she's retired and bound to be free, right? Professionals do it when they assume people

in other professions aren't as important or as knowledgeable.

We offer another's credentials as the reason to distrust him/her. "Don't listen to him. After all, he's just a [fill-in the undesirable profession or category here]." We make it a principle to denigrate individuals with whom we disagree, and we give more credence to negative information about them than to positive information (Asch, 1946; Kanouse & Hanson, 1972). "Don't pay attention to her. She's only a" We feel justified, vindicated, and elevated when we relegate them to the "trivial" and "not-to-be-trusted" categories. People "discount" other people, and they often do it in order to enhance their own feelings of worth. We convince ourselves that self-worth is a "zero-sum" game, whereby others must be less, so that we can be more (Baumeister, Smart, & Boden, 1996).

How does the consideration of personal worth relate to the creation of eldercare programs and activities? It is the starting point. When we overcome the tendency to devalue others (whether they are children, other adults, individuals with special needs, senior citizens...), then we begin to make contact with the importance of all people and the moments of their lives. When we begin to act as if each human has unquestioned, intrinsic value—regardless of gender,

race, ethnic origin, age, background, education, or socioeconomic status—then we can begin to re-value ourselves and others. When we avoid the trap of value-by-comparison, then we can see that there is no benefit in discounting others. We are freed from comparison, and free from diminishing each other, because WE ALL HAVE VALUE SIMPLY BECAUSE WE SHARE THE HUMAN CONDITION.⁴ When we let go of our plan to make others less so that we can be more, we not only release them from unfair attributions, we also release ourselves. How so? Not one of us can live up to the person-on-a-pedestal status. Oh, sure! You might be better at volleyball than one friend, or you might be better at math than another, but *sooner or later, you will run into someone who is better than you are at just about everything you think you do best.* And then what will you do?

About Valuing Seniors

For the seniors who are around us—whether they are our spouses, peers, parents, grandparents, or the strangers with whom we come in contact—we can help them to value themselves. We can help them to more fully experience meaning in life when we behave in ways that clearly show that we: 1) value the moments of their lives as just as important as the moments of our lives, and 2) provide support for activities in which they



"table activities" (see Sheridan, 1987; Zgola, 1987; Dowling, 1995; Bell & Troxel, 1997).



*Application: Individualized Needs for
Affiliation and Involvement*

As Zgola (1987, p. 35) has discussed, at the highest level of participation, individuals can plan, organize, and conduct an event like a party, dance, or creative project. That is what normal functioning adults do—whether they are 29 or 79. They find meaning in creating events in life. Building meaning is a fundamental process of human existence.¹⁶

However, as Zgola (1987) and others have observed, cognitive and health declines can interfere with one's ability to plan, organize, and bring to fruition a meaningful activity. Here are opportunities for a caregiver, an aid, or an activities professional to provide help. If a person has Parkinson's disease (which impairs motor movements and their execution), I might engage him/her in the aspects of planning an event. However, I might delegate a lot of the physical labor (like blowing up and tying balloons or filling small party bags with candy/prizes) to someone else who is more able to carry out tasks of fine coordination.¹⁷ If an individual is in the early stages of probable Alzheimer's disease (and

without physical impairments), I might include him/her in all aspects of planning and execution of an event. However, I would be present at all stages, in order to keep him/her "on task", because short-term memory problems might prompt someone to wander from his/her plan (for examples of structured memory support of this type see Seifert, 2000; also, Zgola, 1990).¹⁸

In an article from the millennium year, I described an individualized project for a lady with mild dementia of the Alzheimer-type (Seifert, 2000). She cherished a family heirloom, and it had begun to deteriorate from age. In consultation with her and with her family, I designed a set of activities to assist as she refurbished the heirloom. The steps in the task were fitted to her affinity for handiwork, and they were tailored to her needs for frequent reminders (a result of her difficulties with short-term memory). I fit the reminders into conversation as she and I worked together to bring the heirloom back to some of its former beauty. Overall, my knowledge of this lady's history, specific cognitive problems, and personal preferences were key as I helped her to act on her world in a meaningful and fulfilling way (Seifert).

My 2000-article about customized activities is consistent with one of the most useful methods of caring for people with special needs (whether they are 2 or 102

years old): with "person-centered" care being an incredibly valuable approach (Cotrell & Schulz, 1993; Kitwood, 1993; see also Bell & Troxel, 1997; Woods, 2001; Barnes et al., 2002). In nursing care, a person-centered approach—which also regards one's culture, the culture of care, and the universal aspects of compassion—has been described by Leininger and McFarland (2006). A main idea of both approaches (i.e., Kitwood's person-centered approach to eldercare and Leininger and McFarland's theory of cultural care in nursing) is that person care requires real, customized "caring" for an individual who receives care.

Greenspan and Wieder (1998) described person-centered care for children with special needs in terms of a tiered prioritization scheme. Their prescription for individualized care can be applied to eldercare, and the approach seems to derive loosely from Maslow's hierarchy of human needs (e.g., Maslow, 1970). According to Maslow, the most essential human needs are "physiological". They are, for example, the requirements of the body for sustenance and nutrition. Second to those are "safety" needs—like having a sense of predictability in one's life. People also have needs for love, attention, and affiliation with others. Beyond those needs, we must feel competent and worthwhile (called "esteem" needs). Ultimately, Maslow believed that we

all have a need to reach for our individual potential—at the pinnacle of human aspirations—which he called the ongoing process of "self-actualizing".

It has been argued that Abraham Maslow later added a sixth level of need to his hierarchy, which involves transcendence of self (Maslow, 1970; see Koltko-Rivera, 2006). Personally, I believe that true self-actualizing must involve a process of optimizing self *through transcendence*. Therefore, my adapted hierarchy for eldercare interventions (Table 1, below; Appendix A, this book) incorporates the possibility for experiences of peak value that are beyond the self and which might involve communion with others (and, even, the universe).

Maslow (1970) described lower needs in the hierarchy as "prepotent", i.e., generally usurping higher needs. If I'm severely famished, then presumably I'll search for food, rather than lounge about and contemplate the meaning of "social justice". Here's the caveat to that rule: that once an individual has experienced the liberating influence of higher needs, s/he might very well sacrifice satisfaction at lower levels of the hierarchy for fulfillment at higher levels. Consider a monk who fasts for days or weeks in order to de-focus from bodily cravings in favor of reflection about life's meaning. One of Maslow's points was that so-called

"peak experiences"—which occur when one seeks to live up to his/her potential—can displace lower-level needs from priority. Even if the monastic is starving, s/he might forego food in favor of the peak experience of breaking through to understand life's essence. That type of behavior is not reserved for people in cloisters and monasteries; millions of members of organized religions routinely fast in order to focus on prayer, supplication, and worship.

Two books about integrated care relate intervention approaches that incorporate Maslow's (1970) hierarchy of needs. Greenspan and Wieder's (1998) model of "integrated... intervention" for children with special needs begins with "[b]asic services for safety, security, and protection" (p. 379; after Maslow). In a similar turn, Bowlby (1993) described an application of Maslow's needs to dementia care. In her approach, Bowlby explained that individuals with AD and related disorders can still achieve even the highest level of need fulfillment (i.e., self-actualizing). Perhaps the major difference between persons with dementia and people without dementia is the level of environmental/social support (e.g., from caregivers, family, nursing home staff) necessary to assist in achieving satisfied need states (especially, Bowlby, pp. 80-83 and Ch. 5). I have adapted ideas from both books

to create a set of steps for 'integrated interventions' in eldercare (in Table 1).

Table 1: Infusing Interventions into Individualized Care*

Step 1: Ensuring nutrition, physical well-being, and basic care of a person with special needs (combining Maslow's two foundational levels of need: health and safety);

Step 2: Providing support for integrity in relationships (per Maslow's needs for love and belonging);

Step 3: Arranging interactions which are aimed at one's personal abilities and the needs for sensing stimuli, interpreting incoming information, and planning actions (per Maslow's esteem needs);

Step 4: Utilizing intervention strategies that *foster development*; Also, for elders, *promoting independence* (when possible) and supporting one's current level of functioning (per Maslow's esteem needs and toward self-actualization); and

Step 5: Enacting person-centered interventions motivated by specific history, preferences, personality, and the potential of the individual who receives care (per Maslow's concept of self-actualization); And using personal history to transform optimal functioning *in context* when/if possible

* **Ideally, all steps occur together in an integrated care plan.** My list is expanded beyond, but adapted from Greenspan and Wieder's (1998, Ch. 18, p. 379; also, see Appendix A of this volume). I use the term "special needs" to refer to persons who might require assistance from others in goal-seeking and in satisfying needs

