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The decisions of ageing

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ABSTRACT
As people age, decisions are made about how we live and how we hope to die. This article encourages wise decision making and is based on the lived experience of the author. New Zealand research supports the notion that patterns of ageing may begin much earlier than is usually recognized. Personal sharing following the death of the author's husband concludes this article.

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When I first studied Human Development at university, I learned that change is constant throughout life. Indeed, this is true, but some changes are welcome and some are not. When a baby takes her first step or gains his first tooth, there are photos taken and everyone in the family is happy. Change happens and change cannot be controlled. This article is about the changes of ageing and the decisions to be made during the later stage of life. The article is divided into areas of life because it is clearer to write this way, rather than deal with later life as it is generally lived. On a day-to-day basis, most individuals live their lives as integrated whole people.

Physiological changes

It is well known that our body changes as we age. During childhood, growth is rapid. Once maturity is reached, tissue strength and integrity begin to decline and the total number of body cells decreases. During adult life, our height decreases between six and ten centimetres and our gait may become unsteady because of loss of muscle tone and coordination.

Age-related changes occur in our cardiovascular systems. Our cardiac output is less than it used to be and peripheral blood vessels are less elastic. A small increase in blood pressure is the result of this change. There are many changes to our skin as we age. Skin is drier, with decreased elasticity and therefore more wrinkles. There is less hair on our heads and more hair in other places such as our faces.

In an excellent article recently published about the long-running Dunedin study, Chisholm (2017) writes:

> We are 45. From now on, our brains will start to shrink by about five percent each decade. Our blood vessels will thicken, our blood pressure will increase and so too will our waistline. We're already less fit than we were at 25, but now the speed of decline will accelerate. (p. 37)

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Recent research in neuroscience suggests that the cells in the brain also change as we age. It has been known for some time now that the brain has some degree of plasticity and, for instance, improved functionality after trauma or stroke may be possible. Brain cells and indeed genes may also change as age increases. However, scientific knowledge appears to stop before we reach middle age. Chisholm asks the question: 'But what is going on in our middle years? When do the subtle signs of the diseases that will eventually claim us first appear?' (p. 38). This year, the 1,000 men and women who have been part of the Dunedin multidisciplinary health and developmental study since the early 1970s will undergo a battery of tests that will help to answer those questions – but, for the first time, researchers will be getting inside their heads in a new way: each will have functional and structural MRI scans of their brains. It is possible that a few might be showing the first signs of a degenerative brain disease they are unaware they have, suggest the study's director, Professor Richie Poulton.

Chisholm quotes Sir Peter Gluckman, the New Zealand Prime Minister's Chief Scientific Advisor:

> This is a critically important study and will continue to be important for the next 40 years. It's ahead of its time because it's continued to adapt to the science. Some of the most interesting stuff is now going to start to emerge as people age. (p. 39)

With these and other physiological changes, it can be challenging to know what is normal and what could be the beginning of a disease process. One of the most common issues older people have is temporarily forgetting where their car keys are, and, while this is generally considered to be within the realm of normal ageing, it can generate the worry which may be expressed as 'Am I losing my marbles?' Another example is the measuring of blood pressure and the boundaries of normality verses the early signs of hypertension.

The brain

We live in the age of brain research. The Neurological Foundation of New Zealand (NFNZ) does excellent research and has contributed internationally to the current knowledge of brain function and brain dysfunction (see www.neurological.org.nz). The brain is a body organ that needs nourishment in much the same way as the heart as ageing occurs. With age, there are some changes in the brain. The NFNZ has published a useful poster, 'Road Map to a Healthy Brain'. I have it on the bathroom wall as a reminder to look after the health of mine and visitors' brains. The headings are as follows:

- Manage stress in our lives as stress cannot be eliminated.
- Get adequate sleep every night.
- Exercise the body at least 30 minutes every day.
- Eat a balanced diet because food which is good for the body is also good for the brain.
- Stay socially connected.
- Do a mental workout every day by staying curious and engaged with life. (NFNZ, 2012)

There is nothing complicated about these guidelines. They are good for all of life, beginning with childhood, and through to the process of ageing. There is no rule about the beginning of ageing. Ageing happens on every birthday and once every 10 years there is a new decade. People have invented sayings about ageing. For example, '80 is the

new 70', 'You're as old as you feel', or 'Ageing is not for the faint-hearted'. Some of us are old before our years, and some of us appear as 'mutton dressed as lamb'. There is no one right way to live our lives as the years go by, and individually we are unique human beings each with our own brain and personality.

Health and ill-health

Most people I know value good health. Life is more pleasurable when we are healthy. It is wise to have an annual medical check with our regular doctors. Most of us would like to avoid the medications we need – but changes occur. We wake feeling wobbly or with a pain somewhere in our body. We decide to see what happens as the day goes on. Some tiny problems resolve while others become worse. The early signs of possible cancer, such as a chronic cough, a wound that does not heal, or blood in my poo, are easy worries to ignore, and we hope for the best. It is important to have a doctor to whom we can talk and discuss our health concerns. Early diagnosis and medical treatment is always advisable for a significant change in any part of our body. At some time, the decision is made to arrange a medical appointment. Sometimes what happens next is straightforward: a prescription is given and the problem resolved. Cure is usually what is anticipated; at other times the diagnosis is not easy, further tests are required, and cure is less hopeful: more drastic medical treatment or a second medical opinion is recommended, though cure is still anticipated.

There's nothing can be done

This often leads to a tough time. Now new decisions are necessary. Medical care is most likely still necessary to maintain comfort and reduce further complications. Ongoing support for what is referred to as 'the new normal' is essential and an understanding doctor is very helpful. Individuals are challenged to accept the 'no cure' message from medical specialists. Family members are also challenged with their new situation.

Generally speaking, individuals find the known preferable to the unknown. Recently, a friend who has not been well for some time told me, 'even though the diagnosis is horrible, I find something definite is easier to live with than the mystery I had'. It seems that to have a path is easier than facing wilderness. Often the path is not straightforward or certain, but at least there's a path. The big question, 'How long have I got?', usually can't be answered by doctors or nurses because no one really knows. There are only indicators from the experience of others and research, and the medical history of the person who has become the patient. Without scientific evidence, the power of the belief system of the patient is very important to consider. However, despite everything we know, the actual length of time an individual has left is usually hard to predict. I have heard many stories about untimely death as well as really weak and debilitated people who simply will not die. People also have their personal theories or religious beliefs about these things.

The 'How long have I got?' question usually leads on to a variety of decisions that need to be made. I have been a supporter of family members and friends having various conversations during these hard times. Isolation and night-time tend to make every aspect seem more difficult. Disease tends to progress when there is no cure – but not always; shortness of breath may increase, so sleeping upstairs may eventually become impossible.

Questions of where to live and where to die will come to the surface: 'Who will look after me when I can't look after myself?' 'Do I have enough cash to pay for the care I might need?' 'Can I fast track through this journey and ask someone to help me die?' At present in New Zealand this is illegal, and there are many sad stories about people assisting others to die. This stage of life with its many transitions needs to be supportively managed by the central person being heard by family and friends when decisions are being made. There are good resources available in the community for palliative and hospice care, and the medical services tend to be the point of entry into such care. When a person is dying at home, adequate pain relief and the prevention of nasty complications usually require medical intervention. With prolonged dying, there is nothing easy or simple about agreeing that she or he 'can die in their own bed' – but this is often what people want.

Preparation for death

There are two certainties in life: birth and death. Each one of us will die at some time in the future. It is wise to be as prepared as possible for our own death, and those who remain in the world will appreciate our preparation. There is a saying, 'we die as we live'. My husband was a great guy and lived his life with the strong principle of 'It might come in handy'. He died 'a man of clutter', as I said at his funeral! He lived his life to the full, but never had time to tidy his study or the garage. However, he did have a lawyer, and his will and power of attorney wishes were up to date, as wills and documents need to be. The final will determines what happens to money and belongings once the person has died. The world continues after the individual has died, and nasty or greedy arguments from anyone are best avoided. In my view, legal and funeral plans are essential aspects for the end of life experience – yet this work is often avoided or delayed by us who are living.

People tend to hope for dying well – without suffering and with dignity. How each of us dies is difficult to know ahead of time. Schwass (2005) writes:

> Death with dignity, dying well, a good death: uplifting phrases like these are often used to describe alternatives to dying alone in hospital hooked up to a barrage of machinery. Yet for those of us who have witnessed people we love suffering terribly in their last days, or have endured the brutal shock of sudden bereavement, it may be impossible to conceive of a death that is peaceful, dignified, appropriate or in any way 'good'. But the notion of a 'good death' spans history, cultures and faiths. (p. 16)

Death

It seems that, these days, many people have not seen a dead body, or do not know what to do when death occurs in the community. Death simply is the cessation of life. This is recognizable by the absence of breathing or heartbeat. When death is expected, the appearance of the person does not usually suddenly change, except there is a sense of stillness. Legally, a person's death has to be certified by a medical doctor who has the authority to write the death certificate and to register the death. This happens easily when the person is in hospital at the time of death. At home, there is no hurry to notify the General Practitioner, especially if death occurs at night; however, in such circumstances, the time of death should be noted. In the case of a sudden or unexpected death, calling for an ambulance is both urgent and wise: the ambulance staff will know what to do.

After death has occurred, the family usually gather and, after an appropriate time, arrangements for the funeral are discussed and decided. These days, some people will already have chosen a funeral director and may have partially paid for their funeral. Otherwise, the decision about a funeral director is made by the next of kin. The phone call is made and the funeral director will usually meet with the family. This is a time to ask questions as arrangements are made. Funerals are a business and are expensive. The director will pick up the body and care for the body until the funeral. There is nothing easy at this time; many decisions are necessary and emotions are mixed and expressed. All offers of help with the ordinary activities of life should be accepted with thanks.

Between death and the funeral

These are weird days and nights. Arrangements simply roll along. There are many people coming and going. Sleep is hard to get and tears come and go. Regular eating and drinking is important. As decisions are made, notes should be kept because the phone will ring and something will change. I had a big writing pad and it was kept beside the phone on the kitchen bench. For example, preparing the funeral card may require suitable photos to be located and agreed to before they are printed. For the funeral card to be ready to be handed to people who attend the funeral implies that many decisions and time requirements have been achieved. I recommend the process of delegation to manage the funeral card preparation. One of the most expensive decisions is for the refreshments following the funeral. The hardest decision is the estimation of the number likely to attend the funeral. It is always impossible to know.

The death of a person is usually a loss for many. The few days following the death are a period of initial grieving for that loss. There are many models and theories of loss and grief which are well known. Tatelbaum (1980, p. 21) writes: 'This time of grieving is called the mourning period, first described by Sigmund Freud in his 1917 paper "Mourning and Melancholia"'. Worden (1991, p. 7) begins with Bowlby's attachment theory as his discussion of loss and grief for mental health practitioners: 'Bowlby's thesis is that these attachments come from the need for security and safety; they develop early in life … and tend to endure throughout a large part of the life cycle'. Open recognition of the loss is a good starting point, and the release of tears is healthy. An early decision our family made was to have my husband at home in his open coffin. It was carefully placed in the lounge with boxes of tissues available. We decided he should wear his 'pink striped party shirt'. Having the coffin and his body at home provided the opportunity for many people to say goodbye to him. Some family members took a photo of his body.

We arranged a wake on the night before his funeral. People shared their stories openly and we ate and drank together. It was a very deep and wonderful occasion. It was real and meaningful and indicated to everyone who came that death is the end of living. Permission to cry is important.

The funeral

This is orchestrated by the funeral director and the celebrant (not necessarily a priest or minister) and is generally a public ceremony. The funeral itself should reflect the values of the person who has died and should be supportive of the relatives who are bereaved.

Funerals tend to be formal and dignified; however, appropriate humour can sometimes provide light relief. Some funerals may include religious rituals. Usually music and singing is included in line with family customs. At the conclusion of the funeral service, the celebrant will talk about either burial or cremation of the body and whether or not the public can attend. There is usually a cup of tea served to guests. Then it is over and the family come home to do what they will.

The first week after the funeral

Life is different. Yes, there are more decisions to be made, but nothing will happen if they are not made today. Take one day at a time. Many financial and other institutions require a certified copy of the death certificate. Get at least 10 copied and certified by a Justice of the Peace. Delegate someone to change what needs to be updated online. Stop superannuation payments for the deceased and notify banks and insurance companies. Be guided by your lawyer and follow the instructions in the will. Catch up on sleep and have plenty of treats. It's hard going.

Transitions

There are plenty of transitions. A very wise older woman I know says: 'following a death, everything changes'. In my experience, this is a true statement. The first decision I recommend people make is that life can be well lived, but it is a different life to the lifestyle that has ended. Life as a couple is different to life as an individual person. An individual is different from being half of a couple after the death of a spouse. The level of difficulty an individual experiences I think depends on many things. From a developmental perspective, the transition depends on what has gone before, especially whether there has been strong individual development or a high level of couple dependency.

I encourage all older people to consider carefully whether their place of living is right for them both in the present and in five years' time. None of us knows what is ahead of us, and accidents do happen. The house for a couple may not suit the living requirements of an individual. The house may be too large and require heaps of maintenance, and the memories may be too painful. I encourage people to make their own decisions after conversations with family and friends. These decisions should never be made in a hurry.

Safety is important for all older people. Financial management is essential, so make wise decisions, and it's better to make big decisions once only. Living alone can be successful and there is the opportunity to make the house different than it was. However, if the decision is made to move, read the small print carefully and with legal consultation before moving into a retirement village. The marketing of retirement living can be very powerful. In times of aloneness, the thought of being surrounded by others may seem very attractive.

Socially, there are many transitions. There is a saying, 'Birds of a feather flock together'. Couples socialize together. Couples travel or play golf together. Couples share a motel and, indeed, share a bed together. Single people probably also flock together. I am not familiar with the social life of many people who have always been single. There are many decisions

that have to be made in order to have a social life beyond one's family following the death of a spouse. The new reality is that former couple friends tend to fall away. To see a dining table set for five people instead of six, as it once was, is a reminder that someone is missing from this party. For some people, it may be easier to phone in sick, so to speak. In my experience, much social life is organized around couples getting together.

I recently attended a very nice wedding. I was invited alone. In my wonderings ahead of time, I briefly thought about whether the words 'and partner' would be added on the beautiful invitation. In a sense, it was a relief to be invited alone. I had decisions to make. Would I even accept? How hard would it be to go alone? What would I wear? (A cocktail dress was suggested on the invitation.) Would I arrive early or just on time? Could I drive wearing high heels or should I wear my flash new sandals? In my former life, i.e. prior to my husband's death, these decisions would have been shared with my husband in the privacy of our intimate relationship and all would have been easy for us. It became apparent that this wedding was a strong stimulus for me to experience being in a new lifestyle. There is no one to ask, 'Should I wear this necklace or this one?', 'Shoes or sandals?' or, more intimately, 'Do I look fat in this dress?'

I grew up in a family where praise was rare. As a young woman, I believed I was of less value than men and I was 'only a nurse' and not very bright, having been told by a university guidance man that he did not think I could manage university study. Since that gloomy time, I have learned about recognition or, as Claude Steiner put it, strokes and self-stroking. As Stewart and Joines (1987) put it:

> There's no doubt that many of us as children were taught Steiner's fifth rule: 'Don't give yourself strokes'. Parents told us 'Don't show off! It's rude to boast!' School continued the indoctrination. When we came out at the top of the class or won prizes on sports day, it was OK for others to say how good we were. But we ourselves were supposed to shrug and say modestly: 'Oh, it was nothing'. (p. 82)

I have learned to nurture my stroke bank by giving myself positive messages. My husband was generous with strokes for me. Without him, I am at risk of my stroke bank running low. Mostly this is an inner dialogue in my head, but sometimes I add voice to and for a job well done. According to Stewart and Joines, a stroke is simply a unit of recognition.

I am fortunate to have my two children and their families living in the same city, and I have many women friends. My husband had friends also and some of them keep in touch with me now that I am on my own. I am in good health and, because I was the oldest daughter in my family of four girls, I used to help my dad do the 'boy' things around the property. I held the piece of timber while he used the saw. He taught me to measure twice and cut once. I am a practical sort of person. However, I do not like going to bed alone. Neither do I enjoy planning my day in silence over my 'alone' breakfast. Listening to the radio breaks some of this silence. I have had to learn to like my own company more than I have ever done before. I miss the intimate and sexual life I used to have. This is my new lifestyle and it certainly beats being on the other side of the grass! Soon after my husband's funeral, an old friend left me a message on the phone saying: 'You will be alright Isabelle. The sun gets up every morning. The flowers still bloom – and your grandchildren will make you laugh'.

I decided instantly to accept this as a gift. It is simple and true, and laughter is always good.

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Notes on contributor

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