DOI: 10.1002/ppi.1466

ARTICLE

WILEY

Ethics and ageing: Facing maturity and fallibility, individually and collectively

Sue Eusden

Nailsworth, UK

Correspondence
Sue Eusden, Stone Cottage, Harley Wood, Nailsworth, GL6 0LB, UK.
Email: smeusden@gmail.com

Abstract

This paper considers the ethics of ageing among practitioners in the psychotherapy profession and the rights, responsibilities, and risks that come with an increasing number of people working at an older age. It suggests that the process of ageing is relevant to us all and how we engage with this is crucial to developing a professional community which lives—or seeks to live—according to the ethics of humanistic psychology.

KEYWORDS

advance statement, ageing, ethics, living will, responsibilities, rights, risk

1 | INTRODUCTION

I want to start with four short examples that offer food for thought about working into older age. I will draw on these stories and questions to consider the impact of ageing in our profession and the rights, responsibilities and risks involved. I aim to raise questions more than answer them, in the hope that the reader's thinking will be ignited, and this might form the basis of interesting conversations with family, colleagues, and professional groups.

i. After running a supervision group for over 30 years, Philip had decided to close it. He was not going to stop work, he was wanting to "wind down" some of his commitments. However, he was deeply attached to these colleagues and ambivalent about what he would lose, as well as hearing the group protest loudly. It seemed too much loss for any of them to bear, so they rearranged the structure. Now it would be a peer group, with Philip as peer rather than leader. Was this an avoidance of an ending or a creative way to thrive and share responsibility as an elder?

(ii) Being the head of a training institute for decades meant that Dianne had many clients and supervisees who had been with her for significant periods of time. However, it also meant that those who had started with her, many years previously, could now not be involved in the Institute's growth. They were "excluded," in a way, from taking teaching posts. Their peers, who had no such conflicts of interest, were thriving and benefitting from professional development. The tension was hard to manage at times. How long does someone hold their place as an elder and what are their rights to do so and responsibilities either way?

(iii) Tom was 73 and still working, albeit at a reduced pace. He was still sought after, refusing more work than he accepted. At a professional conference one night he was found in the corridors in his dressing gown, checking doors, appearing confused. He was helped back to bed. In the morning word spread around the conference that Tom had been delusional and was starting to suffer with dementia. Not long after this event he was diagnosed with a form of cancer, one of the symptoms of which is states of confusion. But the damage had been done: Tom had been branded as dementing. Various colleagues had attempted to "talk with him," but to colleagues he remained "in denial" and did not want to stop working. He only did so when he was diagnosed with cancer. Some members of the community felt some shame regarding how they had misread signs of ill health. How else could this ending have been managed? How do colleagues talk together and explore prejudices and fears around the difference between ageing and health?

(iv) Yasmin never confronted her ageing therapist who regularly fell asleep in sessions, forgot important details, and rambled. However, Yasmin felt protective of her, rather like she did with her own mother. She felt trapped in an inert relationship where, once again, the protection was the wrong way around. How, as a therapist, can we watch for the impact of our age/health on our clients if we don't want to know? How do we take support from colleagues at these times?

2 | THE ELDER LANDSCAPE

We turn not older with years, but newer every day. (Dickinson, 1874)

Five years ago, life expectancy at birth was over 80 in only 19 countries in the world; in 2015 this was true of 33 countries. Only Japan now has an older age group that forms more than 30 per cent of the total population; by 2050, 64 countries are expected to have achieved this (United Nations Department of Economic and Social Affairs, Population Division, 2015).

The statistics on ageing societies are astounding. According to forecasts from the World Health Organisation (WHO), the number of people 60 years or older will rise from 900 million to 2 billion between 2015 and 2050, moving from 12% to 22% of the total global population (WHO, 2015). People are living longer than ever before and birth rates are declining, leading to radically altered age demographics across all countries.

Globally, the proportion of older persons is growing at a faster rate than the general population. This reflects tremendous and welcome advances in health and overall quality of life in societies across the world. With one in nine persons in the world aged 60 years or over, projected to increase to one in five by 2050, population ageing is a phenomenon that we cannot ignore. Increasing longevity is one of humanity's greatest achievements. Indeed, population ageing is cause for celebration. The opportunities that this presents are as endless as the contributions that a socially and economically active, secure, and healthy ageing population can bring to society. Such opportunities come with rights and responsibilities for older people, as well responsibilities for communities, to protect, respect, and value these members.

In researching some of the founders and developers of humanistic psychology I discovered that many died before they were 65; Kierkegaard (aged 43), Nietzsche (aged 56), Merleau-Ponty (aged 53), Berne (aged 60), Maslow (aged 62). All worked up to the end of their lives and others who lived into their 70s and 80s contributed some of their best work in their latter years. For instance, Rogers was devoted to applying his theories in situations of political oppression and national social conflict, travelling worldwide to do so. In Belfast, Northern Ireland, he brought together influential Protestants and Catholics; in South Africa, blacks and whites; in Brazil people emerging from dictatorship to democracy; in the United States, consumers and providers in the health field. His last trip, at age 85, was to the Soviet Union, where he lectured and facilitated intensive experiential workshops fostering communication and creativity.

Bergmann (2014) claimed "admission to a very exclusive club called 'Gerontocracy,' those who have remained creative in old age" (p. 237). He named Sophocles, Johann Wolfgang von Goethe, Giuseppe Verdi, Bertrand Russell and George Bernard Shaw as fellow members. He wrote this as he approached 100 years of age. In transactional

analysis (TA), Muriel James and Fanita English have each recently celebrated their centenaries and were widely appreciated by the TA community across the globe.

Cornell (2008) wrote about witnessing and working with two colleagues until their deaths. He said,

> *I witnessed both these men in the later years of their lives confront their profession's conventions and create new ways of thinking and working. The gifts I received from them were many, but the most precious were their examples of ruthless self-scrutiny, relentless curiosity, and the capacity to change at any stage of life. (p. 304)*

The contributions many older practitioners make to the field is significant and, at times, magnificent. Their voices can bring a reflective critical commentary to the field from a more independent position. The right to be included, to be respected for your experience and the responsibility of the community to make space for elders are part of what we might consider to be a deep and abiding regard for dignity and humanness, fostering respect and competence across the lifespan. This speaks to the very heart of humanistic ethics.

3 | RIGHTS AND RESPONSIBILITIES

One of the benefits of ageing is gaining experience and wisdom. Ageing and sometimes decades of practice offer opportunities for us to deepen our work. We hold stories and histories from clients and supervisees and of developments inside our professional communities. We can share our knowledge and inspire younger people coming into the profession. Orange (2016) was explicit about her intention to "address younger and mid-journey clinicians from an ageing view" (p. xv) and so pass on her knowledge and experience. The story of Dianne, above, who heads a training institute, is an example of someone being actively engaged in a professional community over time. This involves cascading learning, embodying a right and responsibility to teach the younger generation. It also raises important questions about how we share power between generations. Do the elders hold the power at the "top of the tree"? How can knowledge and wisdom be disseminated from a position of mutuality? Possible exclusion, therefore, due to dual relationships has an impact, and not all communities are clear about the ethical guidelines around dual relationships inside institutes, perhaps because of this. Is this what Philip is doing as he rearranges his supervision group into one in which he is now a peer member? Is he sharing rights and responsibilities as his needs and capacities change? Is this a creative solution or a denial of retirement and endings/death? Is this a gift to the next generation or an exploitation of them? I realise the questions stretch across a polarity but they are really intended to help us explore, rather than decide.

An important challenge and responsibility in our profession is how we stay inspired, fresh, and current, especially after decades of working. As we get older the number of people who inspire us may change. In her latest book, *Nourishing the Inner Life of Clinicians and Humanitarians*, Orange (2016) wrote about the maturing of her own inner chorus, which has been a source of support, nourishment, and challenge over her professional life. She speaks to her own experience of maturing inside a profession that is "infinitely demanding" (Critchley, 2007). Her writing challenges professionals to consider their own "inner chorus" of influencers. Who are our role models for staying at the vital edges of learning after decades of practice? Our right to develop and contribute in our own way to our community needs to be balanced with our responsibilities to model good practice.

Michael Carroll dedicated his latest book "to all my supervisees, over the nearly 40 years I have been supervising – you really have been my best teachers" (Hewson & Carroll, 2016, p. 263). His capacity to learn from the younger generation is embedded in his writing and leading.

Both Orange and Carroll are elder practitioners who model learning, staying fresh, and taking the role of educator seriously; both of them continue to make meaningful contributions to the professional community. There are many more; these are just two in my current pile of reading, who are influencing me in my own growth. I appreciate them for continuing to push me and the profession from their depth of experience and I also appreciate the humility with which they offer their mature reflections.

Following on from the rights and responsibilities to learn as a practitioner is the balance of how to wind down or reduce a practice. This can be complex, especially for those working long term. At what stage do you stop taking clients? Can you stop working with clients and still teach and supervise? I suggest that how such experience and expertise can be accommodated to differing life stage needs is an important matter for us to consider professionally, organisationally, and as a community. What forms of consultation might take place to understand and explore what the needs and implications are of an increasing ageing population inside our professions? The rights and responsibilities of the professional community are to protect the integrity of the profession and also to accommodate difference, consider power, and promote equality, fairness, and justice. This is a complex balance that must be striven for; to be aware of the subtle (and gross) forms of active discrimination and to work actively to promote the rich diversity of maturity inside the profession.

I believe we have a responsibility to engage with facing maturity and fallibility in ourselves and others. In thinking about this article one of the key questions I have asked myself has been: What is the difference between health and ageing? Is it the same issue or is "ageing" a frame for declining health in later years? In which case, is considering "ageing" in relation to older age ageist? What are the ethical implications of ageing and how can we consider these without falling into prejudices that are already rampant in our society?

Ageing does bring an added dimension to health as it is framed towards life's later years. The end of life is also in the frame, and whilst that may be true for younger people facing chronic health problems, I believe the issues are different for those in younger or mid-life phases, than for those in later life phases. One of the main characteristics of older age is the disappearance of the future as a dimension and how this impacts us will be significant. I remember one colleague saying to me as he turned 65, "the tree was always over the horizon, now it's in sight!" This raises the question of each of our responsibilities and how we prepare well for the inevitable aspects of ageing, especially those relating to decline in health, memory, and energy. Tom's story (above) brings these challenges into sharp relief, and he died only six months after his diagnosis. His professional career came to a sudden end, leaving many unfinished conversations. For some of us, perhaps this is how it might be. Maybe we cannot protect against such endings, but perhaps we can be prepared for the unpredictable.

4 | RISKS

Still, ethics requires courage, and courage needs support. (Orange, 2016, p. 60)

Tom needed colleagues who knew how to listen and not to condemn. However, he also needed to be able to listen. This was easier when faced with a medical diagnosis rather than a behavioural confrontation. We have to get better at these difficult conversations, both starting them and staying in them.

The vignette involving Yasmin's therapist raises the risks inherent in working beyond capacity into older age. Colleagues of this therapist had previously made verbal agreements with her that they would confront her, but their version of doing so was to encourage her softly away from practice by stopping referrals to her and thereby "easing her out" (which was a phrase they used about her). Their intention was caring but perhaps the negative impact on her clients, such as Yasmin, was missed.

Geller, Norcross, and Orlinsky (2005) pointed out that therapists often struggle to express their vulnerability even within their own therapy, saying that we are "threatened by the dilemma of 'needing help'" (p. 6). The risk in this is that we "place ourselves above our clients, a narcissistic position that splices us from the common humanity of those we seek to treat" (Adams, 2014, p. 125). As a senior member of the community, it may be hard to seek help. Where can you go where you are not known, where your struggle can be held with care and respect, and where you can be helped to consider when and how to retire? How do we draw a line on a contemplative and reflective practice that allows us privileged access to private conversations, the like of which rarely occur outside the consulting room? How do we stop a lifetime of addiction to intimacy, suffering, and healing? How might we stay connected to

professional communities and networks (if we wish to do so), if and when we are not practising? Our relationship to asking for and receiving help at challenging times is pivotal to how we navigate such difficulties.

Advance decisions (sometimes referred to as "living wills") and advance statements are two ways to let others know about our wishes for our health care if there comes a time when we cannot make choices and decisions about them ourselves. They are generally linked (in the UK) to the Mental Capacity Act 2005 and a Lasting Power of Attorney. These are legal frameworks to help medical professionals provide care in line with our wishes. Such practices seem to offer an interesting ethical framework for practitioners of all ages.

This would seem good practice to put into place, whatever age we are. Arranging a professional executor is commonplace and now expected of practitioners to protect their clients in case of emergency. Moreover, making a clear advance statement about how you would like to be treated and your affairs to be managed if your health declines seems ethically attentive, and can be discussed with close colleagues and supervisors as a professional contract.

Such a framework could encourage open dialogue about how we would like to be challenged if our colleagues are concerned about our work and our health. I believe this should be part of ordinary practice, particularly for those of us in private practice where our work operates mainly behind closed doors. The only witnesses to our work are our clients and supervisees and, at one remove, the supervisors/colleagues with whom we discuss our work. How do we invite, welcome and use feedback when we might be at the edges of ourselves, our competencies and our reflective capacities?

An advance statement, as part of a personal statement of ethics, can involve us making clear our wishes and preferences regarding how we want to be challenged and supported in the face of difficulty. The value of preparing such a statement is in the process of thinking, dialoguing, and deciding with others. This can make a sound base for managing the later stages of a professional career and a deepening of trust with good colleagues who support the protection of our clients, practice, and profession. It is one way to mind the gap (Eusden, 2011) between our professional intent and the impact on ourselves, our professional community, and our clients of a decline in physical or mental health.

Universally, for all of us, the ethical confrontation of a colleague is a challenge. Our professional contract, embedded in most if not all codes of ethics and practice, is to challenge each other's blind spots. We need to develop emotional muscles to ask for, be receptive to, and accept (or reject when necessary) feedback and challenges as part of our usual dialogue. We need to practise considering challenges thoughtfully, rather than defensively.

5 | CONCLUSION

> *In a field which purports to work toward the psychological health of others, it is essential that we also promote the good health of our own community. (Adams, 2014, p. 120)*

Ageing is a lifelong process that does not start at age 60 or 65. Today's young people will be part of the 2-billion-strong population of older persons in 2050. A better world for younger people today will mean a better world for older persons in 2050. Ageing is a process we need to account for, whatever age we are, and how we combine the challenges and benefits of ageing is vital for building vibrant and ethically-mindful learning communities. Each of us will be impacted by our own ageing and others ageing around us. These dilemmas are pertinent to us all. Ethics is fundamentally about how to live well. So, the core question of how to age well as a professional, colleague and community member is vital to our health. I believe we need to keep encouraging ethical discussion together to consider risks, find courage and offer support to promote working and ageing together with grace.

REFERENCES

Adams, M. (2014). *The myth of the untroubled therapist*. New York, NY: Routledge.

Bergmann, M. S. (2014). Psychoanalysis in old age. In S. Kuchuck (Ed.), *Clinical implications of the psychoanalyst's life experience: When the personal becomes professional* (pp. 237–246). New York, NY: Routledge.

Cornell, W. F. (2008). *Explorations in transactional analysis: The Meech Lake papers*. Pleasanton, CA: TA Press.

Critchley, S. (2007). *Infinitely demanding: Ethics of commitment, politics of resistance*. London, UK: Verso.

Dickinson, E. (1874). Chapter VI: To the Misses. In M. Loomis Todd (Ed.), *Letters of Emily Dickinson*. (pp. 193–251). New York, NY: Dover Publications.

Eusden, S. (2011). Minding the gap: Ethical considerations for therapeutic engagement. *Transactional Analysis Journal*, *41*, 101–113.

Geller, J. D., Norcross, J. C., & Orlinsky, D. E. (Eds.) (2005). *The psychotherapist's own psychotherapy*. New York, NY: Oxford University Press.

Hewson, D., & Carroll, M. (2016). *Reflective practice in supervision*. Bristol, UK: Minuteman Press.

Orange, D. M. (2016). *Nourishing the inner life of clinicians and humanitarians*. London, UK: Routledge.

United Nations Department of Economic and Social Affairs, Population Division. (2015). *World population ageing 2015* (ST/ESA/SER.A/390). Retrieved from http://www.un.org/en/development/desa/population/publications/pdf/ageing/WPA2015_Report.pdf

World Health Organisation. (2015). *10 facts on ageing and health*. Retrieved February 2, 2018 from http://www.who.int/features/factfiles/ageing/en/

Sue Eusden MA is a teaching and supervising transactional analyst (psychotherapy) and a UKCP registered psychotherapist. She maintains a private practice in Nailsworth, and is a tutor at Metanoia Institute, London. She also has a supervision practice in Edinburgh, Scotland. She has published several articles and has also contributed a chapter on ethics to *Relational Transactional Analysis: Principles in Practice*, edited by H. Fowlie & C. Sills (Routledge, 2011). Her interests are understanding enactments and co-influencing in psychotherapy. She is currently researching the complexity of asking for help.

How to cite this article: Eusden S. Ethics and ageing: Facing maturity and fallibility, individually and collectively. *Psychother Politics Int*. 2018;16:e1466. https://doi.org/10.1002/ppi.1466