CARING
FOR THE ELDERLY

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Anthropologists who study aging are often asked: Isn’t it true that old people are better off in traditional societies? Don’t their families always respect them and take good care of them? The short answer to these questions is “No.” But in fact there is no simple yes-or-no answer. Elder care is complex and cannot be summed up by stark contrasts between traditional and modern societies, or between the extremes of tender loving care and abandonment. Everywhere in the world, behavior toward old people varies greatly, ranging from behavior that is very to moderately supportive to behaviors that are nonsupportive and even death-hastening.

In any society—whether village-based, “tribal,” or national—elders’ experiences of old age vary because of cultural differences concerning the elderly, and because old people are not all the same. They differ in their physical health, the resources they control, their marital situations, and the availability of children as caregivers, among other factors. “Big picture” factors are also relevant; for example, a nation’s political stability and general economic circumstances affect everyone’s well-being.

Support and care of the elderly is the central focus of our discussion, which revolves around these questions: What are the needs of old people? When elderly need assistance, do they get it—and if so, who provides it? Are there alternatives if culturally appropriate family caregivers (such as daughters or daughters-in-law) are not available? What better ways might there be for meeting the needs of the elderly?

In this discussion we draw upon the research of others and upon our own field experiences in anthropological gerontology. We have done research on the elderly in a variety of cultural settings: among the Lak of Papua New Guinea (Albert) and the Samia of Kenya (Cattell); with elders living in their own homes in a Philadelphia neighborhood (Cattell) and in congregate living facilities, such as nursing homes and age-segregated housing (Albert); and among family caregivers to frail elders (Albert). A more complete discussion of aging from a cross-cultural and cross-national perspective can be found in our book, Old Age in Global Perspective.¹

Our aim is to broaden understandings of old age by looking beyond America to consider both cross-cultural variation and universals (or widely occurring trends) in experiences of old age and elder care. We conclude with some ideas about the ways knowledge gained from research can help improve elder care.
Old age is, first of all, the experience of individuals. Younger people experience old age through knowing people who are old and/or caring for frail elderly family members, especially parents. An increasing proportion of people today also live long enough to experience old age as old people.

Old age is also a stage of life that may encompass several stages, with some old people being relatively healthy, contributing members of their families and communities, and others being in various stages of decrepitude or frailty that require varying degrees of support and personal care.

The variety of names for old people among English-speaking Americans reflects our ambivalence and tension about aging, being old, and caring for frail elderly. No term seems truly neutral, or purely descriptive, because growing old, being old and interacting with old people are often emotionally sensitive and disturbing experiences. In our discussion we use some relatively neutral terms: elderly, elders, old people, the old, the aged. But our language also abounds in euphemisms such as "golden agers" or "senior citizens," and in derogatory terms, such as "old codgers" and "geezers."

When is a person old? Because years are easily compared, researchers usually define old age chronologically; many set sixty or sixty-five as the threshold of old age, but some go as low as age fifty. Similarly, in everyday life people do not agree about a given age as a point of entry to old age. In fact, in everyday life people commonly use cultural criteria that recognize that becoming old is not an overnight event but a gradual process. They may go by a person’s appearance: “You’re getting gray; you must be getting old.” Or they may employ functional standards, as in the often-heard “I can’t remember things the way I used to; I must be getting old.”

Chronological age is often taken as a proxy for biologic age, but individuals age physically at different rates. Some people are “young for their years,” others “look their age” or “look older than they are.” Some persons at the age of sixty-five are active and vigorous, others are frail and need nursing care—and some don’t even live to that age.

Old age may be defined by cultural markers. For example, in
her research among elderly Samia farmers in Kenya in the mid-1980s Maria Cattell found that most older people (many of whom are illiterate) do not even know their age in years. They define old age by such signs as loss of strength, physical appearance (e.g., wrinkles, gray hair), using a walking stick, having grandchildren, and, for women, the end of menstruation. Old people are those who have “cleared many granaries” or lived through many harvest seasons. These ideas about old age are tied to a view of aging as a social process, with people becoming parents and then grandparents or in other ways becoming senior members of their family and experts in certain kinds of knowledge.2 The Lak of Papua New Guinea define old age in similar terms: Anyone who has lived long enough to see their children marry is considered to be an elder worthy of a certain degree of deference.3

Another definition of old age is legal, as when a government sets eligibility criteria for old-age pensions. Today in the United States an array of government programs (e.g., Social Security, Medicare) uses chronological age criteria to determine eligibility for benefits. This legal definition may, in turn, influence other conceptions of old age.

**AN AGING WORLD**

It is not only individuals who become old. The world’s population is aging, too. This means, first, that there are larger numbers of old people. For example, by the year 2020 it is expected that China, with the world’s largest population, will have about a quarter billion people aged sixty and over—more people than there will be in the entire population of the United States at that time.4 By then, about a billion people worldwide will be old.

Second, an aging world is one in which a high proportion of the population is old. In Sweden, the world’s oldest country, close to one quarter of the population (nearly 23 percent) was age sixty and over in 1991. In about thirty countries of Europe, Asia, and North America, at least 15 percent of the entire population is currently age sixty and over. Throughout the world, populations are rapidly becoming gray—with the exception of Africa, whose age sixty and over population is expected to remain at under 5 percent of the total until well into the twenty-first century. However, the num-
bers of elderly Africans will increase greatly, to about 102 million by the year 2025.5

The worldwide shift to an aging population results primarily from declining fertility—that is, people are having fewer children, which leads to fewer young people relative to older. But also, old people are living longer. The world’s fastest growing population age group is people who are eighty and over. This means there are more frail and disabled elderly, more dependent elderly in need of care.

The needs of this growing population of elders are often opposed to the needs of younger members of society in debates over “intergenerational equity.” Shall money, other resources, and people’s time and energy be spent on educating youth or caring for elders? However, framing the issue in this way presumes competition between generations. In fact, significant proportions of both children and elders are vulnerable, and the flow of resources between the generations has been and continues to be a two-way, reciprocal flow.6

VARIATION IN VULNERABILITY: THE NEEDS OF OLD PEOPLE

The majority of older people are reasonably healthy and active and able to manage most or all of their daily needs. They take care of themselves and even care for others, such as a spouse, grandchildren, or even other old people. A Pennsylvania man in his eighties regularly went to the county home “to help out the old people,” as he put it. Did he think he himself was old? Certainly not! In Kenya, Maria Cattell often walked past the field of an elderly Samia man, then about eighty-five years old. He was nearly blind and so weak he had to sit to do his weeding—but he grew corn and cassava until he died at about the age of ninety. Many elderly Samia who lamented their loss of strength went on to affirm their competence and claims to others’ respect: “But I can still work on my farm and feed my family!” In the United States, millions of grandparents are raising their grandchildren, and in many parts of the world grandparents (especially grandmothers) regularly care for grandchildren. Women everywhere continue to do domestic work almost to the
end of their lives, finding creative new ways to perform tasks which become difficult for them to do. In this way they continue their social and productive roles in spite of reduced physical capability.

Nevertheless, growing older has its risks. There are many ways in which elders differ in their vulnerability, that is, in their needs and in the availability of support. Some variation in vulnerability is related to general economic and social circumstances, such as a nation’s economy and the availability of pensions and insurance, or the frequency of war and famines that affect everyone, although the very old and the very young may be the most vulnerable. Some variation results from cultural or ethnic differences in attitudes, values, and practices. This is true in indigenous, village- and kin-based societies (often referred to as “traditional” societies) as well as in more “modern” settings, including multicultural countries such as the United States.

However, in spite of cultural or national differences, there are common risk factors for vulnerability among the elderly which have to do with their own characteristics. These include material poverty, poor nutritional intake, low social status, childlessness or sonlessness, and widowhood. Everywhere in the world, women are more likely than men to face these problems. For example, widowed older men are likely to remarry and thus gain a spousal caregiver, while widowed older women often do not remarry; and men in late life are more likely to have co-resident children to provide care because men commonly become parents at later ages than women.

In addition, for men as well as women, the effects of these factors are intensified when the elder becomes physically or mentally frail and consequently unable to engage in productive work or carry out the usual activities of daily living, including personal care. Vigorous elders may have privileged positions relative to juniors, especially if they command resources the juniors want. But when elders become so frail and disabled that they are regarded by others as useless and near death, care may be minimal or the elder may be abandoned or killed.

With increasing age, people are more at risk for decrepitude or frailty, that is, diminished physical strength, increased illness, and dementia (the loss of memory and other cognitive abilities). Compromised cognitive function is perhaps an even more direct challenge to adult competency and social participation than reduced physical capabilities.
Frailty interferes with individuals’ ability to fulfill their roles, for example, to produce food through farming, hunting or foraging, or, in urban contexts, to drive a car, manage personal finances, shop for food, and do housework. Frail elders may take on roles more consistent with their capacities, such as caring for young children, adjudicating disputes, and developing skills in ritual and healing. However, performance of these roles will also be reduced with further debility, as elders require more and more help with personal care tasks such as bathing, mobility within the home or village, transfer to and from a chair or bed, and toileting. The respect and deference normally accorded elders may diminish markedly as the elder passes from active old age to decrepitude.8

Clearly, the aged are at risk for dependency and many eventually need material provisioning and personal care. The critical question then becomes: Do they get help when they need it?

**VARIATION IN VULNERABILITY: MODERNIZATION**

“Modernization” is often blamed for the problems of the elderly. Modernization is a catchall term used to indicate the complex changes brought about by the incorporation of local or indigenous political units (often called “traditional” societies) into a worldwide “modern” political and economic system. This occurred largely through conquest and colonization and, later, the creation of new nations, now known—in reference to their economic development (or rather, lack of it)—as the developing or less developed countries or, less euphemistically, the Third World. Changes accompanying these political shifts included the introduction of money and wage labor, formal education, new technologies and religions (especially Christianity), and foreign goods, ideas, and lifestyles. With better health care, population aging and an increase in the number of frail elders are additional aspects of modernization, as is a shift away from corporate social units such as clans and extended families toward nuclear family units.

Under these conditions of radical and extensive change in indigenous societies, many older people have become socially and
economically marginalized. Their control of resources and positions of authority have been greatly diminished. Local political systems controlled by elders have given way to centralized governments and bureaucratic administrations. Younger family members who go off to rapidly growing cities and even other countries in search of wage employment are no longer under the immediate control of their elders and are much less dependent economically on the old who control land or other productive resources in the home area. Local knowledge, in which older people were specialists, has been devalued and replaced by introduced knowledge (such as medicine, technology and Christianity), a process that diminishes the status of elders.9

The processes of modernization have added to the difficulties, burdens, and stresses of families in their struggles to provide for all family members, including the elderly. One growing problem is caregiver scarcity. With families spread out geographically, because younger members leave home for schooling and employment, caregivers may not be living where they are needed. Also, with the decline in fertility in much of the world, and fewer children per family, there is more likelihood of a very old person having no children or only one surviving child. An extreme case is mainland China, with its one-child-per-family policy.

Other stresses related to modernization also affect families and elder care. For example, poverty in developing countries has increased with the shift from agricultural self-sufficiency (subsistence farming) to cash cropping (peasant farming) and a market economy. Production of cash crops may reduce the amount of food grown for home consumption—especially with a reduced labor supply as family members go to cities for wage employment. The usual caregivers, women, may be “over-employed” as a result of increased demands on their time and energy coming from their expanded economic activities in peasant farming and trading in the face of a reduced labor pool. Women in these situations may find it difficult to give sufficient time and energy to the care of dependent elders.

However, modernization can also benefit the elderly. Better health care and medical technology may improve elders’ quality of life and extend the period of active life. The introduction of pensions may provide an income, enabling the elderly to be self-supporting or to contribute to family income.10 When ethnic revivals cause a renewed interest in cultural knowledge and customs, young people may turn to their elders for advice and leadership.11
Most elder care is provided by families, especially daughters and sons or, often, sons’ wives. Cross-cultural variation in elder care ranges from very supportive care to nonsupportive and even death-hastening behavior; both supportive and nonsupportive behavior are often found in the same society. Nonsupportive behavior refers to behavior that does not help to maintain the life and well-being of an old person, but does not lead directly to death. It includes insults and ridicule, loss of property, and being forced to live apart from the main social group. Death-hastening refers to behavior that results in an elder’s death, such as not being given food or water, or being abandoned or killed.

Nonsupportive and death-hastening behaviors toward the elderly occur in indigenous or traditional societies and in modern nations, including our own. They are found in institutions such as nursing homes as well as among families.

Family Support of the Elderly

Older persons who still contribute to their families (for example, by caring for children or turning over pension money) are likely to receive family support. The hope of property inheritance can be a strong incentive to elder care, as among Somalis who farm and herd livestock: A Somali father will favor a “good son” by giving him the best portion of land and the most animals; the good son in return takes care of his father when the old man becomes frail.

The strategic use of heritable goods and the threat of disinheritance, used to encourage support in old age, are mechanisms that are usually more important to men than to women, since men are more likely to have property to bequeath.

Universally, care of elderly parents is regarded as the final transaction between parents and children, the last outcome in a lifetime relationship that is, ideally, mutually supportive. While both the ideal and individuals’ preferences may be for balanced exchange, it may be culturally acceptable if exchanges are some-
times unbalanced, for example, when parents take care of small children, or adult children care for a frail parent. Thus even frail elderly may receive very supportive family care, which is perceived as the parent’s right for a lifetime of being supportive of sons and daughters. This was true in rural Kenya, as is illustrated by the following case study of a terminally-ill African woman. The account, by Maria Cattell, shows how the caregiver was chosen and the nature of the care given.

Consolata, a Samia woman in her late fifties, was always very active when I knew her in 1985. I used to meet her on footpaths and roads, at church or in the local market, as I walked about to visit and talk with old people in their homes. When I returned to Samia for a short visit in 1987, I saw Consolata for the last time. I passed her house on the way to visit friends and she called me over. I was shocked by her appearance: She was thin and listless. She showed me her breast, eaten away by cancer. "I'm now a very sick person," she told me. "All I can do is sit here where you see me and wait to die." When I later checked with her relatives they told me Consolata had been taken to the hospital, but nothing could be done. Her daughter-in-law Mary came home from the city, leaving her husband, Consolata’s son, in Mombasa to keep up his employment. Mary had been in Samia for some months, caring for Consolata. This was the right thing to do, since the son was responsible for his mother’s care, even though her husband was alive and well (Samia men do not provide personal care to spouses). For a number of months, until her mother-in-law’s death, Mary fed and bathed Consolata, washed her clothes, helped her move about, cooked food and carried water for her, and provided companionship and conversation.

Family caregiving involves similar problems and decisions everywhere: who is responsible, who will provide the hands-on care and the financial support, who will live with or near the elder? Selection of a caregiver often depends on unwritten cultural rules. As we saw with Consolata, her husband did not provide care because that is not considered a husband’s role. Where brides come to live in their husband’s home (as is the case in Samia), a son is likely to be the one who is financially responsible while the actual care is provided by the son’s wife, perhaps with help from their children. By contrast, in the United States, spouses are likely to be
primary caregivers unless the elder is widowed; if a widowed elder has children, a daughter is the first-choice caregiver.

Since women tend to outlive men, wives most often care for elderly males and daughters most often care for elderly females. Everywhere in the world it is mostly women who provide hands-on caregiving. This pattern in familial caregiving is consistent with role assignments that make women overrepresented as nurses, preschool workers, and elementary schoolteachers. It is ironic that women, who provide most elder care, are in turn most vulnerable to the risks of old age, as discussed earlier.

Family caregiving produces strains and tensions between older and younger generations. Conflicts and tensions between the generations are common throughout the lifecourse, as younger generations struggle to gain valued resources and positions of prestige and power, and older people try to retain their privileges. Intergenerational tensions may be intensified when the older generation becomes frail and dependent. Caring for a dependent person is seldom easy, and caregivers usually have other responsibilities that may make elder care burdensome. Caregivers may have to choose between giving time and energy to a frail parent or to their own productive work and their dependent children. Not only that, but the elderly may complain a lot, not so much because of poor care as because they resent being dependent and feeling useless, or as a reminder to young folks to do their duty.

When Families Refuse Care: Gerontocide

Death-hastening behavior ranges from neglect and abuse to abandonment, encouragement of suicide, and even outright killing (gerontocide). While the idea of gerontocide may seem shocking, it usually occurs only when elders live “too long”—that is, when they become so frail and incompetent they can no longer make any useful contribution to their families. Thus nonsupportive and death-hastening behaviors often are preceded by a period—perhaps of years—of family care. The decision to abandon or kill is usually made by immediate family and with the participation (often willing, sometimes reluctant) of the elder.

The classic or often-cited case is that of the Inuit (Eskimo) of Arctic North America, who live by hunting. Inuit respect and love their old people. They take good care of them—as long as the
elders contribute to family life and food-getting. However, when an elderly Inuit becomes too decrepit—when a man can no longer hunt at all or a woman can no longer cook or help care for children—the elder is abandoned on the trail or the elder wanders off alone. Family members may even help them die through drowning or strangulation. Aboriginal Inuit cosmology makes these actions acceptable to both the elders and their families, for Inuit believe that individuals do not really die, because their “name substance” is born again in infants named after the departed elders. 

Death-hastening also occurs in societies in which the majority of deaths occur under medical supervision—one need only think of current debates in Europe and America concerning the ethics of assisted suicide and withdrawal of life-support technology, called “euthanasia” by some, “murder” by others. However, unlike the Inuit and people in other ethnic groups who hasten the deaths of their elders, notions of personal continuity through reincarnation or a spiritual afterlife do not seem to enter into these debates in Europe and America.

Alternatives to Family Care: Nursing Homes

Is death-hastening the only alternative to family care? Sometimes assistance may come from neighbors, community groups, community health workers, or government or private programs aimed at the elderly. In developed countries, residential care in nursing homes is a likely option. Many Americans think most old people end their days in nursing homes. Interestingly, in Kenya and in Papua New Guinea each of us encountered the same myth about America. For example, many Kenyans said, “Americans just put their old people in homes and forget about them. We Kenyans don’t want that.” In Steven Albert’s research in South Philadelphia, family caregivers said virtually the same thing, shaking their heads as they wondered how it is that “a mother can take care of many children, but children can’t take care of even one mother.” In fact, nursing homes are usually the last resort following family care and the majority of elderly Americans finish their lives in their own homes or sometimes in the homes of their adult children.

Nursing homes or other congregate living facilities are uncommon in less developed nations. For example, there are some homes for the elderly in Kenya, Zimbabwe, and elsewhere in
Africa. But these are not medically oriented facilities. They are residential homes for destitute elderly, both the healthy and the frail. Many try to allow elderly residents to live as normal a life as possible, for example, by working in the garden, carrying water, cooking, and caring for the frail residents. However, such institutions provide for only a handful of destitute elderly. For the most part, family care is the only option.25

THE VALUE OF RESEARCH ON THE ELDERLY

Anthropology’s major contributions to aging studies are the discovery of universal aspects of aging and old age and, at the same time, recognition of culturally unique aspects of aging. Understanding local or indigenous values and lifestyles can help point the way to culturally appropriate solutions to problems of elder care.

Knowledge gained from such research can help dispel common myths that old people are weak, incapable and useless. Such myths adversely affect both the attitudes of younger people and the status and activities of healthy, capable older people. In developing countries, for example, the young may look upon the old as getting in the way of badly needed economic development.26 Research showing that older people can make useful contributions could encourage the inclusion of elders in development programs. This would benefit the elders directly by enabling them to earn money and indirectly through promoting economic growth in their nations.

Ironically, however, this same demythologizing that can benefit healthy elders may be detrimental to frail elders who are in need of care. It is important not to look on all old people as the same, and, in making policy and designing programs, to distinguish between healthy, competent elders and frail elders.27

Questions remain. For example, what is the relationship between caregiving and the co-residence of parents and adult children? How do cultural notions of family reciprocity and exchange affect caregiving? What is the quality of family care received by frail elders in different cultural settings? What is the last year of life
like in different societies? How do friends help each other in old age? Knowledge about these and other little understood aspects of elder care is fertile ground for future anthropological research to benefit elderly and their families.

NOTES


SUGGESTED READINGS


and old age.


