Losing Your Home

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It is not sufficiently realized that the loss of one's home - however good the reasons for leaving it - can be experienced as a form of bereavement and can produce the same grief reaction as the loss of a close relative. Peter Marris in his book *Loss and Change* (1974) quotes a study of the reactions of families moved from the West End of Boston under an urban renewal scheme in which it was concluded that:

for the majority it seems quite precise to speak of their reactions as expressions of grief. These are manifest in the feelings of painful loss, the continued longing, the general depressive tone, frequent symptoms of psychological or social or somatic distress, the active work required in adapting to the altered situation, the sense of helplessness, the occasional expressions of both direct and displaced anger, and the tendencies to idealise the lost place. At their most extreme, these reactions of grief are intense, deeply felt and, at times, overwhelming.

Altogether about half the 250 women and 316 men studied said they had been severely depressed or disturbed for a while, and another quarter had been more mildly upset. A quarter of the women were still very depressed two years after they had moved, while a fifth had taken over six months to recover their spirits. The unhappiest exiles described their loss in similar phrases to the bereaved: 'I felt as though I had lost everything.' 'It was like a piece being taken from me.' 'Something of me went with the West End.'

Similar reactions were described by Young and Wilmott (1957) when they studied families moved from the East End of London to a suburban housing estate and by Marris in a study of slum clearance in Lagos, where residents complained bitterly 'it seemed like being taken from happiness to misery', 'I fear it like death': Marris suggests that, like bereavement, a change of home should be understood as a potential disruption of the meaning of life. Those for whom a move represents the realization of a social status and way of life with which they already identify will be able to work through the loss and recreate what they valued in their former neighbourhood. 'But,' he says:

for some, it may be a profound disturbance from which they never recover. And such tragedies are, I believe, more likely, the more slum clearance is
used as an instrument of social change, not merely physical development; and the more it is directed against groups in society, whose non-conformity with the ruling values seems to stand in the way of progress. (Marris, 1974)

Old people who are moved into sheltered housing or residential care may or may not be moved from slum conditions, but the sense of loss must surely be equally great for them. Indeed it may be greater if, in the process, they have to sacrifice not only a home and neighbourhood but the greater part of the possessions of a lifetime. It must also be true that they are likely to work through the loss only if they make a positive identification with their new life. If they are being moved in conformity with ruling social values which are offended by letting them stay where they are, or are forced to go by the physical duress of having no viable alternative, they are still less likely to recover from the loss.

A good deal of research data, much of it American, supports such a conclusion, and it is clear that the loss of a home may be particularly serious for those who are mentally impaired, physically ill, or depressed and thus unable to make a positive effort to identify with the new life. Gutman and Herbert in 1976 quoted 13 studies which showed that the death rate of elderly persons was unusually high during the first year after ‘relocation’ and particularly during the first three months. This was so regardless of whether the movement was from the community into a mental institution, from one institution to another, from one ward to another within the same institution, or from old to new facilities. (The same researchers showed from their own study however, that this effect does not obtain when the community moves en bloc to a new building with improved facilities and every effort is made to prepare patients and relatives for the move well in advance, to keep friends together in their new quarters and to transfer staff as well as patients.)

M.A. Lieberman, in an important paper on relocation and social policy described four studies which he had made: ‘one on healthy moving into affluent high-care, sophisticated institutions; others involving sick, highly debilitated human beings moving into circumstances that would delight a muckraker’ (Lieberman, 1974). These ‘have yielded roughly comparable findings. Namely, no matter what the condition of the individual, the nature of the environment or the degree of sophisticated preparation, relocation entails a higher than acceptable risk to the large majority of those being moved.’ Given that relocation may sometimes be inevitable, Lieberman goes on to ask what steps can be taken to minimize the risk but cannot suggest a solution. He concludes that careful preparation and ‘working through’ of the transitional process and impending loss, important though it may be in relieving human misery, is not a powerful tool in minimizing relocation risk. ‘The reason,’ he says,
is not poor practice but rather incorrect strategy. Relocation is a risk to the individual not because of the symbolic meaning that such transitions imply, but because it entails radical changes in the life space of an individual that require new learning for adaptive purposes. Over and over again, studies on relocation report findings that physical status, cognitive ability and certain other characteristics of personality are powerful predictors to the outcome of relocation.

In other words, those who need institutional support the least are those who are most likely to survive the move into it, and ‘it is often the very people who require supportive services that can be shown to entail the greatest risk’. (He adds that this is another illustration of how the results of empirical research often fail to help with the nitty-gritty of policy issues.)

A study of fatal home accidents made by the Tavistock Institute of Human Relations on behalf of the Department of Prices and Consumer Protection also suggests that old people are not necessarily safer when they are ‘in care’. The authors found that out of 133 fatal accidents studied in the ‘65 and over’ age group (75 per cent caused by falls) 35 per cent were in institutional care, although only 4.8 per cent of this age group live in institutions. They comment: ‘Even considering that residential institutions contain a higher proportion of the infirm, the difference in accidental deaths is high’ (Poyner and Hughes, 1978).

It would seem to follow from all this, that if avoidance of ‘risk’ is indeed a prime objective, moving people out of their homes may not be the best way of achieving it, and that the more they appear to be at risk where they are, the worse will be their prognosis if they are moved. Yet this is a factor which is seldom taken into consideration when considering transfer into residential care, and still less is it taken into consideration when deciding on hospital admission.

Elderly people, like members of any other age group, are of course often admitted to hospital for surgery or investigation which could not be provided in their own home; and they may benefit greatly from such treatment. (For example, a study of 248 patients over 80 admitted as emergencies to acute surgical wards of the Reading hospitals in 1976 showed that the overall mortality rate was 21.8 per cent and it fell to 12.5 per cent if terminal disease was excluded. All but seven patients were discharged home: Salem et al., 1978.) However, there is another large group of elderly people who become patients not so much because their condition demands full-scale hospital treatment as because there is a crisis in their system of social support. The social crisis then has a medical label attached to it in order to make the admission acceptable to the hospital. For example, if an elderly person develops pneumonia and the spouse finds the anxiety of nursing at home too much to bear, an admission will probably be arranged, but the diagnosis is pneumonia, not ‘anxiety in spouse’. Very often the admission may be occasioned by some incident or accident which
proves to be the last straw on an already overstrained support system, or because there is no time to arrange for the domiciliary services required by a change in circumstances (such as the caring relative becoming sick). Or, if an elderly person presents at an Accident and Emergency department of a hospital after, say, a fall in the street, a harassed houseman may ‘play safe’ and keep the person in for ‘investigation’ just to make sure no damage has been done.

The problem is that it is much easier for an elderly person to become a hospital patient than to cease to be one. There are a number of reasons for this. The ‘social space’ in which the person has been living may close behind him on admission, so that he cannot get back. A family may heave a sigh of relief, having realized, perhaps for the first time, what a burden it has been carrying and say, ‘He’s not coming back here.’ A landlord may take the opportunity to repossess his house, or the warden of a sheltered housing complex say, ‘He needs too much nursing now, I can’t cope.’ Ironically, it is often the person who would appear to be most at risk, who lives alone in his own home, who is in least danger of having his social space close up on him.

It is also often the case that if a person has only just been coping with independent life, hospital admission breaks a tenuous level of confidence which can only be restored with time, care and skill. Elderly people who are suffering from some degree of dementia are especially at risk because the experience of admission to a totally strange and unfamiliar environment is likely to increase confusion and generate problems such as falling and incontinence which may not have been present before.

Another possibility is that hospital ‘investigation’ may show up undiagnosed diseases which a person has been living with for years, but which, once diagnosed, the hospital may feel compelled to treat. Observation after a fall may then become treatment for something quite different, so that the person is confirmed in his patient status. Moreover, if the person is being treated in an acute ward, the nursing staff may not have the time, interest or training to help the patient to retain independence and mobility, and even a few days of inactivity may produce disuse atrophy which involves not only loss of muscle power but also loss of the range of movement normally possessed by a joint. Simple skills required for daily living such as combing one’s hair, fastening a button or rising from a chair may then be lost. (It has been shown that even the muscle disuse occurring during normal sleep leads to significant weakness on waking: Browne, 1978.) A period of treatment in an acute ward may therefore mean that an elderly person requires a prolonged period of rehabilitation in a geriatric ward before he can recover his skills sufficiently to manage at home again – and the longer the period in hospital, the more likely it is that the ‘social space’ at home will have closed up.
For all these reasons, hospital admission – which can undoubtedly be ‘life saving’ – may also be dangerous to elderly people, and the dangers need to be weighed against the advantages when deciding whether or not to admit someone to hospital.

References


