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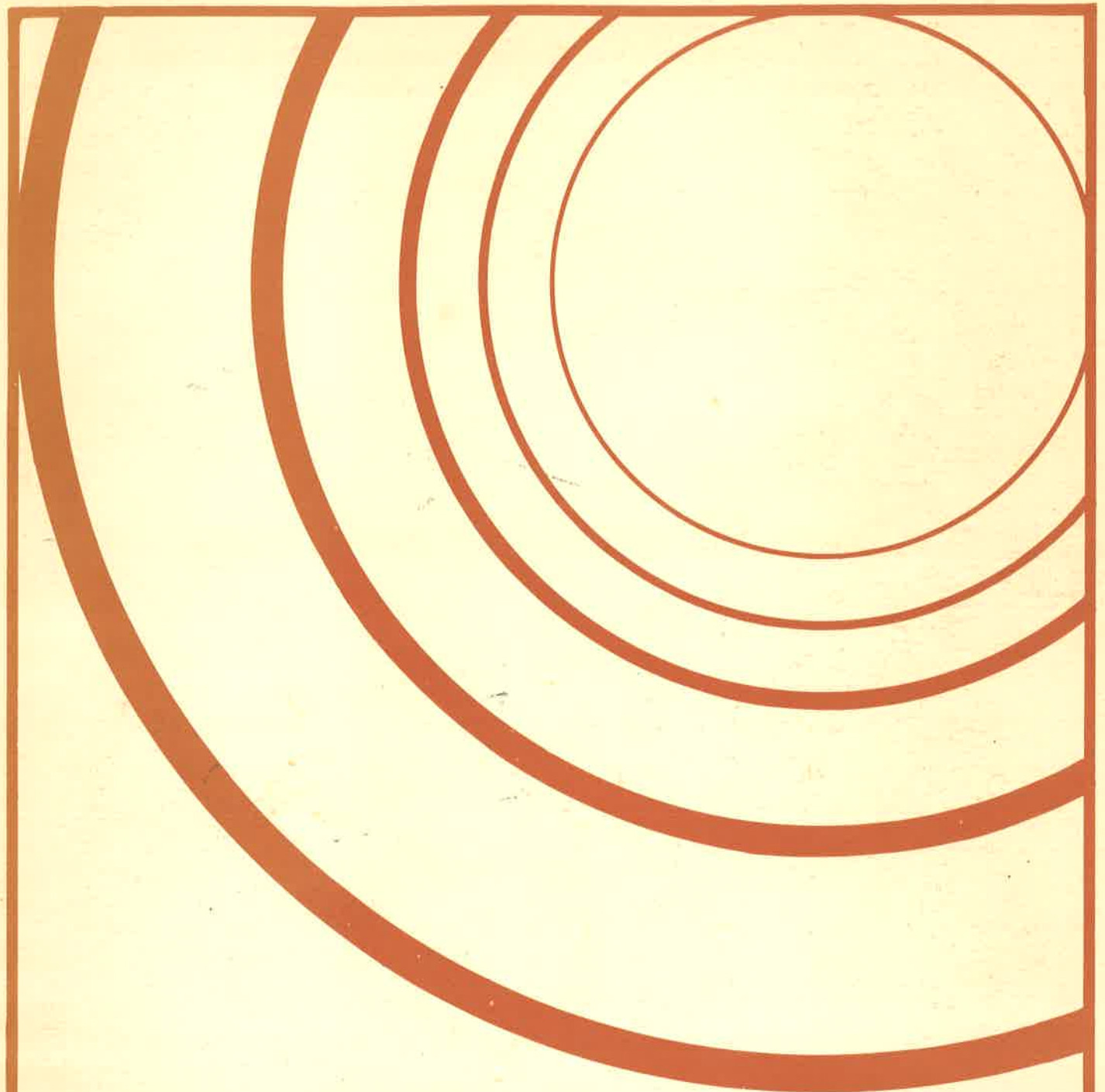
Dynamics of Human Behavior: A Telelecture Program

University of Southern Maine

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DYNAMICS OF HUMAN BEHAVIOR



University of Southern Maine

Department of
Continuing Education for Nursing and Health Professions

DYNAMICS OF HUMAN BEHAVIOR

A Telelecture Program

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BUREAU OF CONTINUING EDUCATION FOR NURSING AND HEALTH PROFESSIONS
UNIVERSITY OF SOUTHERN MAINE

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UNIVERSITY OF SOUTHERN MAINE

Bureau of Continuing Education for Nursing
School of Nursing

96 Falmouth Street
Portland, Maine 04103

Dear Telelecture Student:

I'd like to take this opportunity to welcome you to a new avenue of learning; that is, by something we are all familiar with, the telephone.

As you know our state of Maine is large, rural and often hampered by severe winter storms that make travelling next to impossible. Hospitals and other health facilities are often located in remote areas. Continuing education opportunities for most health workers may or may not be available at the local institution of higher learning or in the area. Associated and escalating costs to attend workshops and meetings even in the state are becoming prohibitive.

So, it was with these facts in mind that the telelecture system was developed. It is an amplified, private telephone system that takes the shape of a huge party line, available only for our use. It is available 24 hours a day, 7 days a week. Because it is designed to be interactive, persons at each site on the network can talk with the instructor who may be as far away as in California or with each other throughout the state. Each site hears the conversation simultaneously.

An important person at each site is the telelecture liaison person. She or he will be happy to assist you in learning how to use the equipment and to answer questions you may have. I welcome your questions as well as your comments and suggestions in order to bring quality education closer to your home or employment setting.

Looking forward to talking with you by telelecture.

Cordially,

Mary Ann Rost, R.N.
Director

Bureau of Continuing
Education for Nursing

MAR/11

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COURSE OVERVIEW

Human behavior and psychosocial development are the focal points for this course. The sessions will include discussions re the general stages of growth, emphasizing the adult and older adult and the influence of early development and the family on present behavior.

MEET YOUR INSTRUCTOR



Nancy Mackay, M.M., M.S.W.

Nancy MacKay brings a wealth of experience to this Telelecture course. With an M.S.W. from New York University's School of Social Work, Nancy has worked in a variety of positions in New York and Maine. Going from a case worker to a student social worker in a variety of organizational settings, she became Chief of Social Services at the Village Counseling Center in New York City. Her Maine experience has included the Directorship of the East Side Day Treatment Program, the Bangor Day Treatment Program and the Day Treatment programs all at the Counseling Center in Bangor. She is presently the Office Director of the Aroostook Mental Health Center's Houlton Office. In this capacity she supervises staff and social workers at local hospitals, carries a clinical workload and consults to local agencies. She is also involved in community education activities.

Nancy is a member of the National Association of Social Workers and the Academy of Certified Social Workers. (By the way, you may have noticed an M.M. degree by Nancy's name. To round out her activities, she also has a master's degree in Music).

We welcome Nancy MacKay to Telelecture!

COURSE OBJECTIVES

Upon completion of this course, participants will be able to:

1. Identify several approaches to the study of human behavior.
2. Recognize the limitations of current knowledge.
3. Describe the developmental tasks and risks of each stage of development.
4. Discuss the role of the family in human development and behavior.
5. Discuss the basic coping/defense mechanisms and the role they play in ourselves and others.
6. Define the developmental/behavioral issues in geriatric care.
7. Discuss the issues which help and/or prevent us from being effective in working with human behavior.

TOPICAL OUTLINE

<u>SESSION</u>	<u>DATE</u>	<u>TOPIC</u>
I	October 2, 1980	Approaches to Human Behavior
II	October 9, 1980	The Family
III	October 16, 1980	Stages In Adulthood
IV	October 23, 1980	Coping
V	October 30, 1980	Issues in Geriatric Care

SESSION TIME: Thursdays, 10:00 a.m. - 11:00 a.m.

SESSION I

Approaches To Human Behavior

- I. Course Overview

- II. Theoretical Biases in Approaches To Human Behavior
 - A. The "Abnormal" view/behavior as disease
 - 1. freud and the medical model

 - 2. psychopathology

 - B. The "normal" view/behavior as health
 - 1. humanistic psychology and self actualization:
Abraham Maslow

 - C. Behavior as "learned"
 - 1. conscious vs. unconscious notivation

 - 2. learning theory

- III. Erickson's Psychosocial Stages of Development
 - A. Relevance to our needs

IV. Problems With Current Theories of Behavior

A. The feminist viewpoint

B. Cultural differences

REFERENCE MATERIALS

SESSION I

Theories of Personality by Duane Schultz, Brooks/Cole Publishing Co., Monterey, California, 1976. pgs. 162-176, "Erik Erikson"

Psychology Constructs The Female, by Naomi Weisstein from Radical Feminism ed. by Anne Koedt, Ellen Levine, Anita Rapone. Quadrangle, New York Times Book Co. 1973 pgs. 178-197.

SESSION II

THE FAMILY

- I. The Family: Matrix Of Behavior and Personality
 - A. Importance of the family in developing trust, autonomy and initiative.
 - 1. relevance of the first three stages of development.
 - B. Importance of the family in developing industry and identity.
 - 1. relevance to stages four and five
 - a. difficulties in "letting go"
 - b. adolescent crisis as a mutual task
 - C. Sexuality and physical change
 - D. What is a healthy family? An alternative model.
 - 1. communication as a way of describing families
 - a. "healthy" communication
 - b. "unhealthy" communication
 - 1. the double-bind

SESSION II (cont.)

2. scape-goating

REFERENCE MATERIALS

SESSION II

Peoplemaking by Virginia Satir

Science & Behavior Books Inc., Palo Alto, California,
1972, pp 9-19 and 59-79

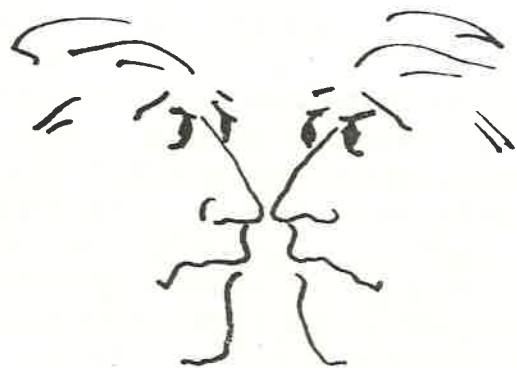
Communication, Family and Marriage, ed. Don Jackson.

"The Family of the Schizophrenic: A Model System" by
Jay Haley. Science & Behavior Books Inc. Palo Alto,
California, 1968, pp 171-197.

along with them. This turns the transaction into a power struggle, which usually works in the opposite direction. It is possible that at this point in time, things are so ruptured nothing can be done. The chances are pretty good that if your family members live under the same roof, they will be willing to at least try.

I have seen much pain in families. Each one has moved me deeply. Through this book I hope to ease that pain in families whom I may never have a chance to meet personally. In doing so, I hope also to prevent the pain from continuing into the families their children will form. Some human pain is unavoidable, of course. But as a people, we don't always put our efforts in the right place, to change what we can and to work out creative ways to live with what we can't change.

There is some possibility that just reading this book may evoke a little pain for you. After all, facing ourselves has its painful moments. But if you think there may be a better way of living together as a family than the way you are living now, I think you'll find this book rewarding.



Does it feel good to you to live in your family right now?

That question would never have occurred to most of the families I have worked with. Before they came to me, living together was something they just took for granted. If there was no visible family crisis, everyone assumed that everyone else was satisfied with the situation. I suspect many of the individual family members didn't dare face such a question—they felt stuck in the family, for better or for worse, and knew no ways to change things.

Do you feel you are living with friends, people you like and trust, and who like and trust you?

This question has usually brought me the same puzzled replies. "Gee, I've never thought about that; they're just my family"—as though family members were somehow different from people!

Is it fun and exciting to be a member of your family?

Yes, there really are families in which the members find home one of the most interesting and rewarding places they can be. But many people live year after year in families that are a threat to them, a burden, or a bore.

If you can answer "yes" to those three questions, I am certain you live in what I call a *nurturing* family. If you answer "no" or "not often," you probably live in a family that is more or less troubled.

After knowing hundreds of families, I find that each one can be placed somewhere along a scale from *very nurturing* to *very troubled*. The nurturing families are individual ones, yet I see many similarities in the way these families operate. Troubled families, too, no matter what the nature of their visible problems, seem to have much in common. I would like now to draw you a word picture of each type of family, as I have observed them. Of course, neither picture will fit any specific family exactly, but in

one or the other you may recognize some part of your own family in action.

The atmosphere in a troubled family is easy to feel. Whenever I am with such a family, I quickly sense that I am uncomfortable. Sometimes it feels cold, as if everyone were frozen; the atmosphere is extremely polite, and everyone is obviously bored. Sometimes it feels as if everything were constantly spinning, like a top; you get dizzy and can't find your balance. Or, it may have an air of foreboding, like the lull before a storm, when thunder may crash and lightning strike at any moment. Sometimes the air is full of secrecy, as in a spy headquarters.



When I am in any of these kinds of troubled atmospheres, my body reacts violently. My stomach feels queasy; my back and shoulders soon ache, and so does my head. I used to wonder if the bodies of the people who lived in that family responded as mine did. Later, when I knew them better and they became free enough to tell me what life was like in their family, I learned that they did indeed feel the same way. After having this kind of experience over and over again, I began to understand why so many of the members of troubled families were beset with physical

humor is caustic, sarcastic, even cruel. The adults are so busy telling their child what to do and what not to do that they never find out who he is, never get to enjoy him as a person. As a result, he never gets to enjoy his parents as people, either. It often comes as a great surprise to members of troubled families that they actually *can* enjoy one another.

When I would see whole families in my office who were trying to live together in such an atmosphere, I used to wonder how they managed to survive. I discovered that in some people simply avoided one another; they became so involved in work and other outside activities that they rarely had much real contact with the family.

It is a sad experience for me to be with these families. I see the hopelessness, the helplessness, the loneliness. I see the bravery of people trying to cover up—a bravery that can eventually kill them. There are those who are still clinging to a little hope, who can still bellow or nag or whine at each other. Others no longer care. These people go on year after year, enduring misery themselves or, in their desperation, inflicting it on others.

Traditionally, we have looked upon the family as the place where we could find love and understanding and support, even when all else failed; the place where we could be refreshed and “recharged” to cope more effectively with the world outside. But for millions of troubled families, this is a myth.

In our big urban, industrial society, the institutions we must live with have been designed to be practical, efficient, economical, profitable—but rarely to protect and serve the human part of human beings. Nearly everyone experiences either poverty or discrimination or unrelenting world pressures or other consequences of our inhuman social institutions. For people from troubled families, who

ills. Their bodies were simply reacting humanly to a very inhuman atmosphere.*

In troubled families the bodies and faces tell of their plight. Bodies are either stiff and tight, or slouchy. Faces look sullen, or sad, or blank like masks. Eyes look down and past people. Ears obviously don't hear. Voices are either harsh and strident, or barely audible.

There is little evidence of friendship among individual family members, little joy in one another. The family seems to stay together through duty, with people just trying to tolerate one another. Now and then I would see someone in a troubled family make an effort at lightness, but his words would fall with a thud. More often



**Perhaps you will find the reactions I describe here surprising. Everybody—every body—has some kind of physical reaction to the individuals around him, but many people are not aware of it. Most of us have been taught as we grew up to ‘turn off’ these feelings. With years of practice one may turn them off so successfully that he is totally unaware that he is reacting until, hours later, he has a headache or an aching shoulder or an upset stomach. Even then he may not understand why. As a therapist I have learned to be tuned into these feelings in myself and to recognize the signs of them in my patients. They tell me a good deal about what is actually going on between us. I hope this book will help you learn to recognize these useful clues in yourself.*

are even harder to bear.

No one would intentionally pick this troubled way of living. Families accept it only because they know of no other way.

Stop reading for a few minutes and think about some families you know that would fit the description “troubled.” Did the family you grew up in have some of these characteristics? Does the family you are living in now? Can you discover any signs of trouble that you haven’t been aware of before?

How different it is to be with a nurturing family! Immediately, I can sense the aliveness, the genuineness, honesty, and love. I feel the heart and soul present as well as the head.

I feel that if I lived in such a family, I would be listened to and would be interested in listening to others; I would be considered and would wish to consider others; I could openly show my affection as well as my pain and disapproval; I wouldn't be afraid to take risks because everyone in my family would realize that some mistakes are bound to come with my risk-taking—that my mistakes are a sign that I am growing. I would feel like a person in my own right—noticed, valued, loved, and clearly asked to notice, value, and love others.

One can actually see and hear the vitality in such a family. The bodies are graceful, the facial expressions relaxed. People look *at* one another, not *through* one another or at the floor; and they speak in rich, clear voices. There is a flow and harmony in their relations with one another. The children, even as infants, seem open and friendly, and the rest of the family treats them very much as persons.

The house where these people live tends to have a lot of light and color. It is clearly a place where people *live*.

planned for their comfort and enjoyment, not as a show-place for the neighbors.

When there is quiet, it is a peaceful quiet, not the stillness of fear and caution. When there is sound, it is the sound of meaningful activity, not the thunder of trying to drown out everyone else. Each person seems to know that he will have his chance to be heard. If his turn doesn't come now, it is only because there isn't time—not because he isn't loved.

People seem comfortable about touching one another and showing their affection, regardless of age. The evidence of loving and caring isn't limited to carrying out the garbage, cooking the meals, or bringing home the paycheck. People show it also by talking openly and listening with concern, by being straight and real with one another, by simply being together.

Members of a nurturing family feel free to tell each other how they feel. *Anything* can be talked about—the disappointments, fears, hurts, angers, criticisms as well as the joys and achievements. If Father happens to be bad-humored for some reason, his son can say frankly, "Gee, Dad, you're grouchy tonight." He isn't afraid that Father will bark back, "How dare you talk to your father that way!" Instead, Father can be frank, too: "I sure am grouchy. I had a hell of a day today!" To which his son may reply, "Thanks for telling me, Dad. I thought you might have felt grouchy with me."

Nurturing families show evidence of planning, but if something interferes with the plan, they can readily make adjustments. This way they are able to handle more of life's problems without panicking. Suppose, for example, that a child drops and breaks his glass. In a troubled family, this accident could lead to a half-hour lecture, a spanking, and perhaps sending the child away to his room in tears. In a nurturing family, more likely someone would remark,

a learning opportunity, which raises the child's self-worth, rather than as a cause for punishment, which puts the self-worth in question. In the nurturing family it is easy to pick up the message that human life and human feelings are more important than anything else.

These parents see themselves as leaders, not bosses, and they see their job as primarily one of teaching their child how to be truly human in all situations. They readily acknowledge to the child their poor judgment as well as their good judgment; their hurt, anger, or disappointment as well as their joy. Their behavior toward him matches what they tell him. (How different from the troubled parent who tells his children not to hurt each other, but slaps them himself whenever they displease him.)

Vital, nurturing parents know they have to *learn* leadership; they didn't get it automatically the day their first child was born. Like all good leaders, they are careful of their timing, watching for an opportunity to talk to their child when he can really hear them. When a child has misbehaved, the father or mother moves physically close to him, to offer him support. This will help the offending child to overcome his fear and guilty feelings, and make the best use of the teaching the parent is about to offer.

Recently, I saw a mother in a nurturing family handle a troublesome situation very skillfully and humanly. When she noticed that her two sons, ages five and six, were fighting, she calmly separated the boys, took each by the hand, and sat down with one son on either side of her. Still holding their hands, she asked each of them to tell her what was going on. She listened to one and then the other intently, and by asking questions she slowly pieced together what had happened: the five-year-old had taken a dime from the six-year-old's dresser. As the two boys talked about their hurts and feelings of injustice, she was able to help them make new contact with one another, return the



"Well, Johnny, you broke your glass. Did you cut yourself? I'll get you a Band-Aid, and then you take a broom and sweep up the pieces." If the parent had noticed that



Johnny had been holding the glass precariously, he might add, "I think the glass dropped because you didn't have both hands around it." Thus the incident would be used as

dime to its rightful owner, and pave the way for better ways of dealing with each other. Furthermore, the boys had a good lesson in constructive problem-solving.

Parents in nurturing families know that their children are not intentionally bad. If someone behaves destructively, they realize that there has been some misunderstanding or someone's self-esteem is dangerously low. They know that a child can learn only when he is valuing himself and feeling valued, so they don't respond to his actions in a way that will make him feel devalued. They know that even when it is possible to change behavior by shaming or punishing, the scar that results is not easily or quickly healed.

When a child must be corrected, as all children must at one time or another, nurturing parents rely on listening, touching, understanding, careful timing, being aware of the child's feelings and his natural wish to learn and to please. These things all help them to be effective teachers.

Rearing a family is probably the most difficult job in the world. It resembles a merger of two business firms, putting their respective resources together to make a single product. All the potential headaches of that operation are present when an adult male and an adult female join to steer a child from infancy to adulthood. The parents in a nurturing family realize that problems will come along, simply because life offers them, but they will be alert to creative solutions for each new problem as it appears. Troubled families, on the other hand, put all their energies into the hopeless attempt to keep problems from happening; when they do happen—and, of course, they always do—these people have no resources left for solving them.

Perhaps one of the distinguishing features of nurturing parents is that they realize that change is inevitable: children change quickly from one stage to another, nurtur-

ing adults never stop growing and changing; and the world around us never stands still. They accept change as an unavoidable part of being alive and try to use it creatively to make their families still more nurturing.

Can you think of a family that you would call nurturing at least part of the time? Can you remember a time recently when your own family could be described as nurturing? Try to remember how it felt to be in your family then. Do these times happen often?

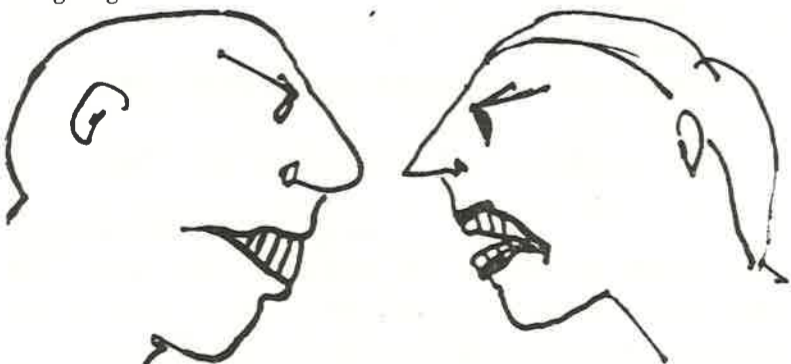
Some people may scoff at my picture of the nurturing family and say it isn't possible for any family to live that way. To them I would say, I have had the good fortune to know a number of these kinds of families intimately, and *it is possible*. Alas, only four families in perhaps a hundred know how to do it.

Others may protest that with all the pressures of daily living there just isn't time for most people to overhaul their family lives. To them I would say, we had better find the time; *it is a matter of survival*. I consider this our first priority. Troubled families make troubled people and thus contribute to crime, mental illness, alcoholism, drug abuse, poverty, alienated youth, political extremism, and many other social problems. If we don't give our best efforts to developing the family and making people who are more truly human, I see our present social problems growing worse and worse, perhaps ending in extinction for us all.

But if the price of failure is high, so is the reward if we succeed. Everyone who holds a position of power or influence in the world was once an infant. How he uses his power or influence depends a good deal on what he learned in the family as he was growing up. If only we can help troubled families become nurturing—and nurturing ones even more nurturing—the impact of their increased humanity will filter out into government, education, business,

closeness between them. Every interaction between two people has a powerful impact on the respective worth of each and what happens between them.

If encounters between a couple become doubt-producing, the individuals involved begin to feel low pot about themselves. They begin to look elsewhere—to work, to children, to other heterosexual partners. If a husband and wife begin to have sterile and lifeless encounters, they eventually become bored with one another. Boredom leads to indifference, which is probably one of the worst human feelings there is and, incidentally one of the real causes of divorce. I am convinced that anything exciting, even if it's dangerous, is preferable to boredom. Fighting is better than being bored. You might get killed from it, but at least you feel alive while it's going on.



If, on the other hand, communication between a couple produces something new and interesting, then aliveness and/or new life comes into being; there develops a deepening, fulfilling relationship, and each feels better about himself and the other.

I hope that now after the many exercises you have experienced, my earlier words about the communication process will have more meaning: communication is the greatest single factor affecting a person's health and his relationship to others.

religion, all the fields that determine the quality of our lives.

I am convinced that any troubled family can become a nurturing one. Most of the things that cause families to be troubled are learned after birth. Since they are learned, they can be unlearned; and new things can be learned in their place. The question is, how?

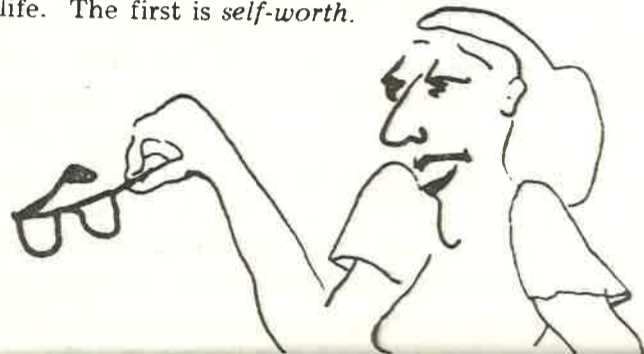
First, you need to recognize that your family is a troubled family.

Second, you need to have some hope that things can be different.

Third, you need to take some action to start the changing process.

As you begin to see the troubles in your family more clearly, it will help you to realize that, whatever may have happened in the past, it represented the best you knew how to do at the time. There is no reason for anyone to feel guilty himself or to blame others in the family. The chances are that the causes of your family pain have been invisible to all of you—not because you don't want to see them but because either you don't know where to look for them or you have been taught to view life through mental "glasses" that keep you from seeing certain things.

In this book you will begin to take off those glasses and look directly at the things that cause joy or pain in family life. The first is *self-worth*.



After thirty years of listening to literally thousands of interactions among people, I gradually became aware of certain seemingly universal patterns in the way people communicated.

Whenever there was any stress, over and over again I observed four ways people had of handling it. These four patterns occurred only when one was reacting to stress and at the same time felt his self-esteem was involved—"his pot got hooked." In addition, the "hooked" one felt he could not say so. Presence of stress alone need not hook your pot, incidentally. Stress might be painful or annoying, but that isn't the same as doubting your own worth.

The four patterns of communication (which will be dealt with in detail later in this chapter) are: placating, blaming, computing, and distracting.

As I went into this more deeply I began to see that the self-esteem (pot) became hooked more easily when a person had not really developed a solid, appreciative sense of his own worth. Not having his own, he would use another's actions and reactions to define himself. If someone called him green, he would agree with no checking and take the other's comment as one fitting him. He was green because the other person said so. It's easy for anyone with doubts about his own worth to fall into this trap.

Do you know your internal feeling when your pot gets hooked? When mine does, my stomach gets knots, my muscles get tight, I find myself holding my breath, and I sometimes feel dizzy. While all this is going on I find that my thoughts concern the pot dialogue I am having with myself. The words are variations of "Who cares about me? I am unlovable. I can never do anything right. I am a nothing." Descriptive words for this condition are embarrassed, anxious, incompetent.

What I say at this point might be quite different from anything I am feeling or thinking. If I feel the only way out of my dilemma is to make things right with you so you will

think I am lovable, etc., I will say whatever I think would fit. It would not matter if it were true or not. What matters is my survival, and I have put that in your hands.

Suppose, instead, I keep my survival in my hands. Then when my pot is hooked, I can say straight out what I think and feel. I might feel some initial pain at exposing my "weaknesses" and taking the risk that I believe goes with that, but I avoid the greater pain of hurting myself physically, emotionally, intellectually, socially, and spiritually, as well as avoiding giving you double-level messages.

It's important at this point to understand that every time you talk, all of you talks. Whenever you say words, your face, voice, body, breathing, and muscles are talking, too. A simple diagram is as follows:

Verbal communication = words

Body/sound communication = facial expression
body position
muscle tonus
breathing tempo
voice tone

What we are essentially talking about in these four patterns of communication are *double-level* messages. In all four instances your voice is saying one thing, and the rest of you is saying something else. Should you be interacting with someone who responds in double-level messages, too, the results of your interactions are often hurtful and unsatisfactory.

The troubled families I have known all have handled their communication through double-level messages. Double-level messages come through when a person holds the following views:



I feel terrible

It is my belief that any family communication not leading to realness or straight, single levels of meaning cannot possibly lead to the trust and love that, of course, nourish members of the family.

Remember that what goes on in a moment in time between two people has many more levels than are visible on the surface. The surface represents only a small portion of what is going on, much in the same way that only a very small part of an iceberg is visible.

Thus in the following:

"Where were you last night?"

"You are always nagging me!"

Something is happening to each person in relation to himself.

Something is happening to the perception by each of the other.

The ensuing direction of the relationship can go toward distrust, personal low pot, frustration, or, on the other hand, it can be the beginning of new depth and trust.

Let's take a closer look at these universal patterns

1. He has low self-esteem (low pot) and feels he is bad because he feels that way.
2. He feels fearful about hurting the other's feelings.
3. He worries about retaliation from the other.
4. He fears rupture of the relationship.
5. He does not want to impose.
6. He does not attach any significance to the person or the interaction itself.

In nearly all of these instances the person is unaware that he is giving double-level messages.

So the listener will be confronted by two messages, and the outcome of the communication will be greatly influenced by his response. In general, these are the possibilities: pick up the words and ignore the rest; pick up the non-word part and ignore the words; ignore the whole message by changing the subject, leaving, going to sleep, or commenting on the double-level nature of the message.

For example, if I have a smile on my face and the words, "I feel terrible," come out of my mouth, how will you respond? Picking up on the possibilities outlined in the last paragraph, you might respond to the words and say, "That's too bad," to which I can respond, "I was just kidding." Your second choice is to respond to the smile and say, "You look great," in which case I can say, "How can you say that!" Your third choice is to ignore the whole thing and go back to your paper, in which case I would respond, "What's the matter? Don't you give a damn?" Your fourth choice is to comment on my double message: "I don't know what you're telling me. You're smiling, yet you tell me you're feeling bad. What gives?" In this case I have a chance to respond, "I didn't want to impose on you," and so on.

Let yourself imagine what kinds of results there could be if each of the above were the basis of communication between two people.

of response people use to get around the threat of rejection. In all cases the individual is feeling and reacting to the threat, but because he doesn't want to reveal "weakness" he attempts to conceal it in the following ways:

1. *Placate* so the other person doesn't get mad;
2. *Blame* so the other person will regard you as strong (if he goes away it will be his fault, not yours);
3. *Compute* with the resultant message that you are attempting to deal with the threat as though it were harmless, and you are trying to establish your self-worth by using big words;
4. *Distract* so you ignore the threat, behaving as though it were not there (maybe if you do this long enough, it really will go away).

Our bodies have come to accommodate our feeling of self-worth whether we realize it or not. If our self-worth is in question, our bodies show it.

With this in mind I have devised certain physical stances to help people get in touch with parts of themselves that are obvious to other people but not to themselves. All I did was exaggerate and expand the facial and voice messages into the whole body and make it so exaggerated that nobody could miss it.

To help clarify the responses (we are actually going to play out these roles in communication games in the next chapter), I have included a simple word-diagram with each descriptive section.

PLACATER

- (1) Words agree ("Whatever you want is okay. I am just here to make you happy.")

Body placates ("I am helpless.")

Insides ("I feel like a nothing; without
him I am dead. I am worthless.")

The *placater* always talks in an ingratiating way, trying to please, apologizing, never disagreeing, no matter what. He's a "yes man." He talks as though he could do nothing for himself; he must always get someone to approve of him. You will find later that if you play this role for even five minutes, you will begin to feel nauseous and want to vomit.

A big help in doing a good placating job is to think of yourself as really worth nothing. You are lucky just to be allowed to eat. You owe everybody gratitude, and you really are responsible for everything that goes wrong. You know you could have stopped the rain if you used your brains, but you don't have any. Naturally you will agree with any criticism made about you. You are, of course, grateful for the fact that anyone even talks to you, no matter what they say or how they say it. You would not think of asking anything for yourself. After all, who are you to ask? Besides, if you can just be good enough it will come by itself.

Be the most syrupy, martyrish, bootlicking person you can be. Think of yourself as being physically down on one knee, wobbling a bit, putting out one hand in a begging fashion, and be sure to have your head up so your neck will hurt and your eyes will become strained so in no time at all you will begin to get a headache.

When you talk in this position your voice will be whiny and squeaky because you keep your body in such a lowered position that you don't have enough air to keep a rich, full voice. You will be saying "yes" to everything, no matter what you feel or think. The placating stance is the body position that matches the placating response.

BLAMER

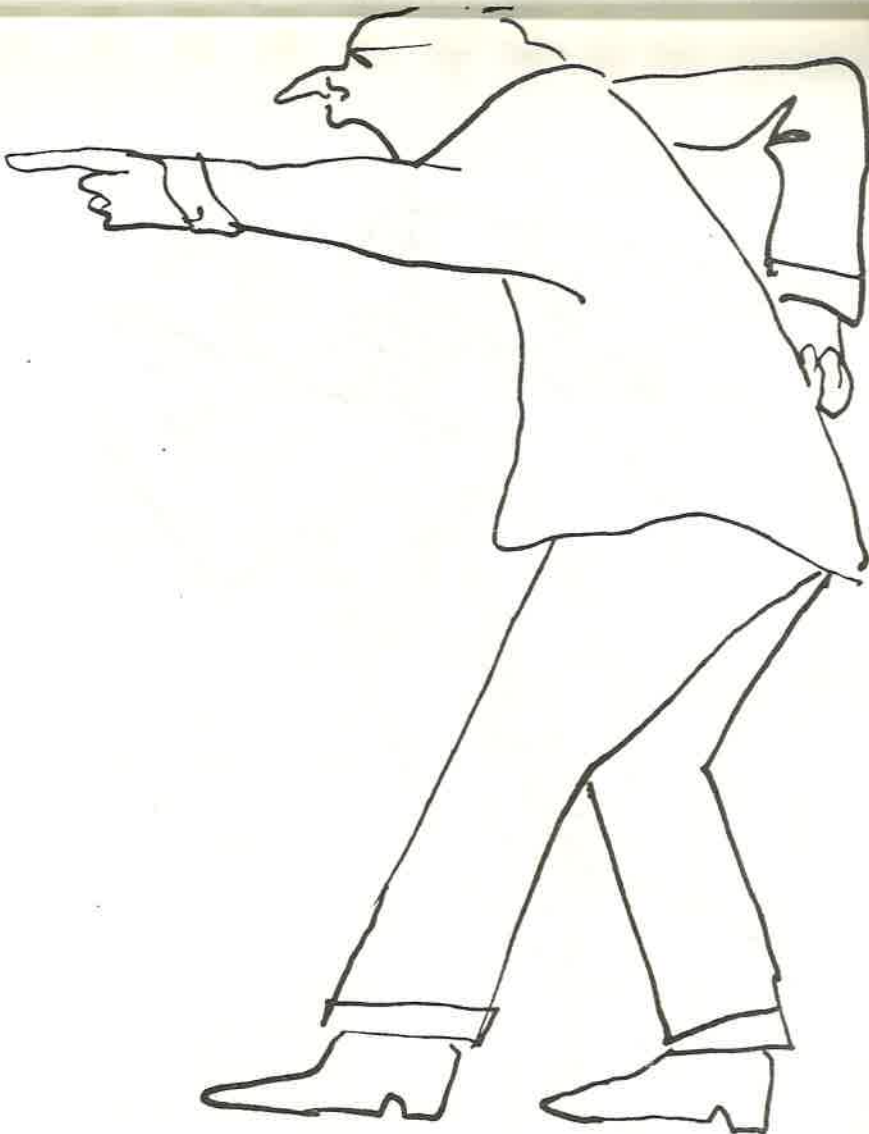
(2)	Words	disagree	("You never do anything right. What is the matter with you?")
	Body	blames	("I am the boss around here.")
	Insides		("I am lonely and unsuccessful.")

The *blamer* is a fault-finder, a dictator, a boss. He acts superior, and he seems to be saying, "If it weren't for you, everything would be all right." The internal feeling is one of tightness in the muscles and in the organs. Meanwhile the blood pressure is increasing. The voice is hard, tight, and often shrill and loud.

Good blaming requires you to be as loud and tyrannical as you can. Cut everything and everyone down.

As a blamer it would be helpful to think of yourself pointing your finger accusingly and to start your sentences with "You never do this or you always do that or why do you always or why do you never . . ." and so on. Don't bother about an answer. That is unimportant. The blamer is much more interested in throwing his weight around than really finding out about anything.

Whether you know it or not, when you are blaming you are breathing in little tight spurts, or holding your breath altogether, because your throat muscles are so tight. Have you ever seen a really first-rate blamer whose eyes were bulging, neck muscles and nostrils standing out, who was getting red and whose voice sounded like someone shoveling coal? Think of yourself standing with one hand on your hip and the other arm extended with your index finger pointed straight out. Your face is screwed up, your lips curled, your nostrils flared as you tell, call names, and criticize everything under the sun. Your blaming stance looks like this:



You don't really feel you are worth anything, either. So if you can get someone to obey you, then you feel you count for something.

COMPUTER

(3) Words ultra- ("If one were to observe carefully, one might notice the workworn hands of someone present here.")

Body computes ("I'm calm, cool, and collected.")

Insides ("I feel vulnerable.")

The *computer* is very correct, very reasonable with no semblance of any feeling showing. He is calm, cool, and collected. He could be compared to an actual computer or a dictionary. The body feels dry, often cool, and disassociated. The voice is a dry monotone, and the words are likely to be abstract.

When you are a computer, use the longest words possible, even if you aren't sure of their meanings. You will at least sound intelligent. After one paragraph no one will be listening anyway. To get yourself really in the mood for this role, imagine that your spine is a long, heavy steel rod reaching from your buttocks to the nape of your neck, and you have a ten-inch-wide iron collar around your neck. Keep everything about yourself as motionless as possible, including your mouth. You will have to try hard to keep your hands from moving, but do it.

When you are computing, your voice will naturally go dead because you have no feeling from the cranium down. Your mind is bent on being careful not to move, and you are kept busy choosing the right words. After all, you should never make a mistake. The sad part of this role is that it seems to represent an ideal goal for many people. "Say the right words; show no feeling; don't react."

Your computer position stance will look like this:



DISTRACTER

(4) Words irrelevant (the words make no sense)

Body angular and off somewhere else

Insides ("Nobody cares. There is no place for me.")

Whatever the *distracter* does or says is irrelevant to what anyone else is saying or doing. He never makes a response to the point. His internal feeling is one of dizziness. The voice can be singsong, often out of tune with the words, and can go up and down without reason because it is focused nowhere.

When you play the distracting role, it will help you to think of yourself as a kind of lopsided top, constantly spinning, but never knowing where you are going, and not realizing it when you get there. You are too busy moving your mouth, your body, your arms, your legs. Make sure you are never on the point with your words. Ignore everyone's questions; maybe come back with one of your own on a different subject. Take a piece of imaginary lint off someone's garment, untie shoelaces, and so on.

Think of your body as going off in different directions at once. Put your knees together in an exaggerated knock-kneed fashion. This will bring your buttocks out, and make it easy for you to hunch your shoulders and have your arms and hands going in opposite directions.

At first this role seems like a relief, but after a few minutes of play, the terrible loneliness and purposelessness arise. If you can keep yourself moving fast enough, you won't notice it so much.

You will look like this:



As practice for yourself, take the four physical stances I have described, hold them for just sixty seconds and see what happens to you. Since many people are unaccustomed to feeling their body reactions, you may find at first that you are so busy thinking you aren't feeling. Keep at it, and you will begin to have the internal feelings you've experienced so many times before. Then the moment you are on your own two feet and are freely relaxed and able to move, you find your internal feeling changes.

It is my hunch that these ways of communicating are learned early in childhood. As the child tries to make his way through the complicated and often threatening world in which he finds himself, he uses one or another of these means of communicating. After enough use he can no longer distinguish his response from his feeling of worth or his personality.

Use of any of these four responses forges another ring in an individual's feeling of low self-worth or low pot. Attitudes prevalent in our society also reinforce these ways of communicating—many of which are learned at our mother's knee.

"Don't impose; it's selfish to ask for things for yourself," helps to reinforce placating.

"Don't let anyone put you down; don't be a coward," helps to reinforce blaming.

"Don't be so serious. Live it up! Who cares?" helps to reinforce distracting.

At this point you may well be wondering if there is any hope for us at all if these four crippling modes of communication are all we have. Of course they are not.

There is a fifth response that I have called *leveling* or *flowing*. In this response all parts of the message are going in the same direction—the voice says words that match the facial expression, the body position, and the voice tone.

Relationships are easy, free and honest, and there are few threats to self-esteem. With this response there is no need to blame, retreat into a computer, or to be in perpetual motion.

Of the five responses only the leveling one has any chance to heal ruptures, break impasses, or build bridges between people. And lest leveling seem too unrealistic to you, let me assure you that you can still placate if you choose, blame if you like, be on a head trip, or be distracting. The difference is you know what you are doing and are prepared to take the consequences for it.

So when you are leveling you apologize in reality when you realize you've done something you didn't intend. You are apologizing for an act not for your existence. There are times when you need to criticize and evaluate. When you do this in a leveling way, you are evaluating an act, not blaming the person, and there is usually a new direction you have to offer. There are times when you're talking about intellectual kinds of things such as giving lectures, making explanations, giving directions, and so on, where precise word meanings are essential. When you are leveling in this area, you are still showing your feelings, moving freely while you're explaining. You aren't coming off like a machine. So many people who make their livings with their brains—scientists, mathematicians, accountants, teachers, and therapists—come off like machines and epitomize the computing response. In addition, there are times when you want to or need to change the subject. In the leveling response you can say what you want to instead of hopping all over the place.

The leveling response is real for whatever is. If a leveler says, "I like you," his voice is warm and he looks at you. If his words are, "I am mad as hell at you," his voice is harsh, and his face is tight. The message is single and straight.

Another aspect of the leveling response is that it represents a truth of the person at a moment in time. This is in

contrast, for example, to a blaming response where the person is feeling helpless, but is acting angry—or is hurting, but is acting brave.

A third aspect of the leveling response is that it is whole, not partial. The body, sense, thoughts, and feelings all are shown, in contrast to computing, for example, where nothing moves but the mouth and that only slightly.

There is an integration, a flowing, an aliveness, an openness and what I call a *juiciness* about a person who is leveling. You trust him, you know where you stand with him, and you feel good in his presence. The position is one of wholeness and free movement. This response is the only one that makes it possible to live in an alive way, rather than a dead way.

Now, to help you distinguish more clearly between a given subject and the different ways of expressing oneself about that subject, let me present five ways of apologizing in the five ways of communicating. This can also serve as a kind of demonstration before actually playing the games in the next chapter. Let's imagine that I have just bumped your arm.



Placating (looking down, wringing hands): "Please forgive me. I am just a clumsy oaf."

Blaming: "Ye gods, I just hit your arm! Keep it in next time so I won't hit it!"

Computing: "I wish to render an apology. I inadvertently struck your arm in passing. If there are any damages, please contact my attorney."

Distracting (looking at someone else): "Gee, some guy's mad. Must've got bumped."

Leveling (looking directly at the person): "I bumped you. I'm sorry. Are you hurt?"

Let's take another imaginary situation. I am your father, and there is something wrong in what you, my son, are doing.

Placating (coming up with a hushed voice, downcast face): "I'm — uh — uh — gosh, gee, Jim, I — am sorry — you feeling okay? You know — promise me you won't get mad — no, you're doing okay, it's just — maybe you could do a little better? Just a little, maybe? Hm?"

Blaming: "For Christ's sake, don't you know anything, you dumb cluck?"

Computing: "We are making a survey of our family efficiency. We find that in this department, namely with you, that efficiency is beginning to go down. Would you have any comments to make?"

Distracting (talking to his other son, standing next to Jim): "Say, Arnold, is your room about the same as Jim's? No, nothing wrong—I was just taking a walk through the house. Tell Jim to see his mother before he goes to bed."

Leveling: "Jim, your room is in bad shape. You haven't made your bed since yesterday. We need to stop, take a look, and see what's wrong."

It's anything but easy to break old habit patterns and become a leveler. One way in which you might be helped to achieve this goal is through learning what some of the fears

are that keep you from leveling. To thwart the rejection we so fear, we tend to threaten ourselves in the following ways:

1. I might make a mistake.
2. Someone might not like it.
3. Someone will criticize me.
4. I might impose.
5. He will think I am no good.
6. I might be thought of as imperfect.
7. He might leave.

When you can tell yourself the following answers to the foregoing statements, you will have achieved real growth:

1. You are sure to make mistakes if you take any action, especially new action.
2. You can be quite sure that there will be someone who won't like what you do. Not everyone likes the same things.
3. Yes, someone will criticize you. You really aren't perfect. Some criticism is useful.
4. Sure! Every time you are in the presence of another person, speak to him, and interrupt him, you impose!
5. So maybe he will think you're no good. Can you live through it? Maybe sometimes you aren't so hot. Sometimes the other person is "putting his trip on you." Can you tell the difference?
6. If you think of yourself as needing to be perfect, the chances are you will always be able to find imperfection.
7. So he leaves. Maybe he should leave, and anyway, you'll live through it.

These attitudes will give you a good opportunity to stand on your own two good feet. It won't be easy and it

won't be painless, but it might make the difference as to whether or not you grow.

With no intention of being flippant, I do think that most of the things we use to threaten ourselves and that affect our self-worth turn out to be tempests in teapots. One way I helped myself through these threats was to ask myself if I would still be alive if all these imagined threats came true. If I could answer yes, then I was okay. I can answer yes to all of them now.

I will never forget the day I found out that lots of other people worried about these same silly threats as I did. I had thought for years I was the only one, and I kept myself busy trying to outwit them, and at the same time doing my best to conceal the threats. My feeling was—what if somebody found out? Well, what if somebody did? We all use these same kinds of things to threaten ourselves.

By now you must realize that this isn't some kind of a magical recipe, but the leveling response is actually a way of responding to real people in real life situations that permit you to agree because you really do, not because you think you should; disagree because you really do, not because you think you won't make points unless you do; use your brain freely, but not at the expense of the rest of you; to change courses, not to get you off the hook, but because you want to and there is a need to do so.

What the leveling response does is make it possible for you to live as a whole person—real, in touch with your head, your heart, your feelings, and your body. Being a leveler enables you to have integrity, commitment, honesty, intimacy, competence, creativity, and the ability to work with real problems in a real way. The other forms of communication result in doubtful integrity, commitment by bargain, dishonesty, loneliness, shoddy competence, strangulation by tradition, and dealing in a destructive way with fantasy problems.

It takes guts, courage, some new beliefs, and some new skills to become a leveling responder. *You can't fake it.*

Unfortunately there is little in society that reinforces this leveling response. Yet people are actually hungry for this kind of straightness and honesty. When they become aware of it and are courageous enough to try it, distances between people are shortened.

I did not come to this formulation via religion or through the study of philosophy. I came to it through a tough, trial-and-error way, trying to help people who had serious life problems. I found that what healed people was getting them to find their hearts, their feeling, their bodies, their brains, which once more brought them to their souls and thus to their humanity. They could then express themselves as whole people, which, in turn, helped them to greater feelings of self-worth (high pot), to nurturing relationships and satisfying outcomes.

None of these results is possible through the use of the four crippling ways of communication. I have found these, incidentally, as inevitable outcomes of the way authority is taught in families and reinforced by much of our society. What is so sad is that these four ways have become the most frequently used among people and are viewed by many as the most possible ways of achieving communication.

From what I have seen I've made some tentative conclusions about what to expect when I meet new groups of people. Fifty percent will say yes no matter what they feel or think (placate); 30 percent will say no, no matter what they feel or think (blame); 15 percent will say neither yes nor no and will give no hint of their feelings (compute); and 1/2 percent will behave as if yes, no, or feeling did not exist (distracting). That leaves only 4 1/2 percent whom I can expect to be real and to level. My colleagues tell me I am optimistic, saying the leveling response is probably found in

only 1 percent of our population. Remember this is not validated research. It is only a clinical hunch. In the vernacular it would seem we are all a bunch of crooks—hiding ourselves and playing dangerous games with one another.

At this point I want to make an even more drastic statement. If you want to make your body sick, become disconnected from other people, throw away your beautiful brain power, make yourself deaf, dumb, and blind, using the four crippling ways of communication will in great measure help you to do it.

I feel very strongly as I write this. For me, the feelings of isolation, helplessness, feeling unloved, low pot, or incompetence comprise the real human evils of this world. Certain kinds of communication will continue this and certain kinds of communication can change it. What I am trying to do in this chapter is make it possible for each person to understand the leveling response so he can recognize and use it.

I would like to see each human being value and appreciate himself, feel whole, creative, competent, healthy, rugged, beautiful, and loving.

Despite the fact that I have exaggerated these different ways of communication for emphasis, and they may even seem amusing, I am deadly serious about the killing nature of the first four styles of communication.

In the next chapter, when you play the games I have invented, you will be able to experience exactly what these ways of communication are like, and you will be able to understand very quickly the toll they take of your body, the distrust that is formulated in your relationships with others and the blah, disappointing, and many times disastrous outcomes that ensue.

this behavior is formally the same as that of the schizophrenic who becomes frightened and enters his doctor's office asking if this is Grand Central Station. He behaves as if he is seeking reassurance and simultaneously qualifies that behavior by a denial of it. The difference lies in the fact that his denial itself is qualified incongruently--he negates the denial by making it clearly fantastic.

A logical hypothesis about the origin of schizophrenic behavior, when the behavior is seen in communications terms, would involve the family interaction of the patient.⁵⁾ If a child learned to relate to people in a relationship with parents who constantly induced him to respond to incongruent messages, he might learn to work out his relationships with all people in those terms. It would seem to follow that the control of the definition of relationships would be a central problem in the origin of schizophrenia.

THE FAMILY OF THE SCHIZOPHRENIC: A MODEL SYSTEM

Jay Haley

This paper will attempt to show that schizophrenic behavior serves a function within a particular kind of family organization. The emphasis in this description will be on the interactive behavior of the schizophrenic and his parents rather than on their ideas, beliefs, attitudes, or psychodynamic conflicts. This work is largely based on an examination of a small sample of families participating in therapeutic sessions where parents and schizophrenic child, as well as siblings, are seen together and recorded. An excerpt from a recording of a family session will be presented and analyzed in terms of the observable behavior of family members, to illustrate the hypothesis that the family of the schizophrenic is a special kind of system which can be differentiated from other family systems.

The hypothesis that schizophrenia is of family origin has led to a number of investigations of schizophrenic patients and their parents. These studies include both impressions of family members and attempts at statistical measurement of individual traits of parents or the conflict between them. Typically the mother of the schizophrenic is described as dominating, overprotective, manipulative of the child and father, and also overtly rejecting (18). The father is usually described as weak and passive, holding aloof from the patient (15, 17), and occasionally overtly rejecting and cruel (8). Many investigators mention a certain percentage of fathers or mothers who appear "normal."

Besides reporting descriptions of the individuals in the family, investigators report on the relationship between the parents on the assumption that conflict between father and mother could be rela-

⁵⁾For a fuller discussion of the family of the schizophrenic see Jay Haley, "The Family of the Schizophrenic; a Model System," *J. of Nervous and Mental Disease*, 129:357-374, 1959. (See p.171, this vol.)

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ted to disturbance in the child. Lidz and Lidz (13) reported in 1949 that 20 of 35 schizophrenic patients had parents who were clearly incompatible. Tietze (20) reported in the same year that 13 of 25 mothers of schizophrenic patients reported unhappy marriages and nine marriages which were described as "perfect" were found by the investigator to be otherwise. In 1950 Gerard and Siegal (7) found strife between 87 per cent of the parents of 71 male schizophrenic patients in contrast to 13 per cent found in the controls. In the same year Reichard and Tillman (17) noted the unhappy marriages of parents of schizophrenics. Frazee (8) in 1953 reported that 14 of 23 parents were in severe conflict with each other and none had only moderate conflict in contrast to 13 control parents who had only moderate conflict. Lidz (16) reported in 1957 that all of 14 families of schizophrenic patients contained marital relationships which were seriously disturbed. Bowen (6) describes the parents in this type of family as experiencing "emotional divorce." Wynne uses the term "pseudo mutuality" to describe the difficulties family members have with each other (23).

These studies provide strong evidence for conflict between the parents of schizophrenics, but do not clarify what strife between parents has to do with schizophrenia in a child. After all, there is conflict between parents who do not have schizophrenic children. Similarly, to show that the mothers of schizophrenic patients are dominating and overprotective and the fathers weak and passive does not clarify how schizophrenia is appropriate in families with such parents. Psychiatric terminology seems particularly unsuited to this problem. The language of psychiatry either describes the processes within an individual, such as his needs, fantasies, anxieties, and so on, or provides static descriptions of two individuals in dominant-submissive or rejecting or dependent relationships. When schizophrenia is described in the traditional psychiatric way, and when other family members are seen with the biased emphasis upon the process in the individual, it is difficult to relate schizophrenia to a family.

Currently most groups investigating schizophrenia and the family are recognizing that the total family unit is pathogenic, and there are attempts to develop a language which will describe the interaction of three or more people. A transition would seem to have taken place in the study of schizophrenia; from the early idea that the difficulty in these families was caused by the schizophrenic member, to the idea that they contained a pathogenic mother, to the discovery that the father was inadequate, to the current emphasis upon all three family members involved in a pathological sys-

tem of interaction. Although it would seem impossible at this time to provide a satisfactory language for describing the complex interaction of three or more people, this paper will suggest a rudimentary approach to such a descriptive system. An essential requirement of any such description is that it show the adaptive function of schizophrenic behavior within the family system.

The present paper is a product of the current research conducted by the Bateson project. Historically this project began as a general investigation of the nature of communication and began to focus on the communication of the schizophrenics in 1953. The observation that the schizophrenic consistently mislabels his communication led Bateson to deduce that he must have been raised in a learning situation where he was faced with conflicting levels of message. From this came the "double bind" hypothesis (5) which was put together with Jackson's emphasis on schizophrenia serving a homeostatic function in the family (12). The research project then brought together the families of schizophrenics to observe the actual behavior in the family. Basically the double bind hypothesis was a statement about two-person interaction and it has been extended to areas outside of schizophrenia (9, 11). When the family was seen as an interactive unit, there was an attempt to extend the double bind concept to a three person system (21). Currently the project is attempting to devise a theoretical system for describing the family as a unit and this attempt had led to several papers (2, 3, 4) including this one.

The importance of describing a total system rather than elements within it may explain some of the inconsistencies in the description of individuals in the family and conflict between them. For example, it is possible that a mother could show rejecting traits when her child is ill and dependent upon her, and overprotective traits when he begins to recover and attempt to achieve independence from her. Similarly, parents may not show discord when their child is psychotic and they are drawn together by this burden, but conflict could appear should the child behave more assertively and so threaten to leave them. Alanen (1) studied mothers of schizophrenic patients and found many of them within the limits of the "normal" on the basis of Rorschach tests and individual interview. He mentions, almost in passing, "Some of the cases in which the mother of a schizophrenic patient had been relatively healthy belong to those in which the father was seriously disturbed. The wives of all fathers who had developed chronic psychosis belong, for example, to this category." If the 'normality' or the pathology of a family member depends upon the influence

of the behavior of other family members at that time, only a study of the total family system will show consistent findings.

The focus of a family study should be on the total family and on the interaction of parents and children with each other rather than on the interaction of family members with interviewers or testers. What a family member reports to an investigator about his relationship with another family member is only hearsay evidence of what actually takes place. To study the system of interaction in the family of the schizophrenic it is necessary to bring family members together over a period of time and directly observe them relating to one another. Inevitably the fact of observing the family introduces a bias into the data for they may behave differently when observed than when not observed. It would seem to be impossible to leave the observer out of this sort of study, and the problem is to include him in the situation in such a way as to maximize the information he can gain. The most appropriate type of observation would seem to be in a therapeutic context. There is serious doubt as to whether this type of family can be brought together without therapeutic support. If the parents are merely asked to be observed interacting with their schizophrenic child, the question is automatically raised whether they have something to do with the illness of the child; accordingly guilts and defenses are aroused and must be dealt with in the situation. Long term observation of the family is also necessary since they may give one impression in a single interview and quite another when they have talked together many times and pretenses are dropping. The presence of a therapist is necessary as sensitive areas in the relationships are touched upon when family members get more intensively involved with one another. Long-term observation also provides an opportunity to verify hypotheses and make predictions as family patterns are observed occurring again and again. Finally, the introduction of a therapist makes possible the observation of a family responding to planned intervention. As ideas are presented to the family, or as therapeutic change is threatened, the family can be observed maintaining their system under stress.

Although the expense of regular filming of therapy sessions is prohibitive, the occasional use of film and the constant use of tape recordings provides data which may be studied at leisure.

AN ILLUSTRATION OF FAMILY BEHAVIOR

Since few investigators have the opportunity to observe a schizophrenic and his parents interacting with one another, an illustra-

tion is offered here. The following excerpt is transcribed verbatim from a recording of an interview where a patient and his parents were seen weekly as an adjunct to his individual therapy, because of his previous inability to see his parents for even a few minutes without an anxiety attack. The patient, a thirty nine year old man, suffered a breakdown in the army and was diagnosed as a schizophrenic. After discharge he returned home and remained with his parents for the following ten years. There were several abortive attempts to leave home and go to work. He was employed for little more than a year during those ten years and was supported by his parents during his temporary absences from home. When he entered the hospital, at the insistence of his parents, he was hallucinating, behaving in a compulsive way, exhibiting bizarre mannerisms, and complaining of anxiety and helplessness.

Earlier in the interview the patient had been saying he felt he was afraid of his mother, and finally she brought out a Mother's Day Card she had just received from him. It was a commercial card with the printed inscription, "For someone who has been like a mother to me." The patient said he could see nothing wrong with the card nor understand why his mother was disturbed about receiving it.

Patient: Uh, read the outside again.

Mother: All right, the outside ways, "On Mother's Day, with best wishes"--everything is very fine, it's wonderful, but it's for someone else, not for your mother, you see? "For someone who's been like a mother to me."

Father: In other words, this card made mother think. So mother asked me...

Mother: (interrupting) When you...

Father: (continuing) what I think about it. So I said, "Well, I don't think Simon--meant that way, maybe he..."

Patient: (interrupting) Well, I mean you can interpret it, uh--uh, you've been like a mother is uh supposed to be.

Father: No, no.

Patient: (continuing) a good--a real good mother.

Therapist: Why don't you like the idea that he might have deliberately sent that?

Father: Deliberately? Well...

Mother: (overlapping and interrupting) Well, that's what I...

Father: (continuing) well, he says he didn't, he agrees...

Mother: (continuing) Well, I mean I believe our son would have...

Father: (overlapping and continuing) that he couldn't get another card.

Patient: (interrupting) Well, I meant to sting you just a tiny bit by that outside phrase.

Mother: (overlapping) You see I'm a little bit of a psychiatrist too, Simon, I happen to be--(laughing) So I felt so--when you talked to (the therapist) I brought along that card--I wanted to know what's behind your head. And I wanted to know--or you made it on purposely to hurt me--Well, if you did, I--I...

Patient: (interrupting) Not entirely, not entire...

Mother: (interrupting and overlapping) I'll take all--Simon, believe me, I'll take all the hurt in the world if it will help you--you see what I mean?

Therapist: How can you...

Mother: (continuing) Because I never meant to hurt you--Huh?

Therapist: How can you hurt anybody who is perfectly willing to be hurt? (short pause)

Father: What's that?

Mother: I uh--a mother sacrifices--if you would be--maybe a mother you would know too. Because a mother is just a martyr, she's sacrificing--like even with Jesus with his mother--she sacrificed too. So that's the way it goes on, a mother takes over anything what she can help...

Therapist: (interrupting) What mother?

Mother: (continuing) her children.

Patient: (interrupting and overlapping) Well, uh, I'll tell you Ma--listen, Ma, I didn't mean to--to sting you exactly that outside part there.

Therapist: Well, you said so.

Patient: Oh, all right, but it--it wasn't that exactly. No, I'm not giving ground--uh--it's hard to explain this thing. Uh--uh--What was I going to say. Now I forgot what I was going to say. (short pause) I mean I felt that this--this is what I mean, uh--that I felt that you could have been a better mother to me than you were. See there were things.

Mother: Uh...

Father: Well you said...

Patient: (interrupting) You could have been better than you were. So that's why--that's what I felt--it was, uh--uh, was all right to send it that way.

Mother: Well, if you meant it that way that's perf--that's what I wanted to know--and that's all I care--you see. But

I still say, Simon, that if you would take your father and mother just like they're plain people--you just came here and you went through life like anybody else went through--and--and don't keep on picking on them and picking them to pieces--but just leave them alone--and go along with them the way they are--and don't change them--you'll be able to get along with everybody, I assure you.

Patient: (interrupting) I mean after all a card is a card--why I d--it seems to me kind of silly (anguish in his voice and near weeping) to bring that thing in here--they have sold them at the canteen, Ma...

Therapist: Are you anxious now...

Patient: Why...

Therapist: Are you anxious now because she said...

Patient: I shouldn't be blamed for a thing like that, it's so small...

Mother: (overlapping) I'm not blaming you.

Patient: (continuing) I don't even remember exactly what the thing was.

Mother: (overlapping) Well, that's all I wanted to know (laughs)

Patient: (continuing) I didn't want to--to--to--to blame you or nothing.

Therapist: Will you slow down a minute. Are you anxious now because she said she didn't like to be picked on? And you've sort of been picking on her today. Is that what's making you so--upset?

Patient: No, it's now what's making me upset. That they s--after all, mother's got to realize that those people--the people that sell the cards--they sell them and people buy them--the wording isn't exactly right--I've stood for half an hour in a store sometimes picking--picking out a card to send mother or to send to one of the family where I wanted to get the wordings just so--and the picture on the thing just so. I was just too particular, that was before I took sick...

Therapist: I think you did that this time too--

Patient: (continuing) And came back to the hospital. No I wasn't--I bought that thing in five minutes. There was only a choice of four cards--but of course that helped. But I--I--I--uh, I--I do have--I've changed now with those cards, I'm not as particular as I used to be. I mean uh--peop--they sell those cards and, uh--I don't think that they--they got--they don't mean anything by

the words. Uh, --they're sold for people to buy, they're sold for people to buy.

Therapist: (overlapping) The person who sends them ought to mean something by the words.

Patient: No, but I...

Therapist: And you seem to be denying that you sent...

Patient: No, I think that can be interpreted in different ways.

Therapist: Sure, it's pretty safe, but not quite safe enough apparently.

Patient: Is that the way you feel too?

Therapist: I feel you tried to say something indirectly so you'd be protected.

Patient: (interrupting) No, I wasn't, I just felt that--that--that thing.

Therapist: Now you're...

Patient: (continuing) was--was--all right I'm changing a little bit. Uh, --that that mother was a good enough mother. It says "For someone that's been like a mother to me."

Father: A real mother.

Patient: Yeah, a real mother--so that's all.¹⁾

Despite its brevity, this excerpt illustrates a typical kind of interaction in this type of family. From the point of view of psychiatric diagnosis, the patient manifests such symptoms as: 1) blocking and forgetting what he was going to say, 2) showing concretistic thinking when he says "a card is a card," 3) implying that someone else caused the difficulty ("They sell them in the can-teen" and later in the interview implying in a rather paranoid way that it was the fault of a post office clerk for mailing it) and 4) claiming amnesia ("I don't even remember what the thing was"). Although less dramatic than symptoms manifested by the full-blown psychotic patient, his behavior could be said to be schizophrenic.

Another family could have responded in this situation rather differently. Should a child in another family send his mother such a card, she might respond to it in any of a variety of ways. And whatever way chosen, her husband and child would also have a range of possible ways to respond to her. This particular family selects these ways, and a description of this family must 1) de-

¹⁾This excerpt is not offered as an example of family therapy but rather as an example of family behavior. The parents in this case were not considered to be patients and the family as a unit was not officially undergoing treatment.

scribe the formal patterns in this type of interaction in such a way as to 2) differentiate the patterns from other possible ones, or those in other families.

POSSIBILITIES OF A THREE-PERSON SYSTEM

One way to describe a particular family is to present its type of interaction against the background of the potential ways a mother, father, and child might interact with one another. If any set of parents and child are brought together in a room, what sort of communicative behavior is potentially possible between them?

1. Whatever they do together can be seen as communication between them; each will do something and each will respond. Although it seems obvious, it is particularly important to emphasize that family members cannot avoid communicating, or responding, to one another when they are in the same room. If one speaks to another and he does not answer, his not-answering is a response in a real and meaningful sense.

2. Not only must parents and child communicate with each other, but each must communicate on at least two levels. Whatever one says and does will inevitably be qualified by the other things he says and does, and when any piece of communication is about, or qualifies, another piece of communication they can be said to be of different levels. Whenever anyone speaks to another person he must qualify what he says because he must speak in a tone of voice, with a body movement, with other verbal statements, and in a particular context. What he says will be qualified with an indication of what sort of statement it is, i.e. a joking statement, a sincere one, an unimportant one, a command, a suggestion, and so on. A man can smile and murder as he smiles, and if his behavior is to be described both levels of communication must be included.

If a man says, "I won't stand for that any more!" in a tone of voice which indicates anger and with a gesture of putting a stop to it in a situation where what he says is appropriate, then his statement and qualifications can be said to be congruent, or to "affirm," each other. Messages and their qualifiers can also be incongruent. If a mother makes a punishing statement while labeling what she does as benevolent, she is disqualifying what she says, or manifesting an incongruence between her levels of message. It is important to note that she is not contradicting herself. Contradictory statements are of the same level, such as, "I will do it," and "I won't do it." Incongruent statements are of different levels: "I

will do it," said in a tone of voice which indicates, "Don't take what I say seriously." Whether family members qualify their own statements incongruently or congruently, and under what circumstances they do so, can be described as they interact with one another.

3. The three people in the room must also qualify each other's statements. As they respond to one another, they are inevitably commenting upon, or classifying, each other's statements. They may affirm what each other says, or they may disqualify the other's statements by indicating that isn't the sort of thing that should be said. If mother says, "I brought you some candy," and her son says, "You treat me like a child," the son is disqualifying his mother's communication. If he accepts it with a statement of thanks, he is affirming her statement. A description of parents and child must include whether, and under what circumstances, they affirm or disqualify each other's behavior.

4. When three people are in a room, some sort of leadership will take form, even if only in terms of who will speak before the others do. Any one of the three may initiate something, and the other two may go along with him or attempt to take leadership themselves. In some families, father and child may consistently turn to mother for a decision, other families may label father as the final arbiter, while other parents may lean on their child for the initiation of what is to happen.

5. The three people may also form any or all of various possible alliances. It is possible for the three of them to ally against the outside world, or for one to ally with someone in the outside world against the other two, or two may ally against the third. In some families father and mother may form a coalition against the child, in others the child may ally with one of his parents against the other, and so on.

6. Finally, when something goes "wrong," there are a variety of possible arrangements for the three people to handle blame. All three may each acknowledge blame, one may never accept blame for anything, two may consistently blame the third, and so on.

This list of some of the possibilities in a three person system is made more complex by the fact that a family member may form an alliance but indicate he isn't forming one, or may take blame but qualify his statement with an indication that he really isn't to blame.

The possible range of maneuvers is considerably increased when people are seen to communicate at multiple levels.

THE RULES IN THE FAMILY OF THE SCHIZOPHRENIC

Given a potential range of behavior between three people in a family system, it becomes possible to look at any one type of family as restricted to a certain range of that potential. No one family will interact in all possible ways: limited patterns of interaction will develop. The patterns described here are those in a particular sample and are those which occur when parents and schizophrenic child interact with each other. They may behave differently with other people, including psychiatric investigators or siblings of the schizophrenic child. Although siblings are included in our observation of this type of family, the description offered here is of the three person system, partly for simplification in this presentation and partly because parents and schizophrenic child form a special triadic system in the larger family unit.

THE WAYS FAMILY MEMBERS QUALIFY THEIR OWN STATEMENTS

Consistently in this type of family the individual members manifest an incongruence between what they say and how they qualify what they say. Many people do this under certain circumstances, but when these family members interact they confine themselves almost entirely to disqualifying their own statements.

In this excerpt, the mother confronts her son with the Mother's Day Card because she didn't like it, but she emphasizes what a wonderful card it is. Then she says she wants to know what was behind his head and if he sent it to hurt her, and she laughs. In a context of accusing him of hurting her, she says she wants to be hurt and is willing to take all the hurt in the world to help him. Her description of herself as a special person who will sacrifice all is qualified a few moments later by the statement that she and her husband are just plain people and her son should treat them like anybody else. This "benevolent advice" is offered in a punishing tone of voice and context. When her son says she shouldn't blame him, she qualifies her statements as not being blaming. Consistently what she communicates she qualifies in an incongruent way.

The father is only briefly in this excerpt, but while there he indicates that the son didn't mean to say what the card said, and, besides, the card said she was a real mother.

The son also manifests incongruent behavior. He sends a card to his mother on Mother's Day which indicates she is not really his

mother. He further qualifies this message by indicating there was nothing wrong with it and then suggests that it says she is like a mother is supposed to be. Following this, he indicates that it means she could have been a better mother than she was. He then protests that it was silly of her to bring the card in, and qualifies this with the statement that they sell them in the canteen. Besides he doesn't remember what the thing was. After indicating that he bought the card hurriedly, he qualifies this by saying it took him five minutes to choose among four cards. He adds that one should be careful in choosing cards with exact wording, but people sell those cards and they don't mean anything by the words. Finally, he qualifies his greetings by saying that it meant she was not only a good enough mother but a real mother.

The more extreme incongruence between the son's levels of message differs from that of his mother, and this difference will be discussed later. Yet basically a similar pattern of communication is apparent. The mother does not say, "You shouldn't have sent me this card--what do you mean by it?" which is implied by her bringing the card to the session. The son doesn't say, "I sent it to you to sting you, but I'm sorry I did now." The mother is condemning him for sending her the card, but she qualifies her messages in such a way that she indicates she isn't condemning him. The son apologizes for sending the card, but he qualifies his apology in such a way that he isn't apologizing. Father indicates the son didn't mean what he said, and the card didn't say what he didn't mean anyhow. Although these incongruencies between what is said and how it is qualified are apparent in the verbal transcript, they are even more apparent when the vocal inflections on the recording are heard. Mother's tone of voice and laughter are inappropriate and thereby disqualify what she is saying, and father and son similarly do not make a flat statement which is affirmed by the ways they say it.

One can listen to many hours of recordings of conversations between parents and schizophrenic child without hearing one of them make a statement which is affirmed. Usually if one finds an exception, it proves on closer examination to fit the rules. For example, during a filmed session a family was asked to plan to do something together and the father said in a positive way that they were going to do this and do that. He fully affirmed his statements by the ways he said them. However, a few minutes later he said he was only saying these things because they should say something in front of the camera, thus disqualifying his previous statements.

HOW FAMILY MEMBERS QUALIFY EACH OTHER'S STATEMENTS

Although it is possible for family members to affirm or disqualify each other's statements, in this type of family the members consistently disqualify what each other says. In this excerpt it is difficult to find any statement by one person affirmed by another. The son has actually disqualified his mother's whole past maternal behavior at one stroke by sending her such a card. When she protests, he indicates her protests are not valid. Similarly, the mother disqualifies the greeting she received from her son and also his defenses of it. When he indicates there is nothing wrong with it, she labels this as in error. When he indicates he knew what he was doing and meant to "sting" her a bit, she indicates this was in error. Father joins them to disqualify both the son's message, since he didn't mean it, and his defense of the message. No one affirms what anyone says except 1) when the son says he doesn't remember what the card was, and his mother says that is all she wanted to know; 2) when the father says the card means she is a real mother, and the son agrees. Both of these affirmations involve symptomatic behavior by the son: amnesia and distortion of reality. From this excerpt one might hypothesize that the family members will disqualify what each other says except when the child is behaving in a symptomatic way. Such a hypothesis requires more careful investigation. Apparently even symptomatic behavior by the child is usually disqualified except in certain contexts. When the mother is under attack, the parents may affirm psychotic behavior but not necessarily at other times.

It might be argued that the behavior in this excerpt is exceptional since it deals with a moment of crisis. However, analysis of other interviews suggests that the pattern is typical. In a previous paper (5) the relationship between mother and schizophrenic child was described as a "double bind" situation in that the mother imposed incongruent levels of message upon the child in a situation where the child must respond to conflicting requests, could not comment on the contradictions, and could not leave the field. Further investigation indicates that this kind of communication sequence is a repetitive pattern between all three family members. Not only is each constantly faced with conflicting levels of message, but each finds his response labeled as a wrong one. (Family therapy with this type of family has its unrewarding aspects since almost any comment by the therapist is similarly disqualified.)

Typically if one family member says something, another indicates it shouldn't have been said or wasn't said properly. If one criticizes the other, he is told that he misunderstands and should behave differently. If one compliments the other, he is told he doesn't do this often enough, or he has some ulterior purpose. Should a family member try to avoid communicating, the others will indicate this "passivity" is demanding and indicate he should initiate more. All family members may report they always feel they are in the wrong. However, they do not necessarily directly oppose each other or openly reject one another's statements. If one suggests going to a particular place, the other may not say "No," but rather he is likely to indicate, "Why must we always go where you suggest?" Or the response may be the sigh of a brave martyr who must put up with this sort of thing. Typically the family members may not object to what one another says, but to their right to say it. Often open disagreements are prevented by an atmosphere of benevolent concern and distress that the other person misunderstands. Family members may also respond in an affirmative way when their response would be appropriate only if the person had made some other statement.

It is important to emphasize that a formal pattern is being described here which may manifest itself in various ways. A mother may be overprotective and thereby disqualify what the child does as insufficient or inadequate. She may also be rejecting and similarly disqualify what he does as unacceptable. She may also withdraw when the child initiates something as a way of disqualifying his offer. Similarly, father may viciously condemn mother or child or merely be passive when they seek a positive response from him, and in both cases he is disqualifying their communication.

Although it is not uncommon for people to disqualify each other's statements, ordinarily one would expect affirmation also to occur. However, when observing these families one does not hear even affectionate or giving behavior appreciated or affirmed. If one person indicates a desire for closeness, another indicates this is done in the wrong way or at the wrong time. (However, if one suggests separation the other will also indicate this is the wrong thing to do. Typically in these families the mother regularly threatens separation but does not leave, and the father does not often threaten separation but spends a good deal of his time away from home or "leaves" by drinking heavily while staying home.) Typically family members behave as if they are involved in what might be called a compulsory relationship. For example, a

mother in one family indicated with some contempt that her husband was afraid to leave her because he could not stand being alone. She suggested he was cruel to her because he was angry at being tied to her. She also rejected his affectionate overtures because she considered them only a kind of bribery to insure staying with her. She herself was unable to leave him even for a night, though he was drunk several nights a week and beat her regularly. Both felt the association was not voluntary, and so neither could accept as valid any indication from the other about wanting to be together. A compulsory relationship is also typical of the parent and schizophrenic child. Since the child is considered incapable of leaving home and associating with others, his staying at home is taken as involuntary. Therefore should he indicate a desire to be with his parents, they tend to disqualify his overtures as merely a request that they not turn him out, and he finds his affectionate gestures disqualified.

LEADERSHIP IN THE FAMILY

Since family members tend to negate their own and each other's communication, any clear leadership in the family is impossible. Typically in these families the mother tends to initiate what happens, while indicating either that she isn't, or that someone else should. The father will invite her to initiate what happens while condemning her when she does. Often they suggest the child take the lead, and then disqualify his attempts. These families tend to become incapacitated by necessary decisions because each member will avoid affirming what he does and therefore is unable to acknowledge responsibility for his actions, and each will disqualify the attempts of any other to announce a decision. Both the act of taking leadership and the refusal to take leadership by any one family member is condemned by the others. The family "just happens" to take actions in particular directions with no individual accepting the label as the one responsible for any action.

ALLIANCES

Similarly, no labeled alliances are permitted in the family. A family coalition against the outside world (represented, say, by an observer), breaks down rather rapidly. Such individuals are also unable to form an alliance of two against one. Often they may appear to have such an alliance, as they tend to speak "through" one another. For example, the mother may ask for something for her child as a way of indicating that her husband deprives her, and so appear in alliance with the child. Or when the parents begin to express anger at each other, they may turn on the child for causing their difficulties and so appear in a coalition against him. Yet

should the coalition be labeled, it will break down. If the child says, "You're both against me," one or the other parent will disqualify this remark and so deny the coalition. If father should say to mother, "Let's stick together on this," she is likely to say, "I'm afraid you'll back down at the last minute," or "It isn't my fault when we don't stick together." The mother and child may appear to form a coalition against the father, but should the child say, "Father treats us badly," mother is likely to say, "He has his troubles too," even though a moment before she may have been complaining to the child about how badly they were both treated by the father. Family members behave as if an alliance between two of them is inevitably a betrayal of the third person. They seem to have difficulty functioning in a two-person relationship, and as a result the separation of any one of the three from the others is a particular threat.

What confines the members so rigidly within their system is the prohibition on intimate alliances of one member with someone outside the family. As a result, the family members are inhibited from learning to relate to people with different behavior and so are confined to their own system of interaction.

DEFENSE AGAINST BLAME

Characteristically the mothers in these families defend themselves by "transfer of blame." Such a defense follows from the mother's consistent manifestation of incongruent levels: what she does, she qualifies as not having been done or not done in that way. If the child becomes disturbed, it happens "out of the blue." If anything goes wrong, mother indicates it is the fault of someone else. In those rare instances where she does admit she did something wrong, she indicates she did it only because she was told to, or out of duty, so that it wasn't her fault. She may also indicate that something must be wrong with the other person, since he ought not to have been affected by what she did, particularly when she didn't really do it. Even when her behavior affects someone pleasantly, she must deny that it was her fault. Typically she presents herself as helplessly pushed by forces outside her control.

The fathers also follow the family rule of incongruently qualifying their messages, yet they cannot use the same denial of blame and remain with their wives. They tend to use types of defense which complement her defense, and these are of three kinds. 1) Fathers who are withdrawn and passive, accept the blame their wives put upon them, but indicate by their unresponsiveness that

they are blamed falsely and do not agree with her. 2) Fathers who have temper tantrums and blame their wives, put the blame on false or exaggerated grounds so the wife can easily point out her innocence. This type of father is easily blamed since he is dominating and tyrannical, yet by going too far he indicates he is an innocent victim driven by forces outside his control. 3) Some fathers do not blame their wives but also do not blame themselves or anyone else. Such fathers make an issue of semantic difference. If asked if they or their wives are at fault, a typical reply is, "Just what do you mean by 'fault'?" By accepting no implicit definition and not defining anything themselves, they obscure everything. Any particular father may manifest these three types of defense, all of which involve both disqualification of one's own statements and a disqualification of the other person's statements.

The child tends to use two types of defense. When "sane" he may blame himself and indicate that everything wrong with the family centers in him, an attitude the parents encourage, while at the same time he gives an impression of being blamed unjustly. When "insane" he negates his own statements and those of others by denying that anything happened. Or, if it did, he wasn't there--besides it wasn't him and it happened in another place at a time when he had no control over himself. The "withdrawal from reality" maneuvers of the schizophrenic make it impossible for him to blame himself or his parents since he defines himself as not of this world.

THE "DIFFERENT" BEHAVIOR OF THE SCHIZOPHRENIC

The inability of the schizophrenic to relate to people and his general withdrawal behavior seems understandable if he was raised in a learning situation where whatever he did was disqualified and if he was not allowed to relate to other people where he could learn to behave differently. Should he be reared in a situation where each attempt he made to gain a response from someone was met with an indication that he should behave in some other way, it would be possible for an individual to learn to avoid trying to relate to people by indicating that whatever he does is not done in relationship to anyone. He would then appear "autistic." However, the peculiar distortions of communication by the schizophrenic are not sufficiently explained by this description of his learning situation. If schizophrenic behavior is adaptive to a particular type of family, it is necessary to suggest the adaptive function involved when a person behaves in a clearly psychotic way.

The recovering schizophrenic patient, and perhaps the pre-psychotic schizophrenic, will qualify what he says in a way similar to that used by his parents. His behavior could be said to be "normal" for that family. However, during a psychotic episode the schizophrenic behaves in a rather unique manner. To suggest how such behavior might serve a function in the family, it is necessary both to describe schizophrenia in terms of behavior and to suggest the conditions under which such behavior might occur. To describe schizophrenic behavior, it is necessary to translate into behavioral terms such diagnostic concepts as delusions, hallucinations, concretistic thinking, and so on.

What appears unique about schizophrenic behavior is the incongruence of all levels of communication. The patient's parents may say something and disqualify it, but they will affirm that disqualification. The schizophrenic will say something, deny saying it, but qualify his denial in an incongruent way. Schizophrenic behavior described in this way has been presented elsewhere (10), but it may be summarized briefly here.

Not only can a person manifest an incongruence between levels of total message, but also between elements of his messages. A message from one person to another can be formalized into the following statement: I (source) am communicating (message) to you (receiver) in this context.

By his body movement, vocal inflections, and verbal statements a person must affirm or disqualify each of the elements of this message. The symptoms of a schizophrenic can be summarized in terms of this schema.

1) Source. A person may indicate that he isn't really the source of a message by indicating that he is only transmitting the idea of someone else. Therefore he says something but qualifies it with a denial that he is saying it. The schizophrenic may also qualify the source of the message in this way, but he will qualify his qualifications in an incongruent way. For example, a male schizophrenic patient reported that his name was Margaret Stalin. Thus he indicated that he wasn't really speaking, but by making his denial clearly fantastic he disqualified his denial that he was speaking. Similarly a patient may say that "voices" are making the statement. In the excerpt presented, the patient denies that he is responsible for the greeting card message by saying "they sell them in the canteen," and yet this denial is by its nature self-disqualifying and so his messages become incongruent at all levels.

2) Message. A person may indicate in various ways that his words or action are not really a message. He may indicate, for example, that what he did was accidental if he blurts something out or if he steps on someone's foot. The schizophrenic may indicate that his statement isn't a message but merely a group of words, or he may speak in a random, or word salad, way, thus indicating that he isn't really communicating. Yet at the same time he manages to indicate some pertinent points in his word salad, thus disqualifying his denial that his message is a message. In the excerpt given above, the patient says, "a card is a card," as a way of denying the message communicated. He also says that he doesn't remember what the thing was, thus denying the message existed for him. However, both these qualifications of the message are also disqualified: the card obviously isn't merely a card, and he can hardly not remember what the thing was when he is looking at it.

3) Receiver. A person may deny this element in a message in various ways, for example by indicating he isn't really talking to the particular person he is addressing, but rather to that person's status. The schizophrenic patient is likely to indicate that the doctor he is talking to isn't really a doctor, but, say, an FBI agent. Thereby he not only denies talking to the physician, but by labeling the receiver in a clearly fantastic way he disqualifies his denial. Paranoid delusory statements of this sort become "obvious" by their self-negating quality.

4) Context. A person may disqualify his statement by indicating that it applies to some other context than the one in which it is made. Context is defined broadly here as the situation in which people are communicating, including both the physical situation and the stated premises about what sort of situation it is. For example, a woman may be aggressively sexual in a public place where the context disqualifies her overtures. The typical statement that the schizophrenic is "withdrawn from reality" seems to be based to a great extent on the ways he qualifies what he says by mislabeling the context. He may say his hospital conversation is taking place in a palace, or in prison, and thereby disqualify his statements. Since his labels are clearly impossible, his disqualification is disqualified.

These multiple incongruent levels of communication differentiate the schizophrenic from his parents and from other people. If a person says something and then negates his statement we judge him by his other levels of message. When these too are

incongruent so that he says something, indicates he didn't, then affirms one or the other, and then disqualifies his affirmation; there is a tendency to call such a person insane.

From the point of view offered here, schizophrenia is an intermittent type of behavior. The patient may be behaving in a schizophrenic way at one moment and in a way that is "normal" for this type of family at another moment. The important question is this: Under what circumstances does he behave in a psychotic way, defined here as qualifying incongruently all his levels of message ?

In this excerpt of a family interaction, the patient shows psychotic behavior when he is caught between a therapist pressuring him to affirm his statements and his parents pressuring him to disqualify them. From this point of view, the patient is faced with a situation where he must infringe the rules of his relationship with the therapist or infringe his family rules. His psychotic behavior can be seen as an attempt to adapt to both.²⁾ By behaving in a psychotic way he could 1) affirm his statement about his mother, thus following the rule in the therapeutic relationship for affirmative statements, 2) disqualify his critical statement of the mother, thus following the family rules that mother is not to be blamed in a way so that she can accept blame and all statements are to be disqualified, and 3) synthesize these two incompatible theses by indicating that the message wasn't his (it wasn't really a message, he couldn't remember it, and he didn't really send it). It can be argued that psychotic behavior is a sequence of messages which infringe a set of prohibitions but which are qualified as not infringing them. The only way an individual can achieve this is by qualifying incongruently all levels of his communication.

The need to behave in a psychotic way would seem to occur when the patient infringes a family prohibition and thereby activates himself and his parents to behave in such a way that he either returns within the previous system of rules or indicates

2)An attempt to synthesize two incompatible situations by a perceptual change is suggested in Weakland and Jackson (22). Describing an incident during a psychotic breakdown, they say, "Psychotic delusions allowed him to free himself of decision making. For example, the cab driver is a hospital attendant in disguise. There is no problem in Home vs. Hospital; it has been resolved."

somehow that he is not infringing them. Should he successfully infringe the system of family rules and thereby set new rules, his parents may become "disturbed." This seems to occur rather often when the patient living at home "improves" with therapy. When improving in therapy he is not only infringing the family prohibitions against outside alliances but he may blame the mother in a reasonable way and affirm his statements or those of others. Such behavior on his part would shatter the family system unless the parents are also undergoing therapy. The omnipotent feelings of the schizophrenic patient may have some basis, since his family system is so rigid that he can create considerable repercussions by behaving differently.

A patient is faced with infringing family prohibitions when 1) two family prohibitions conflict with each other and he must respond to both, 2) when forces outside the family, or maturational forces within himself, require him to infringe them, or 3) when prohibitions special to him conflict with prohibitions applying to all family members. If he must infringe such prohibitions and at the same time not infringe them, he can only do so through psychotic behavior.

Conflicting sets of prohibitions may occur when the individual is involved with both mother and therapist, involved with a therapist and administrator in a hospital setting (19), or when some shift within his own family brings prohibitions into conflict. This latter would seem the most likely bind the patient would find himself in when living at home, and an incident is offered here to describe psychiatric behavior serving a function in the family.

A twenty one year old schizophrenic daughter arrived home from the hospital for a trial visit and her parents promptly separated. The mother asked the girl to go with her, and when she arrived at their destination, the grandmother's home, the patient telephoned her father. Her mother asked her why she turned against her by calling the father, and the daughter said she called him to say goodbye and because she had looked at him with an "odd" look when they left. A typical symptom of this patient when overtly psychotic is her perception of "odd" looks, and the problem is how such a message is adaptive to the family pattern of interaction.

The incident could be described in this way. The mother separated from father but qualified her leaving incongruently by saying it was only temporary and telling him where she was going.

The father objected to the mother's leaving, but made no attempt to restrain her or to persuade her to stay. The daughter had to respond to this situation in accord with the prohibitions set by this family system: she had to disqualify whatever she did, she had to disqualify what her mother and father did, she could not ally with either mother or father and acknowledge it, and she could not blame the mother in such a way that the mother would accept the blame.

The girl could not merely do nothing because this would mean remaining with father. However, by going with the mother she in effect formed an alliance and so infringed one of the prohibitions in the family system. The girl solved the problem by going with mother but telephoning her father, thus disqualifying her alliance with mother. However, her mother objected to the call, and the daughter said she only called him to say goodbye, thus disqualifying her alliance with father. Yet to leave it this way would mean allying with mother. She qualified her statement further by saying she called father because she gave him an "odd look" when she left him. By having an odd look, she could succeed in not siding with either parent or blaming mother. She also manifested schizophrenic behavior by qualifying incongruently all levels of message and thereby adapting to incongruent family prohibitions. Previously the girl could withdraw to her room to avoid the alliance problem, but when mother stopped staying home while saying she was going to leave, and left while saying she was not really leaving, the girl was threatened by a possible alliance whether she went with her mother or stayed at home. Her incongruent, schizophrenic behavior would seem necessary to remain within the prohibitions of the family at those times. If one is required to behave in a certain way and simultaneously required not to, he can only solve the problem by indicating that he is not behaving at all, or not with this particular person in this situation. The girl might also have solved the problem by disqualifying her identity, indicating the context was really a secret plot, indicating that what she did was what voices told her to do, or speaking in a random or word salad way. In other words, she could both meet the prohibitions in the family and infringe them only by disqualifying the source of her messages, the nature of them, the recipient, or the context, and so behave in a psychotic fashion.

It is important to emphasize that schizophrenic behavior in the family is adaptive to an intricate and complicated family organization which is presented here in crude simplicity. The network of family prohibitions confronts the individual members with

almost insoluble problems. This particular incident was later discussed with the parents of this girl, and the mother said her daughter could have solved the problem easily. She could have stayed with father and told him he was wrong in the quarrel which provoked the separation. This would seem to be the mother's usual way of dealing with this kind of situation—she stays with father while telling him he is wrong. However, the mother leaves herself out of this solution by ignoring the fact that she asked her daughter to go with her. This request was even more complicated--the mother asked the daughter to go with her during a period when the mother was saying the daughter must return to the hospital because she could not tolerate associating with her. When the parents reunited later that week, the girl was returned to the hospital because mother said she could not stand daughter in the room watching her, and she could not stand daughter out of the room thinking about her.

The approach offered here differs from the usual psychodynamic explanations. It would be possible to say that the mother's concern about leaving the daughter with the father, even when she could not tolerate the girl's company, might center in the family's concern about incestuous desires between father and daughter. Such a psychodynamic hypothesis could be supported. Later in therapy the father and daughter planned a picnic alone together when they decided they should see more of each other without the mother being present. The evening of the day this was arranged, the therapist received a telephone call from the disturbed mother. She reported that she and her husband had been drinking and arguing all evening and she reported that her husband had told her it was natural for a father to have sexual relations with his daughter. The husband's report was that he had not said this. (He had said it was natural for a father to have sexual feelings for his daughter, but this did not mean he would do anything about it.) This crisis over suggested possible incest could be explained by saying that the threat of closeness between father and daughter aroused forbidden incestuous desires in them. However, it was the mother who made an issue over the possible incest. From the psychodynamic point of view, hints and discussions of incest would represent unconscious conflicts. From the point of view offered here, this type of discussion is an aspect of family strategy. To label a relationship as possibly incestuous would be one further way of enforcing a prohibition on alliances between father and daughter. Such a maneuver is similar to one where the mother inhibits a relationship between father and daughter by insisting that the father should associate more with the daughter,

son tries to avoid being governed or governing others, the more helpless he becomes and so governs others by forcing them to take care of him.

A MODEL FOR DIFFERENTIATING TYPES OF FAMILIES

What is lacking in the study of interpersonal relations is a method of describing, by way of some analogy the process which takes place when two or more people interact with one another. Although there are models for inner activity, e.g., the id-ego-superego metaphor, there is not yet a model for human interaction. Implicit in the approach to the schizophrenic family offered here there is such a model. The essential elements of it are: 1) the proposition that human communication can be classified into levels of message, 2) the cybernetic idea of the self-corrective, governed system. If a family confines itself to repetitive patterns within a certain range of possible behavior, then they are confined to that range by some sort of governing process. No outside governor requires the family members to behave in their habitual patterns, so this governing process must exist within the family. A third essential point is that when people respond to one another they govern, or establish rules, for each other's behavior.

To describe families, the most appropriate analogy would seem to be the self-corrective system governed by family members influencing each other's behavior and thereby establishing rules and prohibitions for that particular family system. Such a system tends to be error-activated. Should one family member break a family rule, the others become activated until he either conforms to the rule again or successfully establishes a new one.

A system of three organisms each governing the range of behavior of the other two, and each communicating at multiple levels, is both a simple idea and a complex model. Yet such an approach offers a general theoretical framework within which the specific rules of any one type of family system can be classified. The rudiments of such a system are suggested here at the most general level. The family of the schizophrenic is a particularly good model for this approach because of the narrow limits of their system. Our few preliminary observations of families containing children without symptoms, children who are delinquent, and children with asthma, lead us to believe that the interaction in the family of the schizophrenic is unique. Members of other types of family sometimes disqualify each other's statements but only under certain circumstances. Mutual affirmation will also

occur. We have observed, for example, parents of an asthmatic child finishing each other's sentences and having this approved. Should the father of a schizophrenic finish the mother's sentence, it seems inevitable that she would indicate he provided the wrong ending. In other families leadership will stabilize into a pattern accepted by family members. Certain alliances will be allowed in some types of families, notably the delinquent where the child is capable of forming labeled alliances in gangs outside the family. In the family of the schizophrenic the range of behavior is as limited and inflexible as is the behavior of the schizophrenic in contrast to other people.

The observation of this type of family system inevitably takes place after the child has manifested a schizophrenic episode. Whether the family behaved in a similar way prior to his diagnosis is unknowable. In this sense it is difficult to assert that the interaction in his family "caused" schizophrenia. There are two possibilities. 1) If the family is a self-corrective system and the child behaves intermittently in a schizophrenic way, then schizophrenic behavior is a necessary part of this family system. 2) Alternatively, schizophrenic behavior as a result of a particular family system which has been disrupted by forces outside the system, such as maturation of the child or environmental influence. The family then reorganizes a new system which includes the schizophrenic behavior as an element, and this is what we are presently examining. The evidence leads us to believe that schizophrenic behavior in the child is reinforced by the present family system.

Although psychotic behavior may serve a function in a family system, a risk is also involved. The patient may need to be separated from the family by hospitalization and so break up the system, or he may enter therapy and change and so leave the system. Typically the parents seem to welcome hospitalization only if the patient is still accessible to them, and they welcome therapy for the patient up to the point when he begins to change and infringe the rules of the family system while acknowledging that he is doing so.

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thus arousing his negative behavior as well as the issue of whether he neglected the daughter. The approach offered here does not deal with supposed motivating forces within the individuals concerned, but with the formal characteristics of their behavior with each other. 3)

THE FUNCTION OF FAMILY BEHAVIOR

The difficulty for this type of family would seem to lie in the inflexibility of their family system. They often maintain the system despite the sturdy attempts of a family therapist to help them deal with each other more amicably. Apparently family members gain only discord, dissension, and a constant struggle with one another, or periods of withdrawal in a kind of truce, yet they continue so to behave. It would be possible to postulate psychodynamic causes for this type of behavior, or self-destructive drives could be sought, but an attempt is made here to develop an alternative descriptive language centering on the peculiar sensitivity of people to the fact that their behavior is governed by others.

When people respond to one another they inevitably influence how the other person is to respond to them. Whatever one says, or doesn't say, in response to another person is a determinant of the other person's behavior. For example, if one criticizes another, he is indicating that critical statements from him are permissible in the relationship. The other person cannot not respond, and whatever response he makes will govern the critical person's behavior. Whether the criticized one gets angry, or weeps helplessly, or passively accepts the criticism, he must either be accepting the rules or countering with other rules. These rules for relationships which people establish with each other are never permanently set but are in a constant process of reinforcement as the two people interact and govern each other's behavior.

3) Although statements in the form of family rules deal with observable behavior and are therefore verifiable, the verification depends to some extent upon the skill of the observer. Such statements are more reliably documented by placing the family in a structured experimental situation where the results depend upon whether or not the family functions under certain prohibitions. The Bateson project is now beginning a program of experiments with families similar to the small group experiments of Alex Bavelas.

Every human being depends upon other people not only for his survival but for his pleasure and pain. It is of primary importance that he learn to govern the responses of other people so they will provide him satisfaction. Yet a person can only gain satisfaction in a relationship if he permits others to cooperate in setting the rules for the relationship and so influence and govern him. The person who dares not risk such control over him would seem to provoke his own misery by attempting to avoid it. If someone has suffered a series of hurts and frustrations with people he trusted, he tends to try to become independent of people--by not getting involved with them in such a way that they can gain control over his feelings or his behavior. He may literally avoid people; he may interact with them only on his own terms, constantly making an issue of who is going to circumscribe whose behavior; or he may choose the schizophrenic way and indicate that nothing he does is done in relationship to other people. In this fashion he is not governing anyone and no one is governing him.

The family of the schizophrenic would seem to be not only establishing and following a system of rules, as other families do, but also following a prohibition on any acknowledgement that a family member is setting rules. Each refuses to concede that he is circumscribing the behavior of others, and each refuses to concede that any other family member is governing him. Since communication inevitably occurs if people live together, and since whatever one communicates inevitably governs the behavior of others, the family members must each constantly disqualify the communications of one another. Should one affirm what he does or what another does, he risks conceding that he is governed by the other with all the consequences that follow being disappointed again by an untrustworthy person. Schizophrenic behavior can be seen as both a product and a parody of this kind of family system. By labeling everything he communicates as not communicated by him to this person in this place, the schizophrenic indicates that he is not governing anyone's behavior because he is not in a relationship with anyone. This would seem to be a necessary style of behavior at times in this type of family system, and it may become habitual behavior. Yet even psychotic behavior does not free the individual from being governed or from governing others. The person who insists that he does not need anyone at all and is completely independent of them requires people to put him in a hospital and to force feed him. To live at all one must be involved with other people and so deal with the universal problem of who is going to circumscribe whose behavior. The more a per-

SESSION III

STAGES OF ADULTHOOD

I. The Three Stages Of Adulthood

A. Early adulthood

1. intimacy

2. career

3. risks

B. Middle adulthood

1. productivity

2. ^{typo}
~~Re~~-assessment/career change

3. physical changes

a. male and female menopause

4. sexuality

SESSION III (cont.)

C. Late adulthood

1. the meaning of integrity

2. need for integration

3. despair

D. Personality factors which affect old age: the need for a ninth stage.

1. interpersonal skills

2. ability to be self-nurturing

3. problem solving ability

4. dealing with disability

SESSION III (cont.)

5. interests

6. sexuality

REFERENCE MATERIALS

SESSION III

Passages by Gail Sheehy, "The Sexual Diamond" pp. 304-320

"The Crisis of Middle Age" by Judd Marmor , from Our Bodies
Ourselves, "Menopause", Boston Women's Health Collection.
Simon & Schuster N.Y., 2nd Edition, 1971, pp. 327-336.

"Emotional Factors In The Aged", by Gloria Francis

Chronic Brain Disorders

"Emotional Problems of the Aged: Preventive Aspects and
Early Recognition" - lecture by Arthur Peck, M.D.

THE SEXUAL DIAMOND

I have deliberately left the discussion of sexual changes and exchanges within the midlife man and woman until last. That is because of the old chicken-and-egg argument. There is little doubt that upheavals in the hormone levels of both sexes stimulate at least some of the psychological changes of the middle years. On the other hand, when the 40-year-old married man says, "Our sex life went to pieces," or the same-age wife says she has taken a lover "to shore up our marriage," it usually turns out that the change in sexual circumstances is not the cause of but the accompaniment to all of the other shifts in perspective already described.

Many modern women exhibit their erotic potential most boldly at just about the time their husbands' sexual incentive is diminishing. For men, the very *thought* of this can be disastrous.

Midlife "impotence" results, in over 90 percent of cases, from a devastating combination of ignorance and male sexual anxiety. Many researchers and studies confirm this. Masters and Johnson lay it flat out: "The susceptibility of the human male to the power of suggestion with regard to his sexual prowess is almost unbelievable."¹ More than any fluctuation in hormone level, it is anxiety, the free-floating fear of losing his male powers as he has known them, that can so often make the first time he can't get an erection crippling. Even the slightest suggestion that his sexual prowess is diminishing can psych the midlife man into a repeat of what too often seems to him to be a humiliating failure.

He notes that it takes more time to become aroused. Where it used to be a matter of seconds and a mere glance at the orbs of flesh colliding beneath a pair of tennis shorts, he may take minutes or more to reach erection as he gets older. He also notices, correctly, that he is slower on the comeback. In the sweet agonies of teen age he may have walked about with an erection all day, seldom completely losing it even after he made love or masturbated—a virtual prisoner of his hormones and tight-fitting pants. But now each sexual act has a definite beginning and end, and it may be a matter of hours or all day before he can reach erection again. Comparisons, stinging comparisons . . . he is not the boy he once was.

The accumulating effect of such comparisons may soon have him believing that he is heading into terminal sexual aridity. In trying to will or force an erection that he thinks may soon be completely unattainable, he becomes a candidate for secondary impotence. That means, having enjoyed a perfectly healthy sexual history, he is now unable to get hard at least a quarter if not half the time. Or, if this episodic failure becomes a pattern to which he resigns himself, not at all.

The facts are these: Masters and Johnson assert that all but the tiniest percentage of impotence cases are psychological in origin. However, one-quarter of men are impotent by the age of 65 and one-half by 75.²

What's normal? How well should the man over 35 be able to perform? (The very emphasis on performance has been the single greatest cause of sexual dysfunction over the ages.) Something is happening and there is no one to tell him how to interpret it. Most men won't ask other men, nor would they be likely to get a straight answer if they did; the level of lying in sexual matters is very early raised to the incorrigible. Hence each man thinks that his failure is in some way exceptional.

There are considerable advantages for the midlife man who lets himself enjoy his sexual maturity. Prolonged lovemaking comes naturally to him. And he is capable of a deepening intimacy. (Intimacy does not flourish in the presence of need to prove machismo.)

One man described to me how threatening some of these changes appeared to him and how he fought them for almost five years. He had been quite a stud during his thirties as a divorced man about town. When he was close to 40 and quite happily remarried, a ripe and willful beauty from his past invited him to a party. His second wife was out of town on business. "I felt I had to try. I'd always been successful before." As he led the temptress to bed, he was feeling not only guilty but—something else—used. There was no emotion here, his feelings were all tied up with his wife. In fact he wasn't leading at all. This other woman (like so many older women, he later observed) was the aggressor.

"After the first few times when I couldn't get hard with another woman, I began to realize it was because I was being forced into something I didn't want to do."

He could not perform on demand, but as time went on he began to

resent being demanded of. All the while he was becoming more attached to, more vulnerable to, and more involved with his wife. It wasn't easy to get used to this switch from using sex for dominance to wanting affection and exclusivity. Gradually he saw an advantage to it all.

"It's the freedom not to feel you have to chase after women." But even when the change was positive, this man resisted it.

A recurring theme in the biographies of men describing midlife is their escapades with younger women who were supposed to restore their waning sexual powers. Sometimes, this does help to dispel the anxiety that is the real culprit. And sometimes, to their chagrin, they find themselves suddenly flat champagne in the presence of the sexual feast, or that the affair reduces them to flaccidity with their wives. In any case, they are baffled. And ashamed. And scared.

When Joe declares at a party, "I wouldn't consider sleeping with a woman over 40," or Sam announces to his friends, "I'm bunking with a 17-year-old girl this weekend," they are revealing more than anything else their own middle-aged fears of inadequacy. The 40-year-old woman is not evaluated as an individual; the 17-year-old girl is given no name, no personal characteristics. In both instances the female is narrowed to one dimension: she is an age.

It stands to reason that as a man begins to sense his own feminine side in this period, he will also feel somewhat threatened by the initiating behavior now showing up in his partner. The shifting characteristics that become evident in both sexes during the Switch-40s cannot be fitted together, not for at least several years. But if a man doesn't understand or can't accept this process, it can cause a locking of feeling. Sexual apprehensions only aggravate the situation. From his perspective, as nature is narrowing his own sexual potential, an eager and experienced woman of his own age knows too much, expects too much. The most obvious defense is to find a way to miniaturize women.

Seeking younger and more superficial partners is not the only device by which women can be miniaturized. The entire sexual experience can be reduced in scope by dehumanizing women, by seeing them as an assortment of only slightly varying objects to be used and discarded. Prostitutes can be paid for. Massage-parlor models can be activated like coin-operated machines. Some men make a contest of trying to seduce other men's wives or women friends, a form of male rivalry in which the female can be discounted for having cooperated in the infidelity. Sexual fetishism also holds great appeal. Most of the readers of *The Fetishist Times* are men in their forties and fifties. A man may insist on sex in odd combinations. Feet suddenly become an obsession, or dark nipples or whatever. Perhaps the real motive is not to attract but to disqualify as many women as possible.

The basis for the ignorance problem is that until recently the American man has had almost no reliable source of information about sex. First

he was a little boy being told by the big boys, "When you're older, you'll know." Next he was an older boy telling another ignorant youth he'd know. Then he graduated from being a son into being a husband and father, rarely asking the girls along the way specific questions because that would have meant admitting he still didn't know.

A bent penis at midlife throws him into a panic.

The least likely action a man will take, according to Dr. David Marcotte at the Kinsey Institute, is to describe his real dilemma to a doctor. To reveal to anyone a real or imagined weakness in living up to our society's standards of virility is repugnant. Furthermore, men don't have doctors for middle age. What man has a long-standing confidential relationship with his urologist the way women do with their gynecologists? Men find unimaginable the idea of opening their legs at the word of any doctor the way women do to have their privates probed, Pap-smear, episiotomied, scraped, fitted with rubber disks, clamped with metal coils; the male role in the reproductive years doesn't require it. Beyond keeping up a solid virility front, then, most men are also squeamish about baring their sexual problems before a physician.

Even if they do, the general practitioner is untrained in sexual problems as a rule. He won't take a sexual history or inquire about the situational impotence that is the real problem. The patient will usually disguise his real concern by describing other physical symptoms ("I'm rundown, overtired, overweight"), or he'll invent an organic factor. If the doctor does ask him direct sexual questions, he will probably lie. As a consequence of all this dodging, the doctor usually ends up by telling him, "Don't worry about it; it's just a natural part of the aging process." The implication being: "You won't need it much longer."

Meanwhile, his female counterpart is often, literally, on the prowl. The "delayed blooming" of sexual desire and orgasmic capacity in women over 30 has been paid profuse attention, of which he is only too uncomfortably aware. Masters and Johnson matter-of-factly state, "A woman will usually be satisfied with 3-5 orgasms."³

This leaves us with what would seem a vicious circle: the midlife woman actively seeking satisfaction of her now uninhibited sexual desires from a man who, wary in the presence of any naked demand, goes into involuntary retreat. How, we wonder, could nature be so perverse?

Facing the Facts of Male and Female Sexual Life Cycles

Males and females are most alike before they are born, at 18, and over 60. In between 18 and 60 they move toward opposite poles that reach an extreme about 40.

The whole configuration can be seen in the shape of a diamond. That is, males and females at the age of emancipation start out quite alike. In

the twenties they begin moving apart in every way: in sexual capacity and availability for sex (especially once the woman's reproductive potential is tapped), in social roles that are massively different and that also favor different personality characteristics, and in the overall sense of themselves. By the late thirties and early forties, the distance across the diamond is at its greatest. Males and females are exhibiting the most strikingly dissimilar aspects of their sexual capacities. At the same time, they are called upon to admit the sexually opposite sides of their natures, which are so frighteningly unfamiliar. In the fifties, they both go into a sexual involution, which eventually brings them back together in the unisex of old age.

Now, to go back and fill in the details . . . In our first five weeks after conception we are all females. The genetic instructions for which sex we shall turn out to be are given at conception, but all mammalian embryos are female until, in some, the growth of ovaries is suppressed. It takes the stimulation of male sex hormones to begin the differentiation of the sexes in the fifth week. But no matter what the genetic instructions were, if the fetal sex organs are removed before this differentiation, the fetus will develop as an otherwise anatomically normal female (without ovaries).⁴

Both sexes continually produce some of the opposite sex hormone. A female who is experimentally injected with testosterone will easily accept the male hormone, and although it often increases her sex drive and enlarges her clitoris, little or no added estrogen is required before the innate human femaleness reasserts itself. The reverse is true for men. The liver closely monitors the estrogen supply in the male and rids his body of any excess. He is also strongly resistant to injected estrogen and its refeminizing effects. As the years go by, however, his liver becomes less efficient. And so in middle age his female-hormone level begins to climb or at least remains stable. Meanwhile his production of male hormone, which has been declining since the late teens, is inexorably dropping off.

As he moves into the fifties, the contours of his body gradually regain some of the femaleness that was anatomically natural to the original embryo. Although the postmenopausal woman does not find herself in a parallel situation (that is, her male-hormone level is not climbing in the same ratio) her estrogen level does fall off once her reproductive cycling ends. The two sexes again become more alike. Or, to be more precise, by exchanging many characteristics they become less different.

But what about the likeness at 18? What was once only shaky and secretive personal experience is now supported by recent sex research and the new honesty among women.

It is widely known that a male reaches his peak sexual capacity at about 18. Sexual capacity is defined as the ability to respond quickly and repeatedly, and the young man lives up to it as indefatigably as the tollgate at the entrance to a superhighway. Not only does a young man erect in seconds, he is capable of having a chain of ejaculations without fully losing his erection. Ten minutes after the first orgasm, he can be restimu-

lated from a state of swollen excitement to full erection again *within the same sex act*. That is to say, the resolution phase is not fully completed for minutes or even hours, and he is potentially able to have multiple orgasms by reentering his partner again and again.

But the true sexual potential of the 18-year-old girl is as yet unrecorded. Suppression of the young female's sex drive has been fundamental in stabilizing cultures around settled family life. That doesn't mean it hasn't always been there.

The shock wave caused by evidence that even nice girls are just as interested in sex as boys has only recently begun to register in our own society. Few can fail to notice that something has been left out in our long-prevailing notion of women's sexuality as a lethargic and quiescent thing, a tight little bud that opens only after ten or fifteen years of prying, prying, prying.

In fact, the vagina is a highly elastic space that enlarges with sexual arousal. Even a small or very young female can receive an exceptionally large penis, just as she can give birth to a ten-pound baby at the ripe age of 18. The more sexual experience she has, the more quickly excitable and repetitively orgasmic she becomes except that no time at all is required for her to return to readiness.

Societies have always suspected this about women, hence the efforts to suppress female sexuality. The ever-ready simplification seems to me to be just the other side of the tight-little-bud extreme. The truth is much more complex. We are touched by our emotions as well as being creatures of our physical capacities.

Having guiltily enjoyed a rather hot-blooded adolescence myself, I always wondered how much truth there was in the "delayed blooming" idea of female sexuality. I put the question to a friend.

"I remember an adolescence of absolute frenzy," she groaned. "Not getting through a day without seventy-five percent of it being occupied with sexual dreaming, wishing, watching, touching if possible."

Many young women "went all the way" with their steadies expecting them to be, of course, future husbands. Still others sought to please. Whatever other motives they had at the time, what now comes out in consciousness-raising groups is that they felt guilty about enjoying it so much. They didn't know if it was normal, and they didn't talk about it.

Even when it ran contrary to our own experience, women of my generation accepted the mythological profile of the 18-year-old boy who is a prisoner of his hormones and the young girl who is reproductively ready but won't sexually arrive for ten or fifteen more years. Indeed, many of us *willed* ourselves back into sexual dormancy. It was common for nice girls who had "gone too far" to do penance for their erotic irresponsibility by entering a period of revirgination.

That explains the kind of letter one man remembers getting over the summer from his girl friend: "What we've done is wrong. When we get back

together in the fall, things will have to be different." He was baffled. All they had done was pet.

The last five years or so have prodded women of my generation to talk and laugh about the sexual intensity we felt when we were very young. And the risks we were willing to run for it. Much of this honesty was stimulated by the abortion issue. Calls went out for all notable women who had had an abortion to speak up. The necessity for abortion on demand could not be ignored if a solid block of celebrities and important men's wives, even wives of legislators, stood up to be counted. Some of them had sought abortions back when they were 18, or 19 or 20.

This is not to say that most 18-year-old girls in the pre-pill era did act in a way that would awaken their sexual energies, only to suggest that a responsiveness close to the male's was there if they had. But religious prohibitions and the double standard, not to mention the legions of premature ejaculators, all together were remarkably effective in cooling the young woman's attitude toward sex.

Boys, too, were given a double message: "Don't do it, but we expect you will." Instead of emphasizing the likeness in his and her desires and capacities, the double standard had an opposite effect that is well known. His part was to play the attacker while she struck the pose of unwilling prey. Any feelings to the contrary had to be falsified or apologized for, and nothing in this ritualized contest allowed for mutuality. It cast a long shadow of mistrust into the adult years for men who continued to believe "Women always give you a hard time," and for women who were convinced, "Men only want one thing."

The Diverging Sexual Life Cycles

The similarity of males and females at 18 extends into many areas other than sexual capacity. At that age they are more alike or allied in the need to break away from their parents than they are unlike as male and female. They need one another to find out how they *are* different. Both he and she are insecure, inexperienced, and as yet undistinguished by the carapace of firm social and vocational roles. Enthralled as much by what they are learning about themselves as by the other one, young lovers gladly lose their egos in each other as if in a warm whirlpool bath. That's why the first love is so hard to give up.

Once into the twenties, the social sorting system begins segregating them by domestic duties and career opportunities, and the massive distinction in sexual roles takes effect. They begin moving apart in every way, including sexually. An overwhelming proportion of the babies born are produced by women in their twenties.⁵ Pregnancies cause sexual interruptions, and small children are distracting. Men have already experienced "the sexual acme of their lives . . . and will never again attain higher levels of total sexual outlet."⁶

After completing her baby-bearing at the statistical age of about 30 or 31, the woman is at her fullest sexual availability. Although a slow physical decline begins in the thirties for everyone, this decline is more than offset in the American female by her gradual loss of sexual inhibition. Psychiatrist Mary Jane Sherfey particularly emphasizes the effects of pregnancy.⁷ The capacity for repetitive orgasms (orgasms that continue in a series uninterrupted by a full resolution phase), she says, most often occurs during the last fourteen days of the menstrual cycle in women who have already borne children. This is because of the high levels of vasocongestion reached by the woman who has already reproduced. The female erectile chambers have the capacity to refill immediately after every climax, and this recreates the sexual tension by engorging the entire pelvis with an inexhaustible supply of blood and fluid. It is one of the most striking differences between men and women and between women and other primate females.

And the man? What changes when, and what remains forever? After 30, it is widely agreed that the man loses his capacity for multiple orgasms. That is, he loses the ten-minute boy power to re-erect by entering his partner again and again. A full resolution follows each ejaculation, and at least a half hour is required before he can have another erection. Nonetheless, the quality of his sex life usually improves as he gains more social skills and higher status. His status not only makes him more desirable in the eyes of women, it makes him more potent in his own eyes. The effect of self-confidence on male-hormone level cannot be stressed enough.

It is a biological fact of life that as the years pile up, the male erection capacity goes down, and he must have longer and longer rest periods between sexual acts. The gradual physical slowing noticed by everybody is not so easily offset for a man by a new sexual experience, the way it often is for a woman, because ordinarily he has fewer inhibitions to give up. On the contrary, midlife is when serious inhibitions are likely to trouble him for the first time.

With unsettling changes in his sense of self going on in every other area, obviously a man's sexual confidence will be affected. He may try to conceal a flagging libido from his partner by picking a fight with her and then retreating into a self-righteous sulk. Or he overworks to the point of exhaustion or gets psychosomatically sick, all to explain why he can't make love on the weekend. There are easily hundreds of ways to avoid the real issue. Although his partner probably senses the real reason, she would be risking annihilation to say so.

In America and all over Western Europe we place a premium on the vertical penis. As anthropologist Ray Birdwhistell says, "Unless the male can get up this hyper-erect vertical penis and not ejaculate prematurely, he thinks he's incapacitated."⁸ And then, too often, he is.

Some societies accept the fact that sex is quite possible with a nonrigid penis. This requires cooperation between the man and the woman. She prepares her tissues for reception of the partially erect penis, using added lubri-

cation if necessary. In a society that assumes only bad girls cooperate, a taboo is created against such helpful efforts. The nearest thing we have had to a sexual revolution, claims the professor, is that women are now allowed to admit what they know about sex without being regarded as bad girls. And to teach men. But a big blind tank of ignorance still rolls through midlife, and I would suggest we have a long way to go to reduce the sexual casualties.

The bright side of the male sexual life cycle is this: A man in generally good health need *never* lose his erective capacity. The sexually educated and experienced middle-aged man can be a most satisfying lover. Once he overcomes the anxiety of no longer being a boy, he can begin to appreciate his matured powers to give tenderness and receive love, and to prolong his own state of excitement by withholding ejaculation while he brings his partner to ecstasy again and again. That's power. But he should also know this: Women don't like to feel they *have* to come again and again, in order to compliment a man's masculinity. As with erection, any rigid expectation of a standard of performance is incompatible with good sex.

Looking at ourselves in cold, hard evolutionary terms, we are all relatively useless after 30. All a species needs to survive is to reproduce itself, which is easily possible at the age of 15, and fifteen years more to raise the next generation to reproductive age. Certainly by 40, when both the male testes and the female ovaries begin to show the changes of age, we are, from an evolutionary point of view, thoroughly disposable.

But we don't want to go! We're doing everything in our scientific powers to prolong our years of health and vigor. Today, an American boy baby who has survived his first year can expect to live to 69 and a girl to 76.⁹ Most child-bearing is over by the time we reach 30. What do we do with all those years of fulminating eroticism and undirected potential we have left? Lamenting the apparent upsurge in male impotence that seems to coincide with the lifting of age-old restrictions on female sexuality, writer Phillip Nobile expressed in *Esquire* a common viewpoint: "Indeed, the design appears badly botched." ¹⁰

Botched by us, I would suggest. Botched only because we continue to set the adolescent ideal into cement and then crab about it when the next fifty years will not reciprocate our wishes for adolescent love, adolescent sex, adolescent male strength and female beauty. We remain wholly unprepared for the long stretch of the life cycle we will spend as nonproductive sexual beings.

The Educated Male Orgasm

One reason we have come to believe that men enjoy sex less as they grow older while women enjoy it more is the Kinsey hangover. Kinsey measured the sexual experience solely in terms of the number of "outlets." Reflecting in his research design the bias of his culture at the time (1943),

Kinsey's definition of male satisfaction was ejaculation—nothing more, nothing less. Kinsey wouldn't put up with any talk about "premature." If primates do it fast, he argued, then men should go them one better:

It would be difficult to find another situation in which an individual who was quick and intense in his responses was labeled anything but superior and that in most instances is exactly what the rapidly ejaculatory male probably is, however inconvenient or unfortunate his qualities may be from the standpoint of the wife of the relationship.¹¹

So, to some degree, we have Kinsey to thank for several generations of premature ejaculators.

The male orgasm does not happen naturally. As Birdwhistell states, far more often than Americans and most Western Europeans like to admit, a full male orgasm, unlike ejaculation, does not happen at all without learning or training. Ejaculation is composed of a two- or three-second sensation that coming is inevitable, followed by three or four strong muscle contractions that expel the semen and produce the most pleasure, then several minor contractions, and it's over. What's more, the man over 50 may feel only one or two contractions before expulsion or may lose the subjective feeling of inevitability altogether and be reduced to a one-stage ejaculation.

The full male orgasm is an exercise in exquisite delay. By training himself to slow down every time he approaches the margin of ejaculatory demand, the man can luxuriate in being stroked, savor the waves of hot swollen tension, fantasize, and delight in bringing his partner through an ascending chain of orgasms until she reaches a moment of climax comparable to his.

Because young men of today generally recognize the pleasure of prolonged lovemaking, they make efforts and experiment with different methods to cause this delay. The problem for the older man is different. Although he is much more easily able to be a mature ejaculator, that unfortunately was not the ideal conveyed by "making it" American style when he was a boy. The ideal assumed that the man must come if he is to give a good performance. The woman was also led to believe she had failed if she didn't "make" him come.

Very recently in America, Masters and Johnson have indicated that the man of 60 will find greater sexual contentment if on two out of three occasions, he reserves his ejaculation altogether. In that way, sexual tension will accumulate to a climax worthy of his expectations. Although this notion is only now being gingerly advanced in this country, in Oriental culture it has been the ideal. The ancient teaching in Chinese sex manuals is that the young man must be trained not to ejaculate, for his own as well as his partner's pleasure. In old Chinese wisdom, the deepest mutual joy in sex derives from stimulating the woman's orgasms. The man is urged to improve upon this pattern all through life: to hold back as long as he can and, if he does

succumb, to do so as infrequently as possible so that on those occasions he will be primed for satisfying release. It all dovetails so gracefully with the changing human capabilities as we grow older. But then, Chinese culture has always venerated age; whereas our own celebrates only a youth we all lose.

As the most sober researchers attest, if sex were the only criterion, the best match would be the adolescent boy with the woman twice his age.¹²

The Curious Ups and Downs of Testosterone

In some ways, the burden of aging put upon American men is more nearly intolerable than it is for the women. Our men must be something that no living creature has ever been able to achieve: They must be eternally strong. We have prepared them for nothing less by ignoring possible evidence to the contrary.

We do know that the male hormone, testosterone, is intimately connected with aggressive behavior, as it is with sexual behavior. And we are just beginning to find out that male hormone level varies enormously with the man's emotional state. Dr. Estelle Ramey, a physiologist at Georgetown University School of Medicine who is actively studying variations in testosterone with particular attention to its role in male heart attacks, called to my attention a fascinating study by Dr. Robert Rose, a professor at Boston University School of Medicine.

When a rhesus monkey is number one in the hierarchy of a primate colony, his testosterone level measures higher than that of any of the other monkeys. One might conclude that testosterone is the take-charge hormone and that the one who has the most gets to the top. But take this primate who is at the top of the pyramid and put him in a colony where he is unknown, where he has to reestablish himself, and his hormone level plummets. It all depends on his sense of security.¹³

A testosterone level is not something that an individual "has," regardless of the social situation; it is an open system. Two more studies by Rose show how very susceptible this system can be. After an animal is defeated in a fight, his hormone level drops and remains low. But put a low-status male in a cage with a female he can dominate and with whom he can have an active sex life, and up soars his hormone level along with his spirits.

Although similar patterns can be seen in humans, there has been an inexcusable lack of scientific research in this area. Only now are new techniques in chemistry being developed to measure sex steroids in human blood accurately. Data are just beginning to come out:

The older the man, the more readily anxiety will cause a drop in his testicular hormone.

From the age of 18, when the male's testosterone secretion reaches a peak per day, there is a slow fall-off until he dies.

Not all men are so gradual. More commonly than was anticipated, men

show a substantial drop in hormone level beginning between the ages of 40 to 55. And then they have all the signs and symptoms of the menopausal woman.

Mysteries of the Climacteric

Up to now this has been a male problem with no name. Well, there is the vague term *climacteric*, but there is nothing visibly markable that changes; he has no menstrual period to stop. People don't expect him to have hot flashes and dizzy spells, memory lapses and irritability. He may withdraw into obsessive work, but other common symptoms such as waking anxiously for hours in the middle of the night, lassitude, chronic fatigue, and headaches are sure to cut back on the energy and quality he once counted on taking to the office. His co-workers will eventually notice something is wrong, even if he refuses to admit to it himself and especially if his moodiness prompts him to lash out at them. Colleagues begin to be concerned about how well he can uphold his end of the enterprise. Competitors may use any of this odd behavior as ammunition against him.

A nasty downward spiral can ensue. Feeling his security on the pyramid slipping, he becomes more apprehensive. He is anxious about getting older. And the older he gets, the more that anxiety will suppress the production of male hormone he needs to take charge with confidence. Eventually the spiral will come back home to play havoc with his sex life. For as we already know, the relationship between sexual capacity and testosterone level is a highly synergistic one. But before going any further, I hasten to add Dr. Ramey's reassurance: "Potency is really not a function of how much hormone you're secreting as long as you have enough."¹⁴ Most men have enough for moderate sexual activity deep into old age.

That question aside, the next two concerns everyone has are: How many men undergo severe disruptions in their physical, emotional, and sexual equilibrium as a result of the climacteric? And what is the age of dread?

A current estimate is that about 15 percent of men suffer from the rapid, sharp decline of testosterone associated with disruptive symptoms of the climacteric. For the other 85 percent of men the hormonal change is slow and gradual, although there is considerable variation. Most hardly notice it; some experience no symptoms at all; and some are buffeted by wide swings in hormone level over a period of a few years, causing equally unpredictable swings of mood, and then the symptoms disappear without treatment. The symptoms of menopause also "affect almost all women to some degree, but only about 10 percent of them are obviously inconvenienced by these problems."¹⁵ There are important reasons that percentage has dropped so low. Menopause has been studied for many years. A woman knows what to expect. Volumes of information are now available to educate her further. Hormone replacement therapy, although controversial because of

the uncertain cancer connection, is nonetheless well along in clinical use. Most of all, menopausal women have a specific event to complain about and adjust to and everyone knows it; they can expect a little sympathy. For men it's all so undefined and unexpected.

Reporting conclusive results from a study of impotence in 100 climacteric patients, Boston urologist Thomas Jakobovits gives this picture:

Beyond the age of 40, a man may manifest symptoms of the strains and stresses peculiar to this particular time of life. An individual may suffer from irritability, nervousness, and a decrease or a loss of sexual function. . . . this decline of gonadal function with associated symptoms of the male climacteric can begin at any age, but most commonly begins between the ages of 40 and 55.

Referring to three other studies, he reports that the average age of the climacteric patient is 53.7.¹⁶

Dr. Helmut J. Ruebsaat, whose practice in British Columbia has become increasingly involved with men experiencing the climacteric, puts more weight on the forties decade. Three-quarters of the cases that have come to his attention began between the ages of 41 and 50 and the remainder sometime before 60. The tricky part of assigning an average age is that many cases are not reported until long after symptoms begin, and many other cases are never presented to doctors at all.¹⁷

Symptoms of the climacteric come in clusters, and they are elusive. A man doesn't wake up one morning feeling suddenly sick all over, as he does with the flu. One or two symptoms may come on for a period of days, followed by a spell of more ominous symptoms; then it all passes, and he feels fine. Until a few weeks or months later when another spell begins. With all this confusion, it's no wonder that a man might think he is suffering a series of illnesses with no connection. In summary, here are the complaints most often associated with the climacteric:

Morning fatigue, lassitude, and vague pains are the most common.

Nervousness, irritability, depressive phases, crying spells, insomnia, memory lapses, apprehensiveness, and frustration are the cerebral symptoms.

Diminished sexual potency and loss of self-confidence are particularly subject to the reciprocal effect of his situation at home and at work.

And then there may be any one of a mixed bag of circulatory signs: dizzy spells, hot flashes, chills, sweating, headaches, numbness and tingling, cold hands and feet, plus an increased pulse rate and heart palpitations. The last one scares the hell out of a man; he thinks he's having a heart attack.

But the most bothersome symptom, as Jakobovits calls it, is the "decline in psychologic stability."

This is what got to Raymond Hull, a successful author in first-class physical condition who began having spells of night fears and drenching

sweats alternating with chills, along with a few days of feeling stupefied at the typewriter where he ordinarily writes 2,000 words a day. When an attractive woman friend turned up at his home eager to spend the weekend and he had to let her sleep alone, he knew he had lost his sex drive. But most unnerving was the topsy-turvy change of temperament. After several weeks of normally good spirits, being ordinarily a placid man, he would fall into an unfathomable depression. For a few days he would be down on himself, his work, his friends, the whole human race—and a fear-ridden spectator of his own volatile behavior.

"I'm wondering how such mood changes affect other men," Hull noted in the journal he began to keep. "This depression is unpleasant; but there is another emotional effect that is dangerous. On any trivial provocation I may switch from the depressed, apathetic mood, to one of near-insane rage."¹⁸ Within a couple of weeks he would be soaring with unaccustomed exhilaration. And then another spell would come on until he began to think he was going mad.

The oddest part of it all was that the symptoms coincided with what was by far the most successful and satisfying period of his life. In two years he found himself just about back to normal. Ultimately the collaboration between Hull and Dr. Ruebsaat produced *The Male Climacteric*, a 1975 book and apparently the first full-length treatment of this subject.

Undiagnosed, the climacteric can have a pretty dreadful ripple effect. "The spells of bad temper that are a common symptom of the climacteric will obviously cause problems for the man at work and with his friends," says Ruebsaat. "In extreme cases they may lead to quarrels, fights, even murders."¹⁹ He also describes the fallout to be expected from the ambitious man who has achieved some success; he commonly reacts with panicky defenses against nonexistent threats to his prestige and livelihood.

An employer who begins to exhibit the emotional symptoms of the climacteric can become a terror to his staff—unpredictable, unfair, the most-hated man in the firm. He may be rash in his judgement of business affairs, slow to take

- necessary action, or wildly changeable in his decisions, as his moods alternate between the optimistic and pessimistic.

That such havoc can descend on an otherwise well-adjusted man is not a pleasant revelation. Indeed, in my experience, men will often dismiss any mention of the climacteric as a misery-loves-company idea cooked up by menopausal women. There is truth in the assumption that the menopausal sex resents having taken most of the blame for their husbands' middle-aged problems. Eccentric behavior due to a change of life has been traditionally ascribed only to women. The terror and fury felt by dumped "old" wives and anticipated by married women upon approaching the age of abandonment, does seem to find a common voice when the climacteric is mentioned. Thus when the *New York Times* ran an article in 1973

asking "Is There A Male Menopause?" letters flooded in from women whose marriages were already among the midlife body count. Their scars showed big as life:

Unfortunately doctors, psychiatrists, men in general, have kept it all under the rug, where they have swept it themselves. They are in terror of acknowledging a condition which affects their behavior beyond control, but which they readily ascribe to women without mercy. They cannot even talk about it among themselves.²⁰

The "Name Withheld" who authored that letter also wrote that had she read about the symptoms when her husband was going through vivid climacteric changes at 46, she would not have turned in hopelessness to divorce.

What can be done? The quest for potions of sexual rejuvenescence is as old as the Bible. Rich men have been braving an icy trail to Switzerland for years to imbibe monkey glands, which may have boosted their sexual morale but otherwise had no physical effect on their gonads. Even when pure male hormone is given, mind seems to be as important as matter.

The results of Dr. Jakobovits's double-blind study are optimistic. He treated 100 men, most of whom were in their seventies and eighties, for impotence. Half were given oral hormone tablets (methyltestosterone) and half placebos. After a month, a favorable response was seen in 78 percent of the cases treated with active medication. Even among those who had been soothed with sugar pills, 40 percent regained their libido. The urologist concludes that hormone treatment provides an uplift both physical and psychological for a complex problem that may involve both influences. "Once successful sexual ability is again re-established and once the patient is thoroughly convinced of his own virility, then medication is usually no longer needed."²¹

To replace or not to replace hormones is nonetheless a controversial question. The flaw in prescription of testosterone for older men is that cancer cells are thought by some to grow well in its presence. One-quarter of all men over 40 have latent cancer of the prostate, although it generally remains dormant and is discovered only on autopsy. It is therefore imperative that any man about to embark on testosterone therapy have a thorough physical and chemical examination first to rule out the presence of any incipient prostate cancer.

Obviously it would be a bum rap to point the finger at every jumpy middle-aged man and say, "Aha, male menopause!" More often than not the poor guy will be struggling through a garden-variety midlife crisis. So far as we know—and we don't know very much—only 15 percent of men are candidates for a riotous change in hormone levels. Given the new laboratory techniques, we shall soon know more about the mysteries of the male climacteric.

Sex and Menopause

The onset of vaginal lubrication for a woman corresponds to an erection for a man. After 40, as the aging process sets in, vaginal lubrication will diminish to a degree. But it need not impair her pleasure or receptivity. Sexologists offer a very direct piece of advice: Use it or lose it.²² Indeed, it is the woman who continues to exercise an active sexual life, even without hormone replacement, who shows the least evidence of this physical change. However, there is for her as big a "but" as for her mate. If she senses this delay of moistening as a loss of womanhood, it *can* impair her spontaneity.

Menopause creeps up on women. Most women think that as long as they are menstruating regularly, they are not in the menopause. But even though their flow may be normal in the forties, a chemical measurement will usually show wide swings in sex hormones. That can bring on all the symptomatology of the menopause, even though the woman has monthly evidence that she is still fertile and may even become pregnant.

Because we have not been aware that these wide hormonal fluctuations commonly occur throughout the forties in both sexes, even the best-known symptoms can be misunderstood. What is happening when waves of heat spread over the upper body, often followed by chills? The medical term is *vasomotor instability*. The vasomotor nerves are responsible for enlarging or decreasing the diameter of the blood vessels. Ordinarily, these nerves will take their cue from the body temperature; if hard exercise heats us up, more blood is sent to the dilated capillaries at the skin's surface so that excess heat can be ventilated out of the body. The same process holds true in reverse; in severe cold, the capillaries constrict and blood is drawn deep into the trunk of the body where the heat can be better conserved and important organs maintained. But when hormones become unstable, they disturb the signals going to the vasomotor nerves. Dizziness, too, in the middle-aged woman or man, is usually caused by some disturbance of blood flow caused by the agitated vasomotor nerves. The palpitating heart can have the same cause.

As I have said, 90 percent of women today are not overwhelmed by problems of the menopause period, and the actual cessation of menses appears later. The severe depression experienced by roughly 10 percent of women, which was once widespread, has been offset by the increasing opportunities and options available to the middle-aged woman and by a profound change in consciousness. All the experts talk about "the world is opening up" attitude that has replaced the closed-book uselessness women once felt when their children left home.

Many women today emerge with a burst of "postmenopausal zest." Once the worries of pregnancy are thrown out along with the tampons and contraceptives, women in good health will often experience a reawakening

*of sexual desire, as well as great enthusiasm for directing their creativity into new channels.*²³

We often wonder, "Who is that woman? She must be 55, and yet her skin is terrific, and her breasts don't sag. What's her secret?" Chances are, she is the woman with especially vigorous adrenal glands. Estrogen is produced by the adrenals, which are not affected by menopause, as well as by the ovaries. Some women then compensate for the estrogen loss from this other source; they age well, remain strong and energetic, and enjoy much the same vaginal lubrication and elasticity they have had all along. Although this defense against sexual aging is out of a woman's control, the other most important counteractive factor cited by Masters and Johnson is not. And that is regular intercourse, once or twice a week over a period of years.

The same can be said for both men and women. Consistency of sexual relations is the key to continuously vigorous sexual expression.

THE CRISIS OF MIDDLE AGE

In recent years the concept of crisis has occupied an increasingly important position in psychiatric theory as a period in which an individual, subject to stress, reaches a crucial point of tension from which either adaptive integration or maladaptive disorganization must eventuate. The significance of crisis, psychotherapeutically, is that at such period of stress, properly presented interventions can be of maximum efficacy.

Erikson¹ originally introduced the concept of developmental crisis in relationship to his well-known "eight stages of man." There are indeed many developmental crises throughout human existence, beginning with the process of birth itself. Others include: the crucial first year of life,--which lays the ground work for basic security in interpersonal relationships; the accumulation stresses of the second and third year of life,-- of fundamental importance in connection with the development of inner and outer control mechanisms and relationships to authority symbols; the crisis of the Oedipal period,--with all of its fateful implications; the separation crises involved in the first school attendance and the first extended departure from home; adolescence; the first employment and heterosexual experiences; marriage, and parenthood.

The purpose of this communication is to focus upon still another period of life--the middle years--as a particularly important developmental crisis which, apart from our concern with the gross psychopathologies of menopause, has not received sufficient attention as an inevitable aspect of the aging process in our society.

What makes middle age a crisis period? There are four major factor--somatic, cultural, economic, and psychological. (1) As individuals reach the middle years of life, the somatic evidences of the aging process can no longer be ignored. There comes a moment in the life of every man and woman when the decreased elasticity of the skin, the accumulating wrinkles, and the coarsening of the features force themselves into awareness in a way that can no longer be denied by the psychologically healthy person. There is the inevitable fateful day when reading glasses are prescribed for the first time, or when a man, catching sight of the back of his head in a three-way mirror, realizes that the balding person at whom he is looking is no other than himself. For the woman there is the sagging of breasts once proudly firm, the beginning of irregularity of menstruation, and then the finality of its cessation. For both men and women there is the slackening of muscular activity and the tendency toward increase in weight, with the never-ending subsequent struggle between oral craving and oral frustration. I am purposely omitting discussion of actual somatic pathologies. My point is that quite apart from any specific pathological syndromes, the normal somatic changes that accompany the middle years constitute a series of critical emotional stresses for all people, the significance and impact of which, however, vary in different individuals for reasons that I shall presently discuss.

The unemployment rate is also higher for women in both groups².

Changes in the level of poverty over the past few years have left working women who are heads of families worse off than ever. While the total number of children in poverty decreased by one-fourth over a period of seven years, the number of poor children in families with a woman head increased by ten percent. In families where the heads is under age 55, a woman's family is nearly six times as likely to be poor as a man's.

The problem is not so much one of women needing more jobs. Women need better jobs. According to the Department of Labor, one-fifth of the sixty-five million women aged sixteen and over live in poverty. Ten percent of the nation's families are headed only by a woman, but forty percent of the families classified as poor have women heads. Most women, married or not, work out of economic necessity; over one-third of the women of marriageable age are not married.

². Jo Freeman, "The 51 Percent Minority Group: A Statistical Essay," in Robin Morgan, ed., *Sisterhood is Powerful* (New York: Random House, 1970), pp. 37-46; Margaret Mead and Frances Kaplan, eds., *American Women* (New York: Charles Scribner's Sons, 1965), pp. 45-53.

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(2) The second important area of stress is the cultural one. This is especially relevant in the United States where youth and physical vigor are particularly valued. One might speculate that the high valuation of these patterns in American culture may be a carry-over of our frontier history where such physical attributes were indeed essential for survival. Regardless of its source, however, it is worth noting that this is a peculiarly potent aspect of American cultural life which does not exist to the same degree for older European and Asian cultures, where middle aged people are still considered attractive and desirable and where the elderly receive considerably more respect and appreciation. Consequently, in the context of American culture, the beginning loss of youth and vigor is a relatively severer narcissistic injury.

Still another relevant factor in American cultural life is the great value placed upon individual success, whether it be in terms of prestige, wealth, or power. The failure to have achieved such success by the time middle age has arrived also, as we shall see, constitutes a significant stress in our milieu.

(3) The middle years of life also carry with them many increased economic stresses. There still exists a prejudice against hiring older people, particularly in the white-- and blue collar areas; indeed, the increasing advent of automation may increase this discrimination rather than decrease it. Moreover, children in a complex technology require more extended support due to their prolonged training needs. In addition, the middle-aged person often is faced with the heavy economic burden of supporting aging and ailing relatives. It is possible that this latter burden now will be somewhat eased with the advent of Medicare, but the steady increase of their own medical costs may well continue to represent a serious economic threat to many people in the middle years of life. The insidious diminution in purchasing power which the steady progress of inflation has brought with it in recent decades constitutes an additional source of strain to most people in this age group.

(4) Most important, however, for the middle years, are the psychological stresses, not only in response to the above mentioned somatic and environmental pressures, but also to specific emotional factors. Separation loss is a key and recurring psychological stress during this period: The loss of one's youthful self-image, the increased frequency of illness and death among relatives and friends, the loss of children who leave home, and the loss of love in the "tired" marriage where intimacy has been replaced by mutual toleration, and sex takes place without passion or tenderness.

Most significantly stressful, however, are two additional factors which are usually unconscious, and which affect all middle-aged people. The first of these--already touched upon--involves the loss of the fantasy hopes of youth;-- the hopes of fame, of accomplishment, of wealth, and of romance. One of the fundamental adjustments that most people have to make in the middle years, if these fantasies have not been achieved, is the facing of the hard

fact that their fulfillment has become improbable. This involves a profound problem in self-acceptance and in the willingness and ability to make compromises with inexorable realities.

The second factor, and perhaps even a more challenging one, is the fact that the somatic changes of middle age carry with them an inescapable confrontation with the fact of mortality. The defenses which have worked so well in youth--the illusion of immortality and the denial of one's own ultimate death--can no longer be maintained. The result is a marked increase in what has come to be known as "existential anxiety",² the anxiety that is derived from fully facing both the limits of existence and our ultimate non-existence.

An interesting fact, however, is that these stresses operate differentially in men and women. In the middle years of life women manifest psychiatric disorders three to four times as frequently as men do. Why is this so? It is certainly not due to a greater physiological vulnerability to the aging process. If anything, modern American women maintain their youthful appearance at least as well as men do; indeed, the artifices of the cosmetic industry help them to maintain the illusion of youth far better than men. The evidence strongly suggests, rather, that the reasons for this difference in morbidity are cultural and psychological. First, there is much greater emphasis in our culture on the importance of beauty and youth in women as compared to men. Second, the cessation of menses is an obvious narcissistic injury as compared to the more insidious, less visible diminution of virility in aging men. Third, the woman's loss of reproductive capacity at menopause is in direct contrast to the preservation of this capacity in men. Finally, the majority of women in our society still form their identities as mothers and wives, within the family, rather than as persons in the outside world. In middle age, however, the functional role of a woman as a mother and a wife assumes less importance, with children becoming less dependent and the husband less attentive. Consequently many middle-aged women are apt to feel as though they are being discarded and retired to a cultural ash-heap, while their husbands are still able to feel relatively needed and involved in the outside world. (Ironically this functional difference is reversed in the sixties and the seventies when the woman is apt to find herself much more useful and needed, in the grandmother role, than is the man of comparable age!)

Despite these cultural variables, the manner in which these normal stresses of middle life are dealt with in any individual man or woman depends upon factors which are highly personal and idiosyncratic. These factors, for both men and women are:

1. The basic ego-integrative capacity of the individual--the capacity for flexible adaptation in contrast to emotional rigidity;

2. The nature of interpersonal relationships--the character of the marriage and of the relationship to children, other relatives, and friends;
3. The sense of continuing usefulness, which depends on the extent of the individual's functional relationships, and the degree of self-fulfillment that they afford; and
4. The breadth of interests in the outside world.

Generally speaking, the weaker the ego-adaptive capacity, the more limited the base of interpersonal relationships, the narrower the foundation of the sense of usefulness and of the interest in the outside world,--the more critical will be the impact of the middle year stresses.

In general, four major patterns of response to the stresses of middle life can be distinguished,* each, of course, subject to considerable idiosyncratic variations and blendings. They are not mutually exclusive. (1) Denial by escape. Here we see people trying to avoid facing their inner anxieties by patterns of compulsive activity. This is why so many middle aged couples fear being alone with themselves or one another, and are constantly escaping into the wasteland of TV, or to movies, card games, and parties. The formula that dominates their lives is "What are we doing tonight?" Another common defense is that of (2) Denial by over-compensation with efforts to recapture the lost feelings of youth. Not for nothing are these years sometimes characterized as "the dangerous forties!" The woman utilizing this defense is apt to embark on a desperate search for the romance and the love that has gone out of her marriage;

*It should be emphasized that these reactions are typical of contemporary American life, and are not universal for all times and all cultures. Obviously, patterns of adaptation and maladaptation are strongly affected by the mores, the outlest, and the technology of the sociocultural milieu-- viz. McLuhan's challenging concepts in "Understanding Media."³ while the man seeks to refurbish his tarnishing narcissistic self-image by pursuing a chain of sexual conquests. As might be expected, this is a crisis period for marriages, and the incidence of divorce reaches a high peak.

If these commonly used defenses fail to work, then we may see various forms of (3) decompensation, with anxiety states, depressive reactions, apathetic surrender, or feelings of rage.* These patterns of decompensation make up what are commonly recognized as the psychological "disorders of the menopause".

On the other hand, if the individual is able to meet the critical developmental stresses of the middle years and deal with them successfully, then the outcome is a state of higher (4) integration than he or she has previously achieved--an integration that means

an added dimension of emotional maturity; a heightened awareness of self and of others; a lessening of narcissistic self-involvement and an increase in the capacity to cathect service to others; a greater ability to find pleasure in the achievement of our children, our students, and our youth in general; a renewed capacity for productivity and creativity; and, finally, a deeper appreciation of the complexity and the rich bitter-sweetness that characterizes our temporary sojourn on this planet of laughter and tears.

"For age is opportunity no less
Than youth itself, though in another dress."
(Longfellow)

*Viz: Dyland Thomas' anguished cry: "Rage, rage against the dying of the light!"

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Menopause

MENOPAUSE is defined as the period of cessation of menstruation, occurring naturally between the ages of forty-five and fifty. Menopause involves the gradual decline of the working of our ovaries. Our ovaries can begin to produce less estrogen starting even in our late twenties. But most of us do not actually begin to notice *signs* of menopause until our late thirties or early forties. In other words, menopause is a long process which ends with the complete cessation of menstruation and of our ability to conceive and bear children. Our bodies have to adjust to these changes in ovarian and hormonal function. The length of time and the quality of this adjustment will vary from woman to woman. Removal of both ovaries (as in a total hysterectomy) before the age of natural menopause will bring on menopause symptoms.

A few older friends sat down and told some of us recently what their experiences of menopause had been like:

* * *

I have found life after 55 and the menopause very similar to life before 55 and the menopause.

* * *

Just beautiful not to have to worry about the damn periods. And no more birth control!

* * *

I was tired in the afternoons for a couple of years and worried that I was going into a decline, but being luckily a vigorous person, I kept going with my work. Then one day I realized it must have been the menopause.

* * *

I don't really think of telling my kids I'm in the menopause because that would be overplaying its importance.

* * *

When I was about age fifty-six I began to menstruate less often and felt mildly nervous at times. The woman gynecologist to whom I had been going yearly for Pap smears probed at some length into any possible dangers and then recommended a daily amount of Premarin, and when this brought back the periods, suggested halving the daily pill. This was six years ago and I have had no menopausal symptoms since.

* * *

Although we know that not every woman has the easy time with menopause that these particular women did, it was a relief for us to hear such positive things about menopause, because so much that we have heard and absorbed about "the change of life" has been negative and scary. The popular image of the typical menopausal woman is negative—she is exhausted, haggard, irritable, bitchy, unsexy, impossible to live with, driving her husband to seek other women's company, irrationally depressed, unwillingly suffering a "change" that marks the end of her active (re)productive life. Our idea of menopause has been shaped by ads like the one in a current medical magazine that pictures a harassed middle-aged man standing by a drab and tired-looking woman. The drug advertised is "For the menopausal symptoms that bother him most." Menopause is presented as an affliction to us that makes us an affliction to our friends and families.

In our youth-oriented culture, menopause for many people marks a descent into un-cool middle and old age. In a society that equates our sexuality with our ability to have children, menopause is wrongly thought to mean the end of our sexuality, of our responsiveness to men, of pleasure in bed. In a society that considers babies to be our major contribution, menopause, often coinciding with our children's leaving home, marks the end of our only important job, the end of our reason for existing. Menopause is called "the change" and all the implications are that life goes downhill from there. ("The words 'change of life' must have had a catastrophically destructive effect on countless women," writes one friend. "I'm not willing to suspect it's such a change.")

These views are being changed by women like those who spoke above—who value themselves as more than baby machines, who move into middle age as a welcome time in which they can pursue other kinds of work, who make careful use of the drugs available to minimize menopausal discomforts, who learn about ways that good diet, rest and exercise can help to prevent problems with menopause. Not everyone finds menopause physically easy, but we are learning that if we feel good about our-

selves and what we are doing at that time in our lives, we will tend not to be so depressed and bothered during menopause. And if we know what menopause is and what to expect, we will be less mystified and alarmed by our body changes. And for many of us, the freedom to talk openly with our family or friends about what we are experiencing promises to make menopause a less trying, tense and difficult time. It also seems important that our awareness of how men feel about themselves during their forties and fifties will help to prevent possible difficulties in our relationships with the men in our lives. (As they reevaluate their own lives during middle age, many men are faced with the fact that they will not "advance" further in their careers or that their lives will not be as they had hoped, and many fear a loss of virility and the approach of old age.)

Because almost all of us at some point during menopause will go to a doctor about physical symptoms, it will be really important to us to insist on good medical care and advice. Many women up until now have been adversely affected by their doctors' own ignorance and carelessness. One woman told us that she went from doctor to doctor asking why she was so tired all the time—not one of them suggested she was going through menopause. Another woman, feeling tired, went to her doctor and complained that she couldn't do as much as she was accustomed to doing. Her doctor said, "Well, after all, you *are* getting old." Used to bowing to his authority, she accepted his verdict and resigned herself to her loss of energy. Pitifully little research has been done into symptoms and cures for symptoms of a physical experience more universally shared by women even than childbirth.

WHAT IS MENOPAUSE?

In order to understand how menstruation eventually ceases, it is helpful to know what causes it. (See the section on menstruation in the "Anatomy" chapter, and the Appendix to that chapter, for a full description of the hormonal process involved.) The following is a simplified explanation of how the normal hormonal process of menstruation changes as menopause occurs.

As we get older, our ovaries become less and less able to respond to the ovary-stimulating hormones from our pituitary, which formerly caused the regular maturing and releasing of ova. Since progressively fewer ova are being released, the cyclic production of progesterone is interrupted, and this in turn causes estrogen levels to fall below the amount necessary to start endometrial bleeding (menstruation). The pituitary, without the usual cyclic feedback of estrogen and progesterone, generally overreacts, producing excessive amounts of those hormones that stimulate the ovaries. The result is a

hormone imbalance, occurring to different degrees in different women. The most important feature of this hormone imbalance is a decrease in the amount of estrogen to which a woman's system has been accustomed.

This estrogen decrease is thought to be the major factor in many of the problems we might experience during menopause. However, the interrelation of all the hormones, and their relation to our physical and mental health, are extremely complex, and to say that all symptoms of menopause are caused by a lack of sufficient estrogen would be inaccurate. Some doctors have gone so far as to declare menopause "an estrogen-deficiency disease," which they claim can be "cured." Most others are more conservative but agree that many of the symptoms can be alleviated in some women by readjusting the body's estrogen level.

If your estrogen level is low, your whole endocrine system is affected. Depending on your individual hormonal and glandular make-up you might have symptoms that may be alleviated by estrogen-replacement therapy. However, if for any reason your doctor feels it would be better to keep your estrogen level low (for example, to permit the shrinkage of any possible tumors stimulated by estrogen), you may feel that taking estrogen is a bad idea. In any event, there is some estrogen secreted by some other glands—the adrenals, for example—and a woman's body may produce enough estrogen from sources other than the ovaries so that she will not experience low-estrogen symptoms, even though her estrogen production is lower than her original level.

An average natural menopause occurs around age forty-seven, although natural menopause may start as early as thirty-five or as late as sixty. The following factors can cause early onset of menopause: removal of ovaries, or infection destroying them or interfering with their blood supply; excessive exposure to radiation; very poor health; prolonged nursing of a baby; disorders of the endocrine glands; hypothyroidism, with serious obesity; having babies too close together; frequent abortions or miscarriages; very cold climates; hard manual labor or excessive output of energy. The claim that the earlier menstruation starts the later it will stop is apparently not substantiated by fact. Women who have late menopause are generally very healthy, although perfectly healthy women can experience menopause any time between thirty-five and sixty.

Ovarian function starts to taper off at age twenty-seven or thirty, but you probably won't notice anything happening until you are in your forties, at which time menstrual bleeding may become shorter and then longer; then this stage may be followed by irregular skipping or lengthening of periods. In a few cases menstruation occurs regularly until one month when it just stops forever. Most women, however, will taper off in both amount and duration of flow, and will experience irregular and

progressively more widely spaced periods for a time of two to three years. Some excessive bleeding is quite common during this time and need not be a cause for worry. However, if you have extremely profuse or prolonged bleeding, or if you bleed between the dates when you think your periods should be coming, you should see a doctor, because you may have a benign or malignant growth. Your breasts may increase in size or become tender, and at this time cystic mastitis (nonmalignant breast growths) or similar conditions may develop or become more serious. It is a good idea to keep a record of exactly what happens after you first notice irregularity in your menses; the information can be useful in determining treatment, if you should need it.

The removal of ovaries by themselves or in combination with other parts of the reproductive system, as in a hysterectomy, will cause early menopause. When ovaries are removed, your body must adjust to a lower level of estrogen, and this brings on all the low-estrogen symptoms associated with menopause. If you have any choice in the matter, hang onto your ovaries as long as you can—don't let anyone remove them as part and parcel of a hysterectomy unless s/he has proved to you that it is absolutely necessary for your health. One ovary is better than none. Ovaries continue to secrete small amounts of estrogen after menopause, and this is useful for strong bones and other parts of your body, as we will discuss later.

I had one ovary and tube removed about three years ago when I was twenty-eight. Since then I have had hot flashes and backaches, and I wondered if I was going through menopause. But my period still comes regularly, and the hot flashes don't come so often now.

Sometimes a complete removal of the uterus, tubes, and ovaries, often called a complete hysterectomy, is unavoidable.

One of my friends recently had a complete hysterectomy, and after a week began to have the hot flashes associated with the drop in estrogen. Her doctor prescribed Premarin, a form of estrogen, and she is now functioning well, working, feeling better than before.

WHAT ARE THE SYMPTOMS?

The symptoms that occur because of the new balance of hormones are chiefly the result of your body's reaction to a drop in estrogen after it has been used to lots of it. Some symptoms usually associated with menopause may occur very early.

The most commonly reported symptom is the hot flush, or the hot flash, with sweating. This is called a vasomotor disturbance, and although the hormonal proc-

ess causing it is not totally understood, hot flushes are often relieved by estrogen therapy. A typical hot flush is usually a sudden wave of heat from the waist up; you may get red and perspire a lot; then when the flush goes away, you feel very cold and chilled and sometimes shiver. It lasts from a few seconds to a half hour and may occur several or many times a day. When hot flushes occur at night, they can cause insomnia, and sometimes perspiration may be heavy enough to require a change of bedclothes.

Suddenly, without warning my temperature seemed to skyrocket about a hundred degrees. It wasn't the sensation of standing in front of an open oven, as some have described it, but the breathless feeling of having stayed too long in a hot shower or a steam bath. I was hot, I was wet, and I was breathless. Charging across the room I slammed up the window and began to gulp down the cool, comforting fresh air.

The book said "hot flashes" were named by woman. Right on. They had to be, the name is so accurate. How to describe them—like a wash of wet heat; unexpected, unwanted and uncontrollable.

Lack of estrogen allows the usually acidic vaginal secretions to become less acidic, thus increasing the likelihood of vaginal infection. Some women have a heavy discharge as a result. Without as much estrogen, the skin and mucous membranes atrophy somewhat, particularly those of the genitourinary tissues. The vagina starts to become narrow, shorter, and less elastic, and the surface of the vagina is easily eroded and may bleed and become ulcerated. This condition can make intercourse painful and may be responsible for so-called emotional problems such as "frigidity" or irritability during and after menopause. Lack of skin and muscle tone often leads to frequency of urination, pain on voiding, and incontinence. After menopause there is often a loss of fat and shrinkage of tissues; breasts usually shrink and droop.

Estrogen, besides being necessary for your general skin tone, is apparently needed for bone tone. Osteoporosis (porous and brittle bones) is related to the long-term metabolic effects of declining estrogen, and estrogen therapy has been shown to arrest mineral loss from osteoporotic bones. Low backache in menopausal women may be the beginning of osteoporosis; as postmenopause advances, women often lose height and develop "dowager's hump" as their spines compress.

The lower estrogen level of postmenopause is now thought also to be related to an increase in coronary heart disease (atherosclerosis) and cancers in postmenopausal women. Some doctors feel that after their estrogen level drops, women become as vulnerable as men to heart disease and more vulnerable to cancer.

A whole range of other physical complaints—common

ones are insomnia, headache, fast-beating heart and palpitations, vertigo, vague abdominal pains, constipation or diarrhea, nausea and vomiting, gas, tiredness, loss of appetite or weight gain, and back or other muscle aches—are not always so clearly related to the lower estrogen level. We feel that these very common symptoms, so often dismissed by doctors as psychosomatic, deserve thorough medical research to find causes and cures. If every male doctor went through menopause, no doubt this research would already be well on its way.

Emotional symptoms of menopause include irritability, nervousness, depression, frigidity, lack of memory, difficulty in concentrating, and temporary distortions in close personal relationships. These emotional symptoms can be caused or aggravated by a feeling of ill health due to some of the physical symptoms of menopause. We feel that they can often be minimized when a woman feels generally happy about herself and involved in what she is doing.

WHAT YOU CAN DO ABOUT IT

Since so many of the physical discomforts of menopause are caused by insufficient estrogen, estrogen-replacement hormone therapy is a solution that many women can turn to, being careful to consult a knowledgeable doctor about its possible side effects and dangers. Before talking about hormone therapy, however, we want to emphasize that there are other important ways of dealing with and preventing some of menopause's discomforts. Good diet, exercise, enough rest, where these are possible, can give our bodies enough physical vigor and good health to minimize menopause's physical effects, just as work that is meaningful to us either in or outside our home can help tremendously to minimize the emotional effects often associated with menopause.

If you are having uncomfortable physical symptoms you might want to discuss estrogen therapy with your doctor. Estrogen may relieve low-estrogen symptoms like hot flushes, sweating, cold hands and feet, osteoporosis, and discharges from the vagina. Sometimes relieving low-estrogen symptoms brings general relief from irritability or depression. Estrogen is commonly given in the natural form, Premarin, or in synthetic forms, Stilbestrol, Progyon, and Meprane. Stilbestrol, however, has been mentioned as a carcinogen (cancer-causing agent) in some research. A natural form is usually well tolerated; side effects from the synthetics include nausea, allergies and pain in the breasts, but they are more powerful and cheaper and you and your doctor may feel they're worth trying. The Maturation Index test is done to determine how much estrogen you should take; it simply involves examining a sample of your vaginal secretions or cells. Estrogen is not generally prescribed for women with

severe kidney or liver disease, some heart problems, or a history of breast or uterine cancer. *(It is important to take estrogen or any prescription drug only under the guidance of a doctor.)*

• • •

Aunt Sarah has not had any estrogen prescribed because she has fibroid tumors in her uterus that should shrink when the estrogen level goes down. She still is having some very heavy menstrual flows, but it usually is on the alternate months. She gets what she calls "fluid headaches," which seem to be period-related—not every month, they vary somewhat. Her doctor was not at all concerned about the tumors, and did not recommend surgery at all.

• • •

The majority of those receiving estrogen at menopause are being given it in cycles: they take a pill daily for three weeks, then stop for a week. This is very similar to many birth-control pill regimes, and similar to the timing of the estrogen a woman's own body produced.

• • •

Here I am, one of the lucky females, taking Premarin since August, a little yellow pill every day for three weeks, then none for a week. I guess this is the answer for me. The gynecologist did not routinely prescribe it until I complained about the depression, the spilling over with tears at very slight provocation, and then I realized that intercourse was really painful. This must have justified his decision, along with the Maturation Index from the Pap smear, to prescribe the hormone.

• • •

Bleeding is a common effect of estrogen, especially on the week you don't take it. For this reason some regimes include progesterone, which brings the total hormone situation closer to the premenopause state in that it promotes a predictable endometrial bleeding—an induced period in effect. You have a menstrual-type flow and feel very much as though you had a regular period but the flow is not as heavy nor for as many days. This "medical curettage" avoids protracted bleeding, which can occur when estrogen only is taken. Relief of menopause symptoms, however, can usually be obtained with estrogen doses small enough so that no bleeding occurs. Mid-cycle bleeding on an estrogen-induced cycle should be checked immediately by a doctor. In fact, any bleeding at all that occurs in a postmenopausal woman, whether or not she is taking estrogen, should be carefully investigated by a doctor; it may be a first sign of endometrial or cervical cancer. In about one-third of the cases reaching surgery the bleeding proves to be of malignant origin.

Possible side effects from too much estrogen are gastrointestinal disturbances, fluid retention and weight gain, breast and pelvic pains due to swollen tissues, headache, high blood pressure, vaginal discharge, and skin pigmentation. As with birth-control pills—most of which also contain estrogen—sensitivities vary enormously. It looks

as though you're damned if you do, damned if you don't take estrogen—the trick is to find the right amount, if any, for you, to get regular check-ups twice a year if you are taking estrogen, and to find a doctor who is aware of both the positive uses and the potential risks of estrogen, who will be very careful about what s/he prescribes.

What can you do about weight gain? Eat less, especially refined carbohydrates, and exercise more. Estrogen relief of some of your other physical symptoms may improve your general feeling of health enough so that this will be easier for you. If the extra weight bothers you, it is probably worth losing; thinner people live longer, according to insurance statistics—and they've got money on it. Excessive weight can also make activity difficult. A good diet and sensible exercise have done a lot to help many women feel better through menopause. (See the chapters on diet and exercise, "Nutrition" and "Women in Motion.") Not nearly enough research has been done on diet and menopause. One woman wrote to us:

* * *

Perhaps I have been fortunate in the matter of diet, which may eventually be found to be important. I had been drinking a concoction of brewer's yeast and wheat germ known as "tiger's milk" for about five years before the onset of menopause. I am sorry that I was not also taking three grams of Vitamin C daily and some Vitamin E at that time, for I might have been spared the recurring bouts of cystitis. The cystitis has disappeared since I have taken Vitamin C, but this may of course be unrelated.

* * *

Another woman, a vegetarian who practices yoga, writes:

* * *

*To you younger sisters, vegetables and headstands may not seem to be the pot of gold at the end of the rainbow, but if you haven't tried it, don't knock it!**

DEPRESSION AND MENOPAUSE†

About one in ten women experience severe depression during menopause. Though physical changes do play a part in these depressions, Pauline Bart feels that we often become depressed simply because we are middle-aged. We have no clear or important role to play in our society.‡ Very little if anything is expected of us. We have no status. But at the same time, our life span has lengthened, we have twenty or thirty good years ahead of us. If we have had children, we end our childbearing years

sooner than we did in the past, and we are left with a lot of time on our hands and space in our lives. For there are no clear societal norms which give us a useful place in our children's lives. Often we are in their way after they leave home. If we have overprotected them or expected them to live out and fulfil our own lives for us, we are both angered by their leave-taking and saddened by our loss. Often, not understanding that we feel anger, unable to direct it toward our children or unable to express it in any way, we turn it inward onto ourselves and become severely and heavily depressed.

We are faced with other real losses. Some of us feel deeply saddened by the end of our ability to bear children. We are losing our youth. And if in general we feel unfulfilled personally, we may be bitter about not having achieved happiness yet.

If we are already working during menopause and middle age, we are less likely to suffer certain forms of depression, though heavy work can take its physical toll on us.

There are many legitimate reasons for our depression. We have to recognize that its causes are not so much personal as social; that is, our society does not recognize us as necessary or valuable members. More research needs to be done on both the physical and social causes of our depression. And we must try to provide discussion and work groups for ourselves and others to understand better our own feelings and capabilities, to share them, and to move out of depression into new and worthwhile lives.

The following is an excerpt from a letter by a woman in her fifties, previously depressed and now taking estrogen and feeling much better.

* * *

Menopause itself is no longer a period to fear and wonder about. It is simply a time when menstruation stops and you can no longer become pregnant. As far as I could tell, from interviewing all the women around, this was a redeeming feature for all but one person, who had had a hysterectomy at thirty-three. Of course, it coincides with the aging process, and as much as we look forward



* Irene Davall, National Coordinator of the Feminist Party.

†For some of the ideas in this section we are especially grateful to Marliese Wior, who let us use her unpublished paper, "The Menopausal Woman" (see "Further Readings").

‡Bart, Pauline Bernice, Ph.D., *UCLA Dissertations: Depression in Middle-aged Woman: Some Sociocultural Factors*. December 1967.

to growing older, it is quite an adjustment to accept yourself with the wrinkles, the sagging, and the aches and pains that may follow. In my case, however, I really feel better. My back doesn't hurt any more, I have more energy than before, I no longer have the premenstrual tension to as great a degree. I still am getting headaches periodically that feel as if my skull is too small for the amount of pressure inside.

I have come to terms with me, though, and that's the most important adjustment. I like what I'm doing. I feel worthwhile; my marriage is better than during the period when my children were all at home. I am looking forward to perfecting some more skills, reading so many books I've never had time for, and sharing thoughts and feelings with more people.

I was always very shy in my younger days, and somehow was afraid to expose myself. It was very hard to trust a relationship. Now, after all these years, I realize that I'm just another human being, a woman with many of the same feelings that my friends have. Building a wall around me was keeping me isolated and terribly lonely. There is a solution to every problem if you stay with it and prepare to make any changes in the present that will improve the situation in the future.

* * *

It makes sense for each of us to try to prevent emotional problems at menopause by doing what we can to keep not only our bodies but our minds healthy. Our psychological state, how we cope with stress and maintain our security, is going to affect how we feel physically all the rest of our lives. Remember, the stress of menopause can often magnify already existing mental problems.

We must make sure that society does not make our later lives miserable by denying us rewarding roles in addition to motherhood. For many of us, dilettante interests are not enough to prevent the feeling of worthlessness that many older women experience. Many of us need to be employed and to be paid fairly by society for work that it values. We must at no time in our lives allow parents, guidance counselors, husbands or anyone else to talk us out of starting or continuing to pursue our interests and careers. It is our present and future mental health that is at stake, not theirs! (See the "Childbearing" chapter for some discussion of the problems of combining motherhood with outside work so that we don't reach 45 with one job all over with and no other work begun.)

PREGNANCY AND MENOPAUSE

It is a very rare thing to become pregnant after menstruation has stopped for a year. Some doctors think that the odds are good enough so that you can do without birth control six months after your menses stop. In an extremely small number of cases eggs have been released

without any sign of bleeding, and they have been fertilized and been born as healthy children of sixty- or seventy-year-old mothers whose menstruation had stopped decades ago. But more often menstruation can occur around menopause, with no egg being shed—it is called an anovulatory cycle.

For all practical purposes you can assume you are infertile a year after your last period. To be extra safe, some doctors recommend two years. If you are that extremely rare bird who has a fertilized egg after menopause, you should certainly consider an abortion if you don't want a child at that time, because the odds of producing a deformed child or mongoloid child are high. If you become pregnant after the age of forty, the incidence of mongolism is one in seven. However, if you want to have the child, there is a test that can determine whether the child is a mongoloid. The test involves taking some amniotic fluid from the womb by needle (amniocentesis), and you should discuss it with your doctor. For women who have not had earlier pregnancies, a late first pregnancy is likely to be a difficult birth.

SEX AND MENOPAUSE

Many of us have feared that menopause would bring an end to our sex lives. But Masters and Johnson tell us, "There is no time limit drawn by the advancing years to female sexuality."* And an older friend says, "I was curious to see if my sexual life would be the same after menopause and am delighted to find that it is." Many women report that they enjoy sex even more after menopause because they no longer have to worry about getting pregnant.

There can be problems with sex for us as we grow older:

Our sex organs gradually atrophy (deteriorate) with the lowering of estrogen, and vaginal lubrication can become scarce, so intercourse can become painful in menopause or post menopause. A lubricant like saliva or K-Y Jelly may help, and estrogen therapy might correct it.

Other non-sexually related symptoms of menopause—tiredness, emotional irritability, nervousness, hot flashes, headaches, and so on—can do a lot to lessen our sexual drive and pleasure. Once we are past these symptoms, through time or hormone therapy, our sexual life can be as good as ever.

Sometimes in going through menopause we may feel that we have "lost our womanhood." It is true that we can no longer offer our partner the chance to produce a child, but the odds are good that our partner wouldn't want one anyway.

Many of us as we get older get fewer chances for heterosexual sex. Middle-aged men often go through a change of life in which they are impotent for anywhere

*William H. Masters, M.D., and Virginia E. Johnson, *Human Sexual Response* (Boston: Little, Brown & Co., 1966), pp. 223-38.

from two months to a couple of years. Divorce, death, and a cultural norm which pushes men to seek younger sex partners, leave many middle-aged women without partners, and in the past it seems that many of them resigned themselves to a life without sex. But an increasing number of women are breaking the silly convention that women should pair up only with men older than they are. We are enjoying male company without insisting on marriage, so that the male-female numbers ratio is not so important. And there are many good kinds of sexual expression that don't involve men: we can enjoy fantasies, masturbation or sex with women.

Here is one woman's experience with sex in middle age:

• • •

Sex was great—probably—until I had a hysterectomy for fibroid tumors five years ago. After the surgery I was sore and rather dead for a long time. Foreplay was less good because there was a broken link—no visceral response when he played with my breasts, and this had been very nice to feel before.

Sex became less joyful. Coincidentally, my husband became ill and was prescribed a tranquilizer which overdosed him to near impotence. My frustration was total, and for the first time in my life, at forty, I masturbated to orgasm. Out loud, in wonder, I said, "So that's what it is!"

I spent about three and a half years trying to reconcile the two very different experiences, very different pleasures, of intense masturbatory orgasm and intense shared love-making with little increments of sensation which make me rest and relax before returning for more sharing. By now I just figure I have two great goods for my pleasure. My husband doesn't thrive on thinking about the vibrator, and I don't have as good an orgasm with it if he's there, so it's a private pleasure. I recommend it to everyone (not person-to-person or door-to-door, but here, anonymously).

• • •

The writer Simone de Beauvoir talks about sex and older people. She points out that for some the joy of sex lies in their own physical beauty, and as this fades from youthful prime, they derive less and less joy from sex. They may even be unwilling to participate at all. However, she says, those for whom sex is a joyous, friendly act will frequently continue to enjoy it into the seventies and later.

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Stopes, Marie, M.D. *Change of Life in Men and Women.* New York: G. P. Putnam's Sons, 1936.

A sensible book though out of date in some areas.

Wilson, Robert A., M.D. *Feminine Forever.* New York: M. Evans & Co., Inc., 1966.

This is a medically radical view of menopause: "menopause is curable," "menopause is completely preventable," and "Every woman alive today has the option of remaining feminine forever." Later in the book the author tells you what "feminine" is: "I believe that such matters as dress, grooming, manners and style of language are as much related to a woman's femininity as her physical attributes. . . . I am often disturbed at the crassness and blatancy with which women themselves proclaim their sexual liberation. Feminine fashion, for instance, appears to have abandoned the ancient wisdom that concealment is the secret of allure." In spite of all this the man has done a lot of research on estrogen, and his medical opinions are interesting.

Wior, Marliese. "The Menopausal Woman." Unpublished paper written for a biology course at the University of Southern California at Los Angeles, 1971.

This extensive and careful study of menopause from the perspectives of biology, developmental psychology, social psychology, and social work is an excellent example of the kind of research and analysis that needs to be done in the area of women and menopause.

EMOTIONAL FACTORS IN THE AGED

What is an emotion? An emotion is a subjective feeling, such as fear, anger, grief, joy or love. Who are the aged? Like all things, age is relative. Since senile changes do not occur with great frequency before sixty-five, this paper will consider those over sixty-five as the aged. The topic, then, becomes one of, how people over sixty-five think and feel. The aged can be separated into the emotionally well-adjusted and the emotionally maladjusted. The well-adjusted constitute the majority of the aged, but it is also true that the incidence of mental illness is highest among the aged in this country.

How does the well-adjusted older person feel subjectively? His emotional needs do not differ greatly from those of younger persons. He desires friendships, both casual and intimate, with both sexes. He needs love, overt expressions of affection and the feeling of being useful and wanted. He needs all of this if he is to remain well-adjusted. Health workers reap nothing but more work and trouble when they do not create experiences which help to fill these common human needs. In fact, one undoes the good that is afoot when old people are made to feel guilty, anxious or ashamed for having "love affairs." They should be encouraged. Persons who work with the aged should help cupid actively as they do in matching young people. Never underestimate the power of libido, even in the so-called oldsters.

The well-adjusted aged person also has the emotional need to keep busy at something, work or play, from which he gets a feeling of accomplishment. One tends to let older persons sit and rest and rock. Man needs to love and to work. Freud wrote of this in his now rather classic phrase, lieben and arbeiten--to love and to work. He called these the tasks of maturity. Maturity occurs well before sixty-five of course, but the need to love and to work is always present. Senescence, or growing old, impairs the capacity to do certain kinds of work but the need to do something is always present.

Another very important emotional need is to maintain self-esteem. To maintain it is the task because self-esteem derives from "making a mark on the world" and that has already been done by the age of sixty-five. In order to maintain self-esteem, the older person will crave appreciation, affection and reassurance. He will also reflect on the days when he was making his mark on the world. This is seen in the stories one hears over and over again about the good old days. One really should listen to the stories. It helps to serve the very important purpose of maintaining self-esteem.

The well-adjusted aged really have the same emotional factors playing upon their lives that play upon all lives. In general, they need to feel good about themselves; they need to

feel good about other people, and they need to be able to meet some of the everyday tasks of living. Some very basic ways of helping older people to feel good about themselves have been mentioned. In addition, anything that helps you to feel better about yourself is a clue to what will probably help the older person to feel better about himself. Street clothes instead of shapeless, colorless night clothes and shoes instead of slippers are examples of specific things that will probably help. Hair that has been cut and set usually feels better than long, straggly hair; and rid yourself of stereotypes such as braids and knots look sweet on little old ladies. A day of Toni permanents can do more than a month of good morning care, meals and medication.

2 It is true that when one feels good about himself he will more than likely feel good about other people.³ In regard to the everyday tasks of living, all people, including the aged, must perform some of them in his own life. This constitutes the latter half of Freud's tasks of maturity--to love and to work. Can you picture a lady in a nursing home ward sitting up beside her bed with a dishpan of raw potatoes in front of her slowly peeling away? It may sound strange. Are you thinking, "more work than it's worth"? The question is, more work than it is worth for whom--the health worker or the old lady? It is more work than it is worth for the nurses or dietary workers, but who are the homes and wards for--the nurses and dietary workers, or the ladies in the home?

Who are the maladjusted aged, and what about them? Aged persons who are complaining, quarrelsome, restless, negativistic, depressed, agitated, angry, suicidal, paranoid, and sexually inappropriate such as exhibitionistic are maladjusted. Much of this behavior may be so common in the aged that one tends to think it is a natural part of old age. It is not.

One way to assess the emotional status of the older person is to use Erickson's 8 ages of man and his accompanying developmental tasks. The 8th or last age of man has as its developmental task the establishment of integrity. Integrity means wholeness or completeness. Disgust and despair result when integrity is not experienced. Does the older person feel a sense of completeness to his life? Does he look back and feel good about his life? In order to feel whole and complete in the later years, one needs to have produced something during a lifetime. That is, he needs to have had children he feels good about; or he needs to have had ideas or done things he feels were worthwhile. He needs to have accomplished something--something lasting and satisfying. He needs to feel pride in his life. He needs to feel that he was on this earth for a reason. This is one of the reasons why so many of the older, outstanding men and women are so sound mentally. One thinks of de Gaulle, who heads a nation at seventy-six; Margaret Rutherford, the English actress who performs daily on the London stage at seventy-five; Konrad Adenauer; Dwight Eisenhower; Robert Frost and many others. They are examples of the well-adjusted aged. They developed integrity or completeness. They generated, produced and created. Fame, of course, is not the essential ingredient, but rather reflective thinking that brings a smile of satisfaction with one's

life. There is growing support, however, in the belief that there is a cause and effect relationship between one's cultural and educational opportunities and one's adjustment in the later years. The more opportunities one has the more he will experience, and the more satisfying his life is likely to be. The greater the satisfaction the less likely the chances for disgust. This hypothesis may account in part for the Schweitzers, the Pope Johns and the many other productive old people. Conversely, the lack of opportunity may account, in part, for the Appalachian miner and the unskilled laborer who do become maladjusted or "senile" as it might be called. Our concern here, however, is the aged--that group whose chances of overcoming such early deprivation are poor if not impossible. There is really a greater message in this concept for us than there is for those in our care. Cultural and educational opportunity is still knocking at our door. There are also frank mental disorders which beset the aged, but this idea has been advanced to help explain the seemingly healthy adult who becomes a problem to himself and others when he reaches old age.

A sense of completeness or integrity, then, distinguishes the emotionally well-adjusted from the maladjusted. The latter have not accomplished this task. They look back, which is the only direction in which to look when one is in the last age of man; and they feel no sense of satisfaction, accomplishment, or completion. Some wish openly for another chance. They know it is not possible; and depending on what specific past experiences they have had, they experience different degrees of disgust and despair. Disgust and despair wear many faces. They may show themselves as continuous somatic complaints, quarrelsomeness, restlessness, negativism, depression, physical agitation, anger, suspicious thinking, sexual inappropriateness or suicidal gestures. Somatic complaints, as a manifestation of emotional disturbance, are commonly seen as headaches, dizziness, constipation, anorexia, sleeplessness, early morning waking, and easy fatigability. The emotionally maladjusted old person also fears death. He is not ready to die. The emotionally healthy person feels good about his life and that helps to remove the sting of death; but for one who feels incomplete, unfinished and unsatisfied, thoughts of death are frightening.

What about the less healthy thoughts and feelings which plague some old people? In a very real sense of the phrase, the dye has been cast; but as professional helping persons we cannot just sit, and with them, wait for their death. Depending upon the degree of emotional impairment, the approximate number of years left, and the degree of physical impairment, there are some things which can be done. Generally, any of the things mentioned for helping to maintain the well-adjusted will also work in helping to rehabilitate the maladjusted. Remember that the major criterion for mental health is how you feel about yourself. It is the Professional health worker's obligation to create experiences which will help the aged to feel good about themselves. One cannot be too imaginative. A ward or nursing home can be a real "jumping" place. Of all the patients there must be a fiddler among the lot. Grandma Moses started to paint very late in life. What about starting indoor flower gardens or quilting bees? One should not

worry too much about bringing work in or finding work within the institution for patients. The idea that patients are guests and must be waited on went out when the idea of therapeutic community came in. People must feel useful to remain well-adjusted; and the maladjusted must feel useful to regain adjustment.

What about some specific emotional illnesses? Chronic brain syndrome associated with arteriosclerosis is a major mental disorder of the aged. This is a psychosis and it can produce a picture from slight peculiarity to gross bizarre behavior. The clinical picture depends not on the etiological factor, but on the pre-morbid or early personality. The middle-aged, suspicious person can become the old-aged paranoid person for example. Whatever the basic personality, it usually becomes exaggerated in a brain syndrome. The orderly middle-aged person can become the compulsive old person. The middle-aged man who "talks dirty" often becomes the old man who actually acts out sexually. The outstanding common characteristics of brain syndrome are impairment of memory, reasoning and intellectual functioning; but the degree and kind of impairment depend largely on the basic personality.

Helping persons with an organic psychosis is difficult. Explanations must be repetitive. Memory may function for only a few seconds. Routines, directional arrows, simple one and two word poster directions, large calendars and clocks will also all help with the great task of orientation. It is when disorientation is not interrupted that anxiety emerges. It gives rise to less healthy behavior. The behavior can range from dangerous to just a nuisance.

Depression is another mental illness commonly seen in old people. Depression is a reaction to loss. Certainly old people are experiencing losses. Their peers are dying; their homesteads and mates may be gone; their children may be far away; and worse than all of that--they are losing their own power and productivity. Their own early view of aging is also a major factor in depression. If they have always felt, "I'd rather die than get old," they can die figuratively--in a morbid depression of nothingness.

Working with these persons requires the patience of Job and the serenity of Olympia. Patiently do for them what they will not or cannot do for themselves. They might not eat, sleep, dress, or even move because they do not feel they deserve those pleasures. Spoon-feed them; dress them; give them small tasks which appear lowly. Scrubbing dirty washbowls may be all they feel they deserve. It actually helps them to punish themselves, which is what they feel they need and deserve. As the need is met, the guilt is atoned for and the depression lifts.

Chronic brain syndrome and depression are two of the frank mental illnesses seen in older people. They will not be seen in the aged who experience integrity. In the case of organic brain impairment in emotionally healthy people, the clinical picture is a mild one. A little memory and intellectual impairment is all that will probably occur. It is hard to topple a house built on a strong foundation.

It is true that the foundation was laid many years ago, but love and work will strengthen it at any period along the way. In order to maintain a useful adjustment to old age or overcome a less useful one, one must provide experiences in love and work which will help the aged to feel good about themselves.

A paper given by Gloria Francis, Mental Health Integrator, at the Short-Term Course in Geriatric Nursing, January 27-31, 1967, under the auspices of the Medical College of Virginia, School of Nursing, Continuing Education Program, in Richmond, Virginia.

CHRONIC BRAIN DISORDERS

RELATIVELY PERMANENT,
IRREVERSIBLE,
DIFFUSE IMPAIRMENT OF
CEREBRAL TISSUE FUNCTION



DISTURBS



MEMORY
JUDGMENT
ORIENTATION
COMPREHENSION
AFFECT



CHRONIC
ORGANIC
BRAIN
SYNDROME

CHRONIC ORGANIC BRAIN SYNDROMES

ARE ASSOCIATED WITH:

1. CONGENITAL CRANIAL ANOMALY;
CONGENITAL SPASTIC PARAPLEGIA;
MONGOLISM; BIRTH TRAUMA;
PRENATAL MATERNAL INFECTIOUS DISEASE
2. CENTRAL NERVOUS SYSTEM SYPHILIS
3. INTRACRANIAL INFECTION
4. INTOXICATION (LEAD, ARSENIC, MERCURY,
CO, DRUGS, ALCOHOL)
5. BRAIN TRAUMA
6. CEREBRAL ARTERIOSCLEROSIS
7. CIRCULATORY DISTURBANCE (CEREBRAL
EMBOLISM, ARTERIAL HYPERTENSION)
8. CONVULSIVE DISORDER
9. SENILE BRAIN DISEASE
10. DISTURBANCES OF METABOLISM, GROWTH
11. INTRACRANIAL NEOPLASM
12. DISEASES OF UNCERTAIN CAUSES (M.S.,
HUNTINGTON'S CHOREA)

PARADIGM - REACTION TO ILLNESS AND LONG TERM CARE NEEDS
(based on paradigm by Goldfarb)

REACTION	MULTIPLE CAUSES EARLY & LATE IN LIFE →	LOSS OF RESOURCES AND OPTIONS →	DECREASED MASTERY →	FEELING OF HELPLESSNESS →	FEAR, ANGER, GUILT RETALIATION →	SEARCH FOR AID HELP, RATIONAL IRRATIONAL
RESIDENT PATIENT	Previous crises Ability to cope Confidence Dependence vs. Independence Resources Life style	Physical Mental Social Economic Mobility Love objects Status Privacy	Internal and external changes Tension Stress Confusion Immobility	Decreased self- esteem, self con- fidence, sense of purpose Feeling of humili- ation, shame, isolation, loneliness	Depression, denial, confusion Regression into dependency, self neglect, impossible demands Flight Withdrawal Manipulation Tantrums	Search for par- ent substitute Acceptance of situation, life review, depen- dence on children, staff Or continuance of irrational behavior, tan- trums, hypochondriasis
FAMILY CHILDREN - SPOUSE	Parent-child relationships Family's ability for dealing with crises Sibling rivalries Long range plann- ing Values	Economic Limitations Inability to take care of family member Distance Legal responsibi- lity Inadequacy of social resources	Tension, stress Lack of experience and skill Difficulty in coping with crisis Role reversal shift in recipient of dependence	Decreased self- esteem, self- confidence Humiliation, sh- ame, guilt Attack on value system Loss of status	Depression, fear of retaliation Regressive behavior Apathy Withdrawal Manipulation Exploitation of guilt Projection Denial	Use of outside resources Exploration of alternatives acceptance of dependency of family members Collaboration between family member
COMMUNITY LOCAL - NATIONAL	Negative attitudes toward aged and sick Fear of illness, dying Inadequate health care, social provisions	Resistance to support of medi- cally indigent Lack of trained manpower Increased cost of health care Limitation of filial responsibilities	Inability to take care of aged and ill in society Breakdown of family resources Shortage of funds Political and economic stress	Decreased confidence Humiliation Guilt, shame Concern, identi- fication Desire for immed- iate and easy solutions	Apathy Withdrawal Attacks on providers of service Denial of problem Temporary but inadequate solutions Red tape	Provision of adequate services Involvement in problem (i.e. volunteering) Increased man- power resource Filial Responsi- bility Accept. needs o

EMOTIONAL PROBLEMS OF THE AGED:
PREVENTIVE ASPECTS AND EARLY RECOGNITION

Lecture by Arthur Peck, M.D., Administrative Officer, Department of Psychiatry and Neurology, The Center for Instruction in the Care of the Aged, The Jewish Home and Hospital for Aged, New York, N.Y.

Delivered June 14, 1967, at Georgetown University School of Nursing, at workshop for professional nurses sponsored by the Division of Community Health Services, U.S. Public Health Service, June 12-23, 1967, entitled "Improvement of Nursing Care of the Older Person."

This presentation is divided into three major parts: (1) Normal and Emotional Aging Processes, (2) Early Recognition of Psychiatric Illness in the Aged, (3) Prevention of Emotional Disorders in the Aged.

Normal Mental and Emotional Aging Processes -- What is here meant by "normal" is simply the most prevalent because there are no measurable criteria of healthy mental and emotional functions in the aged. (Nor, for that matter, are there any such measurable criteria for normal healthy mental function in any age.) Let's consider aging to begin at 65. This is a statistical fiction but some kind of a guideline is needed.

Another guideline that is helpful is to assess individuals in terms of a spectrum of functional capacity. This is simply a common sense evaluation based on the physical and mental functions: On the physical side -- vision, hearing, speech, the ability to dress oneself, eating and walking. And on the mental side -- memory, orientation, general information, emotional control, calculation and knowledge of current events.

If one evaluates any group of people along the spectrum of functional capacity it breaks down something like this: the people in the worst possible condition both physically and mentally are found in state hospitals, next there are those in nursing homes, and then there are those in homes for the aged. At the top level there are those still in the community and who are most easily examined and evaluated at places where the aged congregate such as day centers.

What are the biological changes that occur with aging? First of all, there is certainly a loss of muscular strength, tone and bulk. If a man's living depends on his muscle, one can see what this would mean to him. There is a loss of balance, coordination and of fine skilled movements. Thus, even those people who have skilled jobs which don't require muscular bulk have more trouble walking as they age. There is a loss of sensory acuity and the special senses' functioning decreases. To take vision, for example, the eyes show decreased accommodation, early cataract formation which of course can progress, and arteriosclerotic changes in the retina. As for hearing, there is certainly a loss of hearing of both the upper and lower tones of the audible register.

There is also a loss of the sexual hormones that are produced throughout most of mature life. As a result of the loss of these hormones, there is a decrease in skin tone, hair lustre, and in bone strength. In addition to all of these changes which do not necessarily constitute disease per se, there is also actually an increased incidence

of disease in the aged. The cardiovascular system most prominently but also the neuromuscular system, digestive system, and urinary system - all show more disease as time goes on.

As a result of all this, a truly healthy aged man or woman is rare, in contrast to children where, of course, health is the rule.

What are the social concomitants of aging? We live in a western culture which emphasizes such things as youth, beauty, strength, and success, in terms both of position in the community and in terms of money. The scientific and technological revolution has stressed the new and improved and has emphasized the application of the scientific method to understand human behavior. The net result of all this is a generally widespread negative view of both aging and the aged, by the younger members of society to be sure, but also - and this is perhaps not fully appreciated - to a significant extent by the aged themselves.

Retirement at age 65 or 62, or even 60 now, is currently the dominant trend in our society. Therefore almost all the aged are unemployed, and if they are not unemployed they certainly would not be hired on a par with younger persons. As a result of all these factors, the aged lose status not only in the community but within the family.

An unfortunate fact is that the longer an individual lives, the greater the chance that they will lose through death people to whom they formerly were attached. This is obviously true of parents, and of siblings, and of mates. It's also true of contemporaries who were friends and, unfortunately too, even children. This is a very negative picture but that is unfortunately what the aged individual has to face.

What are the economic concomitants of aging? Most of the aged are living on a fixed income. For at least the last 20 or 25 years, this country has been in inflation which causes decreased purchasing power resulting in a real squeeze on anybody who is on a fixed income. Few of the aged can combat this by working. Many who grew up in the days before social security view being a public charge as a disgrace. And those who have to come to live in public housing as the result of reduced income in their older years, have a special problem, in that they feel that they are superior to the younger people in these public housing developments, who they feel never knew a better way of life as they themselves did when they were younger. The effect of the biological, social and economic concomitants on the aging and on groups of the aging deserves some special attention. Let's take a look at how these things reflect themselves in the individual aged person's personality.

First, most aged people become egocentric. This is not necessarily eccentric, that is odd or queer, different from other people - but egocentric, that is they show an increased focus of interest in themselves, and at the same time a relative decrease in other people and in those events which are not primarily and directly connected with their own lives.

Another personality factor commonly observed is rigidity by which is meant resistance to change and a wish for routine. Changes in daily schedule or in food habits, or in environment are certainly not handled easily or willingly by most aged people. We see this most strikingly in situations where older people remain living in a neighborhood and in an apartment years and years after they belong there in

terms of the changes that are taking place in that neighborhood and in perhaps that same building. And this is not fully explained on the basis of their not being able to afford to live somewhere else.

There is also an emphasis on the past - on what is often called the good old days. Sometimes this is turned around in kind of a negative bragging way such as in talking about how rough it was in the old days - that there never, never has been a blizzard like the blizzard of '88 - for anybody who can remember that far back.

There is also a fear of losing independence - financial independence, social independence, which means the ability to take care of oneself physically without anybody's help. And as a result of this fear of losing independence there is a defense called into play: conservation. This is analogous to what we're trying to do with our natural resources -- we are trying to avoid squandering them, preventing our remaining national forests and beauty spots from being ruined, by conserving them. The aged person tries to do the same thing, to conserve his or her resources. These resources are of various kinds: money, friends, or bodily effort.

The idea of an aged person saving and holding on to money is a familiar one. It has given rise to a fair amount of humor - one of the few things in geriatrics that can still be laughed at. The same is true for holding on to friends, and to doing as little as possible not to exhaust oneself or wear oneself out physically.

There is also an emphasis on those sources of pleasure which are still available to the aged. Food becomes quite important because it remains a source of pleasure that is available. The same is true for reading and for hobbies. There is concurrently a deemphasis on those sources of pleasure which are lost to the aged, primarily sex, but also work and athletics.

What characteristics do a group of aged persons show? First, interest is centered around the immediate group. Gossip becomes a major activity. Rivalry and jealousy are common. Mistrust of the new is a striking factor. New neighbors, new staff members (for those who are living in institutions), new programs of any kind are generally mistrusted per se.

Among the aged there is an emphasis on past events and periods of time. In the aged conservatives and reactionaries are more common than liberals and revolutionaries. There is a group pressure for more help in terms of medicare and other social security benefits, and in general, other programs to help the aged as a group. There is an increased focus upon illness, upon medical care, and last but unfortunately not least, upon death itself.

There is a very wide variation in the response of individuals to all of these stresses that come almost invariably as a result of simply growing older. Not all older people break down under these stresses as severe and as manifold as they seem to be. What then is it that makes for the variation in the response of aged individuals? If the stresses are pretty much the same why should the responses be so variable?

Not all of the aged develop psychiatric illness. The capacity to withstand stress and the resultant illness when stress cannot be withstood depends upon four factors.

The first of these is the individual's constitution. This is the genetic endowment that nature gave one, what an individual comes into life with, his innate physical and psychological apparatus. The more we are beginning to learn about this from long-range studies beginning with the neonatal period the more we see that this factor has been very much neglected; it seems to be an important one.

The second factor in the capacity to withstand stress is the individual's personality. This certainly does not begin and end at the moment of birth. Like the constitution it begins at the moment of birth and continues to the moment of death. Personality is the behavior of an individual as the result of the individual's interaction with his life experience. To put it in other terms, it's the result of interaction of constitution with environment.

The third factor in the capacity to withstand stress is that of physical function. This is the state of physical function, bodily function of the individual. This includes the function of the brain.

The last factor is that of the current human environment. This one is the only one of the four which is subject to much change. One can't do anything about individual biological constitution. By the time of old age personality is fairly fixed. An old person's physical function also is very difficult to improve markedly. What remains that can be changed to any significant extent is the human environment in which aged persons are placed. To give you a brief example of how important this human environment is in everybody's responses to life, think of yourself in the house watching something like Dracula or Frankenstein on the late, late show. First think of yourself in the house completely alone and how you would feel watching the movie; then think of yourself and how you would feel watching the same movie with somebody else there. It doesn't matter too much who the other person is. This is the kind of importance that the human environment has for the function of all of us.

We have considered the stresses of aging and the factors which enable an individual to withstand stresses. Now let us move on to an examination of what happens when the individual is overcome with anxiety. When stress exceeds the individual's capacity to withstand it the individual is flooded with anxiety. If we could take his unconscious and put it into words it might be put into one sentence: "Now that I can't take care of myself, what will become of me?"

The aged individual is at this point in his life forced to depend upon others. There is a vast variation in how an individual responds when circumstances prevent him from taking care of himself and require that other people be depended upon. How the person behaves at this time depends upon his previous lifetime experiences at the hands of others. If those experiences were in general bad, that is, painful, he will now try to disguise or in some way to circumvent his need for help. For example, he can try to bluff and coerce people around him into helping him because they are afraid of him.

Another technique is to reassure himself that he still has his own resources which he does by collecting things, either by hoarding things that are given to him or that he already possesses, or by collecting things that belong to other people, which we usually refer to bluntly

as stealing. Whether it is by hoarding or by acquiring other people's possessions, the aged person is trying to avoid asking for help by building up his own storehouse. Now the more disturbed the individual, the more unrealistic the stock of his storehouse is. Collecting old paper or pieces of string obviously is not going to make anybody very strong and very able to get along by oneself. Yet many people do just that.

Another technique to hide the need for dependency is to lie - to lie about one's current position, to conceal one's need for help from other people. This occurs both in and outside of institutions. It can sometimes lead to disastrous consequences when older people who need medical attention hide this fact out of fear that other people will take advantage of them if they know they are now too weak to take care of themselves.

What happens if an individual was lucky in life and his previous experiences at the hands of others were good? In these persons the need for help can be comfortably tolerated and fairly openly sought, even requested in words. But there is another important factor in determining how an aged person handles his need for help. He may view himself as being dependent, and some persons find being dependent so painful that they suffer a sharp loss of self-esteem and punish themselves by intense self-blame and self-hate, which is recognized clinically as depression. Some of these people can handle their self-concept by finding roles in which they feel they can accept help. For example, they may exaggerate their physical incapacities in order to merit help for other people. They reason to themselves that if they are sick people have to take care of them, it's coming to them, since it is expected in our society that the sick will be cared for. This is a role they can tolerate when simply being weak, old, infirm and not being able to take care of themselves without the symptoms of illness would otherwise be too painful for them to accept.

Sometimes paranoia comes into the picture, and an individual says to himself and to other people: "I'm an innocent victim; they (it's always "they") stole my money; they ruined my health; they made me give up my home", et cetera, et cetera. Dynamically the emphasis is on shifting the responsibility for being helpless from themselves on to other people - these mysterious "they."

Early Recognition of Psychiatric Illness in the Aged.

This topic is presented for those with a background of previous courses in psychiatry plus a considerable clinical experience with aged patients. The purpose of including it here is to provide help toward early recognition of emotional disorders in the aged.

What are the psychiatric disorders? Basically they are divided into two major categories: Psychiatric disorder with known brain diseases, and all others - psychiatric disorder without brain disease. In the aged those psychiatric disorders with known brain disease are more common than among the general population.

These psychiatric disorders used to have names like "Psychosis with Cerebral Arteriosclerosis" and "Senile Dementia." The term that the American Psychiatric Association has substituted for these is a much sounder, much more scientific one. It's simply called Brain Syndrome.

A syndrome is a set of symptoms and signs found together. It's not necessarily a diseases process. It's simply a set collection of signs and symptoms. Now what is brain syndrome? It's a set of symptoms and signs which has been found to be in association with pathophysiological and usually with structural changes in brain tissue.

Brain syndrome itself is divided along clinical grounds into two categories: Acute Brain Syndrome and Chronic Brain Syndrome. Acute brain syndrome is what used to be called delirium. This consists of the sudden onset of confusion in a previously alert person. It is found in association with a generalized disease of the body more often than it is found in association with a disease limited to the brain itself.

If the underlying cause is treated the mental disfunction stops. The prominent symptoms of Acute Brain Syndrome begins with clouding of the consciousness. The individual can have some clouding of consciousness from a mild situation which we could call being dazed all the way down to the individual who is in deep coma. There is no acute brain syndrome without some clouding of consciousness. The most prominent feature of Acute Brain Syndrome is agitation. There is much anxiety and restlessness and often such individuals become quite violent in terms of resistance if a nurse or somebody else makes an effort to restrain them, to keep them from moving around.

Illusions are quite common, especially visual illusions. These are misperceptions of acute stimuli. Many people confuse hallucinations with illusions. Hallucinations are completely false perceptions. They start with no stimulus of the sense organs. If somebody sees a devil standing there he doesn't have to see a shadow; he doesn't have to see a coat on a coathanger; he just sees it without any kind of real stimulus. The opposite is true for illusion. The individual makes a mistake in what he or she understands with their sense organs but there is a real stimulus that begins with the process. An example is a man with pneumonia who heard the rustling of the trees outside his hospital window and was very terrified on the assumption that this was an angry crowd talking outside and getting ready to come in and lynch him. There was a considerable amount of noise; certainly there was no lynching.

Disorientation is another prominent symptom of Acute Brain Syndrome: disorientation for time, disorientation for space, and disorientation for person. Disorientation for time is always affected before the other two. If you find an individual who seems not to know who he is or who you are but who knows what time it is, what day it is - be very cautious about making the assumption he has brain syndrome. If he has brain syndrome this disorientation for time will certainly be present. If it's mild, disorientation for space or for person may not be present.

There are deficiencies in memory if one looks for them. Deficiencies for recent memory are more prominent than deficiencies in remote memory. Decreased attention, attention span, and retention also occur as does decreased intellectual functioning and decreased judgement for things such as calculation and spelling.

If all of these symptoms are present there is no problem in making the diagnosis; even if most are present the diagnosis is secure. If no alteration of consciousness and no disorientation for time exist be very

cautious about this diagnosis even in a patient who looks very restless, agitated and who is not oriented for persons.

What are the causes of Acute Brain Syndrome? The list is quite long. The causes begin with cardiovascular disease including such things as congestive heart failure, strokes, hypertensive encephalopathy. Any renal disease which produces uremia can cause acute brain syndrome. Metabolic diseases such as diabetes, either in coma or in insulin shock, can produce Acute Brain Syndrome. Dehydration and infections, even those which occur in the aged without fever also can result in Acute Brain Syndrome. Concerning head injury, although the skull x-ray is negative, it cannot be assumed that this person will not develop some kind of brain damage. If the x-ray is positive, it is presumed that there has been a serious injury. Even if skull fracture is not found it should not be neglected to observe the patient carefully for some time afterward.

Another form of trauma which can give rise to acute brain syndrome and is not commonly thought of is that which occurs after a long bone fracture. Here the mechanism is fat embolism. Acute painful states of any description can cause acute brain syndrome. Needless to say, palpitation of the bladder and the eyeball do not take much time to detect and can be of enormous help in making a diagnosis.

Toxic causes can occur too. The most common being reaction to drugs, either to drug overdosage or to idiosyncratic response.

In Chronic Brain Syndrome the onset in contrast to acute brain syndrome seems to be gradual. However, sometimes an individual who has mild Chronic Brain Syndrome develops an acute illness and first comes to medical attention at that time. Sometimes a social situation brings out in a glaring fashion the poor judgment of Chronic Brain Syndrome which was not otherwise recognized, or denied. Nobody likes to admit that there's anything wrong with their relatives, certainly with their parents. Often there is a gradual loss of function as a result of Chronic Brain Syndrome which the family does not want to see until something happens that is so bad that they realize they must request professional help.

Chronic Brain Syndrome occurs so far as is known without any direct association to a generalized disease process. There may well be some underlying general disease process which causes Chronic Brain Syndrome but if so it is still unknown. In contrast to acute brain syndrome people develop Chronic Brain Syndrome in the absence of any diagnosable generalized disease process.

The incidence of Chronic Brain Syndrome is striking. This is without doubt the commonest psychiatric disorder in the aged. More than 40% of the first admissions to state hospitals are over 65 years old. By 1980 such admissions will have jumped to 4 times what they are now. And, if anything, that's a conservative estimate.

A survey done by the New York State Department of Mental Hygiene, which has a special Office of the Consultant on Aging, began in 1958 and is still being conducted in three kinds of institutions in the New York Metropolitan area: homes for the aged, nursing homes and state hospitals. Psychiatrists have directly examined residents selected at random. In this way some 1,000 aged persons have been examined. In

homes for the aged 80% were found to have some degree of chronic brain syndrome; in nursing homes 87% were found to have some chronic brain syndrome; and in state hospitals 94% were found to have some degree of chronic brain syndrome. The state hospital statistic, of course, refers only to patients over the age of 65. If, in an institution such as a home for the aged where 80% of the population were admitted not primarily for psychiatric care and who have been found to have Chronic Brain Syndrome, it is evident then that Chronic Brain Syndrome is certainly a major problem in the aged.

What about the people who still live in their own homes, who are not institutionalized? One such group was studied. This was a group of patients of the Westchester Visiting Nurses Society. When these persons, without any preselection, were examined by a psychiatrist, 44% were found to have diagnosed Chronic Brain Syndrome. So these people too have a very high incidence of Chronic Brain Syndrome.

In another study, a group of healthy aged men who volunteered to live at the National Institute of Health for 2 weeks, underwent a battery of tests, observation and interviews. The purpose of this research was to answer this question: What are those aged persons like who have not come to medical attention in any way? In this group, upon examination, 23% were found to have Chronic Brain Syndrome. What are its causes? Senile brain changes do occur, but the cause of these changes is as yet unknown. The incidence of cerebral arteriosclerosis is high. It occurs in association with generalized arteriosclerosis but is not always found in close association with it. An individual can have very severe arteriosclerosis from the neck down and at autopsy be found to have a brain relatively free of arteriosclerosis. In fact, autopsy studies such as those done by Rothschild, and brain oxygen uptake studies done by Kety at the National Institute of Mental Health, fail to show a correlation between the clinical severity of chronic brain syndrome and the degree of detectable brain disease.

This has provoked a good bit of discussion. There is a group of zealous psychoanalysts who say -- "Ahha, you see this proves that the so-called physical changes have nothing to do with the situation. Everything we see in aged people who supposedly have brain disease is the result of their emotional state and their neuroses." The other point of view says, "oh no. It's not that at all. You haven't proven that. What's happened is that because we don't have sophisticated testing techniques we are still unable to pinpoint the primary factor, which is of course some chemical or some neurophysical malfunction." In essence, we haven't yet learned what that factor is and it's nothing as gross as what can be seen in the brain at autopsy.

How does one make the diagnosis of chronic brain syndrome? There is no loss of consciousness except in very severe states where people are nearing the end of their lives. In those people who are still up and walking around there is, in contrast to acute brain syndrome, no loss of consciousness. Disorientation certainly occurs and here the time sphere again is affected before space, and space before person.

The earliest evidence of chronic brain syndrome clinically is the loss of the ability to estimate the passage of time - to tell how long something has been going on. You might find this on a hospital ward not be asking somebody how many days he has been in the hospital but by asking

him something like how long does he think it's been since breakfast, or how long to lunch, or whatever. You may find that somebody who has previously been able to handle this kind of question easily now begins to have quite a bit of trouble and confusion about it. At any rate, when things reach a point when the day of the week cannot be identified, nor the approximate date of the month, then the diagnosis is clearcut.

There is in Chronic Brain Syndrome as in Acute Brain Syndrome some loss of memory. Recent memory is lost more than remote memory, and recall is lost before recognition. Recall means asking someone to tell you something from his own store of knowledge. For example, to use the cliché question that is always used in Hollywood by the psychiatrist in examining a patient: "Who is the president of the United States?" If the patient cannot give the name on that basis, this is loss of recall. Then, when the psychiatrist says to the patient, "The president is one of the following -- Kennedy, Eisenhower, Johnson, Roosevelt" and if the patient can't pick the right name out of that group then he has lost the ability of recognition as well. Recognition doesn't require as good a memory as recall.

There is also a decrease in intellectual functioning: calculation, current events and common facts. What is meant by "common facts?" This means facts which do not require any degree of education whatsoever. For example, one asks what happens if you put an ice cube in a glass of hot tea? The common answer is that the ice cube melts. This is sufficient to give some indication of the retention of the ability to do very elementary "common sense" thinking.

There is present sometimes but not always a heightened degree of emotional ability which means simply that the person is more demonstrative and more reactive than most people are. They cry more easily; laugh more easily; get angry more easily; and sad more easily. Of all the points in the diagnosis of brain syndrome this is the weakest one.

In addition to observation and common sense diagnosis, how you test people you think may have this kind of disfunction? Several tests, simple tests, are available which can be done by nurses, even by aides if they are properly instructed. Dr. Alvin I. Goldfarb, the Consultant on Aging in New York State, and two people who work with him developed a list of ten questions called the Mental Status Questionnaire. These questions are as follows:

Where are we now?
Where is this place - where is this place located?
What is today's date?
What month is it?
What year is it?
How old are you?
What is your birthday?
What year were you born?
Who is president of the United States?
Who was president before him?

It is relatively easy, if only these ten questions are asked, to rule out chronic brain syndrome. If a person can answer all of the questions, he does not have chronic brain syndrome. If he makes mistakes in the

questions, you cannot assume that he does have chronic brain syndrome. He might, or might not. If the answers are correct forget about chronic brain syndrome in that patient. This test is by no means the only one given to determine chronic brain syndrome.

Prevention of Emotional Disorders in the Aged

A recent study pointed out that the stresses of aging hit different groups of people at different decades of their lives. Those who are hit hardest and earliest by changes of aging are women who are extremely narcissistic, that is, very vain and superficial and who have relied mainly on their appearance for ego satisfaction. On the male side, those who are most early affected by aging are the athletes because their strong point, physical agility strength, is the first one to be lost with aging. Next comes the manual workers; then the mental workers; and last the creative, individualistic persons. The reason for this is that the latter had already learned to make things for themselves, to find ways and means to conduct their lives and do not depend on outside forces nearly as much as upon what they create from the inside.

If one takes a group of aged persons and gives them questionnaires on how happy they are - what do we learn about those people who are most satisfied with their situation? We find that these were the same people who also were best adjusted and most content with their lives when they were younger. These are also people who even though they are now chronologically old do not see themselves as being old people. When they are asked to check off how old they feel, or how old they think they are in general, in all respects they do not check themselves off as very old. They check themselves off much younger - down in middle age.

This group of people continues to be active, to work, to participate in community activity and in leisure activity. They show a background of high educational attainment which in turn is closely linked with income. Other surveys have also shown that the incidence of brain syndrome in the aged is lower in those people who have a background of high education, high income, good medical care, and good use of available community social facilities.

Is the best advice to people then that if you want to avoid chronic brain syndrome when you get old, get as much education as you can when you're young? This may be specious reasoning. It may be that these individuals got themselves a good education and did well in life financially and in terms of their career because they already were endowed with a healthy personality and with healthy bodies. If so, then it is the healthy personality and the healthy bodies which are protecting them from Chronic Brain Syndrome as they age.

Leshan and Klein wrote about a series of mental health education groups which showed some interesting things. These were groups of 25 golden age club members who volunteered to meet together for an hour and a half a week for from 8 to 13 weeks. It was not group therapy. Catharsis of an intense nature was avoided and the goal was simply to discuss as a group mutual concerns and interests. The contents of their discussions, the things they wanted to talk about were health, housing, old age and learning, conformity, hope, destiny, parents and grandparents, religion, love marriage, recreational opportunity, work and retirement, finances. Their major concerns could be grouped under

headings of dependency, isolation, status and identification. The authors of these reports feel that the lessons for programming are (1) to provide for the aged access to other generations (2) to encourage their active role as grandparents (3) to encourage interaction, friendships and sharing (4) to encourage responsibility such as sheltered workshops, activity and involvement in philanthropy and in other community affairs.

What can be done to prevent psychiatric disorder in the aged? The maintenance of general physical health can't be overlooked. This sounds vague and trite but it is vital.. It's the exclusive source of resistance to the other stresses of age. Proper diet and exercise need to be maintained. Regular medical checkups including eye, ear and dental checkups also must be maintained. As yet, despite all the talk about arteriosclerosis and cholesterol and fat in the diet, not enough is known about these things in connection with Chronic Brain Syndrome to warrant any restrictions of the diet on that basis.

There are some interesting preliminary studies of the effects of administration of nucleic acids for people with severe chronic brain syndromes. Dr. Ewen Cameron, working at the Veterans Administration Hospital in Albany, N.Y., has given some people with Chronic Brain Syndrome ribonucleic acid and des-oxyneucleic acid with some promising results. Much more will have to be done before it is known how much good this will do in preventing Chronic Brain Syndrome.

Prompt recognition of Acute Brain Syndrome is important because this is one area where we can prevent the development of Chronic Brain Syndrome. If Acute Brain Syndrome is not taken care of the brain damage does become permanent and Chronic Brain Syndrome results. Therefore, close care to head injuries and all the other things listed above as causing Acute Brain Syndrome cannot be overstressed.

There is another problem of the aged which can be prevented and which is called "admission shock." This acute confusional state occurs in many older people when they are first admitted to an institution - either a hospital, a nursing home, or a home for the aged. First, it is necessary to appreciate the stresses involved in this kind of shift - the stresses of loss of privacy, loss of property, loss of individual rights and privileges, separation from the familiar environment, separation from family and friends, and the loss of control over finances.

In recognizing these stresses it is necessary to set up effective programs to counter them such as arranging trial visits, tours, joining in meals and in activity programs of the institution for the aged before their admission. Individual orientation to facilities, to staff and residents, and group orientation sessions both before and after admission have been found to be helpful. All this helps the aged person to ventilate resentment and of the feeling of being rejected by children. In this way the aged person may more easily accept that his admission was necessitated by actual needs for more care than could possibly be provided at home. Another helpful factor to recognize is that all of the aged share as an outstanding fear the fear of becoming incapacitated.

Discussing the programs and the services in the institution with

with the incoming resident is useful as is an opportunity for the newcomer to participate actively in the institution's programs. The aged person can become both a member of a welcoming committee and a volunteer to help take care of other residents, to feed, dress and escort those who are less capable physically. In one institution such a program reduced the number of people who suffered admission shock and who had to be transferred quickly to the infirmary from 65% to 8%.

There is also much to be done by working with the children of those people newly admitted to institutions for the aged. They can be helped to decrease their guilt feelings and to recognize that their parents were admitted for a bona fide reason - to obtain services which could not be given at home. They can be motivated to visit their parents regularly by better understanding the stresses of separation. Active working relationships should be established from the onset between the staff and the relatives in order to alleviate the stresses of the aged person and of themselves.

There are other forms of prevention. It was emphasized earlier that the only factor in the capacity to withstand stress which is subject to any outside control at all is the human environment. This is the key to all attempts of the prevention of development of psychopathology in the behavior of the aged. How can the human environment be made to be helpful? First, the knowledge of how aging affects the individual is a basic factor. Next, the recognition that the individual's behavior consists of efforts to decrease anxiety even though those efforts may be unknown to the individual himself and even maladapted; that is, instead of making things better for himself he makes things worse.

Utilizing the strong dependency needs of the aged to provide support is perhaps the most useful single technique in caring for the aged. Many aged persons accept assurance that help will be given to them when it is needed in the future in place of concrete active help in the present. If a staff member can develop a relationship with the patient wherein he or she becomes really trusted, the aged patient's fears of becoming helpless diminish. Behavior which is designed to attract staff attention and to test the availability of help therefore eases off. With gradual encouragement some increase in independent activity can and often does occur.

Nurses have a key role in the care of geriatric patients. First of all the majority of the geriatric population requires medical care which is involved directly with nursing care. In institutions nurses have much more time with patients than do doctors. The nurse is on the day-to-day care unit, the leader of the people who take care of the patients needs. As a leader she is in a position to indoctrinate the rest of the team and to influence their relationships with patients. The nurse is in reality vested with much power in the daily lives of patients. This in itself can provide considerable assurance for the patient, much more so than brief and intermittent help coming from outsiders or from lower echelon help.

The staff must honestly examine their own attitudes about working with the aged and to recognize frankly that the aged do arouse uncomfortable feelings. Old age and disability do imply that death is near and that withering, wrinkling, loss of coordination, loss of function,

control and independence will some day happen to us. The fears these things arouse in us provoke a wish to get away and to avoid, if not physically, emotional closeness with aged patients. If nurses and others who work with the aged do not know that such reactions are universal to some extent, they will feel unnecessarily guilty and actually leave the situation. With time and effort the satisfactions of properly caring for the aged do become more apparent and tend to balance off these anxieties.

If a nurse can lead the rest of the staff in handling the disturbed and disturbing behavior of aged patients which is an expression of their fears, then those fears and their troublesome behavior will lessen. To an institutionalized old person this single factor can spell the difference between a pleasant life and one of increasing isolation and fear.

SESSION IV

COPING

- I. How Do We Cope? Dealing With Conflict and Anxiety
 - A. What is a defense?
 - B. When are defenses carried too far?
 - 1. relevance to developmental stages
 - C. Fifteen basic defenses
 - 1. introjection
 - 2. projection
 - 3. identification
 - 4. regression
 - 5. repression

6. denial
7. reaction-formation
8. displacement
9. turning-against-the-self
10. isolation
11. undoing
12. ritualization
13. intellectualization
14. rationalization

15. sublimation



B. Analyzing ones own defenses: some extra considerations

1. eating and drinking

2. sarcasm and clowning

3. falling ill

4. sex

REFERENCE MATERIALS

SESSION IV

Personality Development and Psychopathology, by Norman Cameron
Houghton Mifflin Co. Boston, 1963, pp. 232-245.

SESSION V

ISSUES IN GERIATRIC CARE

- I. Some Developmental Issues In Geriatric Care
 - A. Beyond the 8th stage
 - 1. integrity and despair in institutional care
 - a. the importance of reminiscence
 - b. self-esteem
 - c. dependance vs. independance
 - 2. the need to stay connected
 - a. family
 - b. environment
 - c. interpersonal relationships
 - d. interests

e. sexuality

3. some defense mechanisms of the elderly

a. denial

b. conservation

c. sublimation

d. detachment

e. regression

4. organic brain syndrome & ^{Cancel}~~Depression~~

a. importance of pre-morbid personality

1. ability to adapt

2. dealing with loss

3. problem solving

4. hobbies and interests

II. Dealing with families and staff

A. guilt

B. anger

C. denial

D. detachment

E. identification

REFERENCE MATERIALS

SESSION V

"Recent Research Findings on Practice With The Aging"
by Marie Latz Blank Social Casework, Vol. 52 #6, June 1971.

"Emotional Breakdown in Elderly People" by Muriel Oberleder, Ph.D.
Hospital and Community Psychiatry, Vol. 20 #7, July 1979.

Marie Latz Blank

Recent research findings on practice with the aging

An understanding of an elderly person's life history is especially useful in helping him make plans suitable to his life patterns prior to the time of crisis

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This article considers theories and research findings that may have meaningful implications for direct social work service delivery to the aging. It focuses for the most part on a few findings from cross-sectional, longitudinal studies of normal aging persons and on research on the delivery of service. Also discussed are publications on effective therapy and casework with the aging that give examples of ways in which these research findings may be utilized.

An examination of normal aging patterns may help social workers—who are often on the front line of service to aging persons—to better differentiate between those aspects that are mental health problems and those that are part of the normal process of aging. When a mental health problem does exist, it is important to note the elements that may aggravate the problem and the ways by which the elderly person may most effectively be helped.

Social workers are members of a greater society that attitudinally puts little value on the aged, who, in increasing numbers, "benefit" from today's advancing scientific knowledge. This societal attitude has much to do with how each person approaches his own

aging process and how others care for the elderly.¹ Discussing the "sleeping" problem of the conflict between the old and young in society, Robert N. Butler says, "Age-ism describes the subjective experience implied in the popular notion of the generation gap."²

"Age-ism" should not be a problem for social workers. As a result of their training and experience, social workers are aware that each human being is unique and that fixed ideas about any member of a particular group run counter to their professional task. Too often, however, those who contemplate working with the aging or those who work directly with them consider only the immediate problems that are presented and not the underlying needs. These underlying needs should be taken into account if the helper is to be of maximum use to his older client. Social workers, in general, recognize that all people have basic needs that extend beyond food, clothing, and shelter. The needs of the elderly include having someone with whom to interact, having someone to care about and to be cared about, and having something to which to look forward.

¹Karl Stern, Joan M. Smith, and Margit Frank, Mechanisms of Transference and Counter-Transference in Psychotherapeutic and Social Work with the Aged, *Journal of Gerontology*, 8:328-32 (July 1953).

²Robert N. Butler, Age-Isms: Another Form of Bigotry, *The Gerontologist*, Part 1, 9:243 (Winter 1969).

Many aged people suffer physical and mental losses that hinder their ability to communicate their needs and that isolate them from others. On the other hand, as noted earlier, it appears that these losses are often overemphasized and that certain stereotypes are prevalent in describing aging persons. Fixed mental pictures of the elderly are held not only by laymen but also by professional persons who work with the aging, professionals working with younger persons, and by old people themselves.³ In view of the American cultural value of independence, many of these stereotypes have negative connotations.

Stereotypes about the aging

In a recent study professional practitioners and students in professional schools of social work—some of whom were working with the aged—were asked, "What are old people like?"⁴ The thirteen social work practitioners in the sample who chose to work with the aged offered only positive stereotypes about older people; nineteen social workers working with clients of other ages had, for the most part, negative mental pictures of the elderly. On the other hand, six of the twelve social work students in the sample who were working with the aged in their field placements and 60 percent of the seventy-two students who were working with other clients had negative mental pictures of the aged.

Social work students are not the only professional students who hold such views of the old. In a recent study of freshmen and senior medical students in one medical school, medical students characterized old people as being disagreeable, inactive, economically burden-

some, and dull.⁵ The results of this study indicate that these medical students were more prejudiced against the aged than against any other minority group. The small difference between the attitudes of freshmen medical students and those in the senior class toward the aging patient indicates that professional education has no substantial effect on students' opinions.

Several implications can be drawn from these studies as they relate to the people who will ultimately have to deliver vital services to the aging. Of particular concern are social workers' attitudes toward the aging; these attitudes affect the practice of those who work with the elderly and the amount of manpower available for services. In 1964 Edna Wasser wrote that a sense of commitment to social work for older people who are in trouble had yet to be realized.⁶ It does not appear that attitudes have changed in the past seven years.

These studies are of significance for social workers for at least two reasons. First, in view of the shortage of graduate social workers interested in working with the aging, as well as the shortage of skilled professional persons in general, paraprofessionals could be trained to offer services to aging persons living in the community to help prevent mental health problems. Second, schools of social work should include in their curricula study of the entire life cycle of the individual, rather than focus primarily on the infant, child, and young adult. It is possible that, given a more fully rounded picture of the human life cycle, additional graduate social workers might choose to work with the aging, or, at the very least, would obtain deeper understanding of human development from birth to death.

Paraprofessionals and the aging

The following discussion concerns two studies on the use of paraprofessionals in preven-

³See Franklyn N. Arnhoff and Irving Lorge, Stereotypes about Aging and the Aged, *School and Society*, 88:70-71 (February 13, 1960); Jacob Tuckman and Irving Lorge, Attitudes Toward Old People, *Journal of Social Psychology*, 37:249-60 (May 1953); and Jacob Tuckman, Attitudes Toward Aging of Individuals with Experiences with the Aged, *Journal of Genetic Psychology*, 92:199-204 (June 1958).

⁴Robert L. Wolk, Professional Workers' Attitudes Toward the Aged, *Journal of the American Geriatrics Society*, forthcoming.

⁵Donald L. Spence et al., Medical Student Attitudes Toward the Geriatric Patient, *Journal of the American Geriatrics Society*, 16:976-83 (September 1968).

⁶Edna Wasser, The Sense of Commitment in Serving Older Persons, *SOCIAL CASEWORK*, 45:443-49 (October 1964).

tive mental health services for the aging. The Family Service Association of America (FSAA), with funds provided by the National Institute of Mental Health (NIMH), placed social work teams in five FSAA member agencies with the overall goal of learning whether aged clients, with enhanced casework services, could sustain their social, physical, and emotional functioning to enable them to live more effectively in their communities. Teams consisted of a trained social worker and an agency-trained social work assistant; the caseworkers, who supervised the assistants, believed that their services had been significantly enriched through the assistants' activities on behalf of the clients. The assistants encouraged the clients to utilize community health, welfare, housing, recreational, and institutional resources and accompanied them to various places. Their work with agencies and institutions on behalf of clients saved the workers a considerable amount of time in areas in which professional intervention was not required. So successful was the use of the assistants that four of the five participating FSAA agencies have continued to employ the assistants, although they no longer receive NIMH funds.⁷

Another NIMH project, carried out by the Community Service Society in New York City, has demonstrated how mature, nonprofessional agency-trained workers can provide information and referral services to sustain the emotional, social, and physical functioning of elderly persons in public housing. Service workers were available to residents sixty years of age or older in four public housing projects. The aged population of a fifth housing project was used as a control. Interviews to determine the effectiveness of the program and to compare the control and experimental groups were conducted before the two-year service began and after it ended. The final report on this project indicates:

Served tenants (especially those 75 years of age and older) were sustained to a greater extent than the control (unserved) tenants in their attitudes about their environment (the housing project, the neighborhood), and in their perception of their "happiness with life" and their health condition.⁸

Further, the report states:

The two-year experience supported the premise that in-service-trained workers can discharge responsibilities, as defined in this demonstration, satisfactorily and well under professional supervision. Their utilization frees the professional worker to concentrate on tasks where professional training is essential.⁹

Theories about the aging process

It was stated previously that schools of social work should give greater attention to the life cycle beyond the early years. Allen Pincus has suggested that social workers should attempt to formulate a developmental theory of aging in order to increase their understanding of the aging process and to provide appropriate social work intervention with aged clients in need of help.¹⁰ The best way to obtain solid data about changes and the development of personalities in adulthood and old age is through longitudinal studies of individuals from birth to old age. There are a few studies currently under way that may be able to provide such information in the future, but they are too new to have carried their sample populations to old age. Some longitudinal studies have examined persons from middle age to old age and from old age (over sixty-five) to death. Other studies have been done cross-sectionally—by taking samples of different age groups and comparing them—and some researchers have carried these cross-sectional studies further longitudinally.

⁷Family Service Association of America, Social Work Team with Aging Family Service Clients: Third Summary Progress Report, Submitted to the National Institute of Mental Health, mimeographed (New York: Family Service Association of America, August 31, 1969).

⁸Community Service Society, *Senior Advisory Service for Public Housing Tenants* (New York: Community Service Society, 1969), p. 137.

⁹*Ibid.*, p. 193.

¹⁰Allen Pincus, Toward a Developmental View of Aging for Social Work, *Social Work*, 12:33-41 (July 1967).

One of the better known cross-sectional longitudinal studies on aging, carried out by the Committee on Human Development at the University of Chicago, is known as the Kansas City Adult Life Study. From this study came the well-known disengagement theory of Elaine Cumming and William E. Henry. Persons ranging from fifty to seventy years of age were interviewed several times during the overall study, and, for the purposes of the disengagement theory, a "quasi sample" of aged persons aged seventy to ninety was also used. Cumming and Henry state:

In our theory, aging is an inevitable mutual withdrawal or disengagement, resulting in decreased interaction between the aging person and others in the social systems he belongs to. The process may be initiated by the individual or by others in the situation.¹¹

Using samples from the Kansas City Adult Life Study, Bernice L. Neugarten reported later, in summing up a series of studies on personality and aging, that it appeared that chronological aging was ordered to some extent in the study of intrapsychic processes.¹² Intrapsychic processes involve increased importance of inner life and decreased efficiency of certain cognitive processes. On the other hand, other studies in the same series indicate that socioadaptational patterns are relatively independent of age. Such factors as health, financial resources, and marital status appear to influence the social adjustment of persons fifty years of age and over.

Robert Havighurst, Bernice Neugarten, and Sheldon S. Tobin used later studies of the same sample to compare the disengagement theory and the activity theory.¹³ According

to the activity theory, older and middle-aged people have the same psychological and social needs, but society withdraws from the aged person. Withdrawal is not a mutual process as in the disengagement theory. In the sample studied, it was found that social and psychological engagement appeared to decline over the years. As activity decreased, it was found that the sense of contentment in the subjects appeared to decrease, but that life satisfaction did not decrease. The investigators concluded that neither the activity theory nor the disengagement theory of successful aging would in itself explain the results. One can infer from these studies that the basic personality of the individual is the most important dimension for describing patterns of aging.

After years of study by the Committee on Human Development, Havighurst reported that personality organization and coping styles appeared to be the major factor in the life adjustment of the individual as he grows older.¹⁴ Havighurst noted that few of the persons studied refused to try to adapt to change and that, when there is a close fit among the personality, the social environment, and the physical organism, adaptation is relatively easy and will be successful. The concept of adaptation has implications for social workers who are in the position of helping aging persons adapt themselves to whatever their circumstances are.

An NIMH project carried out in the Jewish Home for the Aged in Philadelphia demonstrated that aged persons who normally would be institutionalized and provided with custodial care can be maintained at an effective functioning level within the community if an integrated program of medical, social, and personal services is available to them.¹⁵

¹¹Elaine Cumming and William E. Henry, *Growing Old: The Process of Disengagement* (New York: Basic Books, 1961), p. 14.

¹²Bernice L. Neugarten, Summary and Implications, in *Personality in Middle and Late Life*, ed. Bernice L. Neugarten and Associates (New York: Atherton Press, 1964), pp. 188-200.

¹³See Robert J. Havighurst, Bernice L. Neugarten, and Sheldon S. Tobin, Disengagement and Patterns of Aging, in *Middle Age and Aging*, ed. Bernice L.

Neugarten (Chicago: University of Chicago Press, 1968), pp. 161-72; and Bernice L. Neugarten, Robert J. Havighurst, and Sheldon S. Tobin, *Personality and Patterns of Aging*, *ibid.*, pp. 173-77.

¹⁴Robert J. Havighurst, A Social-Psychological Perspective on Aging, *The Gerontologist*, 8:67-71 (Summer 1968).

¹⁵Home for the Jewish Aged, Final Report Summary: Integrated Community Program of Services to the Aged, mimeographed (Philadelphia: Home for the Jewish Aged, 1967).

The persons studied were applicants for admission to the home who were ambulatory and capable of moderate activity. Through the project's services, many of these old people were enabled to continue to cope with their life situations and to make limited adjustments within the community.

Theories about depression

Ewald Busse and others at the Center for Study of Aging and Human Development at Duke University have made several reports on a cross-sectional longitudinal study of aging that started in 1954.¹⁶ This study includes data on physical examinations, mental status, psychological health, and social histories of the participants. In his report on findings of this longitudinal study and other studies, Busse states:

Periods of depression that are more or less incapacitating but do not require medical help develop in the lives of most people. Evidence indicates that such depressive periods increase in frequency and depth in the advanced years of life. . . . The older subject becomes depressed when he cannot find ways of gratifying his needs; that is, when social environmental changes or the decreased efficiency of his body prevent him from reducing his tensions, he is likely to have a loss of self-esteem; hence, he feels depressed.¹⁷

Busse indicates further that when the aging person is studied longitudinally, the importance of physical health becomes even more evident; the aging person can tolerate the loss of love objects and prestige better than a decline in physical health. There are many important findings in this particular cross-section

tional longitudinal study, but, for the purposes of this article, emphasis will be given to the depressive reaction found in the aged normal population; this reaction has implications for social workers who are in contact with aged persons, many of whom are impaired physically and who demonstrate their depression in varying ways.

Alvin I. Goldfarb, who has written extensively on psychotherapy with the aged, believes that aged persons have been dismissed as poor subjects for therapy because of their dependency. He points out that there is a failure to "recognize the importance of dependency and helplessness as a basic motivational force in the social behavior of most individuals in our culture."¹⁸ Goldfarb believes that underlying the various ways the aged seek help for themselves are feelings of depression. Aged persons may have a constellation of symptoms, ranging from apathy, displays of helplessness, and hypochondriasis, to paranoid, or openly angry, manipulative, and explosive reactions. The basic components and psychodynamic sequence in old-age dependency start from early in life as a result of genetic factors, disease, and familial, educational, and cultural influences. Later come physical, mental, social, and economic losses, followed by the increasing inability to master the problems posed by internal and external changes, threats that lead to feelings of helplessness, and then fear, anger, and fear of retaliation because of this anger. These feelings finally result in a search for aid.

Goldfarb believes the aging person will model his behavior on what he considers as likely to help him obtain a parent substitute to aid him and that reassurance and support can be offered the aged depressed patient. Winning over a protector by the aged person may directly yield pleasure—the pleasure of

¹⁶See Ewald W. Busse, Research on Aging: Some Methods and Findings, in *Geriatric Psychiatry, Grief, Loss, and Emotional Disorders in the Aging Process*, ed. Martin A. Berezin and Stanley H. Cath (New York: International Universities Press, 1965), pp. 73-95; and idem, *Therapeutic Implications of Basic Research with the Aged*, Institute of Pennsylvania Hospital, Strecker Monograph Series, no. 4 (Philadelphia: Institute of Pennsylvania Hospital, 1967).

¹⁷Busse, *Basic Research with the Aged*, pp. 13-14.

¹⁸Alvin I. Goldfarb, The Psychodynamics of Dependency and the Search for Aid, in *The Dependencies of Old People*, Occasional Papers in Gerontology, no. 6, ed. Richard A. Kalish (Ann Arbor, Mich.: Institute of Gerontology, 1969), p. 1; see also idem, Depression, Brain Damage, and Chronic Illness of the Aged; Psychiatric Diagnosis and Treatment, *Journal of Chronic Diseases*, 9:220-33 (March 1959).

feeling mastery again over a problem—and can provide the patient with the comfort of having a powerful parental surrogate.

Before proceeding to the next longitudinal study, it seems pertinent to discuss briefly Erik H. Erikson's theory of the seventh and eighth stages of the life cycle. Erikson describes each successive life stage as one of inner and outer conflict.

Each successive step, then, is a potential crisis because of a radical change in perspective. Crisis is used here in a developmental sense to connote not a threat of catastrophe, but a turning point, a crucial period of increased vulnerability and heightened potential, and therefore, the ontogenetic source of generational strength and maladjustment.¹⁹

These latent capacities, according to Erikson, are present from birth, and with each conflict they reach ascendancy at a particular time in the life cycle. Each stage is dependent on an earlier stage for the development of the self in the following stages. The seventh stage, which occurs at middle age, he calls "generativity": the guidance of the next generation—or its opposite—the sense of stagnation. The eighth and final stage is either one of integration of all stages or of despair in relation to one's life cycle.

Attempts have been made to operationalize these concepts for research, but, as Erikson has noted, these attempts have often been developed as achievement scales, which represent a misuse of his schema. What Erikson believes is necessary is the ratio of conflict in each of the stages between positive and negative feelings. Robert N. Butler's suggestion that the elderly person reviews his life at a particular time appears to concur with Erikson's concept of the eighth stage. Butler writes:

I conceive of the life review as a naturally occurring, universal mental process characterized by the progressive return to consciousness of past experiences, and, particularly, the resurgence

of unresolved conflicts; simultaneously, and normally, these revived experiences and conflicts can be surveyed and reintegrated.²⁰

An NIMH longitudinal study of the normal aging process was started in 1955 on forty-seven healthy men aged sixty-nine to seventy-one. Follow-up studies were done six and eleven years later with the survivors. The persons involved were examined in relation to their social-personal situations, their medical status, their psychiatric conditions, and their psychological functioning.²¹ Butler reported that in the six-year follow-up of twenty-nine of the thirty-nine survivors, "supporting data were found for the hypothesis that, triggered by the approach of death, older people universally undergo a life review leading to various preparations for loss, bodily dissolution, and death."²²

At the third point in this eleven-year study, Robert D. Patterson, Leo C. Freeman, and Butler reported on eighteen of the twenty-three survivors.²³ They state that the survivors often indicated they had reviewed or still were reviewing their lives. Ten of the survivors had been depressed at one of the three times they were examined during the longitudinal study. Three of these depressions were caused by the despair the subjects experienced while reviewing their lives. The

²⁰Robert N. Butler, *The Life Review: An Interpretation of Reminiscence in the Aged*, *Psychiatry: Journal for the Study of Interpersonal Processes*, 26:66 (February 1963).

²¹James E. Birren et al., eds., *Human Aging: A Biological and Behavioral Study*, Public Health Service Publication no. 986 (Washington, D.C.: U.S. Department of Health, Education, and Welfare, 1963).

²²Robert N. Butler, *Aspects of Survival and Adaptation in Human Aging*, *American Journal of Psychiatry*, 123:1242 (April 1967).

²³Robert D. Patterson, Leo C. Freeman, and Robert N. Butler, *Psychiatric Aspects of Adaptation, Survival, and Death*, in *Human Aging II: An Eleven-Year Follow-up Biomedical and Behavioral Study*, ed. Samuel Granick and Robert D. Patterson, Public Health Service Publication (Washington, D.C.: U.S. Department of Health, Education, and Welfare, in press).

¹⁹Erik H. Erikson, *Identity: Youth and Crisis* (New York: W. W. Norton & Co., 1968), p. 96.

subjects who had reviewed their lives without becoming depressed appeared sometimes to have attitudes that Erikson described as an acceptance of one's own life cycle.

Social workers are in contact with many old people who come to their attention because they are depressed and sometimes exhibit symptoms of organic impairment related to depression. John Clancy states:

Among the aged, depression may be primary or secondary to organic brain disease. Primary depressions in the aged must be distinguished from other psychoses of the senium, but all too frequently the diagnosis is based on age rather than the clinical signs. This distinction is doubly important because the prognosis of treated depression is good regardless of age.²⁴

Social workers should be aware that the act of reminiscence in aging persons may be a sign of their need to review their lives and that they may or may not be depressed. Not only listening but helping the aged person accept what cannot be undone or relived—the social worker's task with some younger clients—can be therapeutic in itself. Butler, who has made use of the concept of the life cycle in his treatment of many elderly persons, emphasizes that both therapeutic and social efforts must focus on the possibilities of the present and deal with the grief for past relationships.²⁵

Judith Liton and Sara C. Olstein, writing on the therapeutic value of reminiscence for aged persons who have had some intellectual deterioration, state, "Reminiscing can enable such clients to regain that part of their identity in which they were most comfortable and may even bring about a further development of their identity."²⁶ They note that what the

client remembers appears to be determined by the emotional content of the past experience as well as by the person's present situation.

Another model of human development has been proposed by Charlotte Bühler, who divides the life cycle into five phases.²⁷ The first phase, childhood, ends at approximately fifteen years of age. This period, which is broken down into several categories, is characterized by the absence of self-determination concerning life goals. The second phase covers the period from fifteen to twenty-five years of age, when life goals are tentative and experimental. During the third phase, from twenty-five years of age to approximately forty-five or fifty years of age, a variety of patterns of self-determination is found. Bühler states:

The middle of life might . . . be expected to be the period in which an individual could settle down to live within the frame of reference of the present in pursuing many immediate objectives; he also might be expected to acquire a clearer outlook on the intermediate and even distant future.²⁸

The fourth phase, from forty-five or fifty to sixty or sixty-five years of age is a crisis period, as is the second phase. At this time, a person must reassess his goals.

The fifth and final phase of life begins at approximately sixty-five to seventy years of age. Characterizing this period is the "gradually evolving awareness of the past life as a whole resulting essentially in fulfillment or unfulfillment and even despair."²⁹ This model, which Bühler originally developed from an analysis of 202 biographical studies in 1933, supports to some degree Erikson's theory on the last stage of life. From her studies, Bühler came to the decision that

²⁴John Clancy, *Other Aspects of Depressions, Geriatrics*, 20:97 (February 1965).

²⁵Robert N. Butler, *Directions in Psychiatric Treatment of the Elderly: Role of Perspective of the Life Cycle, The Gerontologist*, Part I, 9:134-38 (Summer 1969).

²⁶Judith Liton and Sara C. Olstein, *Therapeutic Aspects of Reminiscence, SOCIAL CASEWORK*, 10:263-68 (May 1969).

²⁷Charlotte Bühler, *The Course of Human Life as a Psychological Problem, Human Development*, 11:184-200 (1968).

²⁸*Ibid.*, p. 194.

²⁹*Ibid.*, p. 198.

human life is lived under a certain directive that she calls "intentionality."

Gerard G. Brissette's recent study on the significance of life goals in aging adjustment uses a sample of men and women sixty years of age and over. The preliminary report on this research indicates that "once the principal events of a life are laid out for review, certain major thrusts of the personality (both conscious and unconscious) can be discerned by observers."³⁰ Brissette states:

Beyond whatever academic value there might be in knowing the patterns and personality correlates of life goals, there is the hope that such knowledge will aid in the economy of human resources, enlightening particularly those who work for the relief of the burdens of old age.³¹

³⁰Gerard G. Brissette, *The Significance of Life Goals in Aging Adjustment: A Pilot Study*, California Mental Health Research Monograph no. 9 (Sacramento: Bureau of Research, California Department of Mental Hygiene, 1967), p. 8.

³¹*Ibid.*, p. 54.

Conclusion

The theory and research discussed in this article have two major implications for social workers. First, although it is common in social agencies to examine the life history of the younger client, few agencies consider the life history of the older person to be of interest or of use. An understanding of an elderly person's life history can lead, however, to an understanding of his problems and desires. For the social worker such knowledge is especially useful in helping the aged person make plans that are suitable in relation to his life patterns prior to the point of crisis.

In conclusion, the research cited indicates that depression is not uncommon even among normal aging persons. A number of reasons have been suggested for the aged person's despair and a number of helping methods have been described. It is this writer's belief that social workers can improve their services to older people by gaining an understanding of the emotional components of the last stages of the life cycle and that paraprofessionals could be utilized profitably in giving supportive services to the aging.

Emotional Breakdowns in Elderly People by Muriel Oberleder, Ph.D.

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Many of us who work with elderly people believe that senility, as it is commonly called, actually represents an emotional breakdown in elderly people. Its structure, its course, its causes, and its results are very similar to a breakdown at any age. We all agree that loneliness, ill health, retirement, and all the deficits associated with old age cause unhappiness in the elderly but I think we overlook the obvious fact that those things actually cause mental breakdown. Were we to restore the normal props of living to elderly people, we might very well do away with senility.

One factor that may be slightly more common to old age than to any other age is anxiety. In my belief, anxiety is the extra stress of aging; indeed, old age is anxiety. Old age occurs when external stresses overtax the older person's ability to function, and if you remove the stresses, the person can again function. I feel that anxiety underlies all senile symptoms, and causes them. In old age you have more anxiety-evoking situations and fewer anxiety-reducing opportunities; that formula in itself could account for senility, or emotional breakdown in the aging.

Senility is an ugly word, but it is shorthand for all the nonsense we associate with mental breakdown in old age. We have been brainwashed into thinking that there are very erudite and definite explanations for senility. We speak freely of arteriosclerosis of the brain and chronic brain syndrome. We are told that we lose millions of neurons every day from our brain cells, so that our brain shrinks in measurable proportion to our years, and for that reason alone we must expect irreversible changes in old age. Those ideas are so fixed that even when dramatic studies indicate there is no relationship between actual, visible brain changes and function in elderly people, we tend to overlook those results. Thus if Grandpa loses his memory we say it is because he is an old codger, and there is nothing we can do about it but make him happy until his dying day.

We pay lip-service to possible emotional and social stresses and environmental factors, but we rarely consider the possibility that elderly people who have had a breakdown can recover. We usually think of senility as involving memory loss, disorientation, confusion, aggressive and agitated behavior, senseless rambling, phobias, hallucinations, delusions, and infantile regressive behavior. We have all seen elderly patients chewing on their gums, groaning rhythmically, or being incontinent. But how different are those symptoms from the ones of any seriously regressed patient of any age? I think they are the symptoms of psychosis, not necessarily of senility. The only difference is that when a patient shows those symptoms after 60, he is labeled senile.

When elderly people finally do enter a mental hospital, they are in such a severe state of confusion and disorientation that we tend to think they are senile. But the truth is that the elderly are never considered to need hospital care until they are in an emergency state of breakdown, because the danger signals that warn of an impending breakdown have been overlooked. If we encounter unusual nervousness,

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irritability, depression, unaccountable anger, personality change, apathy, or withdrawal in a young person, we make sure he is seen by a physician to prevent more serious consequences. But when those symptoms appear in elderly people, they are considered par for the course of old age. And so the elderly person seldom is regarded as being sick until he is very sick.

We also tend to overlook the dangerous implications of what appear to be very common and ordinary situations. For instance, when an old person loses his teeth and must face people and eat without his dentures, we do not realize how intensely traumatic that is for him, perhaps even to the point of bringing on senility almost overnight. Instant senility might also occur when a person is advised to wear a hearing aid. Any of the harbingers of old age can cause a radical breakdown in some people, particularly those who have prided themselves on being intact and healthy.

Such situations may precipitate senility or emotional breakdown in the aging, but generally they are not the real causes. I believe that they cause senility only in people who have a predisposition for it--perhaps 2 per cent of the elderly population, not unlike the percentage of people in all age groups who have mental breakdowns. I feel that the main predisposing condition is conflict in middle age.

Middle age is a crucial time, because all the unexpressed and repressed angers that accrue over the adult years begin to fester, and the fear of old age begins to encroach. Many middle-aged people find themselves in a bind: they will look neither inside nor outside themselves, they will not look ahead, and they are even more terrified when they look behind. They very often are tense, irascible, unpredictable, menopausal men or women, and we very conveniently tag some physiological condition as the cause. We forget that these people are actually suffering from the same repressed anger, fear, love, need, guilt, ambition, insecurity, failure, feelings of rejection, and, above all, sexual repression that occur in people of all ages.

I discovered the importance of sexual repression as a factor in senile breakdown quite accidentally, in giving the Rorschach test to elderly patients and receiving a great many anatomical responses. The patients saw kidneys, hearts, lungs, and other organs. The accepted interpretation is that as you get older, you become more concerned with your body, and you worry about getting aches and pains. I too accepted that interpretation, because I was a long way from growing old.

However, I also noticed that instead of looking at a part of the ink blot that really did look like a kidney or other organ, the patients would point to an area that was a pathologically sexual area, on card after card. I thought, Well, perhaps there is a kind of sexualization in old age, manifested in bodily complaints and the need for a doctor's attention. Following that hunch, I have found that elderly people very often use somatic complaints, and bodily preoccupations, and relationships with the doctor to fulfill their frustrated needs for sexual satisfaction or at least some physical contact.

That led me to think that perhaps most senile symptoms are substitutes for frustrated impulses or buffers against inner conflict, and so I began to look at some other typical symptoms. Of course memory loss is the main symptom of old age--and of all psychoses, I now realize. We recognize that memory loss is selective in very old patients. They will remember certain things at certain times and forget them at others. There is no consistency to the forgetting, but there is a purpose; that becomes very clear when you have an opportunity to see elderly people fairly regularly, such as in psychotherapy. You can predict when, how, and what they will forget. They forget things they don't dare remember, or things they are afraid they won't remember.

Many also forget under pressure. If you ask an elderly person, as the first question of an intelligence test, "Who is the President of the United States?" he will very often forget the answer because he is so embarrassed and frightened about taking the test. If you ask him the same question later and he gives the answer, obviously anxiety had blocked his thinking altogether. He will also forget things that are threatening, that disrupt the happy dream he has set for himself, or that invoke other memories that are distressing. Very often forgetting is merely a very handy way of tuning oneself out of a totally unbearable situation. Of course memory does deteriorate with disuse, but that does not mean it cannot be resurrected.

Another form of tuning out occurs when elderly persons simply fail to register certain objects and external events. When the elderly person is terribly preoccupied with his inner problems, which he very often is, he will not see the objective reality around him. That can be demonstrated by asking an elderly patient who seems completely out of contact to look around the room and name every object he sees. It is about the hardest thing to get him to do; he has to struggle to keep his eyes on the things about him. All the interference is coming from an inner source, and it is a visible effort for him to stay with the task. But if he does, it is a victory for him, and he feels a sense of power from his ability to concentrate on external matters.

Confusion also can be a purposeful blotting out of reality. For example, consider the elderly people who are found by the police in a state of confusion, who don't remember their name or address, but do remember their son's address and insist upon being taken home to that address. I think that too speaks for itself.

Even incontinence is merely a symptom, a very effective means of vengeance, degradation, and self-degradation, and, more positively, an appeal for care. Incontinence can be reversed, as all who work with elderly patients know, when it is treated like any other symptom: by confronting the patient, helping him to understand why he uses the symptom, and teaching him to relearn control.

The delusions of the elderly do not differ from those occurring at any age. They permit the patient to make a compensatory use of his intolerable feelings--it is much more rewarding for him to think that he owns the hospital or that he is in his own home than to admit he has been put in an institution. I can understand why many patients under stress sometimes have such a delusion; I have learned to wait, for the symptom will disappear when the stress disappears.

It is true that certain symptoms appear more frequently in old age. However, I do not feel they are necessarily due to old age any more than drug addiction is due to adolescence or bed-wetting to childhood. A person usually chooses the symptom appropriate for his age group--appropriate in the sense that it is his main dread. At age 40 we all start to worry about losing our memory, and at 50 we are convinced we have. At 60 we begin not to care any more about losing our memory; at 70 we may get sore as hell about it; and at age 80 we can cause a lot of trouble for everybody because we are so outraged by it. I purposely cited decade birthdays because they are panic periods, crisis times; they are the ages when we review our life situation.

At all ages, when we are anxious, for the usual reasons of repressed anger, we punish ourselves by selecting the symptom that is the worst for our age and times. For instance, if you want to know what symptoms your adolescent patients will show, just watch television; you will find, as I have these past few years, that the majority of young adolescent male patients will present symptoms of homosexuality. Patients will present other symptoms at other times, but whatever television represents as the worst thing a person in a specific age group can be, that is what he fears he is. Symptoms represent a compulsive fear, and one compulsively grasps the symptom that represents the consequence most feared.

As anxiety increases in old age, the symptoms become more and more limited because of the stereotyped and limited expectations of the aged. Thus they have very few appropriate symptoms to select from, and memory loss is the most convenient because it serves so many purposes.

As I indicated before, I believe the problems of old age start in middle age, and that some people are predisposed to senility. The stresses of middle age represent a new life hurdle quite different from those of childhood, adolescence, or young adulthood. Just as we prepare a child for a healthy adolescence and an adolescent for a healthy adulthood, we have to prepare ourselves in middle age for a healthy old age. However, it is during those crucial middle years that people so often tune out considerations of old age.

For example, one of the big difficulties in getting backing for geriatrics programs is that most of the administrators are middle-aged, and they turn a deaf ear when you talk about the elderly. The young people are very cooperative; they do not have many fears of old age yet. Thus you have any number of young students volunteering to work with the aged, but very little professional or administrative help. That phenomenon extends outside the profession into the legislature, and elsewhere. It is almost impossible to get a legislator to listen when you are discussing the elderly.

Scores on IQ tests show a very definite drop for all types of people at age 60, and of course it is unrealistic to think that everybody instantly deteriorates at 60. A more reasonable explanation is that at age 60 you either are faced with retirement or have just retired; the whole galaxy of feelings associated with retirement comes into play, and you bring dysfunction upon yourself. I believe that people bring senility upon themselves, and I think they can do so at any time of life when they feel sick or have been terribly disappointed. We all remember feeling old at many periods of our lives, always low periods. When you are really old and you are feeling stress, you grab at the senile symptoms to end the tension. I believe it is a compulsive thing in some elderly people, especially those in mental hospitals.

Certain special threats of middle age persist into old age. They can be categorized as threats to sexual ability, to status, and to sense of security. As we grow older, we begin to feel signs of weakening in those three most important adult areas, which are closely tied with our sense of self-esteem as a human being. The delicate mechanisms of our psychological balance are easily tilted by the enormous fear that assails us about those areas.

Many common occurrences in old age or even middle age, such as loss of teeth, eyesight, hearing, might start an emotional breakdown. We are aware of the destructive effects of major dislocations, poor health, and death of a spouse, but we seldom recognize that the senile symptoms that often accompany them really are symptoms of acute emotional breakdown. They are transitory reactions to stress, and they are treatable and reversible.

Usually, however, the elderly person is not given a chance to recover. For instance, if a 70-year-old man falls and breaks his hip, the family physician immediately recommends hospitalization. The patient wakes up after surgery and finds himself in a strange place surrounded by his family's anxious faces. He may temporarily become confused, and may not even recognize his family. The kindly physician will say to the family, "He's an old man and that's why his hip broke when he fell. I think you might want to start thinking about the fact that your father will not be the man he was. He may not know you. He may lose his memory. He may become confused. You might do him a favor by putting him in a nursing home." In other words,

the old person is not really permitted to recover. When he does show signs of alertness from time to time, they are regarded as intermittent residual functioning, not as an indication of potential.

So far I have been referring to the elderly as much-victimized individuals who suffer from our many bad treatments of them. The elderly are not angels. They are exactly what they were all their lives. If they were rats, they become worse rats. As they grow older they feel guiltier, often with good cause. In some patients, their guilt, anger, fear, and worry about punishment will result in senile breakdown. It is very hard to make contact with them, because they are terrified of punishment, and with good reason. Very often they want to be senile. It is a way out, a comfortable one, and they don't want you to bother them. When you do bother them, you often find a deeply distressed human being. Then you ask yourself, "Why did I wake him up out of his dream?"

I have had some good results with traditional psychotherapy with elderly patients. However, I have not had an opportunity to follow them up, and I do not know how long our cures last, if you want to call them cures. First of all, I am a little suspicious of the rapidity with which older patients drop their symptoms, although it may be that they have fewer defenses to break down. I usually encounter these patients in a mental hospital, which is the end of the line, and they may have less to defend because they think of themselves as being so completely indefensible.

When such patients do recover, we cannot expect them to continue to function well for long if they go back to the very same situations that drove them crazy in the first place. Family therapy should be used with elderly people's families as with those of younger patients. The families have many attitudes to be changed, and many guilts to be worked with, and they must be involved in plans for the patient. Of course, generally speaking, the situations that cause breakdown in old age are part of our society, and we do not have an atmosphere conducive to emotional well being for the aging.

Suppose the restored elderly patient cannot or should not return to his family and is willing to go elsewhere--to a residential home or a retirement village, or to a pleasant apartment such as our hospital provides for elderly ex-patients in the community. We then face a new problem, which for lack of a better word, I call separation anxiety. It is the same thing we see in children going to school for the first time; they are both eager and afraid to try out new things, and at the same time they feel terribly disloyal to their parents for being glad about leaving them.

The same occurs with retired people and their middle-aged children. The elderly parents look forward to having a nice life near a golf course in Florida, and the middle-aged children may welcome having the parents live further away. But both sides feel they should not be happy to be rid of the other, and so, because people who realistically want to be apart feel that they should stay together, a bind is created.

Sometimes I think a brusque and ruthless approach is best. Just say, "Forget it. You know what the situation has been like, and it has not been a success to this point. Why not separate? Don't worry about your child, go!" You both have other resources available to you. Enjoy yourself." Sometimes that works, but never with a depressed person who is afraid to feel joyful. Depressed people in old age, and perhaps those of all ages, are afraid to feel happy because they are afraid they will be punished for it. Elderly people hug their depression because they are terrified that a lightning bolt will strike them if they dare allow themselves to be a little happy.

Now the question arises about how to prevent an emotional breakdown in old age. You prevent an emotional breakdown in the obvious way, by providing a healthy environment and plenty of opportunities to develop satisfactory roles in life and good self-attitudes. Nevertheless, no one is guaranteed a pleasant old age unless he resolves his middle-age conflicts when they arise. How anger is handled in middle age is a very good clue to how the person will react in old age. He does not necessarily need psychoanalysis or even psychiatric help. I think most people who have lived a healthy life into middle age are perfectly capable of working through the problems of middle age themselves, possibly by talking to a friend or two. The important thing is to immediately identify what triggered the anger, then deal with and dispel the anger, for if accrued, it becomes terribly self-destructive.

One of the things to be avoided, in both middle age and old age, but particularly in middle age, is the tendency we have to dissociate ourselves from old age. In old age, the dissociation is reflected in an actual denial of reality, and can lead to various kinds of bizarre and psychotic behaviors. However, denial sometimes is a helpful defense in old age if it remains within realistic bounds. I am reminded of the questionnaire about negative and positive attitudes toward old age that I gave to elderly people when I was doing my doctoral study. I discovered that people who had the highest intelligence and gave the most youthful Rorschach responses had the most negative attitudes toward old age; they saw other old people as being hopeless.

One such woman I tested had at the age of 83, won \$50,000 on a quiz program as an expert on Shakespeare. Her responses about old age were negative, but she had completely dissociated herself from the elderly; on the attitude scale she wrote, "These are my observations, not necessarily my sentiments, in respect to other people." I might add that she had been and still is living a happy life. She takes her fellow residents at a home for the aged for walks, reads to them, and helps take care of people some 20 years younger than herself.

One of my most recent discoveries is that if a room is bright and cheery, or there is music playing, or there is a pleasant odor about, an old person will suddenly become more alert. When I hold group therapy on the wards I have charge of, we spray cologne around, have bright pictures on the wall, and turn on a radio. We go up to a patient, look him full in the face, and say in a very loud voice: "How are you, Mr. So-and-So?" We find the patients respond and become very alert. This is what is known as sensory stimulation; many studies with younger people show that when you deprive a person of stimulation to his sense, he may become hallucinatory or delusional or lose control of his ability to test reality.

Perhaps there is a neurological explanation for that. Recent studies have shown that connective fibers extend from sense organs in the brain up through the reticular or the limbic area and into the cortex, indicating that an activating process may take place when a sensory organ is stimulated. In any event, I believe that any kind of stimulation--sensory, emotional, occupational--is helpful, and that there is a good possibility that senility can be reversed through it. Hospitals with reality-orientation programs for elderly patients use that principle.

Some hospitals and nursing homes have had good results in stimulating elderly patients to be sociable through a regular social hour where beer or wine is served. On my wards we have served wine with dinner, not so much for its effects on sociability but to remind patients that the day has passed; they know it is dinner time because that is when the wine is served.

In curing senility--and I regard senility as a curable mental disease, a psychosis--it is always important to identify the precipitating causes and crises and, if possible, the antecedents. They should be discussed with the patient as soon as he is in contact. If the explanation is given to him in a kind, gentle, and matter-of-fact way, he will readily understand and accept it.

We must also try to identify the patient's pattern of symptom formation. Is he an aggressive person? Is his behavior an acting out? Is it a form of denial or a consequence of memory loss? We must also try to identify the purpose of his symptoms as we do with patients of all ages. We can then treat him just as we do them; we remain aware of the defensive use of each symptom and take it away from him as soon as he is comfortable enough to operate without the symptom. The patient can find that comfort in his relationship with the therapist, if he is given time to recover.

Very often patients will sit in group therapy without any visible change for weeks, listening intently to the therapist. One difference in group therapy with the elderly is that it is permissible for the therapist to say a lot. He can talk for the patients, and about them, very openly--about how horrible children are to old people, how ugly old people look, how terrible it is to lose your teeth--saying all the things that are unmentionable. Whatever the patients have or are can be discussed without mincing words. The therapist discusses it for them. Some patients are nourished by what is said, and they recover through it.

The method employed here is to release the potentialities of the patients by ventilating their immobilizing tensions. If they cannot ventilate them for themselves, you find out what the dynamics are and do it for them. We have also used role-playing very successfully with elderly patients. Then, of course, through reality-orientation programs, we take active steps to dispel delusions and constantly bring a realistic awareness to the patients.

Activity is therapy for the aging, and almost anything they do will be curative. Allowing them too much idle time for introspection can be harmful, because they are not nourishing the other strengths that they have. If there is a difference in old age, it is that the individual often has fewer inner resources. One has to keep the resources that one has in very good shape, and they have to be exercised and stimulated. The sort of daydreaming that might be fully acceptable at a younger age can become dangerous in older age, if it prevents the patient from having the stimulation he needs.

We seem to have a double standard in treating patients. If we admit a younger patient who is very confused and out of contact with recent events, and if after several months of therapy the confusion and memory loss clear up, we consider him recovered. But when the same happens with an elderly patient, we still expect arteriosclerotic change and do not regard him as recovered. I think it is that expectation of senility we have to work against, more than the reality of senile breakdown.

BIBLIOGRAPHY

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- * Mead, Margaret, Male and Female, New York, 1949
- * Satir, Virginia, Peoplemaking, Science and Behavior Books, Inc. Palo Alto, California, 1972.
- * Sheehy Gail, Passages, E.P. Dutton & Co., Inc., 1976.

* Located at University of Southern Maine Library, Portland Campus

TELELECTURE COURSE REACTION FORM — ALLIED HEALTH

The Bureau of Continuing Education for Nursing—University of Southern Maine

The presentation of a learning experience remotely by telelecture is new. The following questions are intended to help identify the strengths and weaknesses of this system. As one of the first persons to experience telelecture in Maine, your honest responses will be valuable in the improvement and overall evaluation of this instructional method. Thank you.

This form must be completed during the final meeting of the course and returned, along with other materials, to the staff liaison person in order to complete course requirements for Continuing Education Units (CEU's).

NAME: _____ SOCIAL SECURITY NO.: _____

COURSE TITLE: _____ LOCATION: _____

YOUR POSITION: _____

WORK SHIFT:

1. ☐ Days 3. ☐ Nights
2. ☐ Evenings 4. ☐ Rotating

HOW MANY REPRINTED ARTICLES DID YOU REQUEST FROM THE LIBRARY? _____

IF YOU DID NOT REQUEST ANY ARTICLES, PLEASE EXPLAIN WHY: _____

WHY DID YOU TAKE THIS COURSE? (Please select ONE which best applies).

1. ☐ To keep up with latest developments in your profession
2. ☐ To fulfill a specific educational objective
3. ☐ Lack of other education opportunities
4. ☐ Enrollment is mandatory

5. ☐ To qualify yourself for a new position
6. ☐ In order to obtain CEU's
7. ☐ Other (specify) _____

PLEASE INDICATE IN THE LEFT HAND COLUMN YOUR ATTITUDE ABOUT TELELECTURE BEFORE YOU TOOK THIS COURSE; AND CHECK IN THE RIGHT HAND COLUMN YOUR ATTITUDE ABOUT TELELECTURE NOW.

BEFORE CLASS NO. 1

1. ☐ Very positive
2. ☐ Positive
3. ☐ No Feeling Either Way
4. ☐ Negative
5. ☐ Very Negative

FINAL CLASS

- ☐ 1
☐ 2
☐ 3
☐ 4
☐ 5

PLEASE DESCRIBE AT LEAST TWO JOB RELATED INSTANCES WHERE YOU USED INFORMATION FROM THIS COURSE:

1. _____

2. _____

WHAT TOPIC, WHICH COULD BE OFFERED BY TELELECTURE IN THE FUTURE, WOULD BE OF MOST INTEREST AND VALUE TO YOU?

TOPIC

SUGGESTED SPEAKER & ADDRESS

1. _____

2. _____

WOULD YOU BE WILLING TO SERVE ON A COMMITTEE VIA TELELECTURE TO PLAN FOR OTHER COURSES? YES _____ NO _____
AT THE BEGINNING OF THE SYLLABUS IS A LIST OF SELECTED LEARNING OBJECTIVES.* BY PLACING CHECK (✓) MARKS IN THE APPROPRIATE BOXES BELOW PLEASE RATE HOW WELL YOU ARE ABLE TO MEET EACH OBJECTIVE AT THE END OF THE COURSE.

OBJECTIVE NUMBER	RATING (Check one for each objective)					
	Not at All					Very Well
	1	2	3	4	5	6
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						

OBJECTIVE NUMBER	RATING (Check one for each objective)					
	Not at All					Very Well
	1	2	3	4	5	6
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						

*Some program planning objectives may number less than the 20 provided for on this form. In such cases the remaining boxes should be left blank.

PLEASE COMPLETE THE QUESTIONS ON THE REVERSE SIDE

PLEASE INDICATE YOUR RESPONSE TO THE FOLLOWING STATEMENTS BY CIRCLING THE NUMBER WHICH BEST DESCRIBES YOUR REACTION TO EACH STATEMENT. FOR EXAMPLE, IF YOU STRONGLY DISAGREE WITH A STATEMENT, YOUR RESPONSE WOULD BE:

AGREE 1 2 3 4 5 6 7 DISAGREE
 IF YOU SLIGHTLY AGREED, IT WOULD BE: AGREE 1 2 3 4 5 6 7 DISAGREE
 IF YOU WOULD LIKE TO MAKE ANY COMMENTS ABOUT PARTICULAR QUESTIONS, PLEASE FEEL FREE TO DO SO.

The presentation by the instructor was clear and well organized.

AGREE 1 2 3 4 5 6 7 DISAGREE

Comment: _____

The instructor presented the material with a great deal of enthusiasm.

AGREE 1 2 3 4 5 6 7 DISAGREE

Comment: _____

The SYLLABUS for the course supported and clarified the content presented by the instructor.

AGREE 1 2 3 4 5 6 7 DISAGREE

Comment: _____

Course materials other than the syllabus (slides, pictures, articles) were well coordinated with the course content.

AGREE 1 2 3 4 5 6 7 DISAGREE

Comment: _____

The course was accurately described in the information you received before the first class session.

AGREE 1 2 3 4 5 6 7 DISAGREE

Comment: _____

Hearing discussion from other course participants helped you to learn.

AGREE 1 2 3 4 5 6 7 DISAGREE

Comment: _____

You feel that you shared your ideas and knowledge with other listeners on the telelecture network. (Please explain why if you disagree with this statement).

AGREE 1 2 3 4 5 6 7 DISAGREE

Why you disagree or other comment: _____

The balance between lecture and discussion was appropriate to the subject matter.

AGREE 1 2 3 4 5 6 7 DISAGREE

Comment: _____

The length of the course was appropriate to the amount of material provided.

AGREE 1 2 3 4 5 6 7 DISAGREE

Comment: _____

Your knowledge and understanding of the subject area has been significantly improved by the course.

AGREE 1 2 3 4 5 6 7 DISAGREE

Comment: _____

You expect that your job performance will be significantly improved by this course.

AGREE 1 2 3 4 5 6 7 DISAGREE

Comment: _____

You would attend a TELELECTURE course again assuming the content was of interest to you.

AGREE 1 2 3 4 5 6 7 DISAGREE

Comment: _____

You would recommend this course to other nurses as a valuable educational experience.

AGREE 1 2 3 4 5 6 7 DISAGREE

Comment: _____

What would you recommend to improve the delivery of courses via telelecture? _____



***Department of
Continuing Education
for Nursing and Health Professions***

*University of Southern Maine
a unit of the University of Maine*