

PSYCHIATRIC ASPECT OF MIDDLE AGE

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Some thirty years ago Walter P. Pitkin wrote a book called *Life Begins at Forty*. Its sales rocketed to millions and it probably helped to crystallize the attractive image of youthful middle-age which beguiles us from the pages of American magazines, with its sun-tanned greying men with flashing teeth, skilfully concealing girth under colourful, capacious, Hawaiian shirts, or those icily elegant, exquisitely poised ladies of ambiguous age wearing dark glasses and enjoying cocktails with the captain.

A recent magazine article (1960) assures us that both philosophy and science have firmly established that the maximum satisfaction and gratification in life begin at 50 and not at 40. The article contains an interesting table which reflects the change in our attitude towards different stages of the life span during the last 60 years. In 1900, middle age was regarded as extending from 35 to 50 years, whereas now the term is more commonly referred to as the span between 50 and 65; 65 to 80 has displayed 50 to 60 as the period of latent maturity and old age now beings at 80 instead of 60. It is clear, since few achieve such an impressive life span, that most of us, and men in particular, need never grow old.

The middle aged as well as the aged are forming an increasing proportion of the population. In Great Britain at the beginning of the century 23.7 per cent of those aged between 15 and 64 were in the 45 to 64 age group, whereas the figure is now 36 per cent. In the United States there are 31,000,000 Americans between 50 and 70; ten years hence there will be 37,000,000.

As there is no objective measure of biological ageing we have no way of choosing between the periods designated as "middle age" in the 1900s and the 1960s. I shall therefore direct my remarks towards that part of the life span which comes roughly between 45 and 70. From the psychiatric point of view this can be given some justification in that the incidence of the mental disorders characteristic of, and largely peculiar to, senescence is very low under the

age of 70. Moreover, at about the age of 45, the graph representing the variation with age of admission rates to mental hospitals, shows a steep upward incline in both men and women.

Changes in the health of the middle-aged

Is there any evidence that the middle-aged can look forward to a longer and healthier life today than three or four decades ago? In the 1930s a man of 50 could expect to live 21 more years. Today he can expect to live 23 years. As the period covers the introduction of penicillin and a vast repertoire of new substances for dealing with cardiovascular and renal disease, as well as countless developments in surgical technique, this hardly gives cause for jubilation. In the case of women, the expectation has, however, moved up appreciably from 22 to 27 years. But it would not be logical to leave out the dark side of the picture, the "epidemic", as Professor Morris (1957) has called it, of diseases in middle age—particularly in males. This has already been discussed a great deal, and I shall deal very briefly only with one point which seems to have some rather important psychological and public health aspects. The "epidemic" to which Professor Morris was referring is the increase in the incidence of bronchogenic carcinoma, myocardial infarction, peptic ulcer, and other conditions such as hypertensive heart disease. The upward curve in male mortality has been so sharp that it has offset to a considerable degree the decline in mortality from diseases such as tuberculosis and other infections that have been brought under control. If fresh virus diseases were to arise and attempts to halt the toll taken by the new "epidemic" should fail, death rates among middle-aged males might well rise again in the near future.

A fact of public health interest is that the differential between male and female mortality rates is far smaller in Scandinavian countries. For example, in Great Britain and the U.S.A. in the age group 55 to 64 years mortality rates are about 22 to 23 per thousand in men, as against 12.5 in women, whereas in Scandinavia the figures are 14.4 and 10.7 respectively. A discrepancy of this order between these groups of countries is unlikely to be due to simple differences in living standards. More subtle differences in the nature of the social and psychological stresses to which men in particular are exposed may be concerned.

Turning to the mental health hazards, epidemiological data show that in the forties suicide rates show a steep rise to reach a peak at about 65 years in women and rather later in men. This pattern of incidence of suicide is so consistent in the great majority of countries for which suicide statistics have become available that it suggests some underlying biological phenomenon, although the explanation may, of course, be in a quite different direction. Attempted suicides

probably amount to six or seven times the number recorded annually for consummated suicides, which already number over 5,000 per annum in England and Wales. The 35,000 to 40,000 persons who attempt to take their lives each year constitute a large volume of human suffering and a medical and social problem that is of growing proportions in many countries; the middle-aged contribute a substantial part of it. As far as mental illness is concerned, the incidence of the commonest of all forms of mental illness, namely, depressive and allied disorders, rises progressively in middle age to reach a peak at about 60 to 65 years in both sexes. In men there is a steep upward trend from about the age of 45 onwards. (Survey of Admissions to Mental Hospitals in Northumberland and part of Durham, 1957-59).

There has been an overall decline in suicide rates during the past few decades but women and the aged have benefited least from the change. The reasons for this are to be sought partly in the fact that social groups that become more emancipated or isolated are particularly vulnerable to suicide. Danish women, for example, are a relatively emancipated group and also have a high suicide rate; it has been said "Danish women commit suicide because they smoke cigars". The relevance of these facts is that with such high mortality rates among middle-aged males the proportion of middle-aged and elderly widows is rising in many highly developed societies. Nor have we any grounds for complacency as far as mental disease is concerned, for if we judge from rates of first admission to mental hospitals in the U.S.A. and England and Wales the incidence has recently been rising quite steeply in both middle and old age.

Stresses of middle age

Middle age in our culture is undoubtedly a testing ground which tends to reveal the Achilles' heels or vulnerable points of many personalities. Opportunity becomes restricted and the individual is compelled to take stock of where he has got to in life. He may have to face a discrepancy between his ambitions and achievements, and in our society the pattern of his existence has frequently been set once and for all. This is a time when children establish their independence, depriving many women of a meaningful role. As industrial societies are markedly dependent upon speed, drive, inventiveness and enterprise, youth and youthful middle-age tend within them to be exalted, and changes in physical health in men and personal appearance in women are prone to prove particularly stressful. In those who, for reasons of personality or for other causes, have failed to marry, middle age is often a turning-point at which an increasing withdrawal and isolation begin. The changes are frequently more pronounced in women who suffer greater

emotional deprivations in the unmarried state than do men. But, as we shall see, causes and effects are difficult to disentangle in these withdrawals into isolation. In women also, the physical changes associated with the menopause and their accompanying symptoms of flushing, headache, and emotional lability provide more disturbing reminders than in men that they are moving into what they have been taught to regard as the declining half of the life cycle.

Involutional depression, which is merely a variety of endogenous depression, is probably the most widely discussed psychiatric disorder of the middle-aged and exogenous causes, whether these are physical or psychological, can by definition, play very little part in its causation. But too much has been written about this subject and too little attention paid in recent years to neurotic illnesses, anxiety states, reactive depressions, hypochondriasis, and even more ill-defined disturbances which have many more threads of continuity with the individual's psychological development and whose frequency and importance in the middle-aged we are beginning to appreciate.

An alternative to discussing the subject under the headings— anxiety state, reactive depression, hypochondriasis, paranoid reactions, and hysteria—would be to consider the psychological Achilles' heels or weak spots particularly prone to be exposed with the advent of middle age: dependence and inadaptability, egocentric over-concern with physical appearance and physical fitness, coldness or incapacity for emotional contact with others and emotional immaturity and superficiality which are among the underlying psychological origins of these disturbances. But for the sake of simplicity it would perhaps be best to discuss these topics under their generally recognized headings.

Anxiety, neuroses, hypochondriasis and phobic states

It would be superfluous to discuss on an occasion such as this a mode of onset and clinical picture of the usual form of anxiety neurosis, the autonomic disturbances, psychological and physical tension, irritability, irrational fears, and insomnia. It will perhaps be more profitable to concentrate on the less commonly discussed aspects of this form of illness. Let us therefore consider the precipitating stresses and mode of onset of the anxiety neuroses in middle age as at all ages. Men are more prone to fall ill after some physical illness or disability, women after a bereavement or some other threat to their security. The clinical picture also shows variations in the two sexes in that somatic symptoms and concerns about disease and death are commoner in men; phobic features, feelings of terror in unfamiliar surroundings or when inadequately sup-

ported, in the case of women. Needless to say, there is a good deal of overlap between the two sexes. But the distinction is nonetheless of value.

(a) *Anxiety neurosis in men*

A great deal has been said and written about the value and importance of physical exercise, particularly in the case of men. At this symposium its prophylactic value has been emphasized by several speakers. One cannot fail to agree with most that has been said but a psychiatrist would wish to make certain reservations, and it is for this reason that I have chosen to discuss first the anxiety states in men. For the worship of athleticism and physical prowess can have psychological consequences that are not wholly desirable. The danger of being physically incapacitated constitutes a psychological stress for all individuals, but socially and economically physical ill-health constitutes a greater threat to men so it is not perhaps surprising that it is so commonly found among them in association with emotional disturbance in middle age. The psychological processes involved are particularly well exemplified, as is often the case, by caricatures and in this instance they are provided by those individuals who have sought to preserve physical fitness through enthusiastic addiction to weight-lifting, body building and the liberal use of chest expanders and punch balls. These are the patrons of the "You too can have a body like mine" business and the entrants for the "Mr Tarzan" or "Mr Atlas" competition. But for every one of these caricatures there are many more whose sense of worth fluctuates in close parallel with their athletic performance and physical fitness. The emotional feet of clay of such a physical Colossus may crumble quite suddenly in middle age. Following a myocardial infarction, an acute respiratory infection or an infective hepatitis, he may complain for months or even many years, of fatigue, depression, insomnia, and failure of concentration, irritability and, above all, a whole host of physical discomforts. This picture may even follow some quite benign illness or an incident as trivial as a severe bout of dyspnoea following exertion, some submammary pain or a few extrasystoles. The clinical picture ranges between severe psychological tension and a few physical symptoms, at one end, to a continual and compulsive scrutiny of the body which leads to the excavation of bizarre sensations and a fear or firm conviction of disease that are almost delusional.

Doctors are not altogether blameless, for one not infrequently sees a severe anxiety state with prominent and hypochondriacal features initiated by a diagnosis that has been dropped suddenly like a ton of bricks on the patient. It is a well-established fact that for every case of benign hypertension diligently attending at the

surgery or outpatient clinic for treatment, there are two or three others of the general population blissfully unaware of the fact that there is anything the matter with them. The difference between the two groups appears to derive partly from the fact that the first patient has probably been to a doctor who has said to him, "Your blood pressure is very high you know; you will be in serious trouble if you don't ease up". Or the patient may have been perfectly well until rejected as a poor risk following examination for life insurance.

It is of encounters such as this that the great physiologist Lawrence Henderson may have been thinking when he said at the beginning of this century that a man encountering a doctor for the first time in his life has a one in two chance of not coming to harm. For the headaches, difficulty in concentration, irritability, impatience, sense of fatigue, dyspnoea, precordial pain, insomnia, tension, and tremulousness which were once upon a time regarded as common early manifestations of benign hypertension, are now regarded by many workers as being part of an anxiety neurosis frequently initiated by clumsy and disturbing communications of the diagnosis to the patient. In any event, there can be no doubt that the whole range of these symptoms differs in no way from anxiety states unassociated with hypertension.

In the more compulsive and fanatical athletic addicts, there is invariably some hypochondriacal preoccupation with one or other part of the body, and the fear-laden belief that disease may be present quickly hardens into a conviction that the disorder is incurable. This may concern the heart, which is believed to be weak or giving out. There may be continual inframammary pain, aggravated by effort or emotion. Every cardiologist's clinic abounds with cases of pseudo-angina, effort syndrome, and cardiac neurosis. The illness may take a more bizarre form, as when after some quite trivial injury or infection, the patient insists that the genitalia have become numb and painful, that the vertebrae are displaced or the abdomen full of growth. These bizarre forms of hypochondriasis are readily identifiable, but more subtle forms of psychological deflation commonly occur in vigorous, confident, and extroverted men, suddenly afflicted in middle age by some physical disability. When they insist that they have never had a day's illness, this is not altogether a reassuring statement. Their physical complaints may be the subject of long and expensive medical investigations and the more protracted these are, the more firmly ingrained and chronic the symptoms tend to become.

A more rare development from such a starting point in an anxiety state with hypochondriacal features, is the attempt occasionally made to discover some face-saving escape from the humiliation

which ageing or physical disability brings to those whose pride in their physical prowess has been excessive. One of my patients had been a considerable soccer player and athlete in his youth and he had continued playing football well into his forties. Following a menisectomy at the age of 48, this man, who had previously had a quite blameless work record, developed intense pain and recurrent swelling of the knee. He began to complain bitterly of the disability this was causing him and hints were dropped that surgery and an artificial limb might be rather more beneficial than the clumsy and unscientific procedures to which he had been submitted so far. In due course it was discovered that the swelling, which had come to an abrupt and unanatomical end just above the knee, was due to the fact that a tourniquet of rubber tubing had been applied there for several hours each day by the patient.

Although the combination of anxiety, depression, and hypochondriacal self-scrutiny are not uncommon in middle age, the subject we are discussing has wider implications. Women on the whole respond better to the physical handicaps and disabilities which ageing brings than men, possibly because they have a long experience of their bodies as sources of pain and discomfort, as well as satisfaction. Illness in middle and old age occurs more frequently in women but men are more prone to die from identical maladies. One cannot help wondering whether the marked difference between the sexes in the prognosis of essential hypertension has not something to do with the psychological factors which we have discussed. But there is at present no definite evidence bearing on this question.

(b) Anxiety neuroses in women

I have deliberately discussed first the emotional repercussions of middle age for men, since these are much less widely recognized and therefore more prone to be overlooked. Yet psychological difficulties are, on the whole, commoner in women; and the dependent among them are particularly prone to be exposed to stress because bereavement or illness in aged relations may remove emotional supports vital to their sense of security. They may be further exposed because the departure of children and perhaps the weakening of relationships with spouses may throw the patient on her own resources. The anxiety state commonly presents with heightened tension, insomnia, increased irritability, and low frustration tolerance, which tend to subside as the patient adapts to the new circumstances. But the death or serious illness of some supporting figure may prove to be such a severe stress that in an individual whose maturation and capacity for independent life are deficient, much more disabling neurotic illnesses follow. Leaving familiar surroundings initiates attacks of acute panic and a sense of impending death, feelings of

giddiness, syncopal attacks and frequently other complicated subjective experiences which may include depersonalization, visual distortion, transient hallucinations and *déjà vu* phenomena (Roth, 1959). Dependence may be a relatively circumscribed emotional handicap and when it is traumatically uncovered in this way by the development of illness in middle life, the façade of assurance and maturity which many individuals have successfully cultivated by this age may effectively disguise the psychiatric nature of the malady. Elaborate investigations for organic disease are frequently conducted in such seemingly "normal" subjects. The patient may complain of somatic symptoms such as epigastric discomfort, headache, giddiness, and fainting attacks. Only enquiries which span an adequate range of psychiatric symptoms and signs will uncover the true situation, namely that these individuals suffer from a state of chronic, exaggerated fear, a fear of being left alone and unsupported in the world. This is the underlying psychological basis of the phenomenon of the housebound housewife—the individual who cannot shop or travel or enter crowded rooms or stay alone in the house for fear of being overwhelmed by anxiety. But the condition also has an important neurophysiological aspect which may lead in cases with syncope or transient attacks of panic or depersonalization to an erroneous diagnosis of epilepsy (Harper and Roth, 1962; Roth and Harper, 1962).

This brief account of a complex disorder unavoidably oversimplifies matters. Thus although the majority of patients with this particular form of anxiety state ("the phobic anxiety-depersonalization syndrome") are women, the disorders are by no means rare in men. Further, the stresses which precede the onset of illness are not specific in the two sexes; physical illness or an operation such as hysterectomy may be a precipitating factor in women, and bereavement in men. The age of onset also varies within fairly wide limits, but the paradigm of the disorder is provided by those cases in which death of a close relation, usually the mother, initiates in a woman between the ages of 30 and 50 years an anxiety state of the kind described.

The phenomenon reflects an important piece of social psychology for, as Peter Townsend (1957) has pointed out, the relationship between mother and daughter has become the main bulwark of family unity, whereas before the Industrial Revolution it was the relationship between father and son. The relationship between our female patients and their mothers has been an unusually close and intimate one. They usually lived close to their mothers and saw them at frequent intervals. Their interests, aspirations, and patterns of social relationships and even their neuroses were often similar. We are dealing here not with patients who have been exposed in

childhood to the better known stress of separation but relationships that are unusually close and interdependent. Our patients' sense of security had been vulnerable because it was suspended by the slender thread of the survival of one or a very few individuals. The thread was all too prone to be severed in the thirties or forties.

Here again the description oversimplifies, for often warmth and cosiness were not the only components in the mother-daughter relationship. On the mother's side, there were at times elements of coldness, domineering, or possessiveness; on the daughter's an ambiguously poised attitude and a dependence that was resented as well as clung to. After bereavement guilt was blended with anxiety. But the most conspicuous and consistent components were closeness and deep affection and our patients exhibited merely an extreme form of one end of a relationship that is surely part of the everyday experience of doctors and social workers. An important sociological point in this connection is that the rapidly-increasing mobility of population is rendering less and less common the pattern Townsend described in working-class areas such as Bethnal Green where mother and daughter often lived within yards of one another and there was a reciprocal flow of services as well as a closeness between the generations. Hence, when we transplant the younger generation to satellite towns, the social effects are incalculable. These towns and many suburban areas are at present largely occupied by young couples and their children. Twenty-five years hence they will be towns wholly populated by the middle-aged and elderly. The housebound housewives in satellite towns and suburban areas and the infirm and sick old people who have no one to care for them at home in the cities may to some extent reflect different facets of the same problem.

Depressive illness

Psychiatric illness commencing for the first time in middle age, whatever its character, is rarely if ever wholly due to psychological causes. Psychological stress may precede such a disability, but the illness that follows bears little relationship in severity or content to the events that seemed to start it off. These are the endogenous illnesses, and the commonest by far is endogenous depression. In a typical case the illness starts in a fairly abrupt manner and even if there have been psychological difficulties at the beginning, the condition appears to the patient's relatives and friends something of a mystery, since it seems so disproportionately severe in relation to the circumstances. His gloom, slowness of thought and reaction, his groundless self-accusations and feelings of guilt are all-pervading. They are unaffected by circumstances for neither a convivial social group nor news of a change of fortune alters the patient's feelings

of depression and despair. There is insomnia with early-morning awakening and the depression is at its worst in the morning when suicidal thoughts are in the greatest danger of being translated into action. Delusional or near-delusional ideas of guilt, disease and poverty, and fears of punishment and ruin are common but may remain well-concealed from all but the most careful and searching inquiry. The previous personality is generally stable, although there may have been former attacks of a similar kind or psychological swings of mood without markedly disabling effects or a personality conspicuous for its drive, energy, warmth, and ebullience. In some patients, the appearance for the first time in middle age of markedly hypochondriacal, obsessional or paranoid symptoms is due to the development of an endogenous depression.

However, the frequency of endogenous depression and allied affective disorders has probably been overestimated. This is due to the fact that for short periods of weeks or, rarely, a few months, electroconvulsive therapy (which was until quite recent years the only means at our disposal for the termination of severe attacks of depression) mitigates the patient's symptoms whatever the underlying cause. But the long-standing psychological problems which are the starting point of the majority of attacks of neurotic or reactive depression, a disorder commoner than endogenous depression, are quite unaffected by convulsive or drug treatments and, sooner or later, these problems will give rise to fresh emotional disturbances. Painstaking examination shows a relatively high proportion of psychiatric disorders in middle age to be no more than a recrudescence of a pattern of emotional response characteristic of the patient. In these cases the symptomatology is more closely linked with the events at onset and reflects more accurately changes in the patient's life situation. The depression is more variable, the sleep disturbance consists of initial insomnia; there is no diurnal variation of mood and delusional ideas and all forms of self-accusatory thinking are absent.

It is these reactive and neurotic depressions of middle age that are commonly associated with the hot flushes, headaches, giddiness, and irritability of the menopause. These latter symptoms are probably due in part to irregularity in the production of oestrogens. Where the symptoms are largely physical, oestrogens are valuable but the endocrine and gynaecological origins of emotional disturbance during the menopause have probably been exaggerated and so has the efficacy of oestrogens in controlling such symptoms on a long-term basis. Middle age is a great revealer of the emotional imbalance and maladjustment of the basic personality and severe depression and anxiety may occur in the absence of any vasomotor

or other symptoms that can be specifically related to endocrine factors.

Bereavement, loneliness and the departure of children from the home deprive many women of a sense of purpose. The immature and narcissistic individual whose sense of worth rests to a considerable extent upon external appearances finds self-esteem declining sharply with age. Emotional superficiality such as this tends to lead to difficulties in marriage and problems often reach a crisis during middle age, since the departure of children accentuates conflicts which have been tolerable only so long as the partners were separated from one another by their offspring.

The constriction of opportunities for professional advancement and the waning of sexual attractiveness and potency may lead to frantic attempts at bolstering up wounded vanity. Either partner, more commonly the male, may grope out at a life that is felt to be passing. Hysteria rarely commences *de novo* in middle age, but hysterical symptoms are commonly found within the setting of an affective disorder. There may be flight into illness with complaints of fatigue, malaise, backache, symptoms in the reproductive organs or gastro-intestinal disturbances. It is necessary to be vigilant for the possible psychological background of such complaints, for they may reflect a desire to achieve vicariously, through illness and disability, the love, support and protection the patient feels she is losing. Surgical procedures then become the prelude for an interminable succession of further operations, the patient's symptoms becoming all the time more firmly ingrained. There can be little doubt that some patients actively strive for a hysterectomy and the states of depression and anxiety which follow in a proportion of cases may be severe and sustained.

Many of the problems with which the patients attempt to grapple would have been more effectively faced at an earlier stage of life. The sharp conflicts which a woman experiences with her children in middle age may merely reflect her authoritarian and ambivalent attitude towards them during their developing years. Had she managed these problems in a more mature manner, the children might have been capable of an adult affection towards her which could have provided a new form of fulfilment. Jealousy and resentment of her daughter-in-law may again reflect long-standing conflicts; now they effectively bar the new and rewarding gratifications of grandmotherhood.

These and other psychological difficulties may be relevant to a depressive state in middle age, but it would be erroneous to assume that, until they have been eliminated, nothing can be done for the patient's depression. Even reactive or neurotic depressions are to

some extent independent of the stresses that initiate or perpetuate them and the attacks of depression may respond to treatment even though difficulties and conflicts are unchanged. Antidepressive drugs are therefore of some value in the management of these cases.

Organic disease

If one concludes, after careful enquiry, that psychiatric symptoms are presenting for the first time in middle age, the probability is that one is dealing either with some endogenous illness or an underlying organic disease, although this is not always the case.

Organic cerebral disease is likely to present in the early stages with defects of memory for recent events, slowness and poverty of grasp, some emotional lability and slight personality change. The explanation may be myxoedema, general paralysis, pernicious anaemia, primary cerebral neoplasm or a secondary deposit, perhaps from a bronchogenic carcinoma. But much more florid psychiatric disturbances, such as an acute psychosis with some degree of clouding of consciousness, delusions, hallucinations and a strong depressive colouring may be seen. The depressive symptoms may dominate the clinical picture and as, temporarily, a response to antidepressive treatment may be registered, the underlying organic disease may be missed.

Cerebrovascular disease tends to be commonly diagnosed when such florid organic psychoses or a progressive dementia become evident in middle age. It is hardly ever the explanation for such conditions before the age of 65, unless there has been a previous cerebrovascular accident and dementia is in fact rare unless one massive or several smaller infarctions have occurred. In cases of progressive dementia a decision in favour of a primary presenile dementia such as Alzheimer's disease or Pick's disease is rarely justified until specific causes such as those discussed have been excluded by full neurological investigation, including air studies or angiography. As far as cerebral neoplasms are concerned, onset may be insidious, as in old age, and the growth may reveal itself in the early stages with changes in behaviour and personality, rather than with clear localizing signs. Moreover, the signs of increased intracranial tension, such as papilloedema, may be late to develop.

Middle age is also the time when social drinking merges insensibly with the early manifestations of chronic alcoholism. The man holds his drink less well and is drunk before he can benefit from the usual boost effect. He begins to drink alone and to hide bottles in strategic places to ensure supplies. He has to go well "tanked-up" for any social event; hangovers are common, "blackouts" begin to occur

and he starts drinking in the morning. A woman becomes "tiddly" with the first drink at a party or a dinner, or is unaccountably silly or maudlin in the middle of the day. It may be many months before the store of gin bottles is discovered in the kitchen cupboard. In any event, in no case with a decline in memory for recent events, an unexplained attack of delirium or hallucinosis or a change in personality, should the possibility of alcoholism fail to be considered.

I have deliberately deferred a discussion of organic disease until this stage because despite the steep increase in the incidence of conditions such as carcinoma of the bronchus, psychiatric disorders continue to loom as causes of disability in middle age. It should be possible to diagnose them on the basis of positive evidence in the majority of cases. Laboratory investigations are sometimes essential for the exclusion of organic factors, but it is not good medicine or psychiatry to submit every case, whatever the presenting clinical features, to an intensive battery of investigation so as to exclude the remotest chance of physical disease before considering a psychiatric diagnosis. The least of the hazards run in such a course of action is that red herrings may be introduced. Abnormal laboratory findings may be excavated which are not relevant to the patient's complaints. Moreover, as investigations proceed, the patient's anxiety may increase and the illusory belief that he is suffering from physical illness is in danger of hardening into a conviction.

Social isolation and paranoid states

A great deal that we have learnt about the psychological and social aspects of ageing has taught us that the foundations of physical and mental health in old age are laid to a considerable extent in the early and middle years. If we want to intervene effectively we therefore have to take action long before senescence. This is the lesson that emerges from many fields of investigation of the problems of the aged, whether these concern mental or physical health. From studies of aged patients suffering from mental disorder, looking at the wrong end of the telescope, so to speak, we have learned that middle age had been in many cases a time when the supports and sources of strength that might have been reinforced so as to sustain the individual in senescence, had been undermined or removed instead. Failure to marry, separation and divorce and social isolation are commoner among those who break down with mental illness in middle age and late life, than in the general population. To some extent this merely reflects the underlying personality of those who are prone to fall ill. But there is evidence to suggest that such lonely friendless individuals suffer in part from circumstances outside their control, which are to some extent

potentially remediable. In old age we have identified (Kay and Roth, 1961) an interesting group of paranoid subjects who, long before they had fallen ill, were regarded as cold, remote, solitary, suspicious, difficult and sometimes masterful, autocratic, overbearing, and quarrelsome. Their isolation had been frequently aggravated by deafness. In these individuals and many others with related disorders, the steps taken into greater seclusion, abandonment of social interests, and the turning-in upon the self during middle age further restrict the possibility of a reasonable adjustment in senescence. Yet psychiatric help or even recognition of the problem in middle age by some might have helped rectify this cumulative maladjustment. With patient and imaginative help, some of these individuals, often valuable and effective members of the community in other ways, can achieve or re-establish human contacts and interests. A paranoid or schizophrenic breakdown may, of course, occur in middle age but treatment is not infrequently successful for the psychotic as such, and after-care should include an attempt at re-socialization.

Treatment

Prophylaxis is the logical approach to many of the more serious problems of middle age and we have already had some excellent contributions on this subject. I have already expressed some of the qualifications a psychiatrist might wish to make. It is perhaps also worth while recalling that some of the advice we are given on the strength of modern, epidemiological evidence, has been given before. The Venetian nobleman Ludovico Cornaro survived to the age of 99 after a highly energetic and successful life as an architect and civil engineer. At the age of 83 he wrote his celebrated treatise *Discorsi della Vita Sobria* (1558). The counsel he offered was simple as it was sober: moderation in all things and above all in the consumption of food and drink. A dramatist of the following century however concluded after reading the great treatise that Cornaro had lived all his life as an invalid in order to die in good health.

The treatment of the disorders of middle age is a very large subject and I should like to confine myself to a few points. In giving the patient with some psychiatric disturbance a lucid formulation of the nature of his symptoms, a doctor effectively commences treatment, often without knowing it. A good diagnosis provides treatment because so many patients with a psychiatric illness in middle age have anxieties they are unable or unwilling to express. The very tense person often feels he may lose control, run berserk or go insane. If he has had panic attacks or has been near to fainting he will almost certainly have had fears of impending death. Relatively few patients can describe or discuss such symptoms clearly or openly

and in the great majority of instances where a diagnosis can be made and communicated it proves comforting. For skill in diagnosis, however, detailed and intimate knowledge of psychiatric disorders is essential and their clinical picture is just as rich and differentiated as that of the physical maladies of middle age. A comprehensive psychiatric diagnosis involves a number of relatively distinct formulations. In the first place it requires a clear definition of any illness the patient may have recently developed. But in many conditions the personality setting in which the illness occurs is equally important. Among the middle aged with affective disorders some organic factor frequently complicates the picture; there may be hypertension, some anginal pain, a peptic ulcer or perhaps diabetes. The significance of physical complaints can be evaluated only if they are studied continuously in relation to the personality of the patient. And all the time a doctor must take into account the individual's family and social background; headache, failure of concentration, and depression may have less connection with a blood pressure of 150/90 than with the fact that a man of 50 has found himself at a dead-end in his job or that he and his wife have been blaming each other with increasing bitterness for the deficiencies and failures of the children.

A famous psychoanalyst has said that most anxieties about death hide anxiety about something else. The converse of this would be an exaggeration, but is probably closer to the truth. The manner in which death has been dealt with in different cultures makes an interesting story. On the other side of the hedonism of the ancient Greeks there was pessimism and despair. Fate was cruel, for had it not ordained that everyone should grow old and die. So long as youth remained, then beauty and happiness were to be enjoyed to the utmost. On the whole, the culture in which we live faces the issues less squarely and denies that the problem exists. Evelyn Waugh (1948) in his account of death and dying in California, where you can rely on the cosmetician armed with the essential materials to transform your gruesome corpse "into a body vibrant with life and transfigured with peace and happiness", has written a brilliant satire on all this. Thus encouraged you hasten to seek "a before-needed reservation under the statue of the prominent Greek poet Homer". On the other side of the coin of this denial, there is an anxiety which may already loom up in ill-defined form during middle age. To have recognized this emotion and the symptoms that stem from it for what it is, is to take an important step towards helping and comforting the patient.

There is no doubt that the advent of the new drugs for the treatment of depression has made a contribution of great importance to the management of the commonest forms of psychiatric disturbance

in middle age. In endogenous depressions imipramine and allied drugs are of great value, but only in a minority of these cases does one nowadays have to have recourse to ECT.

In the other main family of depressive illnesses, the neurotic or reactive depressions, the imipramine group of substances is also useful but the results are less predictable, partly owing to the side-effects which are less well-tolerated by this group of patients. It is in the neurotic depressions that the monoamine-oxidase group of drugs have found their most successful application. But enough has already been said to make it plain that the administration of drugs does not constitute adequate treatment in neurotic illness.

In middle age there is still time for helping people to find fresh opportunities for the expression of any creative abilities, fostering in this way their sense of achievement and significance. At a symposium on "Ageing" in the United States I recently heard someone say, "It is very difficult to be a hero in New York". Not everyone can be a hero and there is something wrong where each individual feels that he ought to be one. And it is perhaps true that the evaluation and self-evaluation of individuals has tended to be based on more and more limited criteria. Yet we have somehow to aim at a society in which a man who isn't a millionaire, a famous politician or a celebrated film star can, none the less, feel a great success because he has a splendid family, devoted friends, and can play the trumpet or grow the best leeks in Northumberland.

Finally, much of the secret of helping patients psychologically lies in the sort of approach which does not moralize, pontificate or place the doctor on a level more elevated than the patient, but is kindly, receptive and empathic and enables the doctor by small degrees to instil insight and understanding.

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DISCUSSION

Chairman: Before we go on to answering the questions which you have kindly produced for us, I ought to say that we are highly honoured in having the president of the College, DR F. M. ROSE, with us this afternoon. This would be an appropriate time to have from him a word of greeting from the parent body. Dr Rose, we welcome you, sir.

Dr Rose: I have been at many of these symposia and I think most of them have been organized very much along these lines and owe their inception to the same firm as this one does. I think they do an enormous amount of good. I was here in this faculty at its inauguration approximately ten years ago. One of the most biologically interesting points about that was the letter of congratulation from its daughter sub-faculty in Hull, the only incident in which the daughter sent a telegram of congratulation at the birth of the mother. I am very glad to bring the greetings of the College to you all, and particularly to welcome those here who are not members; I hope that they will perhaps have a closer association with the College in the future.

Question: I found Dr Scott's dictum that the deflated chest measurement should be two inches greater than that at the umbilicus most interesting. Does he have a special type of tape measure for the fair sex, and does he consider these measurements of use in females?

Dr Scott: It is not the easiest question to answer. I do use a tape measure in female patients, but it is more a question of seeing whether or not they are losing weight. It is more difficult to show that the chest measurement is two inches greater than that at the umbilicus, but as regards loss or gain of weight the tape measure gives as great a feeling of accuracy to me as do the scales.

Dr A. U. McKinnon: Do the panel agree that many of the hazards