McGILL UNIVERSITY

ADJUSTMENT PATTERNS IN OLD AGE

A Study of the Life Situations and Adaptation Patterns of Eighteen Jewish Immigrant Patients, Aged Sixty and Over, Who Attended the Geriatrics Clinic of the Jewish General Hospital from September, 1955, to January, 1956.

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by

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ABSTRACT

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The project inquires into the life situations and personal adjustment patterns of a group of eighteen elderly Jewish patients attending the Geriatrics Clinic of the Jewish General Hospital. It seeks to evaluate three areas of life functioning, namely the patient as a physical organism, as a group member in society, and as a personality within a culture. While it explores the interactions between these three areas of functioning it also throws some light on the factors which enter into the successful and unsuccessful adjustment in older people. Criteria were established whereby eighteen patients of the thirty patients attending the clinic were selected for this study. Data were obtained from the geriatric records of the Jewish General Hospital. In addition, an interview was the main source of first-hand data and readings provided a basic background.

The project was divided into three parts, namely, a survey of the theoretical background and a discussion of the literature in the geriatric field, an analysis of the case material, and finally conclusions reached as a result of the analysis. It was found that successful or unsuccessful adaptation to life situations is related to the ego resources brought to the situation and the meaning of the situation for the individual patient. Appropriate or inappropriate adaptation in one area of life functioning was found to be related to an ability or an inability to function in the face of life situations.

PREFACE

This study has been undertaken by three second year students of the McGill School of Social Work as a group research project. The study began with the opening of the Geriatrics Clinic of the Jewish General Hospital in September 1955. It became a research project for this group of student social workers in January 1956 and was completed towards the end of June 1956. It was considered relevant that this study be undertaken because of the interest of the hospital in the problems of the older patient and in particular in the bearing which social factors have upon the medical problem. It is also in line with the research focus of the clinic in which various members are engaged in research activities.

The writers acknowledge with gratitude the help of Dr. V.A. Kral, who initiated the project and gave valuable assistance and guidance to the study. Thanks are also due to other members of the clinical team, namely, Mrs. E. Spector, Director of Social Service, Mrs. R. Tannenbaum, and particularly Miss Sylvia Goldberg, who advised the group in the selection of prospective cases for study. The group wishes to express its gratitude to the directors of the Jewish General Hospital and the staff of the Out-Patient's Department for their hospitality and courtesy in assisting the writers to carry out investigations of the Clinic records and interviews. The writers acknowledge with appreciation the cooperation of the patients who were, without exception, cooperative and willing to give of their time.

The group is also extremely grateful to Miss E.R. Younge for her advice and suggestions. Lastly, appreciation and thanks are extended to Miss Helen Tuck, to whom the writers are particularly indebted. Her continued interest, guidance, support, and valuable assistance, throughout the study made it possible to complete this group thesis.

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CHAPTER I

INTRODUCTION TO THE STUDY

The purpose of this social work research project is to inquire into the life situations and personal adjustment patterns of a group of eighteen elderly Jewish men and women who have immigrated to Canada during their adult life. In approaching the study the writers will attempt to evaluate the life functioning of these patients from a three-dimensional focus. They will evaluate the patient as a physical organism, as a group member in society, and as a personality within a culture, and attempt to explore the interactions between these three areas of functioning. It was undertaken on the assumption that the functioning within one area depends on how well the individual functions in the other essential areas. It further assumes that the organization of experience takes place within the individual ego, and that the nature of the adjustment depends upon the ego adaptation patterns which the individual brings to life situations. The theoretical basis underlying these assumptions is developed fully in Chapter II.

It is hoped that by an evaluation of the functioning in each area some light will be thrown on the factors which enter into the successful and unsuccessful adjustment in older people. In the

evaluation the writers will take into account not only external factors in the life situations of the patients, but those personality variables which determine whether situations are stressful or supportive and which result in successful or unsuccessful adaptation.

The study is being undertaken by a group of three student social workers in cooperation with the geriatric clinic of the Jewish General Hospital. This geriatric clinic, the first of its kind in Montreal, was established in the autumn of 1955 and reflects a growing concern in the community with the problems of the older patient and a realization that these problems are a complex of medical, social and psychological difficulties which require a comprehensive program of medical care. It is also in line with current thinking in medicine that the primary purpose of preventive medicine is to build greater health and to prevent illness and premature deterioration. All hospital patients, either from the ward or the out-patient department, who are sixty years and over, are referred to this clinic for medical and social diagnostic evaluation and treatment. Because of the complex nature of the problems that the older patient brings to the hospital, the teamwork approach is used in evaluation and treatment. The members of the team include the physician, the neurologist, the psychiatrist, the psychologist and the medical social worker. Each member of the team assesses the patient in order to achieve as broad an understanding as possible of life functioning before undertaking a treatment program.

This study has relevance at this particular time because of the

interest of the hospital in the problems of the older patient and in particular in the bearing which social factors have upon the medical problem. It is also in line with the research focus of the clinic in which various members are engaged in research activities. This project was undertaken at the request of the director of the clinic and the neuropsychiatrist on the team who were interested in exploring illness in the aged in relation to life stress.

Having defined this area for investigation the writers are asking the following questions of the data.

1. What social and cultural forces in our society are potentially stress or strength producing factors for the older person?
2. How do the factors of immigration and Jewish culture affect the process of adaptation?
3. What are the adaptive patterns by which the older person adjusts to life situations?
4. What ego defense patterns make for relatively successful and relatively unsuccessful adjustment in old age?

These questions are based on the theoretical approach which will be outlined in Chapters II and III. It has been noted that in approaching this study of adjustment patterns the definition of the situation will be assessed in terms of stress and strength. The definitions of terms used in the case analysis is as follows:

A situation of stress: is one which is strain-producing to the individual because of the inept or inappropriate adaptation patterns which he brings to it. It thus demands more than a minimal adjustment and touches off

emotional states which are linked with heightened physiological and psychological reactions.

A situation of strength: is one which is supportive to the individual to which he brings responses which are appropriate and which enable him to make a relatively successful adaptation.

Ego Adaptations (also referred to in the analysis as ego defenses or adaptive mechanisms): are those mechanisms, psychological or physiological, which are appropriate or inappropriate to the situation which the individual uses to make his adaptation.

At the beginning of February 1956, when this project was undertaken, a total of thirty patients constituted the complement of the clinic. This study is based on eighteen of these thirty patients.

In order to keep the sample group as uniform as possible and since most of the patients attending the clinic were Jewish, it was felt that only those patients of Jewish faith should be included. In addition, it was decided to include only patients who still are, or had been married during their life time. This was done in order to facilitate an assessment of the familial patterns of the individual patient. Further, many of the patients in the geriatric clinic had immigrated to Canada during their life time.

Since immigration is a factor influencing social and cultural adjustment it was deemed advisable to choose from the total group only those who were immigrants, even though the length of time since immigration varied considerably. The fact that the geriatric clinic as a general rule

accepts only patients over sixty years, automatically put the sample group into the older age category. Ages in the sample group ranged between fifty-seven and seventy-seven years. The one patient in the sample group who is under sixty was included in the study since she had been accepted by the clinic and fulfilled the other criteria for selection. The remaining twelve patients who were not included for the study were excluded on the basis of the above criteria. In addition, several of them could not be interviewed because of extreme mental deterioration.

Data were obtained from the geriatric records which included a medical history, a neurologist's report, psychological test findings, a psychiatric assessment and a social service summary. In a few instances the clinical findings were incomplete since not all the patients had been seen by all members of the clinical team at the time the study was undertaken. Because of the nature of this study, in which the writers are interested in assessing all levels of the patient's functioning, the medical, neurological and psychological findings are included in the case analysis of each patient.

The early thinking and reading for the project was done by the seminar method of study in order that the writers could become familiar with the literature in the field of psychosomatic medicine, in the social sciences as they relate to medicine, and in geriatrics. Following preliminary planning and formulation of the research design, an interview schedule was drawn up.[1] This schedule was later subjected to minor revisions after one or two inter-

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[1] A copy of the interview schedule appears in Appendix A , p.239

views had been completed by each interviewer.

The main source of first hand data was the interview.[1] The interviewing of the patients was carried out by the three writers with each one being responsible for one-third of the total sample group. It should be noted that many of the sample group could not speak English fluently enough for the purpose of the interview. For this reason many of the interviews were conducted in Hebrew, Jewish or German. The fact that the writers were able to speak these languages made possible a study which could not otherwise have been undertaken. The interview schedule was used as a guide in obtaining the information required and an attempt was made to keep the discussion within the interview as spontaneous as possible. Specific questions were asked whenever the information desired was factual in nature. In addition, certain questions were included in order to obtain an understanding of the patient's feelings, attitudes and reactions. In order to gather information on all areas of the patient's life adjustment, the schedule included four areas of inquiry - the physical, cultural, socio-economic, and familial.

Interviews were arranged by letter from the medical director of the Jewish General Hospital to the patients. This letter, printed in Jewish and English, informed the patients about the study and included the interviewer's name.[2] The interviews were arranged at the patient's convenience and were consequently held either in the hospital or in the patient's home. One interview together with all clinical findings constituted

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[1] A copy of a sample interview appears in Appendix B , p. 245

[2] A copy of this letter can be found in Appendix C , p. 250

the basis for the case report, which was later used for the case study in the analysis of the data. In the compiling of the data, three methods of analysis have been employed. Library research has been used throughout the study to provide an orientation to the theoretical formulations for the research design and a background against which to facilitate an understanding of the information gathered. The statistical method has been used in only a limited way in this thesis to give the writers a summary view of the patient group in order to indicate such quantitative facts as marital status, time of immigration, use of recreational facilities, employment patterns and income.

The main method of analysis is, however, the case study. It was felt that the nature of the study which inquires into the interactions between the various areas of life functioning is such that it does not lend itself to statistical analysis. Rather, it was felt important to see the relationship among these interacting forces as they contribute to the total adjustment pattern of each individual patient. For this reason a comprehensive study is being made on a case by case basis. Through this method, common features in life situations and adjustment patterns become evident and they form the basis of the conclusions drawn from this analysis. In order to facilitate the evaluation of these patterns the cases are grouped according to different levels of present adjustment, and it has been arbitrarily decided on this basis to assign each patient to one of three groups. These three groups comprise those patients who have achieved

a relatively poor level of adjustment in all areas, those who have achieved a level of adjustment in which successful adaptation in some areas is offset by unsuccessful adaptation in others, and those who have achieved a relatively successful level of adjustment in all areas. These criteria are set forth in greater detail at the beginning of Chapter V.

After the interviews had been completed, a case report was drawn up summarizing the material covered in the interview schedule. In order to minimize bias and to familiarize each of the writers with the cases of his colleagues joint consideration was given to each case and a summary was drawn up for each of the areas covered in the schedule. These summaries provided the writers with the material for analysis, and for the grouping of the eighteen cases. The project adviser was consultant in the joint study of each case and in the later case analysis in order to establish a common pattern for analysis and to provide guidance in the evaluation of the material. The case studies are compiled according to the general foci of the study. That is, each patient is evaluated according to his functioning as a group member in society, as a personality within a culture, and as a psycho-physical organism. Stresses and strengths are assessed in each area and the ego adaptations are considered in relation to each aspect of the life situation. These case studies comprise the major part of the analysis in this thesis and are to be found in Chapters V, VI and VII.

In Chapter II it will be pointed out that the trend in modern

research in the field of mind body environment interaction is toward the multi-discipline approach, since no one researcher or group of researchers within one profession can take into account the whole field. This particular study cannot be said to be a multi-discipline project since it has been undertaken from a social work frame of reference. However, the writers are very much aware of the necessity for bringing the findings of the various professional fields concerned with the diagnosis and treatment into the analysis. For this reason they have made use of consultation with the neuro-psychiatrist on the team and to a lesser extent with some of the other clinic members. Further, they are including in the case studies the findings of the psychologist, the medical doctor, the neurologist and the psychiatrist in order to bring into relationship as many facets as possible of the patient's life functioning.

In approaching the study of mind-body-environment interaction, it is possible to perceive certain significant linkages in the individual's life history sequences. According to the theoretical material to be presented in Chapter II, we note the following connections: life situation - definition of the situation according to stress and strength - particular adaptation pattern - physical and psychological malfunctioning. It is impossible for research workers in any one discipline to study all the linkages in this chain. It would seem that the linkage between particular adaptation patterns and physical and psychological malfunctioning is the concern of the medical and psychiatric disciplines. This thesis, therefore, does not attempt to show how life stress manifests itself in

physical and mental illness syndromes. However, as the writers are members of the social work profession which is concerned broadly with the total functioning of the individual within the total environment, it is within their province to investigate the linkage between life situations and the definition of the situation according to stress and strength, and the linkage between the definition of the situation and particular adaptation patterns. It is broadly these two areas which are covered in this thesis.

In developing the study, there have been a number of limitations. One of these lies in the size of the sample group of eighteen patients. From such a small sample it is not possible to draw definitive conclusions concerning the adjustment patterns of all persons over sixty years of age who might avail themselves of the services offered by a geriatric clinic. The conclusions reached in this study can apply only to the sample group. The fact that it was not possible to interview the severly disturbed patients made it impossible to assess what could be assumed to be the lowest level of adaptation. However, the limitation of the size of the sample is to some extent offset by the fact that an intensive study of the life situations and adaptation patterns was necessary to get significant material for this study and a wider coverage was not possible within the allotted time. It should also be noted that the clinic attendance was small at the time when the study was undertaken and sixty percent of the total patient group known to the clinic in the five months which had elapsed since its inception was included.

The fact that the study covered the older Jewish immigrant may be considered as both a limitation and an asset. It is a limitation in that it confines the study of the older person to a particular minority group in the community and therefore does not give a cross-cultural view of the adjustment of older people. On the other hand it provides the writers with an opportunity to observe cultural similarities within an ethnic group. As far as immigration is concerned it was noted that there were marked variations in the length of time since immigration. It is felt that a greater similarity of immigrant status would have provided a more significant coordinating criterion.

A further limitation in the study is the fact that a complete life history was not obtained from each patient. In line with the thinking that the basis for inappropriate reaction patterns is laid down in early childhood, it would have been valuable to the study to explore the childhood experiences of these patients. Such an exploration was not attempted, firstly because of the limited contact with each patient, and secondly, because it was not possible for these elderly patients to recall significant early experiences. However, while the emphasis was placed on the present life situations and adaptations, data were obtained on life experiences in the adult span in order to give as comprehensive a picture as possible of the life functioning and to provide a basis for comparison with the present.

The fact that only one interview was held with each patient also constitutes a limitation in the study. Although the interviews lasted

for at least two hours and in many cases longer, it was found that they did not permit as broad a coverage of material as might have been desirable. Nor was it always possible in one interview to obtain material of sufficient depth in all areas. The well-known inability of older people to recall factual information and their inability to focus on those areas which may not be of particular interest to them also made the collecting of the data difficult. However, within these limitations and also because of the readiness of the patients to enter into discussion of their difficulties, it was possible to obtain a great deal of pertinent material which provided a basis for the study of significant correlations.

It might be argued that the absence of a control group of "normal" older individuals is a limitation in the study. However, there are great practical difficulties in securing such a control group, the main difficulty being that no scientific attempt has been made to define the term "normal" in the aged. However, the fact that the patients in the study have been divided into three groups according to their levels of functioning makes it possible for the patients in the different groups to act as controls for one another.

This study is being presented in eight chapters. Chapter II will be devoted to a survey of the psychosomatic and social science theory which deals with mind-body-environment interaction. Chapter III will discuss the literature in the geriatric field as it relates to this interaction. Chapter IV will be concerned with an overall description of the patient group in order to assess the general characteristics of the sample.

In Chapters V, VI and VII, an analysis of the case studies will be presented and common features relating to each group will be identified. Finally, in Chapter VIII, the findings in Chapters IV, V, VI and VII will be reviewed in order to arrive at general conclusions concerning the nature of life situations and adjustment patterns in the sample group.

CHAPTER II

SOCIAL AND CULTURAL CONTINUITIES

IN PSYCHOSOMATIC THEORY

This group project which is exploring the factors which influence the adjustment of the aged in a modern urban community is, broadly speaking, a study which falls within the field of psychosomatic research. However, within the last decade there has been a broadening of the base in much of the investigation into the factors affecting the balance between health and illness, and this study reflects this trend.

It is recognized in the recent writings of researchers in the psychosomatic field that in the past the approach to investigation has been too narrow. Many observers have studied the phenomena of mind-body interaction from the standpoint of their own frame of reference and have promulgated conclusions regarding the genesis and meaning of psychosomatic processes from a viewpoint which is circumscribed not only in scope and time of observation, but also in the limitations of their own professional frame of orientation. The limitation in this approach arises from the fact that the researcher sets up artificial boundaries in his observation of phenomena. The point of view is now being put forward that no one researcher or group of researchers within one profession can take into account the whole psychosomatic field, since no one re-

searcher or profession has a sufficiently wide approach to examine his formulations against a background of concepts common to all. Lip service is given to the concept of multiple causality, but in effect a consideration of all the factors operating in the complex interactions of mind, body and environment is not possible from a limited frame of reference. Grinker summarizes this problem in psychosomatic research today when he says:

> No one frame of reference implicit in any of the theoretical systems is broad enough to encompass the entire psychosomatic field, and cannot, therefore, satisfactorily explain any single state of health or illness.[1]

Grinker's statement also makes clear the fact that there is not at this point in the research development in medicine and the social sciences, any unified theory of human behaviour.

In the absence of any unified theory it becomes increasingly clear that there is a need for many investigators to combine their efforts in order to broaden the base of observation and to utilize the theoretical knowledge and skills of a number of professional disciplines. In discussing the basic concepts of psychosomatic medicine McLeod, Wittkower and Margolin state that:

> Our current psychosomatic formulations are structuralized within too small a frame of space and too narrow a segment of time to fit into a proper field theory. The absence of any one investigator's capacity to describe and measure more than a single aspect of the field, and for that matter to take a position at more than one point at a time, makes it necessary for him to work with other investigators. One observer, describing a small sector of the field from an identifiable position, can delineate the boundaries at which his operational methods cease to function and can relegate to another observer with other techniques the task of describing and measuring the changes in his system.[2]

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[1] R.R. Grinker and F.P. Robbins, Psychosomatic Case Book (New York and Toronto, 1954) p. 32.

[2] E.D. Wittkower and R.A. Cleghorn, Recent Developments in Psychosomatic Medicine (Philadelphia and Montreal 1954), p. 4

They further delineate seven sub-fields which need to be considered in approaching research in this area. Among these are the field of the illness, the field of the person, the field of the environment and the field of the observer.[1] Holliday[2] also points out that a full understanding of etiology cannot be obtained without taking into consideration the events in at least six sub-fields. Grinker emphasizes the same need when he says that "what is needed now is a view of psychosomatic processes as a field in which multiple, cyclic, self-corrective or spiraling transactions occur."[3]

In approaching the study of the factors which enter into the etiology of health and illness from the standpoint of the field theory, researchers are today proceeding on the principle of multiple causality, and the complexity of the interacting factors is fully recognized. No longer is it considered valid to assume, because observable two-variable correlations exist concurrently in time, that they necessarily have a cause and effect relationship. Correlations have been made in the past between somatic dysfunction and personality structure, between somatic dysfunction and repressed conflicts, and between somatic dysfunction and external stresses. Researchers have now accepted the point, long made by the statisticians, that the assumption underlying such linear correlations is a false one. Current observations of the interchange between one organ system and another, and failure to explain the problem of specificity, or why a disturbance arises in one organ system and not

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[1] Ibid., p. 5

[2] Ibid., p. 6

[3] Grinker, op. cit., p. 32

in another, lend weight to the theory of multiple causality. The field theory, referred to above, offers at the present time the most comprehensive approach to the study of mind-body-environment inter-relationships, and forms the basis of orientation for much of the current psychosomatic research. Grinker states that:

> The time is ripe, it seems to us, to consider the psychosomatic field not as a fractured, disjointed and isolated series of observational sectors, but as a total integrated field which can be studied from many points of view by many disciplines. We feel that all types of observation and all techniques are essential, but are adequate only if they can be integrated in terms of the total field concept.[1]

The field theory as applied to psychosomatic research postulates the concept of interacting forces within any given field. The individual, in dynamic interaction with all the forces in his environment is thus considered a field. It sees man as a "structured organism-environment field, each aspect of which is in dynamic relation to each other aspect."[2] It maintains that the "individual does not unfold simply by virtue of inner dynamics, nor through response to outer forces alone, but as a result of an intricate interaction of the two sets of forces."[3]

Embodied in the field theory is the concept of homeostasis which was developed by Walter Cannon.[4] Homeostasis is a tendency toward biological equilibrium, or the balance and constancy of the body. In all biological systems there is a bilateral exchange between organism and environment which tends to maintain the organism in a steady state.

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[1] Ibid., p. 29

[2] Gardner Murphy. Personality a Biosocial Approach to Origins and Structure,(New York, 1947), p. 3.

[3] Ibid., p. 882, and 883.

[4] W.B. Cannon, The Wisdom of the Body. (New York 1932)

This steady state takes into account nervous, hormonal and other physiological systems, and the behavioral and interpersonal activities of the organism. When the organism is disturbed by physical agents applied from the outside, or by psychological stress, there is activity on the part of the organism which brings its disturbed equilibrium back to its previous state, or to a new level of equilibrium. If the homeostatic mechanism fails to restore a balance, homeostasis of the total organism may be achieved at the expense of a part. Grinker states that:

> There are many examples in which sacrifices of part-functions are successful in saving the whole structure. Very often the effect of stress may so severly disturb the sacrificed part that it becomes the seat of disease. This part-action or part-sacrifice is of particular significance in considering psychosomatic concepts, because frequently certain emotional conflicts or psychological stresses disturb one or another organ most severly, without reaction on the part of the whole organism.[1]

Grinker[2], in applying the concept of homeostasis to the field theory, describes the structured organism-environment field as being made up of parts which act according to their own structure-function and interact with other parts of the whole. Through these processes the parts maintain the whole through integrated transaction. He points out that change in and around any part will affect all parts as well as the whole. The field may, according to this theory, be said to be in "a constant state of transactional, circular, corrective activity....a continuism in which there is a tendency through transaction to maintain equilibrium, orderliness, or a steady state".[3] He sees these transactions as taking place between somatic,

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[1] Grinker, op. cit., p. 10

[2] Ibid., p. 32 ff.

[3] Ibid., p. 32, and 33.

psychological, social and cultural processes which make up the parts of the whole:

> On the somatic focus we could view the enzymatic, harmonal, organic systems, the nervous system and its divisions, etc. On the psychological focus we may view the id, ego, superego, ego-ideals, etc. The social system may be dissected into family, small group, larger group or into a multiplicity of foci which evoke the enactment of social roles by the person.[1]

Grinker maintains that at birth the human organism comprises one undifferentiated functional system with its environment. Out of this develop many smaller systems which are related to one another, but the living boundaries are ill-defined, variable and incomplete. Activity within one system is communicated to all others. When a given system is strained in handling a particular stress preparatory changes become intensified in another system because of the continous transactions. The integration within one system is dependent upon its ability to act alone without strain before a new order of action is set off in other systems with which it is in transaction. This would account for fluctuations between one system and another and between physiological and emotional disturbance.

Inherent in this approach is the concept that interpersonal, social and cultural forces are integral factors in the maintenance of the total adjustment of the individual. While many theories have been postulated and much research work has been done in the field of mind-body interaction, there is increasing emphasis being placed today on

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[1] Ibid., p. 33

the effect of social and cultural forces in influencing successful or unsuccessful adjustment. Although psychoanalysis has been largely interested in the effect of unconscious processes on behaviour, one of its basic tenets is the conflictual nature of the instinctual life struggling to meet the demands of reality. Jurgen Ruesch in this communication theory maintains that communication is a process which goes on internally among the various organ systems, and externally between the individual and the various people in his environment. Any social field is held together only if its members are in communication with each other. He states that:

> Communication is for the human being, an absolute must in terms of survival, in terms of pleasure, and in terms of maturation. Failure experienced in communication gives rise to a sense of frustration and leads, sooner or later, to failure in the realm of action.[1]

According to his theory, the mature person is one who is in successful biological and social interaction with his world, and he suggests that psychosomatic illnesses are primarily associated with arrested development as exemplified in the infantile personality.[2]

Erikson in "Childhood and Society" has added significantly to the understanding of the impact of society and culture on maturational processes. According to his view a human being is at all times "an organism, an ego and a member of society", and he is involved simultaneously

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[1] Jurgen Ruesch, "The Therapeutic Process from the Point of View of Communication Theory", American Journal of Orthopsychiatry, (Volume XXII, No. 4), 1952, p. 694.

[2] Jurgen Ruesch, "The Infantile Personality, The Core Problem of Psychosomatic Medicine", Psychosomatic Medicine (Volume X, No. 3), 1948.

in all these processes of organization. Hence, it follows since "mind is not a thing apart from body or society, a 'thing' outside the individual"[1] that man's physical and psychological well-being is intimately related to his life as a social being. His well-being in any one sphere depends on how well he functions in the other essential areas. In showing how his ego development is influenced by forces in his environment he points out that:

> The drives man is born with are not instincts and do not carry in themselves patterns of completion. Tradition and conscience must organize them. They are drive fragments to be assembled, given meaning and organized by methods of training and schooling which vary from culture to culture and which are determined by tradition. In this lies his chance as an organism, as a member of society and as an individual...A being with organs can take things or beings unto itself, it can retain or let them out, or it can enter them. The child learns these modes of physical approach and with them the modalities of social life. He learns to exist in space and time as he learns to be an organism in the space-time of his culture.....Societal processes requisition early sexual energy and modes and completes by traditional child training the drives with which the child is born.[2]

From the above review, it may be seen that the types of research in a number of scientific fields are converging. Traditional concepts in medicine, in psychoanalytic and psychosomatic theory are being modified by contributions from the behavioral and social sciences. The behavioral and social sciences are beginning to relate psycho-social formulations to the biological sciences. From this convergence of the sciences a more precise view of the forces in personal and group adaptations is emerging. Particularly in recent years the contributions of sociology, anthropology and

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[1] Erik H. Erikson, Childhood and Society, (New York, 1950) p. 19

[2] Ibid., p. 56

social work have made more explicit the nature of the forces within the external environment and the ways in which they make impact on the individual and on the group. Psychoanalysis has given us some understanding of the working of conscious and unconscious processes; medicine, and more specifically psychosomatic medicine, has given us some understanding, however incomplete, of the interaction of biological and psychological processes; the social sciences are now giving us some understanding of the impact on the individual of social and cultural forces. It is from the convergence of these heretofore independent disciplines that we may hope for new scientific insights into the understanding of health and disease.

This study takes as its point of departure this relatively new frame of reference. It is attempting to assess the factors influencing the adjustment of a group of elderly Jewish men and women who have immigrated to Canada during their adult life. In order to evaluate the factors which influence the present adjustment of this group, the writers will approach the study from a three-dimensional focus. In line with the newer thinking in the psychosomatic field as embodied in the field theory, and by relating this to the contributions of the social sciences which give greater specificity to the nature of the social and cultural forces which influence adjustment, the writers will attempt to analyze the interaction between the individual and his environment. It is thus a study which combines the approaches of both psychosomatic and social science theory.

The individual may be viewed as adapting to life situations on three levels of integration between himself and his environment. He reacts as a physical organism, as a group member within society, and as a personality within a culture. It is this three-dimensional approach which the writers will use throughout the study[1] in order to arrive at a beginning understanding of the continuity between these three levels of organization. It is felt that it is in the area of this new thinking, particularly as social and cultural forces impinge on the personality, that social workers have a particular contribution to make to multi-discipline research.

It has already been pointed out that the newer thinking places a greater emphasis on social and cultural forces as they influence the process of adaptation. In attempting to examine the connections between the three above-mentioned levels of organization from a theoretical point of view the concept of the environment will first be considered from the standpoint of both society and culture. Later this concept will be related to the concept of the individual as a physical organism who is affected not only by his own physical and personality organization, but by factors in the external world.

To consider the environment as "anything outside the individual" is too broad and over-simplified a concept to be of value in analyzing the nature of individual-environment interaction. It may well be asked

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[1] This three-dimensional approach is the one adopted by Leo W. Simmons and Harold T. Wolff in Social Science in Medicine (New York, 1954), p. 51.

whether the mechanisms of interaction in man as a member of society, and man as a member of a culture within that society are the same. Simmons and Wolff make clear the necessity for greater specificity in understanding the nature of environmental forces when they say:

> If, then, we are to seek a clear-cut formulation embracing both the physical and social scientific approaches in medicine it is necessary to analyze the individual-environment concept much more closely and endow it with more content and meaning.[1]

They further point out the need to distinguish between culture and society in the impact they have upon the individual. The fact that society and culture are both aspects of the outer milieu, and that they are both indispensable to survival, does not mean that they are synonymous, or that they can be thought of as interchangeable.

Society, as distinct from culture, may be thought of as being more concrete, and as having organization.[2] Its phenomena are more easily identified than are those of culture. It is a system of organized group life in which the members play assigned roles in relationship to one another. In its simplest terms it may be referred to as a structured system of group relationships. According to Simmons and Wolff:

> The outstanding characteristic of society is a system of membership positions and interacting relationships that effect certain regularities in the adaptive behaviour of the individuals within the organized group. In a society the several organisms, or member agents, take their places in some observable relationship to one another and interact in a more or less repetitive and predictable manner. The recurring pattern is referred to as a structured group relationship.[3]

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[1] Ibid., p. 51

[2] Ibid., p. 51

[3] Ibid., p. 55

However, the individuals who make up society vary in many significant ways according to age, sex, aptitude, personality, position, performance and other variables. Individual differences lead to differentation and specialization of function, and a ranking of the members in relation to one another. Such ranking sets up relationships in which the member may occupy a superior, an inferior, or an equal position with respect to his fellows. In this way positions are established for all the members within a structured social life which both meet the interests of society and give the individual a place to fill, and a role to play within the established structure. Within the system, however, the individual can never be entirely independent. Because he has a place to fill his behaviour is to some extent governed by the system, and he has to conform to its demands sometimes at the expense of his individual needs and wishes.

Thus it may be seen that man as a member of a social system is dependent upon it for his place in the structure and for the role which he performs. It provides him with status and with a measure of security. At the same time it puts pressures upon him. Interactions with his fellow members force upon him roles of dependence or responsibility with which he may not be prepared to cope, and which may result in conflict. It is important for him to play his role acceptably and to live up to the expectations of his fellows. The roles he has to play may be fraught with tension, since if he is unable to live up to his responsibilities

and to meet the expectations demanded of him, he suffers loss of status and may fail in his own eyes and in the eyes of others. The relationships which he has with his fellow group members may become highly charged with emotions which also set up recurrent stresses. Such socially derived stresses may accumulate over long periods and constitute a large portion of the strain the individual must undergo as he progresses in the social structure from childhood through adulthood to old age, each stage bringing with it both added satisfactions and added obligations which expose him to new stresses. Simmons and Wolff point out that:

> Society thus becomes for us a significant concept. It helps to make clear the vast network of relationships and compulsions that propel, direct and constrain man's individual efforts but that bear forcefully upon his strongest and most intimate feelings about himself, reinforcing his personal satisfactions, yet increasing the tensions occasioned by frustration or failure in the achievement of his goals.[1]

Society is thus an important and highly complex aspect in the relationship between the individual and his environment.

It has been said that society is more concrete than culture, and that its phenomena are more readily identified. How, then, can cultural forces be distinguished from social forces, and in what ways are those two sets of forces related in their impact upon the individual? Ralph Linton, in comparing culture and society, states:

> Culture and society are mutually dependent. Neither can exist as a functioning unit without the other. It is the possession of a common culture which gives society its esprit de corps and makes it possible for its members to live and work together with a minimum of confusion and mutual interference. At the same time,

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[1] Ibid., p. 62

> the society gives culture overt expression in its behaviour, and hands it on from generation to generation. However, societies are so constituted that they can only express culture through the medium of their component individuals and can only perpetuate it through the training of these individuals.[1]

Man has been described as a culture-bearing creature, and every individual from birth onward comes under the influence of individuals who are already products of their own culture. Ruth Benedict[2] has stated that culture is not a biologically transmitted complex, nor is it some mysterious entity or force, but rather the total of the ways by which people pattern their functions and behavior into certain habits, customs and ways of living which they transmit to their children. It is composed of ideas, values and principles which comprise the social philosophy of a society and is a complex of codes, attitudes and sentiments which motivate overt behavior and are integrated into consistent patterns. According to Simmons and Wolff:

> Perhaps the simplest and most useful formulation of the concept of culture is to say that it is an acquired or learned system of shared and transmittable ways of adjusting to life situations.[3]

Cultures, when considered broadly, can thus be described as organized, patterned wholes. When considered in relation to a particular group or combination of groups, cultural configurations[4] exist which arise in the context of everyday living. Members of a society comprehend the meaning of such precepts in the process of socialization, even when they are expressed tenuously or obscurely, and configurations are generally difficult

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[1] Ralph Linton, The Study of Man (New York 1936), p. 271

[2] Ruth Benedict, Patterns of Culture (New York, 1951)

[3] Simmons and Wolff, op. cit., p. 63

[4] Ralph Linton, Cultural Background of Personality (New Yor, 1936) p. 75

to state theoretically because they frequently operate below the level of awareness. Nevertheless, these configurations become the basic units of value systems in a society since they express the dominant values which are thought to be necessary for the continued functioning of the society. Erich Fromm[1] has called them "socially immanent ethics" as contrasted with universal ethics.

These socially immanent ethics are to be found in group-sanctioned norms and rules and are observable as ideas, attitudes and actions.[2] They find expression in the folkways and mores, in the laws, and in the moral or religious mandates of the cultural group. They reach into the most intimate areas of individual and familial behaviour, and they furnish the meaning and determine the nature of what is acceptable and what is unacceptable action. It is possible to use only general terms in describing the culture of a particular group since regional and ethnic subcultures differ in many ways from the main pattern. Families of ethnic minorities, for example, have patterns which are dissimilar from those of native-born families. However, configurations are generally valid, or will tend to become so, for the entire society, in the sense that they represent the moral standards by which all behavior is evaluated.

Man as a member of his cultural group must cope with his culture. As Simmons and Wolff point out:

> Man's image of himself, his life goals, and his successes and failures in them, are defined and assessed under the dictates of his culture...While man through the centuries has created his

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[1] Erich Fromm, Man for Himself (New York, 1947) p. 241

[2] Simmons and Wolff, op.cit. p's. 68-71

> culture, and continues to modify it, culture in turn molds man and mirrors his life situations, cueing the stresses, teeing off his reaction patterns, and tallying up the score.[1]

Thus, it may be seen that in the life of an individual, cultural norms and sanctions press him to comply with and fulfill the roles that are ascribed to him in the social structure. His personal attitudes in terms of values and goals may conflict with the cultural patterns of his group. Key persons in the life of the individual may apply pressures or sanctions which intensify this conflict. Within the culture itself there are contradictory cultural elements to which he must adapt. Rapid cultural change may result in an intensification of fears and leave the individual without controls.

It is within the power of the socio-cultural system both to magnify fears and to diminish them. In the interests of the group it may exaggerate certain fears in particular situations or it may operate so as to diminish them. The culture also provides mechanisms for the regulation and resolution of fears as well as for the instigation of fear. An effective societal system usually functions so as to maintain an equilibrium within its membership, but when disruptions occur, as in time of war or in sudden cultural change, the fear-reducing mechanisms may be overpowered by the fear-inducing components, and the individual may be assailed by excessive amounts of fear.

Thus it may be seen that the man is both a social and a cultural

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[1] Ibid., p. 65

individual whose well-being is bound up to a large extent with these outer dimensions of his life. His ideals, his goals and his self-image are ordered by his culture and sanctioned by his society. He is both supported and given security by some elements in the socio-cultural system, and at the same time he is often frustrated and victimized by some of the forces within it. The influence which his socio-cultural system exerts over him, "may be sufficient to make up the difference for him between sickness and health and even between life and death."[1]

Earlier in this chapter it has been stated that this research project will approach the study of adjustment from a three-dimensional focus -- the individual as a physical organism, as a group member in society, and as a personality within a culture.[2] We have already considered the last two dimensions of this triad. How, then, are these systems related to man's functioning as a physical organism? The link, as seen by the writers of this thesis, is to be found in man's functioning as a personality, a functioning which takes into account both somatic and psychological elements. It has already been pointed out that "a human being is at all times an organism, an ego and a member of society", and that his well-being in any one sphere depends on how well he functions in the other essential areas.[3] The same frame of reference has already been presented in the description of the field theory. However, as Erikson has stated,

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[1] Ibid., p. 96

[2] Supra, p.23

[3] Supra, p. 20

the "organization of experience takes place in the individual ego", and it is to this concept that we look for further clarification of the interconnecting links.

It has been implied in the above discussion that harmful and helpful forces in the life of an individual blend and balance for long periods of time, and that he may be carried along with only minor fluctuations within his milieu as long as this equilibrium exists. At any given time, however, stresses which relate to illness may accumulate critically by a clustering of forces in any one or in all three areas of his functioning. What is the key to the upsetting of this equilibrium? Is it to the nature of social and cultural interactions alone that we may look for the answer? It is common knowledge that individuals vary over a wide range in their responses to situations in the extreme world, and that what constitutes stress for one individual does not do so for another.

It is suggested that we seek the answer in the ego-functioning of the individual, and that the critical differential is to be found in the meaning of the particular situation to him. It is not the situation itself, but the way a particular individual perceives, defines and reacts to it, which illuminates the relationship between himself and his society and culture. Simmons and Wolff put forward this point of view when they say:

> It may not be the situational factors <u>per se</u> that constitutes a serious threat to the individual in a given setting, but the way they are perceived and the amount of conflict they engender. It

> is not, for instance, the generalized behavior toward parents, power, possessions, sins, the hours of work, or the freedoms and restraints involved, but rather the attitude of a particular person to any one of a constellation of these and the threats they arouse for him that provide the key to an understanding of the stresses plaguing his life.[1]

Stressful situations, then, are those which arouse manifest emotional tensions and set off protective patterns of response. That such protective patterns may be either physiological or psychological or a combination of both is well substantiated in the psychosomatic literature. Weiss and English point this out when they say:

> Failure of adjustment to the environment may therefore be manifested by a disturbance in some part of the personality either as bodily symptoms of various kinds or as affections of the mind resulting in attacks of anxiety, obsessions, phobias or depression, and other disturbance of mood.[2]

Psychomsomatic research gives further evidence that when emotional tensions cannot find release in suitable behaviour they express themselves through disturbed physiological functioning. Leon Saul, in describing this body response pattern states that:

> The stresses and strains of life are, in the final analysis, emotional. And, our emotions are essentially our perceptions of the biological forces within us which motivate our lives. Each person feels these forces as various needs, responses and urges which seek satisfaction -- needs for food, shelter, occupation, ambition, love and so on. These he tries to satisfy in life which is no easy task. But to make it even harder, he must, as a social being, strive to satisfy these needs only in accordance with the restrictions <u>externally</u> of society and <u>internally</u> of his conscience and ideals which result

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[1] Simmons and Wolff, <u>op. cit.</u>, p. 115

[2] E. Weiss and O.S. English, <u>Psychosomatic Medicine</u> (Philadelphia, 1943) p. 12

> from past training and experience. Each person is more or less hard pressed on these fronts -- by his needs and desires, by his ideals and conscience and by the difficulties and dangers of the world, all of which he must strive constantly to reconcile and harmonize. No one succeeds completely in this three-fold task ...And the less he succeeds, the more emotional tensions develop. That these emotional tensions, can affect the physiology normally and abnormally is common knowledge.[1]

All people, in dealing with the stresses and strains of life develop protective patterns of response. That these may either be physiological or psychological in nature, or a complex of both, has been indicated in the above quotations. Saul elaborates further on the parallelism and intermingling of these types of response when he says:

> Once a man is threatened by increasing pain, frustration and anxiety and weakening forces of control, he reacts as does every animal organism by physiologic and psychologic mobilization for flight or fight. This mobilization is felt subjectively as anger and/or fear. The fight impulses manifest themselves, so far as they are directed outwards, by tendencies to aggressive behaviour, irritability and belligerency; so far as they are repressed they probably always generate anxiety and flight reaction, with which they combine to cause all kinds of psychologic and somatic symptoms from anxiety, paranoid trends and nightmares to palpitations of the heart and many other physiologic systems. The flight impulses, so far as they are expressed outwardly, lead to actual fleeing from unbearable situations to consciously attempting withdrawal in some other way. When repressed they may unconsciously motivate misbehaviour, produce physiologic symptoms which produce a means of escape, or they may cause flight in the form of physiologic regression, that is, an unconscious partial return to childish and infantile reaction, which results in eating and disorders, difficulties in walking, loss of capacity for responsibility, and so on.[2]

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[1] Leon Saul, "The Place of Psychosomatic Knowledge in Casework", The Family (November, 1941),p. 220

[2] Leon J. Saul, Emotional Maturity (Philadelphia, 1947) p. 5

As far as the bodily processes are concerned, Simmons and Wolff describe these reaction patterns as being apt or inept.[1] This is in line with the thinking that "all healthy and sick human functions are psychosomatic".[2] The protective devices are "apt" when they are appropriate for the situation at hand. They become "inept" when they are invoked too frequently or when they are inappropriate to meet the situation. Thus, while these patterns are necessary in order to protect the individual, their misuse in the course of time may make them seriously harmful to the physiological integrity of the organism.

It is these protective reaction patterns that constitute the key linkage between the psycho-social and bio-physical dynamics in illness. These patterns explain the mechanisms by which situational threats have a bearing on both functional and structural changes in the organism. They relate man's functioning as a member of society and as a physical organism - that is, through his functioning as a personality and the way the personality as an ego is able to cope with the threats to its integrity.

It is important to realize that these threats arise not only realistically in the interactions of his life, but may come from the symbolic meaning that these interactions have for him. In the words of Scarff, "anything may be considered a stress if it threatens the biologic integrity of an organism, either directly by its physical or chemical properties, or indirectly because of its symbolic meaning".[3]

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[1] Simmons and Wolff, op. cit., p. 118

[2] Franz Alexander, as quoted in Wittkower and Cleghorn, op. cit., p. 18

[3] John Scarff, "Reaction to Life Stresses following Unilateral Prefrontal Lobotomy", Life Stress and Bodily Disease, 1950, p. 175

Under such stresses the protective patterns are inept when they revert to earlier responses which were once appropriate, or when short-term devices are used for long-term purposes. Although they are adaptive, they are inappropriate as persistent patterns of response, and may damage the organism they were designed to protect.

There is much evidence to suggest that these reaction patterns or habituated attitudes of response are conditioned by previous life experiences. Cobb summarizes this thinking when he states that "our reactions are quite individual, but fall into general biological patterns. Just which pattern will be brought out by a given stress is a matter of each individual's past history".[1]

There is much evidence to suggest that the basis for such habituated inept response patterns is laid down in childhood during the early developmental stages of life. Alexander describes the stress situation as a "specific" nuclear conflict, stemming back to the early development of the individual and his particular instinctual conflicts".[2] This same theorectical concept is embodied in the field theory approach as outlined earlier in this chapter. Grinker maintains that some variations between individuals are constitutional, others occur in inter-uterine development, and others are determined by the nature of the early patterns which are developed in the process of maturation and differentiation through expressions in the environment. He states:

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[1] Stanley Cobb, Emotions and Clinical Medicine (New York, 1950), p. 204

[2] Alexander, op. cit., p. 50

> If the visceral mass responses (of the infant) are permitted and accepted as healthy and expected reactions until the child begins to indicate readiness for differentiation and control, differentiation will occur without loss...On the other hand, when fragments of the total adaptive pattern are prohibited too early, before they can be conditioned into appropriate responses, lacunae will appear in the subsequent integration...not only will there be a relative absence of some functions but an overloading on others.[1]

It is important in this connection to recognize that natural maturation plus environmental factors influence the physiological and psychological patterns developing at the same time. These patterns form the base on which later stress operates to create neurotic or organ disturbance syndromes, or a combination thereof. Later traumatic events, acting on a more organized structure or function are limited in site and localization of effect. Grinker's[2] approach also holds that within one differentiated system disturbed functioning is on a regressive level because of inadequate development in the maturation process. This is borne out by the fact that many of the psychosomatic disturbances of adults express the constellation of dependency, frustration and hostility at an oral level. Thus, the earliest responses to stress are undifferentiated, severely regressive modes of response in adult life repeat this pattern, and partial response to stress is interchangeable under certain circumstances. He states in summary that:

> Any hypothesis concerned with psychosomatic functions or disturbances should deal with the intermediate process of development between the undifferientiated whole functional pattern and the integrated matured

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[1] Grinker, op. cit., p. 38

[2] Ibid., Chapter III.

process. It is this period that probably determines the formation of healthy, sick or potentially sick organisms.[1]

It is clear from this presentation that many writers in the fields of research which bear on the adaptive processes accept the theory that the key link in relating environmental situations to malfunctioning is to be found in the type of reactive patterns developed by the ego in the early maturation process, and this approach is embodied in this thesis.

The concept that life situations in terms of social and cultural forces and the interpersonal relationships within them may be supporting or stress-laden for individuals has already been developed. The concept that the individual brings to a given situation a constellation of attitudes which are based on his previous life experiences and which relate him to this situation has also been put forward. These attitudes or organized attitudinal sets in interaction with elements of the situation result in adaptive patterns. In the words of Simmons and Wolff, "situation and stress, then, are linked by means of a definition derived in part from reality and in part from the fund of habituated attitudes brought to the situation by the person".[2]

In approaching this study of the adjustment patterns of older persons the "situation" of the patient's life will be defined in terms of both stress and strength. A situation of stress will be considered as one which is strain-producing to the individual because of the inept

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[1] Ibid., p. 37

[2] Simmons and Wolff, op. cit., p. 161.

or inappropriate patterns which he brings to it. It is thus, a situation which demands more than a minimal adjustment and which touches off emotional stress which are linked up with heightened physiological or psychological reactions. A situation of strength, on the other hand, is one which is supportive to the individual, to which he brings responses which are appropriate and which enable him to make a relatively successful adaptation. "Stress" is thus defined as a reaction to the situation which evokes emotional tensions and sets off inappropriate, protective patterns of response. "Strength" is defined as a reaction to the situation which is based on emotional adaptation and which sets off appropriate protective patterns of response. Response patterns (referred to in the thesis as "adaptations", or "ego defenses") are those mechanisms, whether appropriate or inappropriate to the situation, which the individual uses to make his adaptation.

In the following chapter the theories which have been set forth in this theoretical presentation will be related more specifically to the group under study. In it, the concept of stress and strength will be viewed in relation to the older person. Stress and strength will be considered both in relation to the social and environmental forces which affect the individual, and in relation to the adjustment patterns which he brings to life situations.

CHAPTER III

PHYSICAL, CULTURAL AND SOCIAL FACTORS IN AGING

In the preceding chapter the writers have discussed the factors which influence adjustment from a theoretical point of view. In so doing they have shown how physical, psychological and socio-cultural forces are interwoven to create patterns of adaptation. In this chapter they will attempt to illustrate how these same factors operate in the adjustment patterns of the older person. Such a presentation will serve as a background against which to assess the nature of the adaptations of the patient group under study, namely a group of aged Jewish men and women who have all immigrated to this country in the course of their adult life.

It is common knowledge that the aging process creates special problems of adjustment for all members of society, and that these problems are evident in each of the areas of life functioning discussed in the preceding chapter. Stieglitz, in a recent publication, has stated that:

> The problems of the mind in later life cannot be segregated from the problems of somatic health and disease, the stresses peculiar to senescence and senescents, and the emotional homeostatic capacities developed by maturation.[1]

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[1] Edward J. Stieglitz, "Problems of the Mind in Later Life", Geriatrics (April, 1956), p. 137

He has further pointed out that many of the disorders of the older person are caused by failure of the homeostatic mechanisms to adapt adequately to stress.

Aging may be defined briefly as "that element in life pertaining to the passage of time".[1] Thus, living is inseparable from aging, and there is no single chronological age at which old age may be said to begin. It can be described as a long life continuum of adaptation. It "begins with conception and ends with death".[2] The concept of aging is intimately bound up with cultural attitudes toward aging. Our culture is ambivalent in the values which it places on longevity. There are two extremes in the attitude of society to the aged person, the one in which the later years are viewed in too-glowing terms, and the other in which these years are seen as those of mental and physical deterioration in which little can be accomplished. This latter attitude, which tends to predominate in our culture, is based on an assumption of general organic functional and psychological deterioration beginning in middle life and proceeding rather rapidly until it becomes disabling and finally incapacitating. Consistent with this is the idea that little or nothing can be expected of older people. For the most part older people have accepted the concept of little usefulness, though there is evidence that they are dissatisfied with their role.

Popular beliefs about the aged are set up by the younger members of society, not by the aged themselves. Well-meaning people strive to

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[1] Anton J. Carlson and Edward J. Stieglitz, "Physiological Changes in Aging", The Annals of the American Academy of Political Science: Social Contribution by the Aging (Philadelphia, 1952), p. 18

[2] Lawrence Greenleigh, "Some Psychological Aspects of Aging", Social Casework, March, 1955, p. 99

comfort the aged by relieving them of responsibilities. Often their attentions are mis-directed. Because of these cultural attitudes, the aged, in a sense, may be considered a sub-group in our society with specific stresses and strains which do not face the younger age groups. In addition to the stress-producing situations which the aged person has faced throughout his life, his withdrawal from active roles creates new demands for adjustment peculiar to the last stage of life. Further, the older person faces life stresses at a time when he is least able to cope with them. Consequently it is to be expected that he will have exaggerated difficulties in certain or all areas of life functioning.

Aging is a process involving numerous inter-related elements which may be described broadly as biological, sociological and psychological in nature. The aging individual has needs which are common to all human beings. However, as he grows older it becomes increasingly difficult for him to meet these needs within the fabric of his social relationships. The reasons for this increased burden of adjustment may be summed up in the fact that the human body, culture and human society all conspire to insult the person as he grows older, with the result that even greater demands are made upon his emotional homeostatic mechanisms.

Physical and Mental Aspects of Aging

The fact that health is only a relative concept is nowhere more clearly illustrated than in old age. Embodied in the concept is much more than the idea of the mere absence of disease. Further, the biological

elements are so bound up with inter-related psychological and sociological elements that it is not possible to define health in old age with any degree of certainty. Tibbitts and Sheldon point out that:

> Aging per se is so complicated with disease processes on the one hand and with the restrictions of culturally assigned roles on the other that it is difficult as yet to describe or measure it with any degree of confidence.[1]

Biological aging, not attributable to disease processes, has been described by Carlson and Stiegitz as:

1. Gradual tissue dessication.
2. Gradual retardation of cell division, capacity of cell growth and tissue repair.
3. Gradual retardation of the rate of tissue oxidation (lowering of the speed of living, or, in technical terms, the metabolic rate).
4. Cellular atrophy, degeneration, increased cell pigmentation, and fatty infiltration.
5. Gradual decrease in tissue elasticity, and degenerative changes in the elastic connective tissues of the body.
6. Decreased speed, strength, and endurance of skeletal neuro-muscular reactions.
7. Progressive degeneration and atrophy of the nervous system, impairment of vision, of hearing, of attention, of memory, and of mental endurance.
8. Gradual impairment of the mechanisms which maintain a fairly constant internal environment for the cells and tissues.[2]

From this statement it is evident that "aging is a continuous and complex series of processes, some of the changes starting early, others later in life, and proceeding at variable rates.[3]

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[1] Clark Tibbitts and Henry O. Sheldon, "Introduction: A Philosophy of Aging", The Annals of the American Academy of Political Science, op.cit., p.7

[2] and [3] Carlson and Stiegitz, op. cit., p. 22

The writers add that all changes are not necessarily in the direction of decline. Compensations exist so that while muscular strength, vigor and speed of reaction decline with advancing years, skills tend to increase with long practice. Though there may be less intense emotional drive, there may occur an increase in loyalty and calmness and a clearer definition of purpose in living with increasing maturation. Tibbitts and Sheldon point out that intellectual and emotional endurance increases with advanced age up to a given point, and when endurance finally breaks, the failure is more often associated with the accumulated consequences of disease than it is with aging per se. In general it may be said that the process is a gradual one, and it differs widely among individuals, and that there are variations in the rate of aging of different organ systems within the same individual.[1]

Nevertheless, the bodily changes which come with aging make increased demands on the individual for adjustment. In our culture, in which much emphasis is placed upon youth, loss of physical attractiveness is likely to be keenly felt. Grey hair, loss of hair, wrinkles and other physical evidences of aging make the person feel "old" and consequently unattractive, with a resultant weakening of the sense of self-esteem. At the same time aging brings with it a decline in sexual capacity. Women lose the ability to have children, and with the menopause many feel that they will no longer enjoy sexual experiences and, as a result of this attitude, are unable to do so. This leads them to feel that they

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[1] Tibbitts and Sheldon, op. cit., p. 7

have lost their worth as women. Men, as a consequence of their declining sexual capacity may feel inadequate as men and may indulge in fruitless sexual fantasies. To the man or woman who has been neurotically insecure in his or her sexual role the aging process may be so traumatic as to preclude a stable adjustment. Further, all of the special senses become less keen with aging. The individual sees and hears less of what is going on about him. He may attempt to compensate or he may withdraw in a depressed and embittered fashion. Loss of teeth may lead the older person to live on a soft, poorly balanced diet which may result in nutritional deficiencies, and which in turn results in a lower level of physical and mental functioning. Finally, there is the lessening of physical strength and vigor. Much emphasis in a young society is placed upon physical capacity, less upon the wisdom which comes with maturity. Older persons have to fact the loss of physical strength, and many fear disease and helplessness. Related to the fear of helplessness is the fear of death itself, a fear which may lead to severe personality disturbance in the individual whose defenses are inadequate to meet the onslaught of the passing years. As Bacon put it, "men fear death as children fear to go in the dark". All these factors in aging may be said to face the older person with new and unsolved problems for which the well-tried solutions of middle years no longer provide the answer.

Mental as well as physical changes occur within the process of aging. As with physical changes there are also great variations among individuals. There is also variability in the rate at which mental capacity is lost. Further, the inability of present intelligence tests to

measure such qualities as wisdom and judgment, make it impossible to measure accurately the rate of intellectual decline. It is known that the speed of mental and physical reactions decreases with age, though reasoning ability and memory may be unaffected.[1] There is evidence that mental activities which are carried out regularly and habitually tend to be preserved and show a slower rate of decline.[2] It is also known that autopsy findings on persons dying at advanced ages show little correlation between mental symptoms and brain changes.[3]

In addition, certain specific abilities seem to be lost gradually as part of the aging process. Memory appears to show a progressive loss from thirty years onward, possibly caused by atrophy of the brain, possibly as a result of the loss of interest and intensity of feeling which comes with increasing age. Most older people have slight memory loss for childhood experiences, greater for newly learned material. Learning ability decreases with age, possibly because new learning may require the breaking down of long-established patterns. Again, it is directly related to the intensity of interests, and motivation to learn in the older person is not as great.[4] Decline in reasoning ability shows a similar deterioration. This deterioration is more marked when the individual attempts to deal with unfamiliar material. It is known that those who continue to apply themselves to the use of verbal materials all through life are able to maintain their efficiency better than those

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1, 2, 3, 4 Karl M. Bowman, "Mental Adjustment to Physical Changes With Aging", Geriatrics, April, 1956, p. 142 and 143.

who do not have such a history.[1] In general it is agreed by authorities in the field that there is some decrease in intellectual functions with age, but studies in this aspect of aging are by no means conclusive. As Bowman points out, "certain recent material makes it doubtful that intellectual deterioration starts in the 30's".[2]

The Aged in Our Culture

It has already been pointed out that our culture is ambivalent in the values which it places on longevity. This ambivalence arises from the fact that while modern civilization has brought longer life for longer proportions of the population, it has disrupted the established adaptation patterns of the aged. Successful aging depends, according to Simmons, on the "capacity of individuals to fit well into the social framework of their own times, to win their rights to prolonged participation and recognition, and to know when they are through".[3] In our culture the older person has not yet won a secure place within the social framework, nor has the social framework been modified to accommodate the presence of large numbers of older people.

It is not difficult to see how this dislocation has come about. Attitudes toward the aged in our culture have their origin in a period when the country was gradually shifting from an agricultural to an in-

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[1] Oscar J. Caplan, "Psychological Aspects of Aging", The Annals of the American Academy of Political Science, op. cit., p. 35

[2] Bowman, op. cit., p. 143.

[3] Leo W. Simmons, "Social Participation of the Aged in Different Cultures", The Annals of the American Academy of Political Science, op., cit., p. 50

dustrial economy, and when few people lived beyond the fifties and sixties. In such an economy young people were needed and emphasis was placed upon the value of youth, of action and of "know-how". With industrialization came urbanization and with it new ways of life. The large three-generation family gave way to the two-generation conjugal family in which grandparents had nc positive role to play in the family economy. Work was conducted outside the home and recreational activities were increasingly sought within the community. As a consequence urban housing was designed to meet the needs of two generations and did not provide the space for grandparents within the family group. In such a society older people came to be regarded as superfluous and no longer useful. Younger people rationalized their feelings concerning the aged by adopting the attitude that older people had made their contributions and were entitled to withdraw and enjoy the leisure of their declining years. At the same time they looked to the community to meet the needs of older people, needs which could no longer be met within the family group.

But the community, in spite of the fact that it has provided public and private pension systems and institutions for the aged, has met these needs, insofar as it has done so, in accordance with the prevailing concept that the elderly are no longer capable of making a useful contribution to community living. The aged have been relegated to the rooming-house, the old age home, the nursing home and the mental institution. It is only in recent years that this concept has been questioned as more is being discovered about the aging process and society is being faced with the problem

of increasing numbers of aged and non-productive citizens within its ranks. This older concept is gradually giving way to a more positive one, the concept that middle and older age brings with it new opportunities for social contribution. Tibbitts and Sheldon express this emerging philosophy when they say:

> Attainment of middle age may be viewed as bringing us to the threshold of a new phase of life - a phase that can represent a new stage of development, growth, maturity and social contribution. Freed to an increasing extent from the responsibilities of early adulthood, we find ourselves ready to make further and broader contributions to the social welfare, effective because they grow out of half a century of experience gained through living.[1]

However, this newer approach is only beginning to make itself felt. For most older people the opportunity for activities suitable to their years, for friendships, for economic and emotional security, and for the fulfillment that comes from the knowledge of being useful, are not present. Old age has become and remains a stress concept, not only to the older person himself, but to those with whom he has close psychological relationships.

Thus it may be said that our culture does not yet provide the climate for successful aging. Older people are bewildered and insecure in a fast-moving world which has failed to provide the opportunity for normal satisfactions. In community affairs they are frequently encouraged to give way to the oncoming generation, and leadership roles in civic, political, religious and social institutions are taken over by younger

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[1] Tibbitts and Sheldon, op. cit., p.'s 8 and 9

people. Such roles as remain to the older person are usually poor substitutes for those he has lost. At the same time the older person, in addition to the loss of respected roles, has to face the loss of friendships as more and more of his friends pass away. He is robbed to an increasing degree of those associations which have made him feel valuable and understood, and which have contributed in the past to his emotional security. It can be easily seen that loneliness is one of the most serious problems of old age. In the face of this problem the elderly individual may lack the opportunity, the financial resources, or the will to find companionship for himself among a group of his contemporaries.

The adjustment to their roles as older persons is complicated for the patients in this study by the fact that they were immigrants, and that nearly one-third of them were recent immigrants. They had all within their adult lives had to adapt to a culture in which the cultural patterns were different from those in which they had grown up, and to which they had adjusted for varying lengths of time. Further, they all belonged to a minority group, and many left their home countries because of religious and racial persecution. The recent immigrants in particular had suffered under the extermination policies, the wide-spread social upheaval, and the concentration camps of the second World War, both prior to, and in the process of immigration. In such periods of upheaval which are marked by sharp social and cultural conflicts the uncontrolled and destructive fears which are engendered are so overwhelming as to upset the emotional equilibrium of even the most successfully adjusted individuals. Simmons

and Wolff describe the effect of disruption in the following terms:

> In other words, with a relatively constant culture and a stable physical milieu, society can change for an individual member, much like shifting sands around a once firm structure, and with similarly undermining effects upon his stability and security.[1]

Within the process of immigration itself these patients had to adapt to value systems and mores which were alien to their own culture. In such a transition the individual is often trapped between two cultures. Many elements of the new culture are adopted while large parts of the original culture survive, and the individual is caught in a dilemma involving the old and the new. It is possible that the older members of a society suffer less in the transition than do the younger members. They are more inclined to rely successfully on their old culture and to adhere to the tried and tested ways of their former days. They are in consequence, likely to be less insecure in the new situation than are the more sophisticated younger adults. Nevertheless, rapid changes produce new areas of stress, and shifts in role and status are imposed upon the normal conflicts which exist between the older and the younger generations. The situation of immigration is also complicated by the fact that for newer immigrants the cultural assimilation takes place more slowly than for their children, a fact which puts added strain on the relationships within the family.

The fact that the patients in this study were all Jewish had a bearing on their adjustment as elderly individuals. Since every minority

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[1] Simmons and Wolff, op. cit., p. 86

group has its own value systems and folkways within the broader society of which it forms a part, it is important to consider Jewish cultural patterns in order to see how they may have influenced the adjustment of the patients under study.

The Jewish people have been subject to persecution, discrimination and isolation in all the European countries in which they have lived as exiles throughout the course of their history. At many critical points in their history their numbers have been greatly reduced. Under the influence of persecution they have acquired a vitality and drive, a sense of cultural identity and solidarity which has throughout the years added strength to their will to live.

Their cultural identity has rested on a strong religious faith in God, a faith which is deeply rooted in their early history. Out of the depth of their experience they have attained a unique vision which they have translated into a way of living. The distinctiveness of the Hebrew faith is revealed in the observance of the Sabbath, in the religious festivals, in the daily religious practices and the ethical studies prescribed for everyday living, and in the laws of social justice. These are manifestations of man's spiritual relationship with God, and form the heart of the Hebrew religion.

Within the Jewish home the religious observances embrace the whole family and weld the family into a closely knit unit. Food is treated as a symbol of God's providence, and the laws guiding the preparation of meals have significance in maintaining the cultural and religious identification.

In the Jewish family of today the husband, as the head of the family, is exhorted to treat his wife, his children, and his parents with sympathy and understanding. In general it may be said that both historial influences and the nature of the Hebrew religion itself combine to give a heightened sense of meaning to the family and to place a special value on the closeness of family ties.

Nevertheless, the influences of foreign cultures have had an effect on the Jewish people, depending on the extent to which policies of discrimination operated to produce isolation. In Austria, Hungary, Italy and France there was a higher degree of assimilation into the cultural life of the country, while in Russia, Poland, Roumania and Lithuania where the ghetto pattern was more rigidly observed, Jewish cultural identification was more closely adhered to. In the latter countries the Jewish people tended to remain more strongly orthodox.

The effect of immigration, and the extent to which Jewish cultural identification influenced the lives of the patients in this study will be observed in the ensuing chapters of this thesis.

The Aged in Our Society

It was pointed out in the preceding chapter that society is so organized as to give the individual a place to fill and a role to play within the established structure, a role which lends him status and a measure of security. Perhaps the most severe stress is occasioned for the older person as a result of his loss of role in the world of affairs. This is particularly true for men when they must retire from work, the

principal status-giving role for men in middle-age. Many men make no preparation for retirement and expect to shift from the habits and practices of a lifetime into unaccustomed idleness. Retired individuals who have not found a substitute outlet for their energies in the form of part-time work or satisfying leisure-time activities are likely to become bewildered, self-centered, and embittered. The fate of retired individuals has been described by Tibbitts:

> Retired individuals, gradually bereft of companionship, characteristically become lonesome, complaining, and self-centered and may make excessive demands on children, physicians, case workers, ministers and others. Their children, who must devote their energies to their own young, find themselves burdened with salvaging the social life of the older generation.[1]

It has also been noted that people invest a libidinal interest in work, so that withdrawal from productive activity also affects the sense of worth as a man or as a woman. To the well-adjusted person the giving up of occupation may come as a pleasant relaxation and of looking back on a job well done. To the unstable one the period of retirement may be one of increasing tension.

Loss of role usually comes less suddenly for women and is less traumatic in its effect. This is due to the fact that most women are housekeepers and as such are able to carry on their duties within the home even though they may do so in a more limited way. However, women also have to make an adjustment to their changing status. The rearing of children has been their major source of interest and gratification. The time comes when the children grow up and leave the home, and no

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[1] Tibbitts, as quoted in "Age Introduces Stress into the Family", by Franklin E. Ebough, Geriatrics, April, 1956.

longer need their care. The well-adjusted woman will find substitute satisfaction in her role as grandmother; the poorly adjusted woman will make unreasonable demands of her children and complain that her children have left her.

Another problem which accompanies retirement is a reduction in income with a corresponding reduction of expenditures. This problem, too, may impose a burden on the family, with consequent tensions, a need to make new housing arrangements, and may result in a giving up of social interests because the older person can no longer afford them. It also may affect the individual's sense of status as a self-maintaining member of society.

Within the family there are also new demands for adjustment. The most serious adjustment the older person has to make is to the death of the spouse. After fourty or fifty years of wedded life the necessity of facing life without a partner leaves the man or woman without his or her most important source of emotional support at a time when it is most needed. The pattern of a life-time is broken and the individual is faced with making a new pattern of living. If the remaining partner is a woman she may have to learn about business matters, she usually has to make new living arrangements, she often has to manage on a smaller income, and above all, she has to learn to be alone. If the surviving partner is a man he has to make the same adjustment to loneliness and he may have to learn to cook and keep house or find a home with his children. Whatever the solution, whether it be living alone in the old home, moving into a smaller home,

moving in with relatives, living in a rooming-house, or going to an old people's home it requires the unlearning of old ways and a learning of new ways at a time when learning is less easy that it was in former years.

It has been said that old age places a burden upon those with whom the older person is in close psychological relationship. The reaction pattern of the old person has a complementary reaction pattern in those caring for him. They are afraid of loss of freedom, the necessity of caring for a potential chronic invalid, economic hardship, and the need to control resentment against the old person who disrupts the former family routine. These fears are accentuated if the older person is complaining and demanding. In addition there are the irrational fears of the younger members of the family, the hidden fears which exist because every individual is afraid of old age and death. Ebough states that:

> We reject the aged because they remind us of death. This is repellent and unacceptable in our culture, where the accent is on living each precious moment to the full, where time must be saved by ever-increasing speed, and where, in fantasy, we continue to search for the fountain of youth.[1]

Where the fears of the older and the younger generation meet tension is unavoidable if there is lack of understanding, each of the problems and situation of the other. Where family bonds have been strong and affectionate these tensions are at a minimum. Where relationships have always been strained they are a source of increased stress.

Adjustment Patterns in Old Age

It is seen from the foregoing that stresses accumulate in old age in all areas of living. The accumulation of stresses may produce a crumbling

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[1] Franklin E. Ebough, Geriatrics, April, 1956, p. 148

not only of physical defenses, but of psychic defenses. The adjustment patterns of a life-time may weaken and reveal anxiety, depression, or even psychosis. In the fact of the weakening of the adaptive patterns the older person may adopt defense mechanisms which are irrational or inappropriate and which are regressive in character. These may take the form of:

1. Living in fantasy or in the past. When the present is uncomfortable or make demands which the person is unable to meet he may turn to the past and dwell on its pleasures and successes, or he may withdraw into a world of fantasy where all his needs are met.

2. Regression into infancy. A more infantile response takes the form of return to early childhood. When life becomes unbearable the older person may fall back on his earliest adaptation pattern, when all his problems were solved by others. He may revert to infantile behavior and become dependent on others for feeding and care, and may even go to bed and stay there as much as possible.

3. Regression into illness. This is a common pattern of defense in all ages, and particularly so for older individuals. It may be used as an attention-getting mechanism and it also serve as a means of meeting the need to be dependent.

Other less regressive, but neurotic defenses are:

4. Depression of mood.

5. Withdrawal and social isolation.

6. Self-depreciation and self-pity.

7. Denial of the aging process and of physical limitations.

8. Rebellion against, and over-compensation for the loss of physical strength and/or lowered social status.

On the other hand, the well-adjusted older person will develop adaptation patterns which are effective and appropriate to his life situation. Some of these patterns are:

1. Mobilization of ego strengths to meet new situations.
2. Ability to reach out for substitute gratifications and meaningful social relationships.
3. Ability to maintain relationships with children on a basis of mutual consideration and respect.
4. Ability to verbalize and resolve fears.
5. Acceptance of old age and its limitations on the basis of reality.
6. Acceptance of reality factors in the present life situation.
7. Ability to make constructive use of leisure time.
8. Ability to assume a role of leadership in the family on the basis of seniority and wisdom

It was pointed out in Chapter II that the key to stressful responses to situations lies in the type of reaction patterns which the individual has developed in the early maturation process. Nowhere is this more apparent that in old age. As Ebough points out, "the basic factor in old age is the attitude of the person concerned; all else is secondary".[1] Thus, individual experiences are the primary determinants of old age reactions, and the older person will reiterate his early patterns of adjustment If his adjustment throughout life has been a stable one, he will adjust to the changing circumstances of old age in a mature way. If it has been unstable, his life will be characterized by physical, mental, and psychological deterioration. Thus we may say that man becomes in old age what he has always been.

The nature of the adjustment patterns of the patients in this thesis will be discussed in Chapters V, VI and VII. In the following chapter consideration will be given to the general characteristics of the sample group.

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[1] Ebough, op. cit., p. 146

CHAPTER IV

GENERAL CHARACTERISTICS OF THE SAMPLE

In this chapter an attempt is being made to assemble the basic factual data concerning the life situations of the patients under study. It will describe that material covered in the questionnaire which lends itself to generalization and which has importance as a background against which to assess the adjustment patterns which will be described in later chapters. It has further value in providing some understanding of the bearing which common factors of a social, cultural and familial nature have on the group as a whole. It is hoped that in assessing these factors some light may be shed on the elements in our society which influence the older age immigrants within the Jewish minority group. The statistical method is being used for the presentation of this material and the writers will adhere to the sequence followed in the interview schedule.

It has already been pointed out in Chapter I that the interviewees selected for the study were all of Hebrew faith, and that all had immigrated to Canada during their adult life. The fact that many of them could not speak English did not constitute a barrier in establishing the necessary rapport, since the interviewers were able to conduct the interview[1] in the language in which the patients were most at home.

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[1] A copy of the interview schedule is included in the Appendix, A p. 239

Age and Sex Distribution

There were seven males and eleven females in the sample group. Their ages varied from fifty-seven to seventy-seven years. In Table I, it can be seen that the great majority (sixteen out of eighteen patients) fell into the age group of sixty-five years and over, and that one-half of the total (eleven patients) were over seventy. In the female group the oldest patient was in her seventy-fourth year. The one patient in the seventy-five and over group was a male of seventy-seven years of age. It is thus clear that the patients in this study fall into the more advanced age range of the older age group, and that many of them may be described as senescents.

TABLE I

Age and Sex Distribution of 18 Patients
Arranged in Quinquennial Sequence

Age in Years	Total Patients	Male	Female
Total of Patients	18	7	11
55, under 60	1	-	1
60, under 65	1	1	-
65, under 70	5	2	3
70, under 75	10	3	7
75, and over	1	1	-

Immigration

Countries of Origin

It is interesting to note that all the patients in the study, with one exception, came from the Eastern European countries of Russia,

Poland, Roumania, Lithuania, Hungary and Austria. The one exception was born in Palestine and immigrated to Canada from that country. Although the patients were born in the above countries, three moved during their lifetime from one Eastern European country to another. One patient experienced three such moves before her immigration to Canada in 1924. Another moved from Russia to Vienna following her marriage, where she lived for fifteen years before coming to this country. A third was born in Hungary but grew up in Vienna where she remained until 1939.

As a result of World War II, two patients and their families experienced extreme hardship in the process of immigration. One left Vienna with her husband following the Nazi occupation in 1939. They hoped to settle in Israel (then Palestine), but their displacement was prolonged due to the outbreak of World War II, and the immigration restrictions which the British Mandate Power had enforced. Finally after six years in concentration camps in Italy and North Africa they were able to immigrate to England. After five years of residence in that country they followed their son to Canada.

The second patient immigrated from Hungary with his family to Israel following World War II, Israel being the only country at that time which admitted immigrants without a means test. After having established himself in Israel the patient suffered a cerebro-vascular accident, and then followed his daughter and son-in-law to this country.

It has already been pointed out in Chapter I that there is a marked variation in the length of time since immigration in the sample

group. This variation is shown in the following table.

TABLE II

Length of Residence in Canada[a] According to Quinquennial Periods

Length of Residence in Canada in Years	Number of Patients
Total of Patients	18
0 through 4	4
5 through 9	1
10 through 14	-
15 through 19	-
20 through 24	2
25 through 29	2
30 through 34	4
35 through 39	-
40 through 44	-
45 through 49	3
50 through 54	2

[a] Unless otherwise indicated the table refers to all patients in the sample group.

From the above table it is seen that in this group of 18 patients, five are recent immigrants, having arrived in Canada in the past ten years. Eight have immigrated between twenty and thirty-five years ago, and the five remaining patients have been living in Canada from forty-five to fifty-five years. There is no record of immigration between 1936 and 1946 or between 1912 and 1921. Significantly this indicates that during

and immediately following the two World Wars none of the sample group under review emigrated from his country of origin.

Motivation for Immigration

In exploring the motivations for immigration there was difficulty in obtaining reliable data in the interviews from the patients who had been in Canada for over twenty years. These patients were not able to recall specific reasons for leaving their countries of origin, and in many instances more than one factor was operating in motivating the immigration.

In analyzing the data the writers accepted at face value the statement of the patient as to the main reason for immigration. These reasons fall into three main categories which can be described broadly as familial, political and economic. Under "familial" is included coming to the country because the spouse or other close family members were already established here. Under "political" is included the desire to evade conscription in the country of origin and to escape the political unrest, the religious and social persecution, and the social and economic disturbance which preceded and followed two major world wars. Under "economic" is included the wish to improve economic status. Ten of the patients gave familial ties as their main reason for immigration. Seven patients immigrated mainly to escape political unrest. Only one patient gave as his sole reason for immigration a desire to improve his economic status. Political pressures cannot be considered the sole reason for immigration in all the seven cases. In this group familial ties in addition to political reasons overlapped as precipitating factors. This is particularly

true for the five recent immigrants in the study.

Cultural Patterns of Immigrants

It was noted earlier in this chapter that 17 of the 18 patients had emigrated from Eastern Europe. However, different patterns of cultural life existed in these countries, a fact which has a bearing on the adjustment problems following immigration to this country. The cultural pattern of the Jews in Russia, Roumania, Poland and Lithuania was that of the ghetto community which began to disintegrate only in the latter part of the last century and the beginning of the present century. This must be distinguished from the cultural pattern of Jewish life in Hungary and Austria where the ghetto pattern had broken down earlier and a high degree of assimilation had resulted. Thus it may be observed that two distinct types of Jewish cultural life have emerged. On the one hand there is the strongly orthodox Jew, and on the other, the assimilated Jew who no longer adheres to orthodox religious practices, who takes an active part in the general cultural life of his own country, but who still identifies broadly with Jewish culture.

In this study these two patterns of cultural identification were evident, although there was a wide variation in the degree of cultural identification. The extremely orthodox identification is illustrated by one patient who derives her main source of strength from the belief in the coming of the Massiah. The pattern of the assimilated Jew is observed in the cases of two recent immigrants who found it difficult to adjust to the Montreal Jewish community. Both of these patients had immigrated from Hungary, where they had been highly assimilated into the cultural life of the community. In this country they found it difficult to accept the

separation between ethnic groups which exists in this particular urban centre.

Factors in Cultural Adjustment

Recreational Activities

It was found that in general the recreational activities of the patient group were limited in nature. There was a conspicuous lack of interest in creative hobbies in both the patients who were employed, and in those who spent most of their time in the home. The activities which were found were passive in type and consisted of reading, listening to the radio and watching television. It was noted that the women did very little needlework, and that the men found their outlet through casual meetings with their men friends. This passive trend was marked in the immigrants who had been in Canada for more than twenty years, and appeared to be a continuation of their adult recreational pattern. In the recent immigrant group there had been active participation in community affairs and cultural pursuits in their cities of origin. In this country, however, they have not been able to sustain these interests because they have no established place in the community, and language and financial considerations interfere with their participation.

A similar pattern was observed as far as interest in sports was concerned. Only one patient in the sample group expressed any interest in sport whatsoever. As a young man he had been a champion cyclist. This striking lack of interest again reflects a life-time pattern. It is not possible to generalize on the basis of the small sample under study, but it would appear that lack of interest in sports is characteristic of Jewish

people who have grown up in Europe. This cultural pattern is probably related to the restrictions which were placed on the Jews in most European countries in the past.

Social and Group Activities

In general it has been found that the recreational activities were limited. However, the lack of recreational life in this group was to some extent overcome by sharing in family social life and activities. It has already been said that ten of the patients came to this country for familial reasons, and strong family ties were found to be characteristic of this group. This is in keeping with the tradition of family solidarity which is observed in the Eastern European Jewish culture. This same family solidarity appears in this study to be fundamental to all aspects of life adjustment for these patients.

Those six patients who were living with their children shared in varying degrees in the social life of the family. Those who were living by themselves visited frequently with their children or other relatives and it has been observed that the children and relatives, in general, maintain an active interest in the patients. This interest is expressed in frequent phone calls, visits, and a recognition of their responsibility within the ties of the kinship group.

Apart from family activities, one-third of the patient group have been found to participate to some extent in group activities. These include Golden Age clubs, Zionist organizations and Synagogue societies. In some instances the patients have been more active in the past, but their failing physical strength and lessening of interest has forced them to reduce their

participation.

Although six of the patients take part in organized group activities, informal social life with friends and neighbours was of greater significance to the group as a whole. Over half the patients spoke of relationships with friends as being important to them. However, many of the contacts with friends, particularly with the men, appeared to be of a casual nature and to take the form of conversations after services in the synagogue, chats on the park bench and going for walks. In only three patients was it felt that friendships outside the family were really meaningful in themselves to the patients. This is again related to the dominance of family ties in this group.

Religion

It has been pointed out earlier in this chapter that there is a wide variation in the nature of identification with Jewish culture exemplified in this group. While all the patients are identified with the cultural patterns, the religious observations vary according to the extent of orthodoxy. With the more orthodox adherents, the men attend services to a much greater extent than the women, while the women follow the religious pattern in attending synagogue on Saturdays and in adhering to the orthodox code of ethics within their own homes. In the less orthodox group, attendance at synagogue services is less frequent, being confined to the High Holidays and the days of memorial. However, it is noteworthy that this group maintains the traditional Jewish way of life in terms of dietary laws and festival observances. It should be said that one patient

in the group expressed agnostic beliefs and has no affiliation with formal religion. Another patient stated that he was an atheist, but it was noted that he nevertheless attended synagogue periodically.

The pattern of synagogue attendance is shown in Table III. In order to point up a comparison between the pattern in adult life and the present pattern, the table was designed to present both levels of participation.

TABLE III

Patterns of Synagogue Attendance of Patients in Adult Life and at Present According to Sex

Nature of Attendance	Total Patients	Daily	Every Saturday	Periodical	None
Total Patients	18	3	5	9	1
Adult Life					
Male	7	3	-	4	-
Female	11	-	5	5	1
Total Patients	18	3	3	11	1
Present					
Male	7	3	-	4	-
Female	11	-	3	7	1

For most patients the present extent of synagogue attendance is similar to that followed in the past. The table shows that patients who formerly attended services every Saturday morning, now attend less frequently, due largely to physical incapacity.

Factors in Social and Familial Adjustment

Employment

It has been pointed out in Chapter III that loss of employment is one of the most important environmental factors in old age to which

the patient must adjust. Conversely the ability to maintain himself in employment is of significance in preserving the individual's sense of status and self-worth. It is important, therefore, to consider the past and the present employment patterns of the sample group. In Table IV, the present employment pattern is being analyzed. Since at the present time the patients are not actively employed on the basis of their former occupation and training, it is not possible to categorize the types of employment specifically. In Table V , the nature of employment in earlier adult life is being presented. It is hoped in this way to point up significant changes between past and present employment patterns.

TABLE IV

Nature of Present Employment According to Sex

Nature of Employment	Total Patients	Full Time Employment	Part-Time Employment	House Keeping	Unemployed
Total Patients	19[a]	3	2	6	8
Male	8	2	1	-	5
Female	11	1	1	6	3

[a] The additional patient in the total indicates that one female patient has a part-time job and manages a household as well.

It is evident from this table that more than half of the patients are employed in some fashion. The writers found it significant that of the sample group such a large proportion are engaged in productive activity. Physical disability and increasing frailty accounts for the unemployment of the eight patients in the sample group. Two men hold full time jobs. One of these is employed as a handyman in a fruit store, and the other in an agency-supervised sheltered workshop. The only female employed full time

has a job as a domestic and companion to an older woman.

Of the two patients who are employed part-time, one is a woman who does dressmaking to supplement her Old Age pension and at the same time keeps house for a widowed sister. The other is a male patient who takes most of the responsibility for managing the home because of his wife's partial invalidism.

Six woman are maintaining the major responsibility of a household, although in the case of one patient the household consists of a single rented room and she cares only for herself. The other five women care for the homes of children and their responsibility is shared to some extent by other family members. It is noted that the women in the sample group are continuing in the same occupational pattern they have formed in adult life, though the pattern has been adapted to their status as grandmothers rather than as mothers.

In the unemployed group, the three women are physically unable to carry any more than very limited and simple tasks in the home and are cared for by others. The large number of unemployed male patients follows the generally observed trend of lack of renumerative employment for the aged. Even limited and part-time employment is unavailable to this group, though in the case of the five males in the study four are actually incapacitated due to physical and mental handicaps which preclude employment. In spite of the fact that these males are physically unable to work, they all express a desire to do so and feel keenly their inability to find employment. One male patient is voluntarily retired.

In Table V , in which the pattern of employment in adult life is being shown, it has been possible to categorize the types of employment according to occupational status. In assessing the data in this table it must be kept in mind that in the cases of the new immigrants their adult life employment was in Europe. In view of the different standards and the writers' lack of familiarity with the employment conditions on that continent it has been difficult to categorize these patients with any degree of accuracy.

TABLE V

Nature of Adult Life Employment According to Sex

Nature of Employment	Total Patients	Male	Female
Total Patients	21[a]	7	14
Semi-skilled[b]	3	3	-
Skilled	2	1	1
Clerical	2	-	2
Self-employed	2	2	-
Professional	1	1	-
Housekeeper	10	-	10
Unemployed	1	-	1

[a] The additional three female patients in the total indicates that three women worked outside the home in addition to maintaining their own households.

[b] The "cutter" in this group owned his own business for a number of years prior to the depression.

In the table wage-earners are divided according to "semi-skilled" and "skilled". There were no unskilled workers in the sample group. "Clerical workers" in the sample are those who were engaged in office management. "Self-employed" refers to those who owned their own business. "Professional" covers the patient in the group who had training as a pharmacist. The categories of "housekeeper" and "unemployed" are self-explanatory.

The table indicates that in adult life all the male patients were productively employed. The three men in the semi-skilled category were employed as presser, painter and cutter in a garment factory respectively. The skilled male patient was trained as a "heating engineer" in a technical school and later owned a tin and blacksmith shop. It was not clear to the interviewer what the exact nature of this patient's employment was in Europe. The two self-employed males owned their own businessess, the one a fur business, the other a lunch counter. The professional worker was a pharmacist who owned his own business, was active in professional associations and accepted students for training.

From this analysis it is clear that the male patients in the study have in the past all been successful to a degree in establishing themselves in the labour market, and have been able to provide adequately for their families. The two males who were employed in Europe appear to have achieved a relatively high status in the community, particularly the pharmacist. The five who came to Canada early in their working life apparently had little difficulty in establishing themselves in employment in this country. Of the five one was only sixteen years old on arrival,

and he began work as a presser. Three continued in the same type of occupation they had been engaged in before immigration. Only one patient changed his occupation from that of chemical engineer to owning a fur business and this he did by his own choice.

When the past employment is compared with the present employment in this group the difference is striking. The two males who are working are working only for the sake of keeping themselves occupied and are unhappy with their present status. In general the men in this group have had a great deal of difficulty in old age in accepting lack of satisfactory employment.

The women in the study have on the whole been engaged in housekeeping throughout their adult life, and this is in keeping with both European and Jewish cultural patterns. With one exception the women have maintained the responsibility of a home. The exception has always been too physically and emotionally handicapped to carry other than limited household tasks.

In addition to their housekeeping responsibilities three women have engaged in other forms of employment. Two of these women worked in Europe in their husband's businessess. One managed her husband's toy shop, the other supervised the workers in her husband's small weaving factory. It is significant that these two women were employed within the family unit. The third woman was employed as a dressmaker within the home in order to support the family after her husband became an invalid.

Income

The present income of the eighteen patients is influenced by their age and by the length of time they have spent in this country. It is difficult to evaluate the adequacy of income because the concept of adequacy is influenced by the value judgement and by the standard of living achieved by each individual family. In general none of the patients was experiencing severe financial deprivation. It was not possible within the study to assess the actual income of the patients. However, the sources of income were the Old Age pension, relief from welfare agencies, assistance from children, savings in the form of insurance policies, and salary and other earnings. By "salary and other earnings" is meant income from wages, and earnings from dress-making.

The present sources of income are indicated in the following table.

TABLE VI

Present Sources of Income According to Sex

Sources of Income	Total Sources	Male	Female
Total Sources	29[a]	12	17
Old Age Pension	10	5	5
Welfare Relief	5	2	3
Assistance from children	6	1	5
Insurance	3	2	1
Salary and other earnings	5	2	3

[a] The total indicates that more than one source of income was available to some patients.

It is noted from the table that over half of the sample group are in receipt of the Old Age pension. The others are not eligible because they do not fulfill the eligibility requirements. Only two patients in the sample, who are husband and wife, live entirely on the Old Age pension. This couple is not satisfied with their present status but are able to manage fairly adequately because they live in a low rental district.

The five patients who are receiving welfare relief either have no children to support them or their children are not in a position to do so. All the patients in this category accept relief as the only possible source of income but are dissatisfied with the amount which they receive. It was not found that any of these patients expressed concern over the fact that they were the recipients of relief.

Of the six patients who receive support from their children only one is completely supported by this source. The other five receive partial support to supplement their income. In these cases the children willingly assume their share of financial responsibility for their parents, a fact which reflects the strong sense of family solidarity which has already been noted as characteristic of this ethnic group. It should also be said that in the cases where the children do not give actual financial assistance they express their concern for the comfort of their parents in the form of frequent gifts. It was noted, for example, that the children in one family paid their parents' telephone bills.

There are three patients who benefit from insurances to which they have contributed during their productive lives.

Of the five patients who receive income from employment two are the employed males who were referred to in the previous section. In neither of these cases are the earnings sufficient to support the families of the patients. The three women who are earning find it possible to support themselves and supplement their children's income. In contrast to the cases in the previous category these parents are assuming some responsibility for their children.

The past financial status of the patients in the study is difficult to evaluate because the patients were not all in this country and because the income levels in Canada were influenced by changing economic conditions in this country. Though the level of income varied throughout the lifetime of these patients none appear to have suffered from severe economic deprivation.

Housing

It was found that the patients in the study resided in all areas of the city. Seven of the patients lived in a district where the concentration of Jewish people as compared to other ethnic groups is more dense than elsewhere in the city. For all the patients facilities in terms of shopping, transportation and synagogues were adequate and within reasonable walking distance of the home.

In the following table housing is analyzed in terms of the type of accomodation in which the patients were living.

TABLE VII

Nature of Present Living Accomodations

Type of Accomodation	Number of Patients
Rented Apartment	7
Rented Room	2
Room and Board	1
Institutional Care	1
Living with children or other family members	7
Total	18

It is clear from this table that seven patients of the sample group were maintaining their own apartments. An equal number were living in the homes of their children or other family members.

Two of the patients were living in rented rooms. Of these one patient had no living family members. In the other case financial inadequacy made it impossible for the patient to afford a more adequate type of housing. One patient who worked as a housekeeper received room and board through her employer. One patient has been recently accepted into the Hebrew Old People's Home.

Marital Status

It has already been pointed out that one of the criteria for selecting the sample group was that the patients must have been married. Table VIII illustrates the present marital status of the eighteen patients.

TABLE VIII

Present Marital Status

Marital Status	Total Patients	Male	Female
Total of Patients	18	7	11
Spouse Living	9	6	3
Widowed[1a]	8	1	7
Divorced	1	-	1

[1a] "Widowed" refers to both men and women.

It is evident from the above table that of the nine patients who have spouses living, six are males. This is in line with the well-established fact that women live longer than men. Also, eight women in contrast to one man are widowed. The one divorced patient is a woman who was divorced four years after her marriage and who never remarried.

Nature of Marital Relationships

Under this heading the nature of the marital relationships of the eighteen patients is being considered. Since the marital situation is being discussed fully for each patient in the ensuing chapters only a brief analysis is being attempted in this section.

Table IX analayzes the present marital relationships of the nine patients whose spouses are still living. "Close, interdependent" includes those relationships which have always been harmonious, where the bonds are close and affectionate, and where tensions are at a minimum. "Satisfactory; some tensions" refers to those relationships which appear to have been relatively satisfactory in the past but in which tensions have

developed in old age because of the inability of the breadwinner to carry his former role in the family. "Unsatisfactory, open hostility" covers those patients where the marital relationship has always been obviously poor and where the negative or stress-producing elements were emphasized during the interview.

TABLE IX

Present Marital Relationships of Nine Patients, According to Sex

Type of Relationship	Total Patients	Male	Female
Total Patients	9	6	3
Close Inter-dependent	5	2	3
Satisfactory, some tensions	2	2	-
Unsatisfactory, open hostility	2	2	-

Five of the patients, two males and three females, had close inter-dependent marital relationships. In these cases it was noted that there had always been a high level of mutual inter-dependence. In one of the cases, both the husband and wife were professionals, the husband a pharmacist, the wife a doctor. In spite of the fact that the wife had been able to continue in her profession in this country and the husband had not, the quality of the marital relationship had not been affected. In another case where both husband and wife are included in the sample, and in which the wife was an invalid, the husband was able to accept his wife's great dependence upon him. In a third case the wife had always been the more dominant partner, but this had not affected the mutuality of the relationship.

In the two cases which have been included under "satisfactory, some tensions" the relationships were described as interdependent in the past. However, they were not strong enough to withstand the tensions which had arisen because of the physical incapacity of the patients, an incapacity which prevented them from maintaining their former role as breadwinners. In these two cases one patient worked in a sheltered workshop. He was dissatisfied because he could not earn more than a token wage. In the other case the patient was unable to work and wanted to have "any kind of work" which would enable him to assume his former role.

In the two cases in which the marital relationship had been unsatisfactory throughout the married life there had always been many tensions. In one case, at the time of interview, the patient was considering legal separation. He had apparently always felt misunderstood and rejected by his wife who had never included him in her many interests outside the home. In the other case in which the patient married late in life and with some reluctance, the wife had always been very domineering and the patient had always felt inadequate. It should also be noted that in these two cases inability to find suitable employment had resulted in an increase in the marital tension. Thus in four cases in this group of nine patients, loss of status as the head of the family has had a negative effect on the marital relationship.

It has not been possible to tabulate the nature of the marital relationships of the eight widowed patients. This is due to the fact

that in these cases it was difficult to get an accurate picture of the former marital relationship. In general the patients tended to give a conventionalized account of the marriage. In the cases of two women patients, the husbands had died eighteen years ago and it was not possible to get any picture of the relationship. In the other six cases the spouses had died within the last ten years. Without exception in these cases the relationships were described as having been very good, and such comments as "my marriage was perfect", "my husband loved me dearly", were made. It was noted, however, that in one case where the husband had apparently overprotected his wife, she had been unable to accept his death and since that time had deteriorated and was living in the past. In another case in which the husband had died only one year ago, the patient had had difficulties with her son's family which had been aggravated since her husband's death. In a third case where the husband had died within the past year the patient had to move into the Hebrew Old People's Home, where in spite of a superficial adjustment, she had suffered under feelings of rejection and later had a cerebro-vascular accident. In a fourth case the patient had been married twice. In her first marriage there were some tensions because of the fact that the husband was an invalid and the patient had to work. However, her second marriage appeared to have been a satisfying one.

The one patient who is divorced was divorced many years ago and appeared never to have made a satisfactory adjustment to marriage.

Relationships with Children

It was not deemed within the scope of the thesis to explore the

life situations of all the living children of the patients. Many of the children were living in other cities and in other parts of the world. It was noted, however, that two patients had no children. Another patient had lost all her family during the war. Eleven of the patients had children living in Montreal and of these six patients were living with their children. In two out of the five cases in which the patients were not living with their children, family tensions had made it necessary for the patients to move out of their childrens' homes. In the other three cases there was sufficient income for the patients to maintain themselves independently.

The nature of the relationships with the children is being explored fully in the following three chapters. It has already been pointed out in this chapter that in spite of some tensions in inter-familial relationships, the family bonds were strong, and that the children in general accepted a high degree of responsibility for their parents.

In this chapter an attempt has been made to analyze broadly the material obtained from the interviews with the patients. The data obtained in the social, cultural and familial areas has been correlated and evaluated in order to point up significant characteristics of the sample group. In the following three chapters an intensive analysis of the individual cases will be presented in order to evaluate the particular adjustment patterns of the patients in the study.

CHAPTER V

ANALYSIS OF CASE STUDIES IN GROUP I

In chapters V, VI and VII the writers will follow the approach outlined in Chapter I. In the case analysis, the functioning of the patient will be explored in three areas — in terms of his functioning as a physical organism, as a personality within a culture, and as a member of society. Within each of these areas the writers will note the findings which have been taken from the clinic records, and from the interview.

It should be noted that in presenting the material on the patient as a personality within a culture and as member of society, it has not been possible to distinguish between cultural and social adjustment in a clearly defined way. As pointed out in Chapter II culture and society have been considered as being mutually interdependent. In the analysis of the individual cases in these chapters "culture" is arbitrarily interpreted to cover the areas of immigration, recreation, religion and relationships with people outside the immediate family. "Society" is interpreted to include employment, income, housing and family relationships. The overlapping between these areas is recognized in cross references within the case analyses themselves.

In order to eliminate as much as possible the personal bias of the interviewee it was thought advisable that each case should be analyzed by all of the three writers. In the analysis of the cases it was observed

that the patients exhibited a wide range of life situations and levels of functioning within these situations. The total individual situation varied according to the nature of the stress-provoking factors, the extent of the supporting environmental factors, and the adaptation pattern of the patient. In order to study the factors which determine the various levels of life functioning it was felt that three categories within this range would provide the writers with a tool for comparison.

The following three categories cover the overall range of adaptation patterns and provide a lead for investigating the more basic processes of interaction. The categories defined were those that have been generally regarded as criteria of life functioning, with particular emphasis on the functioning of the older person. In setting up the categories the writers were aware that they represented points on a continuum, that there was a considerable range within each category, and that there was a good deal of overlapping between them. Still each category was regarded as sufficiently unique and important to warrant a separate classification.

Ratings were assigned by assessing the data in the three areas. The categories represent an assessment of total functioning and the adequacy of ego defences. The three groups may be described as follows:

Group I:

Severe crippling symptoms on the basis of medical, psychiatric, and psychological reports, and the interviewers' observation of social functioning. There are inadequate patterns of reaction. The reactions even to mild stress tend to be incapacitating and chronic. There is apt to be marked regression, dependency, frequent emotional upsets, over-reaction or

minor crises and well-marked psycho-neurotic sympton formation. In all cases, however, the individual is not immobilized or made completely helpless by his reaction patterns.

Group II:

Moderately severe symptoms in one or more of the three areas: physical, cultural and social. The patient may have a good many worries and may over-react to stimuli but the ego defenses on the whole are able to handle stressful situations. There may be a few neurotic symptoms or slight disturbances in taking appropriate action, or adapting to situations.

Group III:

Ability to handle most crisis in an adequate and realistic manner through the use of mastery and adaptation. Ego defenses are adequate and flexible. The individual utilizes his ego resources well and, if necessary, finds substitute gratifications. There may be minor disturbances of mood or affect or evidence of ambivalence.

On the basis of the above categorization seven of the patients of the sample group fall into Group I, five into Group II, and six into Group III. In this chapter the writers will present an analysis of each of the seven cases which fall into Group I. These analyses are followed by a discussion of the life situations in terms of stress and strength, and the adaptation patterns which are characteristic of this group.

The same pattern of analysis will be followed in Chapters VI and VII in which the patients in Group II and Group III will be presented. It should be noted that in presenting the clinical findings on the patient as a physical organism, the writers have adhered to the form and wording of the reports as they were written in the geriatric records.

CASE I

History

The patient is a 71 year old man who looks his stated age and is dirty and unkempt in his physical appearance and dress. He was born in Moscow, Russia, and immigrated with his wife and children to Canada through Poland in 1926. The patient's wife is a dentist by profession but has never practised. The patient is by professional training a chemical engineer, but upon immigration he changed his type of job and was self-employed as a furrier. He started to attend clinics in 1950, but no significant findings were reported. He has been blind in the right eye since age nine and is a suspected alcoholic.

The Patient as a Physical Organism

Clinical Findings

Medical: Patient started to attend clinics in 1950. No particular findings noted. In April, 1950, patient was in a car accident and was unconscious for some time. His attendance at medical clinic has been regular and he constantly demands needles and pills. Patient may be alcoholic, though this is not proven. He has been blind in the right eye since age nine. Patient's adjustment is considered appropriate.

Neurological: Presently complains of dizzy, drunken sensation. Was hospitalized in early February, 1956, for ten days. "Alcoholic Intoxication".

Psychological: Unrealistic, no insight into the present situation, average

intelligence, some memory difficulty, very passive adjustment, introvert, dependency needs, inter-personal relationships difficult, long-life character disorder, border-line adjustment.

Stress in the Physical Area

The patient is physically unable to work. He had to retire eight years ago due to blindness in one eye and weakness of sight in the other. He is unable to accept his physical handicap and is anxious to find work. He stated, "If I had a job, half of my troubles would be over". The patient has always considered himself healthy and at present is denying his physical limitations. He has made a sincere effort to find work in the community and is bitter over the fact that none is available. His wife shows little understanding or acceptance of her husband's condition. As a result, the patient's needs for status and recognition are not being met and tensions and frustrations result.

Strengths in the Physical Area

There is some degree of strength in this area in that the patient is struggling to maintain his social role. However, his defense mechanisms are on an unrealistic level. The tensions are aggravated through lack of understanding on the part of the patient's wife which intensifies his need for recognition.

Adaptation

The patient's adjustment to physical stress is in terms of:

1. Denial of physical limitations.
2. Rebellion against the aging process.

The Patient as a Personality within a Culture

Findings in the Cultural Area

Immigration: The patient emigrated from Russia with his family in 1926 due to political pressures. Immigration was not considered stressful by the patient as he was able to establish himself successfully in business. He liked Canada and Montreal, found it more modern than Moscow, "but not as good a cultural center".

Recreation: The patient has limited cultural group and recreational interest at present. In earlier life he had meaningful contacts with groups, but those people who shared his interests and intellectual pursuits are now dead. He has a few casual acquaintances through his contact with the synagogue. The patient's wife is actively associated in political associations but does not include her husband in her activities. He claims that this is due, "partly because I do not share her political views". However, he suffers under the rejection and feels excluded.

Religion: The patient does not believe in religious teachings or practices. He derives no spiritual satisfaction from his synagogue associations. He sees this association as a way to meet and chat with his compatriots and contemporaries. The patient claims that he is an "atheist".

Interpersonal Relationships: The patient has a few casual acquaintances at present, but the general level of satisfaction is poor. From his own account his former contacts with his now deceased companions were very meaningful and lack of new friends is a source of discomfort to him.

Stress in the Cultural Area

The patient has found it difficult to create new interests or make new friends in his later years. He has been unable to utilize community resources, such as the Golden Age Groups, and other voluntary associations in the community.

Strengths in the Cultural Area

There is little strength in this area although the patient claims that he would like to do things and participate in community activity. One questions, however, how much inner motivation he has. The patient's son is a teacher and well-versed in the Jewish philosophies. This son devotes many hours to disputing these theories with his father who delights in this contact.

Adaptation

In earlier life the patient appears to have been more actively engaged in social activity. His many friends shared his interests and the contacts were a source of satisfaction to him. The patient has been unable to make new friends, and attributes this to "just being old". He has failed to make adequate adjustments in the cultural areas. Ego defenses operating here are:

1. A large degree of social isolation.
2. Passive acceptance of the situation.
3. Limited ego resources.

The Patient as a Member of Society

Findings in the Social Area

Employment: The patient is presently unemployed. In Europe he graduated

from University with a degree in chemical engineering. He later worked as a chemist in a liquor factory where he held the position of "taster". After immigration he had a choice of several jobs in his own profession, but preferred to set up his own fur business with the help of his brother-in-law. The firm was very successful for twenty-three years and then went bankrupt. The loss was very traumatic for the patient. At first, he liked being retired and having nothing to do, but now he is bored.

Income: Both the patient and his wife receive the Old Age pension. In addition, the patient receives an adequate income from insurance. He feels that the present income is sufficient to cover the family's needs and he is able to rent a room if he "feels the pinch". He noted that his wife resents their lowered financial position as she feels "degraded". Her attitude creates additional tensions in the marital situation.

Housing: Living accomodations are satisfactory, and the four-room apartment is located in a good residential area.

Family Relationships: At present the patient's two children are married. One lives in the city, the other in New York. The marital relationship seems to be full of tension and the patient was reluctant to discuss this during the interview. His inability to maintain his role as breadwinner has contributed to the tensions, as well as the lowered financial status due to unemployment. The marital difficulty has reached the stage where the patient intimated that his wife had asked for a legal separation. The patient feels misunderstood and rejected by his wife. His dependency needs are not being met in the marital relationship.

Stress in the Social Area

The loss of the business firm was traumatic to the patient, as it forced him into retirement. Presently he is unemployed and very dissatisfied with his lot. He just "sits around all day". The many tensions in the marital relationship are aggravated by the patient's lack of something to do, to the point where the wife was considering separation.

Strengths in the Social Area

The children and grandchildren visit frequently and there is a constant interchange of letters and visits with out-of-town relatives. The close ties with the children and grandchildren are a source of strength to the patient. The children appear to understand the patient and are kind and generous. The son who is well-versed in Talmudic learning devotes much time to the patient and together they discuss and dispute the teachings. The children are the supporting figures in the family unit. Income has never been a stress factor.

Adaptation

Defense mechanisms in this area are:

1. Partial suppression of aggressive feelings towards his wife.
2. Depression and regression — dependency needs are not being met.
3. Denial of physical limitations which prevent his working, resulting in the loss of his role as breadwinner in the family.

CASE IV

History

The patient is a 61 year old man of medium stature who looks his stated age. He was born and raised in Budapest, Hungary. He graduated from a technical school and continued throughout life to work as a tinsmith and blacksmith. In 1950 the patient, together with his wife, daughter and son-in-law, immigrated to Israel. There he continued in his occupation but specialized as a heating engineer. In 1955 the patient and his wife followed their daughter and her family to Canada. In the clinic he was found to have arteriosclerotic-vascular disease, following a cerebro-vascular accident. This impaired his vision and affected his legs which are painful upon exertion.

The Patient as a Physical Organism

Clinical Findings

Medical: Chronic brain disease. Peripheral arteriosclerotic occlusive vascular disease affecting legs. Limbs very painful upon exertion. Never been sick.

Neurological: Post cerebro-vascular accident. Can see only directly before him. No side vision (lost sight suddenly in December 1954).

Psychological: Better than average ability; functioning significantly impaired. Difficulty in coping with present environment. Some situational anxiety and depression of mood. Good ego resources and integration. No breaks in reality testing.

Psychiatric: Attacks of depression due to inability to find work. Paranoid tendencies (in work area).

Stress in the Physical Area

The patient is incapacitated in so far as he is physically unable to work. His inability to work created emotional stress with behavior changes so severe that commitment was considered by his family. Since his cerebral accident he has realized his incapacity to some extent. At the same time the fact that he verbalizes his desire to work indicates his failure to accept his physical condition. Patient remarked, "But can I not get an easy job, such as sweeping a factory or even cleaning washrooms - only to get my mind off just sitting around and getting older everyday?". It is noteworthy that the patient always considered himself healthy until his cerebro-vascular accident, but that since then he has become over-concerned about his physical condition to the point that his inability to cope with the situation created a major source of disturbance to the family.

The psychiatrist noted attacks of depression due to his inability to find work and paranoid tendencies in this area.

Strengths in the Physical Area

Although the patient tends to deny his physical incapacity, he maintains his desire to work and his denial is only partial. The patient's family recognizes his limitations and are accepting of his behaviour. They have shown resourcefulness in planning a suitable living arrangement for the patient.

Adaptation

The patient's adjustment to physical stress is in terms of:

1. Partial denial of his physical limitations.
2. Self-depreciation in that he sees himself as working in menial employment in contrast to his past work history when he was a heating engineer.
3. Rebellion against his present status as an older member of society

The Patient as a Personality within a Culture

Findings in the Cultural Area

Immigration: The patient emigrated from his country of origin in 1950, due to political pressures. He went to Israel with his wife, daughter and son-in-law. After a period of five years in Israel, where he had established himself "quite adequately", he followed his daughter and son-in-law to Canada which was then considered by them the "Golden Country".

His hopes were not realized and this has been a source of disappointment which is shared by the entire family.

Recreation: In earlier life the patient was interested in, and participated actively in sports. He was a champion cyclist and took an active part in boxing and wrestling. After marriage he withdrew from active participation, but maintained his interest by coaching others. At present he exhibits no interest in, and derives no satisfaction from sports. His recreational interests are limited. He has occassionally attended a Golden Age club,

but has not developed friendships due to the language barrier. He has, however, casual acquaintanceships with a few Hungarian compatriots whom he has met through the Golden Age club.

Religion: Religion never had meaning for this patient. His identification with it has always remained negative. He claims to be disinterested in religious practices and goes rarely to synagogue, even on High Holidays.

Interpersonal Relationships: Although this patient has casual acquaintances here, the overall level of satisfaction is poor. It reflects significant changes from his life prior to coming to Canada. Both in Europe and in Israel he had a more established place in the community and claims to have had many more friends.

Stress in the Cultural Area

The major source of stress for this patient arises from his present physical deterioration. In earlier life he participated actively in sports, and had an outlet for his aggressive drives. He had a feeling of belonging in the community and developed satisfying social relationships. At present he has failed to make an adaptation by finding substitute gratifications. Consequently, much of his aggression is turned inward, resulting in depression, and looking into the past.

Strengths in the Cultural Area

Neither within the individual nor the environment have there been sufficient positive forces which might be considered strengths in this area of the patient's functioning. Ego defenses operating here are:

1. Partial social isolation.
2 Living in the past, though not to a significant degree.

3. Depressed mood over failure to find satisfaction in his social relationships, largely resulting from the stresses occasioned by immigration.

The Patient as a Member of Society

Social Findings

Employment: The patient is presently unemployed In Europe he graduated from a technical school as a heating engineer. He later set up a tin and blacksmith shop, where he developed his own patents for designing and improving heating equipment. Since his immigration he has attempted on several occasions to work in the Sheltered Workshop of the Jewish Vocational Service. These attempts were unsuccessful due to patient's physical limitations.

Income: Due to employment difficulties, the patient receives complete maintenance from a family agency. This is inadequate to meet current expenses and is supplemented by the patient's wife who keeps house for her daughter and son-in-law. The patient states that "being dependent is a terrible feeling. In Hungary we helped many people, we supported the 'places of learning' heavily and now we have to ask for charity. We are ashamed of it, but what can we do? Often I think I much rather kill myself, take sleeping pills or throw myself under a train rather than continue to live and beg for support". This is in contrast to the former income level in Europe where the patient through his factory and ownership of real-estate, earned a stable and adequate living.

Housing: Living accomodations are unsatisfactory. The patient and his wife rent a double room in the home of another family. Under these circumstances kitchen and bathroom facilities are shared with the owners of the apartment. The two young children in the household irritate the patient constantly.

Family Relationships: Upon arrival from Israel the patient and his wife resided with their children. Friction, aggravated by the presence of a young grandchild, developed in the home because of the patient's physical and mental deterioration However, the situation has improved since the patient and his wife moved into their own home away from the children.

The marital relationship seems to have been an inter-dependent one, according to information obtained in the interview. However, definite tensions have arisen because of the patient's inability to maintain his former role as the head of the family. He makes this clear by emphasizing the importance of his doing "any kind of work" which he feels would help to restore his status in the family.

The daughter and son-in-law are eager to support their parents. They feel that this is their responsibility since "mother and father always helped us to get on our feet". It is noteworthy that the patient and his wife left Israel to come to Canada even though the daughter and son-in-law were not in a position to offer adequate support.

Stress in the Social Area

Stress in this area arises from the patient's inability to find employment which is related to his physical deterioration. Closely associated with this is his present financial dependency which he feels so strongly that he expresses suicidal thoughts. In the familial area, the

former good relationship with his wife is adversely affected by the feeling of loss of role.

Strengths in the Social Area

The fact that the patient's wife has been able to work has made it possible for them to maintain themselves with the assistance of agency support. At the same time this arrangement has created stress for the patient. There has been sufficient strength and family solidarity to enable the family to use help from the clinic staff in working through their problems of income and housing. An additional strength here lies in the desire of the daughter and son-in-law to help their parents. With these supports the family is able to function in a limited way.

Adaptation

Defence mechanisms in this area are:

1. Inability to accept financial dependence, and loss of role as head of the family.
2. Depression of mood related to failure to find satisfying energy outlets.
3. Denial of reality factors preventing him from working.

CASE V

History

The patient is an aristocratic-looking woman of 74 years of age. She immigrated to this country from Roumania more than fifty years ago. Shortly after her marriage her husband immigrated to Canada and she came to join him a year and a half later.

The patient has three children with whom she has close relationships. Sixteen years ago she and her husband moved to the United States to live with one of their sons and his family. After living in the United States for eight years they returned to Montreal and took up residence with a married daughter. One year ago the patient's husband died, and after his death the family moved to a newer city district.

The patient is not aware that she has any particular illness but complains of aches and pains all over her body. The physical findings indicate impaired functioning on all levels. She is hard of hearing and has forgotten many earlier life experiences which in the interview were filled in by her daughter.

The Patient as a Physical Organism

Clinical Findings

Medical: Burning sensation and pains all over body; pains across lower back and feeling of coldness even on hottest summer days. Sometimes inability to sleep or to awaken from sleep.

Neurological: Negative

Psychological: All functioning impaired.

Psychiatric: Regression and living in past.

Stress in the Physical Area

The patient's physical deterioration has increased since her husband's death. She is bedridden for long periods of time. When she has enough energy to force herself out of bed, she stays at home because she claims she is not able to walk. The patient is hard of hearing and has difficulty in participating in conversations. She is also not fully aware of daily happenings and the passage of time.

The stressful response is related to her husband's death, and appears in the form of both physical and personality regression. However, according to her daughter, the patient has always considered herself sick, and flight into illness would seem to have been a life-time pattern which has been aggravated by her husband's death.

Strengths in the Physical Area

The patient's children have accepted her limitations in the physical area and have provided her with pleasant, suitable living accomodation.

Adaptation

The patient has been completely unable to make an adjustment to the trauma of her husband's death. Adaptation is in the form of:

1. Denial of her husband's death. Patient still lives with him in fantasy.
2. Physical deterioration to the point of being bedridden.
3. Psychological regression through living in the past.
4. Partial lack of orientation to reality.

The Patient as a Personality Within a Culture

Findings in the Cultural Area

Immigration: Since the patient immigrated more than fifty years ago and does not remember much of the past, it was difficult to obtain evidence of stress factors.

Recreation: In younger years the patient lived in a close family group and confined her activities to housekeeping and sewing. There was little or no social participation because of her belief that she was a sick woman. At the present time she shows no interest in participating in any activity. She watches television and this pastime stimulates the development of her fantasy life.

Religion: The patient's husband belonged to a synagogue. However, her attitude to religion was indifferent, and has not changed since her hsuband's death. On the other hand, the patient has remained closely identified with Jewish culture by maintaining a traditional home.

Interpersonal Relationships: The patient has no acquaintances and has always relied on close family relationships. Her life pattern reveals that she has failed to develop social relationships outside her family.

Stress in the Cultural Area

In general it may be said that this patient has failed throughout her life to develop her own relationships or interests outside the home. She appears to have been completely satisfied with her role within the family. According to her daughter's statement, she used illness as a defense against meeting the demands of the world outside her family. Even her religious interests were limited to keeping a traditional home.

With her husband's death, the patient has retreated into an even more negative pattern in which she finds her only satisfaction in living in a fantasy world.

Strengths in the Cultural Area

The only strength in this situation arises from the fact that the family accepts the patient's complete dependency and provides an environment in which she can carry on her limited life.

Adaptation

The patient always depended heavily upon her husband, who was the guiding person in her life. At present she has failed to make an adaptation to reality and consequently lives in the past.

Ego defences operating here are:

1. Complete social isolation.
2. Complete dependency on others for care.
3. General regression and living in past with the development of fantasies.
4. Depressed mood over husband's death.

The Patient as a Member of Society

Social Findings

Employment: The patient worked moderately hard as a housewife until the household was dissolved about 16 years ago. Since then she has never made an attempt to do even the slightest amount of housework.

Income: The patient has no conception of her financial situation, and her every need is provided for by her children. Throughout her adult life her

husband earned an adequate middle-class income and finances were not a stress factor.

Housing: The daughter's home, in which the patient is presently living, is a lower duplex in which she has her own room. The family moved within the last year into this duplex in order to remove the mother from the associations with her husband. This move has made the patient unhappy in that it disturbs her fantasy life.

Family Relationships: Throughout the life-time of this patient, the family relationships were always very strong. The patient was dependent on her husband who was at all times very devoted and seems to have over-protected her.

Stress in the Social Area

In this area the patient follows the same pattern as already noted. She has always been a limited and dependent person who has overtly taken a dependent role. She was able to function more adequately as long as her dependency needs were met by her husband. There appears to have been no conflict arising from this pattern during his lifetime. In the daughter's words, "he always catered to all her wishes".

Strengths in the Social Area

The strength in this patient's life stems from the close family ties and the acceptance of the patient by her children. The care the children provide has increased since the death of the patient's husband and can be looked upon as a substitution, though the degree of dependency has increased with the husband's death.

Adaptation

1. Regression into dependency throughout life.
2. Inability to adapt to her husband's death, resulting in continuous deterioration.

CASE X

History

The patient is a 65 year old male of light build. He is a meek-looking man and is very meticulous about his appearance. The patient was born in Austria and left his family of origin at the age of sixteen years to escape conscription into the army. He has worked as a presser since his arrival in Canada. He married late in life, at the age of forty-nine. He has no children.

The Patient as a Physical Organism

Clinical Findings

Medical: Patient had been well until 1954 when he developed dizziness after a second stage prostatectomy operation. He is totally and permanently incapacitated for employment.

Neurological: Patient's memory is fine. He is not depressed. His wife irritates him.

Psychological: Patient is responsive, but does not volunteer any information. Average intelligence, common sense, insecure and fearful about coping with the environment.

Stress in the Physical Area

The patient talks constantly about his physical symptoms and is overly concerned about them. He is capable of looking after his own daily needs, but his wife is very protective of him and does everything for him. His wife commented, "I can't let him out of my sight". This attitude is unhealthy for the patient and hinders any rehabilitation plans made by the clinic.

Strengths in the Physical Area

The patient is able to accept the fact that he cannot work due to his physical incapacity. In spite of the tension in the marital area, he is receiving a great deal of attention and this enhances his feelings of self-worth.

Adaptation

Although the patient shows realistic acceptance of his physical limitations, and of his inability to work, he talks constantly about his symptoms. This appears to be an outlet for him as well as an attention-getting mechanism.

The patient's adjustment to physical stress is in terms of:

1. Regression into illness revealed in over-concern.

The Patient as a Personality Within a Culture

Findings in the Cultural Area

Immigration: The patient immigrated to Canada at the age of sixteen, in order to escape conscription into the Prussian army. He experienced considerable difficulty, for political reasons, in securing permission to leave Austria. Upon arrival in Canada the patient was faced with economic hardships, though he did not elaborate on these in the interview.

Recreation: The patient states, "In my younger days I was well and could do more". At present he does not take any interest in social activities. He attributes this lack of interest to the fact that he gets dizzy when he spends any great length of time in contact with people.

Religion: The patient goes to synagogue daily, but only because "it gives me something to do and it is right across the street". It tires me out

and I sleep better". He claims never to have been orthodox in his religious practices, but continues to maintain the traditions of his religion.

Interpersonal Relationships: The patient has few friends, and his contacts with them are of a casual nature. These contacts afford him little satisfaction or interest.

Stress in the Cultural Area

In earlier life it appears that the patient was able to participate more actively in social activity. Now his illness and pattern of withdrawal has resulted in a large degree of isolation. It is noted that the patient has a few friends but derives little satisfaction from them.

Strengths in the Cultural Area

The patient identifies with his culture. His friends are from his own ethnic group and are his only source of social interest.

Adaptation

The patient derives limited satisfaction from his cultural affiliation. Ego defenses operating here are:

1. Passive acceptance of his present circumstances.
2. Partial social isolation.

The Patient as a Member of Society

Social Findings

Employment: Due to his recent prostatectomy, the patient is totally and permanently incapacitated for employment Two years ago he retired. Since his arrival in Canada he has always worked as a presser. He never felt the need to change his job.

Income: The patient has always lived on a marginal income. Since his illness and consequent loss of employment, the problem of sufficient income has become serious. At present the patient receives the Old Age pension and this is supplemented by a family agency. It appears that both the patient and his wife found it difficult to accept financial aid.

Housing: The family live in a six-room unheated flat. The patient feels that the house is too large and "open" which makes it difficult to heat. The family have tried to rent a room, but this has not been possible due to the plan of the flat.

Family Relationships: Neither the patient nor his wife has relatives in Canada. There are no children. The patient married late in life at the age of forty-nine years and, apparently, with some reluctance. The patient attributes his late marriage to the fact that he could not see his way clear to undertaking the responsibility of supporting a wife and possibly children. His wife is a domineering, over-bearing person who wants to control her husband's life. The patient is fighting to maintain his personal independence, but due to loss of employment and his role as head of the family, he is unable to do so As a result there are increased tensions in the marital relationship.

Stress in the Social Area

The chief stress in this patient's situation stems from his loss of employment. This has imposed a state of financial dependency which the patient has found difficult to accept. It has also resulted in the patient's feeling inadequate in his role as head of the household. This increased feeling of inadequacy is superimposed upon a marital relationship

which has always had many tensions The patient's late marriage and choice of partner would suggest that he is essentially a dependent person who has difficulty fulfilling his male role. He both wishes to be dependent and at the same time rebels against his dependency and consequent domination.

Strengths in the Social Area

This is a situation in which there are few strengths. However, the fact that the patient is receiving help from the community, has adequate housing and a marital relationship in which his dependency needs are being met, in spite of tensions, does enable him to function, although at a minimum level.

Adaptation

1. Suppressed hostility as a result of conflicts over dependency in the marital relationship.
2. Inability to maintain his male role, accentuated by recent loss of employment.

CASE XII

History

This 74 year old woman is the wife of the patient in Case XI[1]. Although the patient and her husband are both the same age, the patient looks much older and more deteriorated than her husband. She is hunched over, has a marked limp, and finds it very difficult to move about. Although she is neatly dressed her withered physical appearance makes her appear much older than her years.

The patient was very pleasant and anxious to cooperate in the interview. However, because of her hardness of hearing, her husband provided most of the information and she supplemented as best she could. It was difficult to obtain much information about the patient's feelings concerning her regressed physical condition.

The patient was born in Lithunia and immigrated to Canada in 1929 at the age of forty-five, five years after her husband had come to this country.

The patient had four children, one of whom died in infancy and another who died in an accident. At present one daughter is widowed and living in the United States. Another daughter, who also lives in United States, is married and has children.

The Patient as a Physical Organism

Clinical Findings

Medical: Remote cholecystectomy. Remote fracture of the right hip. Possible mild congestive failure. Possible bilateral renal calculi. Right sinusitis.

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[1] See Chapter VI

Deafness of right ear.

Psychiatric: Pain in right hip, back and abdomen. Gall bladder operation - 1954. Oriented in three fields. Relates main events of her life apparently well. Affect eupheric, but not unduly so.

Neurological: Pupils react to light and in accommodation. Right eyeball deviated to the right. Right periferal fissure narrower than left. Patient complains of involuntary closing of right eye. Fundi could not be visualized. Right mouth corner is deeper than left. Tongue deviates to right. Hoffman and Meyer reflexes present. No difference in deeper reflexes of upper and lower extremities. Babinski and Oppenheim reflexes doubtful, but right hallux kept in extension. No gross impairment of deep and superficial sensation.

Stress in the Physical Area

The patient became disabled ten years ago when she broke her hip while waxing a floor. She has never recovered from this injury and the limp which resulted is very noticeable. Since her injury the patient has become a semi-invalid. Although she is seriously incapacitated she appears to have a realistic acceptance of her state of health.

Strengths in the Physical Area

In spite of her semi-invalid condition and great dependency upon her husband, the patient is able to function in a limited way in the home, and helps her husband with the housework. She manages to come to the clinic in spite of her difficulty in walking.

Adaptation

The patient's adaptation is in terms of:

1. Realistic acceptance of her physical condition which is severely crippling.

The Patient as a Personality Within a Culture

Findings in the Cultural Area

Immigration: The patient immigrated in 1929, five years after her husband. He came first in order to secure a job.

The patient feels that she is better off since her immigration. She realizes that, like her family who remained in Europe, she would also have been persecuted during the last war.

Recreation: For the past twenty-two years the patient has had little activity outside her home. At present she has no social interests or activities, but at one time she claims that she knitted, sewed and read.

Religion: At present the patient does not attend synagogue because of her physical condition. She has, however, always had close religious ties. She claims to have been more strict in religious observances than her husband and attended synagogue on Saturdays.

Interpersonal Relationships: The patient and her husband at present have no social contacts. The patient is vague about her past activities, but it would appear that she participated to some extent in social activities.

Stress in the Cultural Area

The patient's present physical condition limits her social participation. She is socially isolated and has no recreational interests. She is unable to verbalize her feelings about her restricted life and appears to

have a passive acceptance of the situation.

Strengths in the Cultural Area

The patient expresses no noticeable discomfort with her present circumstances, but it is impossible to say what lies beyond her feeling of resignation. At least she appears to be reasonably comfortable within her present circumstances.

Adaptation

1. Social isolation.
2. Passive acceptance of dependency which may conceal repressed feelings or may be evidence of her basic dependency needs.

The Patient as a Member of Society

Social Findings

Employment: The patient has always been a housewife and at present does a limited amount of housework. Her husband has not been employed for the past ten years and he assumes most of the household responsibilities.

Income: The patient receives the Old Age pension as does her husband. As will be noted in Case XI the income has always been marginal.

Housing: The patient and her husband live in a rented five-room flat in a low income neighbourhood. The possibility of moving is being considered, due to the patient's difficulty in climbing stairs.

The present household arrangement wherein the husband shops and the patient does some of the cooking is considered by both to be better than moving into the Old People's Home.

Family Relationships: The marital tie appears to be a close, affectionate one. The patient's husband seems quite accepting of her great dependency

upon him. Two daughters are married and live in the United States. One is able to give slight financial assistance by sending money to cover the telephone bills. Close contact with the children is maintained by letter and phone calls.

Stress in the Social Area

The patient has a possible fear of complete dependency and loss of her ability to be self-maintaining. As noted above, the present living conditions are regarded by the patient and her husband as being better than the Old People's Home.

Strengths in the Social Area

The patient's husband is able to accept his wife's dependency and manage the home. The patient derives limited pleasure from her children.

Adaptation

1. Withdrawal into an over-dependency pattern which is related to physical incapacity.
2. Sheltered and withdrawn existence.

CASE XV

History

The patient is a nervous, apprehensive-looking female of 57 years of age. She was born in Russia and immigrated to Canada with her mother, brother, and his family in 1929; shortly before immigration she divorced her husband. Her delicate mental and physical health prevented her from working and she lived with her mother until the latter's death one year ago. At present she lives with her widowed brother and makes an ineffectual attempt at keeping house for him.

The Patient as a Physical Organism

Clinical Findings

Medical: Patient complains of periodic hot flushes and migraine headaches from which she has suffered for as long as she can remember.

Neurological: Neurological findings negative.

Psychological: Average intelligence. Difficulty in adjustment. Shows feeling of inadequacy and judgement fair.

Stress in the Physical Area

The patient has always felt that she lacked physical strength. She left school at 14 years of age, because of ill-health. After immigration, she felt that she could not attend English classes, participate in social activities, or seek employment. She attributes this inability to mental and physical "delicacy" which has prevented her active participation in living. Ill-health appears to have influenced the patient's entire life functioning. Neither within the patient herself nor the family unit have

there been sufficient enabling forces to help her overcome her feelings of physical inadequacy. Her family accepted her "delicate" condition and supported her withdrawal, allowing her to regress to a state of complete dependency. The patient remained at her mother's home in a secure environment and adopted a very passive, indifferent attitude to life.

Strengths in the Physical Area

The family's acceptance and support of this patient have enabled her to function in a very restricted way. At the same time, their over-protection may have stifled any potential for growth. Her failure in marriage would appear to bear this out. She makes some attempts at light housekeeping but this is apparently only when she feels able to do it.

Adaptation

1. Almost complete regression into functional complaints, the only positive medical findings being migraine headaches.
2. Excessive dependency needs which are dealt with by withdrawal into passivity.

The Patient as a Personality Within a Culture

Findings in the Cultural Area

Immigration: The patient immigrated from her country of origin shortly after divorcing her husband. She arrived in Canada in 1929, with her mother, her married brother, and his family. The whole family lived together and they suffered extreme financial hardships during the depression years.

Recreation: As a young girl the patient states that she enjoyed going to weddings, dances, and having a good time. This is in contrast to her adult pattern, and the patient cannot account for the differences. Upon her

arrival in Canada, she participated to a limited degree in a ladies' group which she still attends, though infrequently. Lately she attempted to attend a Golden Age club, but "could not stand the confusion or the thought of travelling to and from the meetings alone". The patient's recreational interests are limited in view of the fact that she does not like large groups since "too many people give her a headache".

Religion: The patient identifies with her religion and its practices in that she goes to synagogue one the High Holidays. She does not make use of her religious affiliation for social contact and religion has little meaning for her.

Interpersonal Relationships: The patient claims that her mother kept her at home and "influenced the direction of my life". She has few friends and blames this on her mother's influence. It appears from the interview with the patient that she prefers the solitary companionship of her widowed brother.

Stress in the Cultural Area

The patient's inability to function adequately in this area seems to be related to the mother-daughter conflict stressed by the patient during the interview. Difficulties have been noted in all findings in the cultural area.

Strengths in the Cultural Area

The patient has failed to adjust adequately in this area of life functioning. There are not sufficient ego strengths in the patient to make any adjustment outside of the family group.

Adaptation

Ego defenses operating here are:

1. Almost complete social isolation.
2. Inability to form other than dependent relationships - no capacity for social interaction.

The Patient as a Member of Society

Social Findings

Employment: The patient has not been employed since the age of 29 years. She learned dressmaking in Europe and worked at this occupation before immigration. After immigration she found it impossible to carry on dressmaking in Canada. During the depression, the patient was briefly employed in a factory, but the bustle and noise disturbed her and she had to leave. Following this attempt she remained at home with her mother and did light housekeeping.

Income: At present the patient receives partial maintenance from a family agency. Her widowed brother with whom she lives, supplements her relief. This brother supported the entire family after immigration. For the past ten years, the patient and her mother (until the latter's death one year ago) were supported by a family agency.

Housing: Living accomodations are satisfactory. The patient and her brother live in a five-room apartment.

Family Relationships: Upon arrival from Russia, the patient lived with her mother, married brother, and his children. As financial problems lessened after the depression the patient and her mother moved out of the married son's home. The patient claims that her mother hindered her

efforts to adjust to life here. There apparently was a great deal of mother-daughter conflict and the patient stressed the fact that she was with her mother constantly during the latter's illness prior to her death one year ago. It is noteworthy that the patient now says she does not know why she divorced her husband, although she described their marital relationship as poor. Her husband was an army friend of her brother's. After a short courtship they were married, and four years later divorced. At present, the patient is very much attached to her widowed brother.

Stress in the Social Area

All the patient's interpersonal relationships are disturbed. The patient expressed much conflict over her relationship with her mother. Her marriage ended in failure and the present relationship with her widowed brother is an over-dependent one. The patient attempted to support herself for a limited time in Europe, but following her immigration withdrew completely into the home and made no further attempts at being self-supporting.

Strengths in the Social Area

As in the other areas of life functioning the patient demonstrates a passive acceptance of the total situation. She is well accepted in her own environment, feels secure and is able to function in a very limited way.

Adaptation

Adaptation in this area is in terms of:

1. Dependency conflict in her relationship with her mother resulting in feelings of hostility and guilt, and failure to

achieve any independence from her.

2. Inability to be self-maintaining and withdrawal into a completely dependent role.

3. Inadequacy in all inter-personal relationships.

CASE XVII

History

The patient is a pleasant-looking, short, plump woman. She looks somewhat younger than her stated age of 72 years. Her expression was a sorrowful one, and when speaking of her ailments she was on the verge of tears.

The patient was born and grew up in Galicia. After her marriage she lived in Vienna for fifteen years. She immigrated to Canada from Vienna twenty-seven years ago, at the age of fifty-five years. Two of the patient's sons came to Montreal first, and lived with a sister of the patient's. The remaining son and two daughters immigrated with the patient and her husband.

At present the patient and her husband live together in a rented flat. All of the children are now married.

The patient's present physical condition, which is reported to be neuralgia, is very painful and incapacitates the patient for lengthy periods. The patient's husband, who is not employed, takes over the household responsibilities when the patient is ill.

The patient's marital relationship is a close one and the patient is the more dominant partner. Although the patient's husband also states that he is ill, he willingly cares for the patient.

The Patient as a Physical Organism

Clinical Findings

Medical: Chief complaints: Nerve trouble. Cries easily. Pains in back and feet. Sleeps poorly. Facial flushes. Complaints re gallbladder.

Impression: Chronic anxiety state.

Psychological: Limited intelligence whose capacity to function is somewhat impaired. Lack of concentration with environment, a tendency to withdraw and low level of energy output. The difficulty in coping with the reality situations, the impatience and low organizational capacity suggests the possibility of a deteriorative process with some depressive elements.

Psychiatric: Numerous and various somatic complaints - flushes, headaches, sleeplesness - feels depressed and anxious about her health. Daughter died five years ago of cancer of stomach. Financial situation poor, husband is sick. The patient is depressed with hypochondriacal ideas and self-pity.

Neurological: Findings negative.

Stresses in the Physical Area

Illness is presently very meaningful to the patient and is sufficiently severe to incapacitate her for months at a time. When recalling the past there is an over-emphasis upon the significance of illness. The patient states, "I suffer terribly, ever since I am in Canada". She complains of "illness of the head" and related this to the fact that one of her sons had been in a concentration camp for five years, and that she had undergone a "big operation". Five years ago, one of the

patient's daughters returned to Montreal from New York, prior to her death. The patient consciously relates her own illness to these traumatic events.

The patient had a gallbladder operation three years ago. She has been hospitalized in Vienna, the Jewish General Hospital, the Royal Victoria Hospital and the Montreal Neurological Institute. She was hospitalized at the Montreal Neurological Institute for what she calls "trouble in her head". (A letter in her file from the Montreal Neurological Institute described the condition as neuralgia). She claims that it is a very painful condition which requires freezing of the facial nerves. The patient states that she does not mind being old, but cannot stand the suffering. From the clinical findings, evidence of chronic anxiety and depression should be noted.

Strengths in the Physical Area

The patient is often incapacitated by her illness. Her husband is accepting of her condition and is able to manage the home for both when the patient is unable to do so.

Adaptation

The patient's adjustment to physical stress is in terms of:

1. Over-concern about herself and her symptoms.
2. Regression into illness which is revealed in terms of recalling her past sufferings, and is her way of responding to traumatic life situations.
3. Depression of mood and self-pity.
4. Rationalization of her inability to accept the aging process by

using illness as a defense.

The Patient as a Personality Within a Culture

Findings in the Cultural Area

Immigration: The patient had one sister living in Montreal, prior to her immigration. Two of the patient's sons come to Canada to live with their aunt. They later brought their parents, brothers and sisters to this country.

Since immigration economic difficulties have existed because the patient's husband has had difficulty in establishing himself in a trade. The patient relates the beginning of her illness to immigration. It was necessary for her to supplement her husband's income by taking in roomers.

Recreation: At present the patient has little interest in handicrafts. She claims that her "eyes and her head hurt". She occassionally watches television and listens to the news on the radio, although noise bothers her.

In adult life the patient had more interest in recreational life. Although she was busy raising a large family, she knitted, sewed and read.

Religion: The patient is an orthodox Jewess, and when she was well would accompany her husband to the synagogue on Saturdays. The patient claims that she can pray (daven) as well as a man. She observes the dietary laws, and while in hospital ate very little because the food was not kosher.

Interpersonal Relationships: At present the patient has few friends and almost no social contacts. She relates this to her own lack of participation. When she was more active she states that she had many friends, both immigrants and Canadians, and was well liked. Now she says that "no-one knows her" and her only social contacts are with her family.

At one time the patient was president of the Women's Auxiliary of a synagogue. She held this office for six years and her husband was a member of the board of the synagogue at the same time. She worked hard and appeared to have enjoyed this activity.

Stress in the Cultural Area

At present the patient does not participate in social activities. Her only contacts are with her family. The change of pattern in social activity is to be noted. At present the patient has no recreational outlets. Immigration may be considered economically stressful, in that until this past fall, the patient has always helped to supplement the income by taking in roomers.

Strengths in the Cultural Area

The patient's strong religious ties and idenfiication with her culture are supporting factors in this area. Regular visits by her sons and daughters are substitute gratifications for the lack of social activity.

Adaptation

Because of her physical ailments, the patient does not consider herself well enough to engage in any social activities.

Her adaptations may be considered in terms of:

1. Partial social isolation.
2. Living in the past when the patient was active, both within and without the home.
3. Partial rationalization of her present lack of participation in terms of her physical condition.

The Patient as a Member of Society

Social Findings

Employment: Prior to her marriage and after the death of her father, the patient worked when she was very young. After marriage the patient helped her husband in a dry goods store. Since immigration the patient has taken in roomers.

Since her marriage the patient has always worked hard. The loss of her mother role in the family was difficult. She said, "It was hard when the children left. They all married at a very young age".

Income: The Old Age pension is presently the only actual source of income. In earlier years the children helped to support their parents by their earnings. Now they help their parents by supplementing income with large gifts, such as a frigidaire and television set. The parents accept this situation and their income is adequate to meet their needs.

In the past income had always been a stress factor. The patient's husband was never employed steadily due to his lack of trade and strong religious convictions which prevented him from working on Saturdays.

Housing: The patient and her husband live in a five-room flat in a low income district. The home is neatly kept, although modestly furnished. The patient complains of the stairs, that the floors creak and states that she would like to move. However, she realizes her financial limitations. The home is close to a shopping area and the synagogue.

Family Relationships: The patient is the more dominant marital partner and presently takes the lead in family planning. The marital relationship is a close one. When the patient is unable to carry on household duties

her husband willingly takes over this responsibility.

The patient has three sons, two daughters and fourteen grandchildren. The patient's relationship with her children has been very satisfying to her. The death of one of her daughters and the divorce of another, have been traumatic to the patient, and she sees these events as aggravating her condition.

On Saturdays the patient is visited by her sons, and her daughters visit on Sundays. On festive occasions the family gather together. There is frequent telephone contact with the family.

Stress in the Social Area

Economic difficulties have existed since, and very likely prior to, immigration. The patient seems to resent financial support from her children as she states that she is used to "giving rather than taking". Difficulty in accepting loss of mother role should be noted.

Strengths in the Social Area

Strong familial ties are a source of pleasure to the patient and are the only source of social activity.

Adaptation

In this area adaptation may be considered in terms of:

1. Conflict over dependency revealed in inability to accept loss of mother role and financial assistance from her children.
2. Probability of hidden hostility toward her submissive husband who was never able to earn a satisfactory living.
3. The patient's ability to function at present is significantly poorer than it was in the past.

Discussion

Stress

The patients within this group, without exception are all incapacitated to a marked degree by physical illness and handicaps. It is noteworthy that although the conditions cover a wide variety of diagnostic groups, the patients have in common a high level of impairment as a result of their illnesses. The physical conditions include partial blindness, cerebro-vascular accident, prostatectomy, crippling due to hip injury, severe migraine headaches, an incapacitating neurological condition, and general deterioration. In four of the cases the illness is of a long-standing and chronic nature. All the patients showed over-concern about their physical symptoms and used marked regression into illness as an adaptive mechanism. This pattern was expressed in terms of pre-occupation with illness and an inability to accept the aging process.

In the psychological area, all seven patients reveal a borderline adjustment, and an impaired capacity to function. Psychoneurotic tendencies are present in such patterns as probable alcoholism, long-life character disorder, situational anxiety and depression of mood, paranoid tendencies, regression into illness, living in the past, and generalized psychological deterioration.

In the socio-cultural area these patients exhibit a long-standing difficulty in coping with their environments and poor interpersonal relationships. The inability to relate to others, at least in older age, has resulted in withdrawal from activities outside the home and social isolation. Recreational life is limited to passive pursuits such as reading

and watching television. There are a few contacts with friends, but these are of a casual nature and afford the patients little satisfaction.

All the patients in this group, with the exception of one male who came to Canada within the last year, immigrated more than twenty-five years ago. Immigration does not appear to have been unduly stressful though the reliability of this finding is questionable due to the patients' inability to recall their reactions. Four of the early immigrants recall financial stress following immigration and one female patient relates the onset of her illness to the move. The recent immigrant has been unable to make an adjustment and has deteriorated to the point where commitment to a mental institution was considered, though the difficulties of immigration were complicated by his physical condition following a cerebral-vascular accident.

Religion has had little meaning for five of the patients in this group. Two of the males express no interest in religious beliefs and three patients do not derive any satisfaction from the spiritual values of religion, though they attend synagogue for social reasons. Two female patients in this group maintain Jewish homes, though illness prevents their attendance at synagogue. In general it may be said that for this group religious beliefs are not a source of strength, in spite of the fact that most of the patients are closely identified with their Jewish culture.

None of the patients in this group is employed outside the home and there is little productive activity within the home. The three males have lost the capacity to work and this incapacity has precipitated much emotional stress. For all patients the inability to accept the loss of

constructive activity has influenced their low level of adjustment in all other areas. All patients receive financial assistance in the form of Old Age pension, supplementation by children, and welfare relief. In spite of this financial aid six of the seven patients complain of their financial difficulties, and nearly half the group find it hard to accept financial aid. In all cases loss of status resulting from lack of employment or loss of mother role creates stress and arouses familial and marital tension.

The three men in the group all have poor marital relationships in which there are many tensions. The tensions in each of these cases are related to the inability of the patient to maintain his role as head of the family. It would appear that for these patients their security as men has been seriously threatened by their loss of employment to the point where they are no longer able to fulfill their masculine role in the home. One woman in this group was divorced early in her married life but is dependent upon the brother with whom she lives. The others are, or have been, very dependent upon their husbands, and no longer fill an active role as housekeeper and mother.

Strengths

In spite of the fact that all the patients in this group are severely crippled by physical and emotional handicaps, they are not completely immobilized by them, and are struggling, in most instances, to maintain a social role. They manage to function in a very limited way in their own homes. In spite of familial tensions, in all cases their dependency is accepted by family members who support and encourage

them in their limited functioning. Close familial ties and a sheltered environment provide the greatest source of strength in the life situations of these patients. Relationships with children and grandchildren are meaningful. Strong family ties and social activities within the family compensate for the lack of cultural and social activities within the community. In spite of the fact that these patients do not appear to obtain spiritual comfort from their religion, they are all strongly identified with Jewish culture and this identification provides them with a sense of security and cultural identity. Within their cultural group, the hospital and social agencies provide additional sources of support which make it possible for these patients to function in a minimal way.

Adaptations

In spite of the pre-occupation with illness which has already been noted, the patients in this group respond to illness by the mechanisms of denial or passive acceptance. There is a tendency for the patients to project their present difficulties upon illness or circumstances in their immediate environment without having any insight into their own inadequacies. The three male patients have indicated that their domineering and rejecting spouses are largely responsible for their present situations. In cases V, X, XV and XVI the patients show marked regression into illness. Expressed rebellion against the aging process is observed in four of the seven cases. Other ego defenses are in the form of depression, suppression of aggressive and hostile feelings, conflicts over dependency, living in the past and self-depreciation. In the social area there is a high degree of isolation

which ranges from partial to complete. Within the family there has been an inability to maintain the mother and father role, and associated with this is a loss of status which is particularly marked for the male patients. There is also a failure to find substitute activity which influences the life adaptation of all the patients in this group and which is indicative of limited ego strengths. In general, the adaptive mechanisms of these patients operate in all areas of life functioning.

Although the seven patients are severely incapacitated, it should be noted that there is some variation in their ability to function.

Summary

In summarizing the findings on the life situations and defense patterns of this group the following significant observations may be noted:

1. Physical incapacity affects the functioning in all areas.
2. There is marked regression into illness.
3. Borderline adjustment is revealed in a high degree of psychoneurotic tendencies.
4. There is difficulty in coping with the environment which results in social isolation.
5. There is an inability to accept the changes in role brought about by the aging process.
6. Strong family solidarity and cultural identification provide the main source of stability and security for these patients.
7. There has been an inability to adapt to the environment and failure to find substitute gratifications to replace former satisfactions.
8. Generally the ego defences are weak and inadequate.

CHAPTER VI

ANALYSIS OF CASE STUDIES IN GROUP II

This chapter will consider the five patients who fall into Group II. As has already been pointed out in the previous chapter, these patients have moderately severe symptoms in one or more of the three areas of life functioning. According to the criteria of life functioning the patients in Group II may have a good many worries and may over-react to stimuli, but the ego defenses of the individual are able to handle stressful situations. There may be a few neurotic symptoms or slight disturbances in taking appropriate action or in adapting to situations.

The same plan of presentation will be followed as was used in the preceding chapter.

CASE II

History

The patient is a short, slight woman who looks her stated age of 72 years. Her dress was tidy. Her appearance was one of dejection, and she spoke in a sorrowful manner. She willingly shared information in a rather abrupt way, but it was difficult to obtain detailed information from her.

The patient and her family immigrated from Palestine in 1914. They had always lived in that country and came here in order to better their financial status.

The patient was widowed eighteen years ago, and since that time she has lived with her single daughter who has always worked in a factory. The patient has another daughter who is now a grandmother and is living in San Francisco. The patient's only son died eight years ago.

Throughout her life the patient has always been a housekeeper and has worked as a dressmaker in order to supplement the family income.

The Patient as a Physical Organism

Clinical Findings

Medical: Cholecystectomy - (New York) - 20 years ago. Rectal polyp - 1956. Looks depressed but healthy. Left ventricular hypertrophy.

Psychological: Alert woman of limited intellectual resources, but able to deal actively with the environment in an adequate manner. Sees things in a conventional manner and retains capacities within impairment of aging. Perceptual difficulties are not marked. Some depressive features, but these

are mild. Considerable energy output, no retardation of thought. Reality testing is well maintained as is the emotional control.

Psychiatric: The patient is oriented in time, but not too exactly. She knows data of her life and age of her children. Looks depressed, worries about herself and her daughter. Does not sleep well, lost more than 50 pounds.

Neurological: Findings are within normal range, except for absent vibration sense in both extremities.

Stress in the Physical Area

The patient claims that she has been sick for thirty years. She complains of her stomach and rectum. She says that "she has attacks", and actually can eat very little. In discussing her physical symptoms, the patient's manner was one of dejection. The patient's complaints about her health are exaggerated in view of the actual physical findings. The same pattern of over-concern is noted in the patient's expressed worry about her daughter's health.

Strengths in the Physical Area

In spite of the above-mentioned subjective findings, the patient is able to do all her own housework in a small apartment. In addition she does a little sewing to augment her income.

Adaptation

The adaptation in this area is in terms of:

1. Regression into illness in the form of exaggeration of physical symptoms.

2. Identification with her daughter who complains of similar symptoms to those of her mother.

The Patient as a Personality Within a Culture

Findings in the Cultural Area

Immigration: The patient came to Canada with her family from Palestine in 1914. She was 30 years of age at the time. Immigration was for financial reasons. A sister of the patient, who has since died, paid for the passage. The financial situation changed little after immigration.

Recreation: The patient sews, knits and watches television. She does a little dressmaking in order to supplement the income and derives satisfaction from this occupation. She belongs to Hadassah, the Hospital of Hope, Ladies' Relief, and a Golden Age club. Her attendance at meetings is infrequent due to her financial situation, but she appears to enjoy her long-established contacts with friends, particularly in Hadassah.

Religion: The patient is closely identified with her religion and attends synagogue on Saturdays.

Interpersonal Relationships: The patient states that she has many friends, both Canadians and immigrants. She has met most of her friends through her lengthy membership in the above-mentioned groups. The interviewer's impression, however, was that social relationships are not very meaningful. This may be related to the patient's poor intellectual resources, or to her tendency to withdraw into herself and think only of her complaints.

Stress in the Cultural Area

Although the patient and her husband immigrated in order to better their financial circumstances, the financial situation has always been poor,

and this has been a source of disappointment to the patient.

Although the patient belongs to several groups, she does not attend them regularly. Her main concern is with her own difficult situation and the problems of her unmarried daughter.

Strengths in the Cultural Area

The patient maintains some interests outside the home, although they are actually on a superficial level. Religious identification is a source of some satisfaction.

Adaptation

The patient's adaptation in this area may be considered to be in terms of:

1. Partial withdrawal from interests outside the home due to financial difficulties, and to her preoccupation with herself.
2. Slight depression of mood which is noted in a flat emotional tone, general apathy, and an attitude of hopelessness.

The Patient as a Member of Society

Social Findings

Employment: The patient does dressmaking in order to supplement her income. She has always worked since the age of eight. She gains some satisfaction out of her interest in sewing and her ability to supplement her income.

Income: The patient's main source of income is Old Age pension. She is actually being partially supported by her daughter who earns $31.00 weekly.

Housing: The patient and her daughter live in a two-room flat on the second floor. The neightbourhood is a commercial one, close to shopping

and to the synagogue. The home is well kept. The patient would like to have a roomer, but because the rooms are unpartitioned this is not feasible.

Family Relationships: The patient was widowed eighteen years ago. She is presently living with her daughter who is in her forties. The daughter is said to be "easily upset" and refuses to eat meat.

The patient has a married daughter in San Francisco and also a grandson and great grandchildren in Los Angeles. She visited them last summer and corresponds with them regularly.

A son died eight years ago. Every Sunday the patient visits with some of her nieces and nephews who are living in Montreal. These are the children of a deceased sister.

Stress in the Social Area

Financial difficulties have been a source of stress throughout the patient's life. The patient is very protective toward her single daughter. Both seem to live a rather sheltered life. Although the patient has some social life within the family there seems to be a limited capacity to enjoy such opportunities as are present and to reach out to form new ones.

Strengths in the Social Area

The patient has a close relationship with her married daughter and the latter's children. Her contacts with her nieces and nephew are also a source of limited pleasure.

Adaptation

The patient's adaptation is in terms of:

1. Partial social isolation and self-pity.
2. Depression of mood which is related to the low level of satisfaction in her life.

CASE VIII

History

The patient is a 72 year old woman who looks her stated age. She was born in Russia and immigrated to Canada with her husband in 1910 to escape religious and racial persecution. The patient's husband was employed as a presser, and the income was sufficient to support the family. The patient always remained a homemaker. There were two children in the family, a son, who died of tuberculosis at the age of thirteen, and a daughter who is married. The patient's husband died one year ago and she has since then moved to the Old People's Home. It was not possible for her to live with her married daughter who has six children. The patient has attended clinics since 1939. She has glaucoma and mild cardiac failure.

The Patient as a Physical Organism

Clinical Findings

Medical: The patient has glaucoma and is presently blind in the right eye. She is mildly deaf and has cardiac failure.

Neurological: Memory not impaired, adequate behaviour. Neurological findings negative.

Psychological: Average intelligence. Overly sensitive. Some tendency to withdraw in inter-personal relationships, not interested in new situations. Anxious in face of these limited interests. Contact with reality good. No significant disturbance on the emotional level.

Stress in the Physical Area

The patient is slowly going blind and this disturbs her as she fears being dependent on others. Physically, she is able to cope with her daily needs. Illness has not been a significant factor in the patient's life.

Strengths in the Physical Area

The patient has been able to accept her physical handicaps, and is able to manage her daily activities. Her long association with the clinic has been a source of strength to her in that the clinic staff have helped her to understand her condition and have been instrumental in arranging her acceptance into the Old People's Home.

Adaptation

The patient's adjustment to physical stress is in terms of:

1. Realistic acceptance of her physical condition, though she exhibits normal fears in relation to her gradual loss of sight.

The Patient as a Personality Within a Culture

Findings in the Cultural Area

Immigration: The patient immigrated to Canada in 1910 from Russia in order to escape religious and racial persecution. She and her family established themselves without much difficulty and they "liked the new country".

Recreation: The patient participates more actively in group activity now that she is in a communal institution than in earlier years. She states that she enjoys the social contacts of the home though she claims

that she was always active socially.

Religion: Religion has meaning for the patient. She attended synagogue on the High Holidays and observed the festivals and traditions of her religion both before and after her husband's death. She now takes an active part in preparations for festivals in the Old People's Home.

Interpersonal Relationships: The patient claims to have good social contacts and enjoys having people around her. In contrast to her own statement, the psychologist noted that she tends to withdraw in interpersonal relationships.

Stress in the Cultural Area

Although the patient expressed little feeling about going to the Old People's Home, it should be noted that this move was the last in a series of traumatic events. Within the past year she lost her husband, and following his death broke up her home and went to live in a rented room. Although she would have liked to live with her married daughter, this plan was not feasible because the daughter had six young children and was herself living on a marginal income. Three months before she came into the home the daughter, with whom she had close ties, moved to Ottawa. Because of these sudden disruptions in her family situation the writer questions whether what appears to be a good adjustment does not mask feelings of rejection and anxiety in the face of new situations which the patient is unable or afraid to express. It is noteworthy that she suffered a cerebral accident within a few days after the interview took place.

Strengths in the Cultural Area

The patient has remained closely identified with her culture

and religious observances are a source of satisfaction to her. This is evident in the way in which she has adjusted, at least superficially, to the situation in the home. At present in this secure environment the patient is able to participate in social affairs more actively than before. Perhaps the reason for this lies in the fact that she found it hard to reach out into the community for social contacts. Living in the Old People's Home these group activities are within easy reach.

Adaptation

Ego defenses operating here are:

1. Possible repression of feelings of hostility and anxiety as a result of abandonment following the loss of her husband.
2. Denial of dependency needs which are being met superficially through the group situation. The loss of supporting figures has brought the patient's dependency needs to the fore.
3. Overcompensation is shown in the patient's need to emphasize the positive aspects of her present situation.

The Patient as a Member of Society

Social Findings

Employment: The patient has never worked outside her home. She appears to have been an adequate housekeeper. When her daughter married, and had children, the patient assumed an active role as grandmother. She visited frequently and was interested in the children.

Income: Income in the past was fairly stable. The husband's income as a presser was sufficient to support the family until his illness two years ago. At this point it was necessary for the family to accept financial

help, which they were able to do without conflicts over dependency. At present the patient receives full maintenance from a family agency.

Housing: The patient has a room to herself in the Old People's Home and finds the arrangement "very nice".

Family Relationships: The marital relationship appears to have been close and mutually interdependent. The patient's husband died one year ago and she states that it "was difficult to carry on without him". The patient is close to her married daughter and writes to her often. She had hoped to go to live with her in Ottawa, but this was not possible as her son-in-law has a marginal income and six children to support. It has already been noted that there is some stress here, although the patient states that she accepts the realities in the situation and is content to maintain contact with her daughter through correspondence.

Stress in the Social Area

The loss of her husband and the daughter's move to Ottawa, as well as her own move to the Old People's Home are the stress factors affecting the patient's functioning at the present time.

Strengths in the Social Area

The patient has throughout life achieved satisfying relationships with her family, and has adequately maintained the role of mother and grandmother. At the present time the reality situation has created a difficult problem of adjustment, but the patient has been able to accept the situation, at least on a superficial level.

Adaptation

Defense mechanisms operating in this area are similar to the ones noted in the previous section.

1. Repression of feelings associated with her husband's death and her daughter's move away from Montreal.
2. Denial of feelings of rebellion and resentment over her daughter's inability to take her with her family.
3. Rationalization of her present living arrangement in terms of over-emphasizing its positive aspects.

CASE IX

History

The patient is a 71 year old woman who looks her stated age. She was very nervous and cried when speaking of situations which disturbed her. She was born in Hungary, but lived in childhood and until 1939 in Vienna. The patient married, when 26 years of age, a previously married man of 31 who had a son. They later had a son of their own. The couple emigrated from Vienna in 1939 after the Nazi occupation, when life had become unbearable. They arrived in Canada in 1949 after the patient's own son had established himself in this country. The patient's husband, who had been sick for some time, died suddenly in June 1954, of a heart attack. During the war years the patient and her husband were always together. The patient has always been closely attached to her husband who was, according to the son, somewhat promiscuous, having had affairs with other women, but at the same time loving his wife dearly. Following their arrival in Canada the patient and her husband lived with their son and daughter-in-law, and the patient continues to live in their home. During their residence in Vienna, the patient shared in the management of a toy shop which was owned by her husband.

The Patient as a Physical Organism

Clinical Findings

Medical: Ectopic pregnancy - age 36. Rheumatic fever - many years ago. Impression - cardiac enlargement (April 1950). Fracture of the greater tuberosity of the left humerus with slight displacement (March 1955).

Treatment and exercises in physiotherapy clinic were followed.

Appears depressed, complains of not feeling well, being sad,[1] anxious, does not sleep, no appetite, lost more than 10 pounds. This condition started after death of husband one and one-half years ago, and became worse after son had a heart attack a year ago. Never before had similar condition.

Complaints: Pain in arms and legs, "nervousness", crying spells, flushes, lack of appetite, difficulty in sleeping.

Rorschach Result: The content analysis suggests an individual who has had some difficulty in interpersonal relationships in her adjustment in the past and becomes somewhat disturbed in attempting to cope with a new situation. Adjustment involves tendency to withdraw. Better than average intelligence. Shows low energy output.

Summary: Medical chart reveals that the complaint difficulties have been present for several years. They may be emphasized in that they indicate the attempt of a dependent woman to adjust to her husband's death in a not-too-helpful environment. During war years husband and wife always together. In Canada husband was ill and spent most of his time at home. Despite his irresponsibility and the couple's disagreement patient has always been closely attached to him and depended on husband. Lack of understanding of son and daughter-in-law.

Stress in the Physical Area

The patient has been partially incapacitated for many years. This

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[1] The information on this medical chart was not organized under the headings used for the other cases. This statement is taken directly from the clinic record.

condition of incapacity became aggravated by the husband's death and the son's heart attack. In addition, the patient is having to cope with difficult relationships within the family, particularly with her daughter-in-law. However, according to the Rorschach results, the patient seems to have had some difficulty in interpersonal relationships in her adjustment in the past, and becomes somewhat disturbed in attempting to cope with new situations. This is manifest in the present difficulty she is having in adjusting to her husband's death and to her present family situation.

Strengths in the Physical Area

Even though this patient appears depressed, suffers from crying spells, flushes, lack of appetite, and difficulty in sleeping, she does most of the housekeeping in the home. Although the family does not completely understand and accept the patient's behavior, they have all planned together for suitable living arrangements for the patient and themselves. This patient, prior to the last war, apparently was able to take considerable responsibility in her husband's business. She now shows a similar capability in managing the home.

Adaptation

1. Withdrawal into somatic complaints, as a result of unmet dependency needs, following her husband's death.
2. Acting out of feelings of hostility to the daughter-in-law. This is related to the above dependency conflict and also to the fact that she identifies her son with her husband and is in competition with the daughter-in-law.
3. Acceptance of present status as an older member of society in

spite of the conflicts which this creates for her.

The Patient as a Personality Within a Culture

Findings in the Cultural Area

Immigration: The patient and her husband left Vienna in 1939 because of the Nazi occupation and the impossibility of continuing in business. They had decided to immigrate to Palestine where the husband's son lived. However, they never got to Palestine. Instead, they lived for one year in Milan, Italy, until their internment in a concentration camp. Afterwards they bought their way out of the camp with a promise to immigrate to Palestine. Again this plan did not materialize. They were brought to Bengazi, North Africa, where they were stranded for over five years. The patient's son was then able to bring his parents to England, where they lived for three and one-half years. The son immigrated to Canada and brought his parents to this country in 1949.

Following their emigration from Austria, the patient and her husband were shifted to three different continents. During this time living arrangements were unstable and of a makeshift character, and there was not opportunity of making a secure re-establishment.

Recreation: In early life and until marriage the patient participated actively in calisthenics and other sports. In her married life this interest was replaced by attendance at concerts and operas in the highly cultural city of Vienna. Her main interest, however, was in the management of her husband's business. This pattern was consistent until emigration. At present the patient's recreational interests are centered almost entirely in the home, and consist of knitting and viewing television,

with little or no understanding of content because of language deficiencies. She also plays cards with three or four widow friends who come from the same cultural background. She is not satisfied with her recreational life and attributes her dissatisfaction to the fact that she no longer has a husband to share in it with her. Also, a recent change of domicile has made it impossible to continue participation in the social activities of the synagogue.

Religion: The patient has always followed a traditional Jewish way of life, which included membership in a synagogue and observation of the High Holidays. However, she has no formal synagogue membership at the present time.

Jewish culture, generally, played only a minor role in the life of the patient. This may be attributed to the assimilation patterns of Jews in the Viennese culture.

Interpersonal Relationships: Although the patient has several friends who are from a similar cultural background and who are also widows, she has some difficulty in interpersonal relationships and the overall level of adjustment indicates a tendency to withdraw.

Stress in the Cultural Area

Immigration for this patient was prolonged and difficult. It is interesting to note, however, that she makes little reference to the difficulties in this ten year period. Rather, she sees the significant stress in her present life as her husband's death, a fact which indicates how traumatic this has been for her. The same pattern is exhibited in her lack of satisfaction in her recreational life. The difficulty in interpersonal relationships, mentioned in the psychological report, may

be operating here. The patient's lack of satisfaction in her recreational life is also related to tensions with her daughter-in-law, in that the daughter-in-law attempts to convince the patient of the value of assocation with friends. The patient resents this attitude and interprets it as an attempt to lower her status in the home. The many circumstances which have played an important role in all areas of this patient's situation are interwoven. They reflect the results of world-conflicts from which she has suffered and to which she is unable to make an adequate adjustment.

Strengths in the Cultural Area

In general, we may say that the patient's adjustment to her present way of life is relatively unsuccessful. However, she has some satisfaction in that she fulfills a useful role in the home, and in a very limited way enjoys associations with friends.

Adaptation

1. Partial social isolation, with difficulty of adjustment in interpersonal relationships.
2. Temporary depressed moods characterized by memories of her husband's death.
3. Expressed hostility over conflicts in the home.

The Patient as a Member of Society

Social Findings

Employment: The patient is presently in charge of her son and daughter-in-law's household. The daughter-in-law, however, buys the groceries and arranges menus, thus maintaining her role as the dominant woman in the

home. In Vienna, the patient was the "soul" of her husband's toy business, and even though she realizes that at her age she could not have her own business any more, she resents her secondary role.

Income: The patient is completely supported by her son. She receives a small weekly personal allowance which she does not even use, "not having opportunities for expenditures". She is aware of the marginal earnings of her son, who suffered a heart attack a year ago, and the need of her daughter-in-law to supplement the income by working as a seamstress in a downtown store. However, she feels that neither her son nor her daughter-in-law are doing work which brings them sufficient prestige. Her reaction is related to the lowered status of this family in Canada, a status which she is unable to accept.

The toy shop in Vienna, in which the patient played such an important role, seemed to have provided a much more adequate income and one which enabled them to buy freedom from a concentration camp in Italy.

Housing: The son's six-room home is nicely decorated and well furnished, and is in a good residential area. The patient has a room to herself. The physical surroundings are very adequate.

Familial Relationships: The patient exhibits a high degree of jealousy toward her daughter-in-law and, to some extent, toward her son, a feeling which has been aggravated since her husband's death. The patient is suspicious of her children's sincerity in their relationship to her, and claims that the daughter-in-law "never has a friendly word for her". This is substantiated by the daughter-in-law's feeling that the patient should attempt to adjust to her situation, and by her unwillingness to

see her mother-in-law in her home as a dissatisfied person.

There seems to be a great lack of understanding of the son and daughter-in-law by the patient on the one hand, and a similar lack of understanding of the patient on the part of the son and daughter-in-law. The patient sees the absence of grandchildren as a further grievance against her daughter-in-law.

Stress in the Social Area

The stresses in the social area have already been indicated in the foregoing description of the case. The dependency conflict which was brought to the surface by the husband's death is further enhanced by her loss of role in her son's home. Not only is she resentful of her daughter-in-law because she has displaced her in her son's affection, but she resents the fact that her daughter-in-law does not accord her the position to which she feels she is entitled. Income and housing are stressful only in relation to this situation. The fact that the family has not achieved as high a financial position as they enjoyed in Europe with consequent loss of prestige, is a related and additional source of stress.

Strengths in the Cultural Area

The fact that the patient has accepted the present living conditions and financial support as realistic, is indicated by her rationalization that "parents help their children to achieve something in life, and if parents are at a later age in need of material support they should get it from their children". This arrangement has, however, also created the above-mentioned frictions, and it is therefore suggested

that the patient's feelings are ambivalent. She functions in a limited way in an uncongenial environment.

Adaptation

1. Overt hostility in relation to dependency conflict and loss of status in the familial area.
2. Impaired physical functioning in general, as a consequence of the patient's inability to adapt to a new and difficult situation in which the patient is expected to function in a dependent and insecure role.

CASE XI

History

The patient is a short, stalky man who looks his stated age of 74 years. His right leg is shorter than his left and he walks with a very noticeable limp. His general appearance is untidy and his clothing is poorly cared for.

The patient was born in Lithuania and immigrated to Canada in 1925. He was later joined by his wife and a daughter. A second daughter was born after his wife's arrival in Canada. Two sons died in infancy.

The patient found work as a semi-skilled painter and continued in this trade until nine years ago when his wife's illness necessitated his staying at home. The patient and his semi-invalid wife (see Case XII, Group I) are now living in very poor circumstances.

The patient's need to talk about his desire for work influenced the interview to such an extent that it was difficult to obtain information in other areas of his life situation. This pre-occupation is also evident in the clinical findings.

The Patient as a Physical Organism

Clinical Findings

Medical: Partial ankylosis (fusion of joint) of right hip with shortening of the right leg. Mild hyper-tension with cardiac enlargement. Peripheral arterio-sclerosis - a symptomatic.

The patient is active and not handicapped by the above diagnosis.

Out-patient chart reveals that the patient has had gastro-intestinal complaints for ten years.

Psychological: This picture is that of an elderly man of low average intelligence, with possibility of a greater than usual degree of rididity. He shows marked difficulty in coping with situations which require a slightly new approach and has a defensive need to prove himself. He has some anxiety and a tendency to occasional impulsive outbursts which may also appear as some irritability. He is not able to easily adapt to new situations and he is not concerned with interpersonal relations. There is no evidence of significant disintegration of the ego or breaks in reality testing.

Psychiatric: Oriented in all three fields. Cooperative. Wants to work. Active and talkative.

Neurological: Findings negative.

Stress in the Physical Area

The patient stated that his health has always been good. He made no mention of any complaints, except his limp, which he has had since the first World War. His only preoccupation with this handicap is in relation to his work ability.

Throughout his adult life, the patient has never considered his limp a handicap, even though his walk is very awkward and he exerts much effort in balancing himself. It is noteworthy that he always worked as a painter, a job which is very difficult for a person with his handicap. Nevertheless, the patient considers himself an excellent painter and states that he is a "talented decorator".

This same pattern is revealed in the patient's account of how he came to Canada. He had difficulty in getting through the immigration authorities because of his limp. He stated that he was able to prove to them that he was as strong as anyone else, and did so by throwing someone across the room in order to display his strength. Following this display, the patient claims that he was accepted as an immigrant.

The patient does not accept the fact that he is aging and is suffering from a loss of physical strength. He regresses into the past and exaggerates his former abilities as a painter and decorator. He tends to overcompensate for his inadequacy and presents a very robust picture of himself.

Strengths in the Physical Area

Although the patient suffers from a very noticeable limp, which impairs his walk, he does not consider it an impairment. The patient's defense pattern may be considered a fairly adequate means of adaptation. He has been able to earn a marginal income and at the present time is physically able to carry a great deal of responsibility in the home and in caring for his semi-invalid wife.

Adaptation

The patient's adjustment in this area is in terms of:

1. Denial of physical limitations and the aging process.
2. Overcompensation by emphasizing his capacity to work as well as any younger person. This overcompensation appears to be a long-standing pattern which is carried over into denial of the aging process. It is displayed as an emphasis on physical

capacities and is a pattern which may be covering his basic feelings of inferiority.

The Patient as a Personality Within a Culture

Findings in the Cultural Area

Immigration: The patient had a certain amount of difficulty in obtaining permission to immigrate. The patient's parents and siblings had been living in Canada since 1900. After immigration the patient faced economic pressures as he was saving his money in order to bring his family of marriage to this country. Shortly after the arrival of the family they faced a depression. Immigration difficulties are to be noted in terms of economic stress.

Recreation: In adult life the patient claims to have had little time for recreational activities. His present social relationships stem from casual contacts he has made at synagogue. Because of his wife's illness there have been practically no social activities in the past nine years.

Religion: The patient attends synagogue twice daily and has always done so. He has participated actively in chanting and praying. The synagogue has always been the main source of social contacts outside the home.

Interpersonal Relationships: It is difficult to assess the patient's adjustment in this area, because of a lack of information. He claims that since his wife's illness they have had little contact with friends. However, in adult life he appears to have had a few friends from his own Lithuanian Jewish group. It is possible that many of these old friends have died. On the basis of the data, it is probably safe to assume that this patient has always been limited in his social relationships, and

the fact that he has never participated in any organized group outside the synagogue lends weight to this assumption.

Stress in the Cultural Area

It would appear that this patient always strove to be successful in the work area and has never reached out in order to find satisfactions in interpersonal relationships. This has made it difficult for him to achieve substitute gratifications in old age. It is for this reason that he puts such an emphasis on his prowess as a capable worker.

Strengths in the Cultural Area

There are few strengths in this area since the patient's satisfactions, outside the home and work, have always been limited. At the present time his synagogue attendance is an important outlet as it gives him an interest outside the home.

Adaptation

1. Partial withdrawal from social contact.
2. Overcompensation for lack of accomplishment in this area by emphasizing work achievement.

The Patient as a Member of Society

Social Findings

Employment: The patient has not been steadily employed as a painter for about ten years and has never accepted his retirement. It is significant that he considers himself unemployed and not retired. In spite of his age, his physical disability and the long period which has elapsed since he did work, he enlarges at great length upon his inability to find a job. He feels that he could undertake carpentry.

At the present time, his only activity is caring for the household, doing the shopping, and looking after his semi-invalid wife. One factor which may have influenced the relatively poor work adjustment, in addition to language difficulties, is his relatively low I.Q. (noted by psychologist), and his limited education. It is probable that the lack of drive which is characteristic of his social adjustment contributed to his low level of achievement in employment.

It is significant that he emphasized to the interviewer that "I can read and write, both Hebrew and English". Yet in attempting to prove this by writing the interviewer's name, he had much difficulty in doing so.

Income: The patient's income has always been marginal, due to the above-noted factors. At present the only source of income is the Old Age pension. The patient stated, with pride, that since his wife's illness he had only taken money from a social agency once.

Housing: The patient and his wife live in a five-room rented flat in a low-income neighbourhood. The patient's wife has difficulty in climbing stairs. For this reason the possibility of moving is being considered, although the home is near a shopping centre and within walking distance of the synagogue.

Family Relationships: The marital relationship is a close one. The patient assumes the responsibility for the care of his wife. He accepts her dependency with kindness and he is very devoted to her. Recently he has become discouraged by her suffering and the fact that he is increasingly tied down. Two daughters are married and living in the United States, Occassionally one is able to give slight financial assistance to the parents. Both daughters keep close contact with their parents through letters and

phone calls.

Stress in the Social Area

The chief stress in the patient's life is in his poor adjustment in the work area. The personal inadequacies of this patient, his lack of education, and his inability to modify his employment goals are characteristic of his adjustment. Housing accomodations are poor but cannot be improved due to lack of income.

Strengths in the Social Area

Although little is known about the patient's marital adjustment, every indication is that it is a close, affectionate tie. It is likely that the need to care for his wife is important in his adjustment, for the need to be useful enhances his feelings of adequacy as a husband and as head of the household. Relationships with children, although they are separated, also seem to be close.

Adaptation

This is a basically dependent, inadequate person lacking in drive and suffering from feelings of inferiority. It is probable that there is much deeply repressed hostility which was not apparent in the interview. These feelings are masked by the following mechanisms:

1. Denial of reality factors in the employment area.
2. Regression into the past in order to emphasize his adequacy.
3. Dependency conflict as revealed in his need to deny financial assistance.
4. Ability to accept wife's dependency with kindness and understanding, yet realistic feelings of annoyance.

5. Acceptance of children's inability to offer financial assistance.

In spite of the fairly low level of adjustment which this patient has maintained throughout his life, he has been able to support his family and function reasonably well within his limitations. In old age the fact that his achievement has never been on a high level, and that he feels adequate in relation to his wife's greater dependency gives him a feeling of security.

CASE XVI

History

The patient is a 71 year old man of medium stature who looks his stated age. He was born in Russia and immigrated to Canada in 1922 with his wife because of political pressures and persecution. He chose Canada because he had relatives in the country. The patient has three children of whom two are married and have families of their own. The patient's oldest daughter is divorced. It is noteworthy that the patient married late in life when "I finally found a girl who would have me". It appears that the marital relationship has always been an interdependent one. The familial contacts are frequent and the ties close.

During his adult life the patient experienced several changes in employment. Prior to his retirement three years ago he and his wife kept a lunch counter where they worked twelve to fourteen hours daily. At present the patient is employed in an agency-supervised sheltered workshop.

The patient has attended the clinics at the hospital for many years. He suffers from duodenal ulcer, asthma and allergies. He has twice within the past three years been treated with electro-shock therapy because of "nervous breakdowns".

The Patient as a Physical Organism

Clinical Findings

Medical: The patient has a duodenal ulcer. A prostatectomy was done several years ago. The patient had a "nervous breakdown" after the death of his youngest son, and again in 1953, when his daughter whose husband

failed in business was divorced. The patient developed asthma in the fur trade.

Psychological: The patient is functioning on the level of good average intelligence. He reacts appropriately in social situations. Impulsive outbursts. Good capacity with inter-personal relationships and an interest in social relationships. Difficulty in immediately learned information.

Psychiatric: (1953) Patient is subject to extreme environmental stress (unemployment, divorce of daughter) and is feeling very lonely. In addition, his wife is aggressive and hostile and is constantly disturbing him. Advise E.S.T. (administered, patient better). The patient is interested in keeping busy, is cheerful, reasonable and pleasant.

Stress in the Physical Area

The patient has always regarded himself as "capable of carrying on". His present fear is that the "humming in his ears is causing his memory loss".

In this patient it would appear that his difficulties in adjustment are revealed in "nervous breakdowns", which have been noted twice in his life history, and in asthma and duodenal ulcer, which are generally believed to have emotional components. It is also noted that he had to leave the fur business because of an allergic reaction. In addition, he complains constantly about his symptoms and is preoccupied with discussing the pills and "needles" which he is given.

Strengths in the Physical Area

In spite of the above complaints, the patient is physically able to keep busy everyday by packaging candy in a sheltered workshop. He is

not satisfied with his present employment and expresses a desire to organize adult groups and teach the Talmud. While this hope is unrealistic in terms of the patient's qualifications, and reveals a need for status and acceptance, it nevertheless reflects his desire to take an active part in normal living.

Adaptation

The patient's adaptation to stress in this area is in terms of:

1. Regression into illness, both physical and psychological, and constant preoccupation with physical symptoms and treatment. This appears to have been a life-time pattern and may be aggravated by his inability to obtain regular employment.
2. Denial of physical and mental limitations.
3. Over-compensation for feelings of inadequacy in terms of unrealistic aspirations to be a teacher.

The Patient as a Personality Within a Culture

Findings in the Cultural Area

Immigration: Immigration is described by the patient as being difficult. He and his family were forced to leave their country of origin because of racial and religious persecution resulting in the loss of personal freedom. Upon arrival in Canada both the patient and his wife worked. His former trade as bookkeeper could not be used in this country and it was necessary for him to change his occupation.

Recreation: The patient has had some satisfactions in this area. He has been active with Zionist and Labour groups in the past, but because he worked twelve to fourteen hours a day he felt that he had little time for

leisure and recreational activity. At present he is still affiliated with the above-mentioned groups.

Religion: The patient is not orthodox in his religious practices, but goes to the synagogue periodically. He enjoys the festivals and maintains the tradition of the code of laws.

Interpersonal Relationships: In contrasting his experiences in Canada with those in Russia, the patient stressed the fact that his friends in Canada were of both French-Canadian and Jewish origin. He said that he felt no discrimination in this country. However, he considers his "real friends" to be those compatriots who arrived with him from the old country. He visits these friends periodically and corresponds with them, though infrequently. The patient notes that he has few friends now because it is "hard to make friends when you are old". He noted that he could not find people to share his interests now, and this is difficult for him because of his need for social acceptance.

Stress in the Cultural Area

Immigration was difficult for this patient as it necessitated a change in employment. There is stress in the area of interpersonal relationships in that he no longer finds a group around him to share his interests. Social relationships have always been important for this patient. At present he expresses feelings of lack of acceptance because he has no friends who can share his interests.

Strengths in the Cultural Area

The patient still maintains group affiliations which appear to support him. It is noteworthy that he is able to derive satisfaction

from his contact with the synagogue.

Adaptation

Ego defenses operating in this area are:

1. Denial of dependency needs, which are expressed in physical complaints and which are being partially met through group affiliations.
2. The patient is able to use social resources to meet needs which are not met in the family and occupational situations.

The Patient as a Member of Society

Social Findings

Employment: The patient is presently working in the sheltered workshop. He is very ambivalent about this work and his level of interest is not satisfactory, although he is busy. In Europe the patient was trained as a bookkeeper but upon his arrival in Canada he discovered that he could not use his trade. He learned the fur business but shortly after he had achieved a measure of stability in this trade he developed asthma and had to leave it. He then bought a lunch counter and together he and his wife worked twelve to fourteen hours daily, until his retirement three years ago. Loss of employment was very difficult. The patient feels that he must be busy so he took "what was given me", but he is dissatisfied with the present situation.

Income: The patient feels that the present income is adequate. Income was never a stress factor in terms of poverty. The patient noted that he "always managed a decent living". At the same time he expressed the fear of becoming a public charge.

The patient's present income is derived from the Old Age pension, insurance, income from renting a room, and the weekly pay from the

sheltered workshop. It appears to be quite sufficient to maintain himself and his wife.

Housing: Living accomodations are satisfactory. The four-room apartment is large and comfortably furnished.

Family Relationships: The presently living family members are the patient's wife, three married children and ten grandchildren. In addition, the patient adopted two of his sister's children after their parents were killed in World War II.

The marital relationship appears to be mutually interdependent. There are some normal tensions due to illness and to lack of renumerative employment. It is noteworthy that the patient married late in life when he finally "found a girl who would have him". The dominance in the marriage was shared at first. At present it would appear that the patient's wife has taken over the dominant role and that he is dependent upon her.

The children visit often and have given their parents a television set, a radio phonograph and other furnishings. The relationship is close.

Stress in the Social Area

As noted previously in the cultural area, the problems of employment and resultant illness cause the patient considerable difficulty upon immigration. Although income may at one time (immediately following immigration) have been marginal, the status was only temporary and the patient is at present in comfortable circumstances. Following the death of a young son and the divorce of the eldest daughter the patient had two "nervous breakdowns", for which electro-shock treatments were administered. This area was avoided in the interview as the patient was reluctant to

discuss any details. It appears that throughout life the patient has reacted to stress by some form of psychosomatic or psychological complaint.

Strengths in the Social Area

In spite of the psychosomatic complaints the patient has been actively employed and has been able to make major adjustments in employment. The interdependent marital relationship and the close contact with children and grandchildren provide environmental support for this patient and help meet his dependency needs.

Adaptation

On the basis of the patient's noted mental and physical disturbance, it would appear that there is some lack of ability to make major adjustments to the environment. However, his problems are unexpressed except through his disturbed functioning.

Defense mechanisms operating in this area are:

1. Repression of feelings of inadequacy which are expressed in disturbed functioning.

Discussion

Stress

All the patients in this group have a history of long-standing physical illnesses which interfere with their daily functioning, but are not immobilizing. In contrast to the patients in Group I, they do not suffer from the same degree of impairment as a result of their illnesses. In spite of their illnesses they are able to function and do not regress to the same extent as a means of coping with their life situations. At the same time, they exhibit neurotic patterns of defense in attempting to achieve a level of equilibrium. The illnesses include gastro-intestinal complaints, glaucoma, cardiac conditions, long-standing lameness, ulcers, asthma and allergy. In dealing with their illnesses the neurotic tendencies take the form of anxiety, exaggeration of and pre-occupation with physical symptoms, over-compensation for feelings of physical inadequacy on the part of the two men in the group and denial of physical and mental limitations. These neurotic patterns, in most cases, appear at present as an exaggeration of life-time mechanisms of adjustment.

In the psychological area, the patients in this group, in general, reveal a lesser degree of deterioration than do those in Group I. Their reactions tend to be exaggerated as a response to traumatic life experiences, but they maintain their capacity to function within the impairment of aging. On the whole, the patients maintain a good contact with reality and, within the limits of their neurotic defenses, are able to adjust adequately to stressful situations. Although one patient has

suffered two neurotic breakdowns as a result of traumatic events, he is now able to react appropriately in social situations.

In the socio-cultural area, the patients in this group are able to cope with their environments fairly adequately, but in a somewhat limited way. They are able to reach out for available recreational opportunities in the community, though these are confined to relationships within their own cultural group and within their own families. The narrowing of the older person's world is a contributing factor to their withdrawal from inter-personal relationships. Added to this are life circumstances such as economic difficulties, semi-invalidism, and death of spouse which limit participation in recreational activities. The patient with the history of mental breakdowns derives his satisfaction from active participation in ideological groups and the degree of his participation differs greatly from that of the other four patients in this category. All the patients except one immigrated more than thirty years ago, and experienced financial hardship in adjusting to living conditions in the new country. However, these factors do not play a significant role in the patients' lives at present. The one patient in the group who is a recent immigrant, suffered financial difficulties as a result of prolonged displacement. Her inability to adjust was further aggravated by the sudden death of her spouse.

In contrast to Group I, four of the five patients in this group are engaged in productive occupations, though the present extent of work differs from that of the past due to old age and physical limitations. It is significant that the patients are able to devote themselves to fulfilling a

useful role. Three of the patients are keeping house and one works in a sheltered workshop. The fifth patient is living in the Old People's Home and contributes to the communal life of that setting. It should be noted that the two men in this group are unhappy with their present level of employment and that both overcompensate for their feelings of inadequacy by setting unrealistic goals for themselves.

In general the patients in this group have some tensions in their family relationships. The three women in the group show indications of feelings of hostility toward younger female members of the family. In two cases these attitudes are unexpressed, but in the third, the patient reveals overt hostility toward her daughter-in-law. In Case XVI, the marital relationship is strained, due to the fact that the patient is unable to accept his wife's dominance and to carry his former role in the home. In general, however, in spite of their limitations, the patients in this group are able to fulfill their roles as men and women in the family group and are less threatened by their loss of role than are the patients in Group I.

Strengths

In spite of some physical limitations, the patients in this group are all able to fulfill a productive role which is to some degree satisfying. Four of the five patients maintain close bonds with their families and obtain support and satisfaction from these relationships. In the fifth case, there is some family unity, since there is family planning for the operation of the household, but the interpersonal relationships in the home are a source of tension. Although family solidarity is an

important source of support for these patients, they nevertheless have sufficient ego strengths to find other sources of satisfaction. Their social activity is to a lesser degree centered within the family. Like the patients in Group I, the patients in this group are strongly identified with Jewish culture. In addition, religious observances appear to have more meaning for them. The two men in this group participate actively in synagogue services and the women all adhere to the traditional Jewish way of life.

Adaptations

The adaptations of the patients in this group to physical limitations take the form of over-emphasis of physical complaints, over-compensation for physical inadequacy and denial of physical and mental limitations. While there is some regression into illness, the regression is not of such a nature that it interferes with the carrying out of daily activities.

In the social area there is some withdrawal from social activities, but this withdrawal does not prevent their obtaining some satisfaction from inter-personal relationships. Within the family there is evidence of tension in most cases but they are nevertheless able to fulfill an active role.

In three of the cases, the patients suffer from a loss of status which is a continuing source of dissatifaction. In general, the less appropriate mechanisms of these patients operate in only some areas of life functioning and they are, in a measure, successful in coping with the reality situations in which they find themselves. In spite of this fact all the patients in this group appear to be caught in life situations

from which they cannot escape. Four of the patients express a desire to be doing something in their old age, but their patterns of adaptation and the reality situations in which they find themselves are such that they are unable to move out of their difficult circumstances.

Summary

In summarizing the findings in the life situations and defense patterns of this group, the following observations may be noted:

1. Physical handicaps are incapacitating but not immobilizing.
2. Neurotic patterns are evident in the patients' reaction to illness and reflect life-time mechanisms of adjustment.
3. Within the limits of neurotic defense patterns, the patients are able to adjust adequately to stressful situations.
4. There is a limited ability on the part of the patients to cope with the environment, and they are able to reach out for social outlets.
5. All the patients are able to fulfill a useful and productive role within the limits of the aging process.
6. There is a strong sense of family solidarity and cultural identification.
7. There is evidence of tension in the inter-personal relationships in the family.
8. There is a limited ability to find substitute gratifications to replace former satisfactions.
9. Generally, the ego defenses enable these patients to function adequately and to deal with stress in most areas of life functioning.

CHAPTER VII

ANALYSIS OF CASE STUDIES IN GROUP III

This chapter will consider the six patients who fall into Group III. As has already been pointed out in Chapter V, these patients have the ability to handle most crises in an adequate and realistic manner through the use of mastery and adaptation. Ego defenses are adequate and flexible. The individual utilizes his ego resources well and if necessary finds substitute gratifications. There may be minor disturbances of mood, or affect, or evidence of ambivalence.

The same plan of presentation will be followed as was used in the preceding chapter.

CASE III

History

The patient is a 65 year old woman of large stature, who dresses in good taste and looks much younger than her actual age. She was born and raised in Budapest, Hungary. Before her marriage she was a mannequin in one of the largest dress stores in Budapest. She married at the age of 22 and had one son. The patient's husband died after 26 years of marriage in 1938. He was a drugstore owner and his son worked in the store and continued to manage the business after his father's death. The patient claims to have belonged to the "middle income class". She lived in Budapest until her immigration to Canada in February 1955. She immigrated in order to be with her son and daughter-in-law, who sponsored her. The patient's most recent visit to the clinic was more than four months ago, before she accepted her present employment. At that time she complained of pains in her lower back and received treatment for recurrent hepatitis.

After her arrival she lived for a few months with her only son and daughter-in-law and their two children, age four and nine. For the last four months she has been working as a housekeeper and companion for an older woman.

The Patient as a Physical Organism

Clinical Findings

Medical: Total hysterectomy, 13 years ago. Adeno-carcinoma. Pains in lower back on sitting and lying on back, relieved by walking. Recently in hospital for "recurrent hepatitis".

Psychological: Rorschach - Beta revised test results show an average intelligence and good retention of learned material. Personal adjustment is somewhat passive, but patient has a great deal of interest in interpersonal relationships.

There are guilt feelings, depressions of mood, tensions and some anxiety.

Psychiatric: Negative test findings - patient expressed difficulties in adjusting to Canada, resulting in nostalgia.

Stress in the Physical Area

The patient's clinical findings all indicate difficulties in her adjustment to Canada with resultant depressions of mood, tension and anxiety. At the time she was last seen her symptoms were related to a desire for work. Since that time she has established herself in employment and the situational stress has been to a large extent relieved.

Strengths in the Physical Area

Evidence of the patient's ability to adjust is revealed in the fact that she was motivated to accept employment as a housekeeper and companion to an older lady. This employment has reduced her anxieties and tensions. Also significant is the fact that the patient has not returned to the clinic since she accepted employment. The patient has shown resourcefulness in planning her life, with consequent relief of her somatic complaints and of her need to seek reassurance from the clinic.

Adaptation

The patient's adjustment to physical stress is in terms of:

1. Exacerbation of physical symptoms in response to the stress of

immigration.

2. Mobilization of ego strengths to meet the new situation.
3. Ability to verbalize her difficulties and to seek help when indicated.

The Patient as a Personality Within a Culture

Findings in the Cultural Area

Immigration: The patient immigrated to Canada to be reunited with her son and his family, who are her only family members and who had been here for about five years. She also wished to get away from a Communistic controlled system in which her personal liberties were threatened. The patient expressed, however, ambivalent feelings when she said that "not everything is as good in Canada as I had imagined". She felt that her son had misrepresented the country by presenting a rosier picture than his circumstances warranted. The son, who is a druggist, immigrated in 1950 and has never since worked in his profession. At times he has even been on relief from a family agency.

Recreation: Until the Communists occupied her country of origin, the patient indicated that she had attended concerts, operas, and theatrical performances regularly. She misses these cultural pursuits and attempts to substitute for them with radio and television. She feels, however, dissatisfied and frustrated at not being able to understand enough English to make these pastimes meaningful.

Religion: Past and present synagogue affiliation reveals a moderately traditional adherence and does not seem to be a factor in cultural identification. However, a closer identification with Jewish culture occurred

after the invasion of Hitler's and Stalin's armies into Budapest, and this alleviated guilt feelings arising from her former lack of identification.

Interpersonal Relationships: The patient has no club or group affiliations but she does have some friends and acquaintances from her own country with whom she talks frequently by phone. She compares her life here to her life in Budapest where "I went to official community and educational functions, which I miss here, not understanding English". These relatively casual acquaintances fulfill only some of her needs for social contact.

Stress in the Cultural Area

In spite of the fact that this patient has been able to find employment and fulfill a useful role, her adjustment to displacement is still only partial. She has not yet completely identified with Canadian life, nor has she found her place either in the Jewish or Hungarian community. This points up the fact that a different pattern of assimilation existed in the Hungarian-Jewish culture. In the local community, however, there is greater separation between cultural groups, and this fact poses additional difficulties in assimilation for the immigrant who comes with this particular type of cultural orientation.

It would seem that this patient is struggling to find the same place in the larger community that she occupied a few years ago in her own country. On the one hand she maintains friendships with some Hungarian friends with whom she converses in her native language. On the other hand, her present economic status and lack of English prevent her from association with community cultural interests. There is some ambivalence in accepting the more restricted role in her own Hungarian group. At the same time,

there is evidence of her difficulty in adjusting to the lowered status that immigration has forced her to assume. This is accentuated by the fact that her son has failed to achieve the position in the community that she would like him to fill.

Strengths in the Cultural Area

The patient has been partially able to accept the many limitations which are inherent in her recent immigration. This is obvious in her attempts to learn English, in her maintenance of friendships with friends from the Old Country, and in her identification with her own culture by using the facilities of the Jewish General Hospital, and by seeking employment with a Jewish employer.

Adaptation

The defences operating here are:

1. Ambivalence in the area of cultural identification, partly related to reality factors.
2. Mobilization of ego strength to adapt on a reality basis.
3. Mild rebellion against the status she has to assume, expressed in terms of dissatisfaction with her cultural pursuits here.

The Patient as a Member of Society

Social Findings

Employment: The patient found employment as a housekeeper and companion to an older lady approximately four months ago. This is the patient's first employment since her marriage, though she was employed as a mannequin before marriage. In her married life she was very content with her role of housekeeper for her own small family.

Income: The patient was used to a middle income status in Hungary. At present she earns $40 monthly, plus board and room. With this the patient supplements her son's income which is unstable and a source of great concern to her. Before the patient was employed, she lived with her son and daughter-in-law in an environment which created many frictions. She responded to this situation with aggravated somatic symptoms.

Housing: This area was a stress factor only as long as the patient lived in her son's home. At present she has a well-furnished room in the spacious 5½ room lower duplex of her employer, where she has been accepted as part of the household. In this environment the patient fulfills a similar role to that in her own former home. This enhances her feeling of dissatisfaction with her son's less adequate home.

Family Relationships: Upon arrival in this country the patient lived with son and his family. Conflicts arose from this close living arrangement, aggravated by differences of opinion in the way the grandchildren should be raised and by dissatisfaction with her son's low financial status. Although the patient shared living quarters with the son's family in Budapest, she could not adjust happily here. The son seems to have brought her to Canada under false pretenses, giving the impression that he was more favorably established than he actually was. It may be that his failure to succeed has caused him to seek in his mother a strong parental figure, and the patient, while accepting his need for help, at the same time resents his demands upon her.

Stress in the Social Area

The patient cannot adjust fully to the present living arrangement

and feels a need to visit her son's home frequently. Although the patient says, "Young people should live by themselves, especially since they adjust much easier to a new country", there are indications of a conflict in the mother-son relationship. The son was a partner in his father's drugstore, and after the latter's death became the owner. However, it would seem that the son was always over-protected by the patient, who continues to maintain her role as head of the family. Ambivalence is revealed in her need to assume this role and resentment as a result of it. She has moved out of the son's home but cannot separate herself from it.

Strengths in the Social Area

The patient moved out of a friction-producing environment and found employment in a setting in which her role, as a protecting mother, was accepted. She has marked strength in her ability to adjust to a new environment. In the above areas, there is evidence of good personal resources revealed in the need for independence and self-maintenance, and in her ability to supplement her son's income.

Adaptation

Defence mechanisms in this area are:

1. Ability to transfer her need to assume the mother role to a substitute household.
2. Ability to be independent and to adapt to a new setting.
3. Ambivalence in her relationship with her son's family.

CASE VI

History

The patient is a 77 year old man of medium height who looks younger than his stated age. He is intelligent and very cooperative.

He was born in Ukrania and immigrated to Canada in 1904. He adapted to the way of life easily. After immigration he worked as a cutter. At one time he owned his own business, but when it failed during the depression, he began to work for someone else. He entered his nephew's manufacturing business and was employed by the latter as a cutter until his retirement. He retired of his own accord one year ago.

The patient's wife was ill for some ten years prior to her death and died five years ago. Since his wife's death the patient has lived with a divorced daughter and her young son. The patient is the male figure-head of the family and cares for his young grandson in order to enable his daughter to work.

The Patient as a Physical Organism

Clinical Findings

Medical: The patient complains of a 'biting feeling' under the right calf and in the right thigh, when sitting and doing nothing.

Impression: Mild prostatism. Recent fracture left ribs, 7, 8, 9. Systolic hypertension. Pulmanary emphysema.

Psychiatric: Complains of pain in left shoulder and arm. No memory impairment. Does not work for past five years, after death of wife. Depressed, and it lasted for about six months. Stays with daughter, studied Talmud

all his life and continues to complain of fear to be alone in a home. Even presence of a small child would help him.

Neurological: Findings negative.

Psychological: Tests not carried out.

Stress in the Physical Area

In October 1955, the patient fell and fractured his ribs. He has complained of pain in the left shoulder and arm and a 'biting feeling' in the right calf and right thigh since his accident. The patient's reaction to his wife's death was one of depression which lasted for six months. Illness can be considered a source of only minor stress, although physical examination revealed the above positive findings.

Strengths in the Physical Area

The patient is in good physical health for his years. He is able to accept the discomforts resulting from his accident as being more uncomfortable than they would be for a younger person. The patient is in general well-adjusted to the limitation of the aging process.

Adaptation

The patient's physical capacity and his ability to verbalize in a realistic way his feelings about his condition are an evidence of strength. Ego defenses operating here are:

1. Adequate adjustment to reality.
2. Capacity to rationalize in a healthy way.

The Patient as a Personality Within a Culture

Findings in the Cultural Area

Immigration: The patient came to Canada from Ukrania in 1904 in order to

escape conscription for the Crimean war. He claims that he ran away from the country and shortly afterwards his wife and daughter followed him. The patient considered his immigration easy, as he had no difficulty in finding employment or adapting to the way of life in this country. He stated that even the climate here is the same as that of his country of origin.

Recreation: The patient's recreational activities include occassionally watching television and membership in communal groups. He was a founder of Misrachi and the Jewish Library and belonged to a 'societal club' for forty-nine years. Most of the patient's leisure time is presently occupied with reading the studying the Talmud. His social relationships are not as extensive as they once were.

Religion: The patient is strongly identified with his religion. He attends the synagogue twice daily. Through his studies and readings, religion plays a significant part of the patient's life. It gives him a sense of intellectual achievement, and is an outlet for his need for constructive activity.

Interpersonal Relationships: The patient's participation in group life has minimized as of recent years. He has friends whom he has met at the synagogue and occassionally lunches with them. He apparently derives satisfaction from social interaction.

Stress in the Cultural Area

There appear to have been few stresses in this area throughout the patient's life. He has always found satisfying outlets and has formed positive social relationships.

Strengths in the Cultural Area

The patient is less active in social relationships, and at the

present time he leads a more restricted life. Nevertheless, he is by no means a withdrawn individual who spends all his leisure time studying alone. He has integrated both social activities and personal pursuits and is able to find satisfaction either alone or in company. There is no obvious stress in this area. The patient, through his strong religious ties and identification with his culture, is able to channel his energy into suitable activities. Immigration has been easy and is indicative of this patient's capacity to adapt to new situations.

Adaptation

This positive aspect of the patient's adjustment may be considered in terms of:

1. His ability to adapt to changing situations in his life.
2. His capacity to rationalize and intellectualize enables him to find substitute satisfactions in interests appropriate to his years and station in life.

The Patient as a Member of Society

Social Findings

Employment: In his adult life the patient maintained a satisfactory level of employment. He began as a cutter in a tailoring factory and later established his own business. When this failed during the depression, he assisted his nephew in establishing a business and worked as a cutter in the nephew's business until his retirement, by his own choice. Although the patient is at present not working, he finds compensatory ways of using his energy. In addition to his reading, he takes responsibility for small chores within the home, and cares for the grandson while his daughter works.

Income: Throughout the patient's adult life the income has been adequate. Fifteen years ago his wife became ill and was bedridden until her death, five years ago. This lengthy illness exhausted his life savings since it necessitated having outside help in the home. At the present time he receives the Old Age pension, which is supplemented by his daughter's income and financial support from his nephew.

Housing: Prior to his wife's death, the patient lived in his own apartment. He now lives with his daughter and her son in a five-room duplex, in which he has his own room. The home is comfortably furnished and is in a lower middle class district. It is close to a shopping area and a synagogue.

Family Relationships: The patient's marital relationship appears to have been a mutually interdependent and satisfying one. The patient and his daughter are very close and the patient derives much pleasure from his grandson. Since his daughter's recent divorce, he has become the male figure-head of the family. His daughter states that 'he is more of a help to me that I am to him, and has always minded his own affairs'. The patient has contact with his two brothers, nephews and nieces. He is the patriarch of the family and is consulted frequently on many matters.

Stress in the Social Area

There have been few stresses in the patient's social adjustment. Indications of stress were noted in the patient's concern over his daughter's divorce and in the depression following his wife's death. In the former situation he identified closely with his daughter. It is significant that in this area alone the patient was unable to reveal his feelings.

Strengths in the Social Area

Strengths in this area of the patient's life are evident in his ability to find a satisfying role as head of the family from which he derives recognition and a feeling of self-worth. His life history reveals an ability to adapt to changing conditions of employment, income, and, with stress, to the loss of his wife. Although the psychiatrist's report noted depression for six months following his wife's death, he is now able to accept the reality of his life situation. He has also been able to find a useful role following his retirement.

Adaptation

In this area adaptation is in terms of:

1. Capacity to redefine his role and function effectively within its limits.
2. Ability to assume leadership within the family and gain the respect of family members.
3. Sublimation of his feelings concerning the daughter's divorce which enables him to support her and assume a dominant familial role.
4. Dependency conflicts are well resolved. The patient is able to accept financial assistance at the same time to give leadership.

CASE VII

History

The patient is a 68 year old woman who immigrated within the last year from Hungary. She was dressed in the typical Eastern European attire, wearing a black shawl on her head which covered a wig. The patient "could not bear living in Hungary, in the emptiness of her home which had meant life, prosperity and family", and immigrated to Canada because, "some of my City folks live here".

She immigrated to "save my skin", and to get away from the memories of having seen her husband killed by Nazis, and her son taken to concentration camp. Her married daughter was sent to the extermination camp at Ausschwitz, and she herself was buried under the debris of a bombardment. The patient seems to have lost her faculty of hearing since the bombardment. She is a potential applicant for the Hebrew Old People's Home, but is not interested at present since she considers this move, "the nearest step to close the door to life". The patient maintains an active interest in living. She reveals a surprising alterness, sense of humour, and strongly religious belief in the coming of the Messiah.

The Patient as a Physical Organism

Clinical Findings

Medical: Congestive cardia failure due to hypertensive cardio-vascular disease. Blindness in right eye. Deafness in right ear. Shortness of breath. Obesity (patient's condition requires restricted physical activity and salt free diet).

Neurological: Negative.

Psychological: Good intelligence. Good contact with reality. Little energy output and depression. Tendencies to become preoccupied with somatic complaints. Rigid - fair interest in environment.

Psychiatric: Negative.

Stress in the Physical Area

The patient is slightly incapacitated in so far as she is restricted in physical activities. She walks little, and confines her interests almost entirely to the home. In spite of the psychologist's finding that the patient is preoccupied with somatic complaints, this was not revealed in the interview. Her physical condition does not appear to be a significant stress factor.

Strengths in the Physical Area

The patient accepts the reality of her aging process and states that she is yet a candidate for 'Paperman'. Nor does she wish to apply for admission to the Hebrew Old People's Home. She maintains an interest in living, which is remarkable in view of the traumatic nature of her past experiences.

Adaptation

The patient's adjustment to physical stress is in terms of:

1. Realistic acceptance of the aging process.
2. Tendency to become preoccupied with somatic complaints, revealed in frequent visits to hospital, though not expressed in the interview.

The Patient as a Personality Within a Culture

Findings in the Cultural Area

Immigration: The patient immigrated from her country of origin within the last year, because there was "nobody left at her home", and she "could not bear the emptiness of the place". She lost all her family members during the war. She herself survived the holocaust after having been buried under the debris of a bombardment, and finally had to get away from the painful associations of her homeland.

Recreation: After the patient's children had obtained a professional education, one of them becoming a doctor and the other an engineer, she was introduced by them to concerts, theatre and opera. But at present these interests are completely absent. This is due to her present economic situation, the inability to understand the English language, and because she is removed from the stimulation of her family and former social group.

The conventional recreational media such as television, and radio are meaningless to this patient. Friends of the family with whom she lives provide her only circle of friendship, a pattern which is quite different from her former pattern of life in Hungary.

Religion: It is from her religion that this patient derives comfort, substitute gratification, and spiritual strength. Throughout life, even in the most dangerous times of Nazi occupation, she always adhered to the orthodox code of ethics of the Jewish religion from which she derives a strong belief in the coming of the Messiah and the salvation of mankind. This conviction has helped the patient to overcome the almost overwhelming trauma of survival, immigration, and religious and political persecution.

The hardships which the patient has been exposed to result at times in crying spells, which are an indication of reduced resistance. While she goes to synagogue to pray, she does not make use of her synagogue association to establish social contacts.

Stress in the Cultural Area

This patient has experienced extreme personal stress as a result of war experiences and recent immigration to this country where she has no familial ties. Her former cultural interests, as a result of her experiences in the past two decades, are completely absent. In general she has had to create, with almost no support from the environment except the association with her substitute family, a completely new life. In maintaining this adjustment she has made no attempt to recruit a circle of friends with people from her own culture.

Strengths in the Cultural Area

The fact that this patient has been able to make a relatively adequate adjustment is an indication of strong ego strengths and a firm hold on reality. This has been supported by her strong identification with culture and a firm hold on religious values. The friends and activities of her substitute family have to some extent supplied her need for social contact. It will be noted in the social area that the patient, following the loss of her own family, sheltered displaced and homeless young people in her own home. It may be that she has adjusted in as healthy a way as possible to life in a disrupted society, and is consequently able to carry that pattern into what she sees as a more secure existence. Also, it would appear that she follows a natural pattern of giving and taking in inter-

personal relationships.

Adaptation

Ego defenses operating here are:

1. Calculated, accepted, social isolation, without making use of available community resources.
2. Substitution of other satisfactions through strong religious faith and identification with her own culture.
3. Partial repression of traumatic experiences suffered during the war.
4. Some regression into the past, in that she enjoys talking at length about her pleasant life before the war in Hungary.

The Patient as a Member of Society

Social Findings

Employment: Until 1944 the patient together with her husband, maintained a weaving factory in which over 30 people were employed. The patient was the general manager and her husband, with his training in bookkeeping, was in charge of the office procedures. The housework was performed by servants.

The patient always worked hard but the degree of satisfaction was rewarding. Towards the end of World War II, however, the patient lost her role and never regained her position. At the present time her only occupation is in caring for her own room and in preparing occasional meals.

Income: The patient receives complete maintenance from a family agency which she feels to be inadequate. The low income creates many difficulties and hard feelings especially when the patient relates it to her level of income before the war. She indicated that her family was related to Baron de Hirsch who as she says, "certainly would not have been satisfied with the relief which is

given in his name". The patient finds it difficult to accept this relief, but money does not seem to be important in terms of status.

Housing: The patient shares the family quarters which are adequate and well kept, and she commented favourably about this arrangement. The housing seems to be quite different from the patient's former home in Hungary, where she had servants to look after the household tasks.

Family Relationships: The patient is the only survivor from her family of World War II and is completely alone in the world. She describes her marriage as 'perfect', and it was not possible to get any clear picture of the relationship with her husband. It was broken by the death of her husband who was deported to a concentration camp. The patient showed strength after the war in the way in which she was able to find a partial substitute for her lost role by providing a home for young immigrants to Israel. This seems to have given her support and satisfaction, especially at a time when no other satisfactions were available.

Stress in the Social Area

The major stress in this patient's life is in the complete absence of close familial ties. She handles this by repressing to a large degree her recent traumatic experiences, and by living regressively in a happier past. Financial dependency is an additional source of stress, in that it is low, and also in that it is so different from her former income level. However, it is felt by the writer that after having survived so much, her present conditions of living are not important to her, and she finds her satisfaction in looking back to the past, and in her conviction of the coming of a better world through the liberation of the Messiah.

Strengths in the Social Area

The patient has been able to make a realistic adjustment to her life experiences and is living fairly comfortably through the above-mentioned mechanisms of defence. While she is dissatisfied with her dependent financial status it does, nevertheless, give her a measure of security. The substitute family which has been accepted by the patient fills an important role in that it provides protection and familial interests. The substitute family has accepted the patient as well, and provides therefore a sympathetic environment.

Adaptation

The patient's adaptation in this area is in terms of:

1. Regression into a happier past.
2. Devaluation of present life as relatively unimportant.
3. Ability to find satisfactions through a substitute family.
4. Rigidity in adjusting to new patterns of life.

CASE XIII

History

The patient is an elderly, white-haired woman of medium stature who looks somewhat younger than her age of 69 years. Her appearance is neat and she is well dressed.

She was born in Russia, but lived in Roumania, Poland and Hungary before immigration to Canada in 1924. At that time she had been married for seventeen years and came to this country with her husband and three children.

At present the patient and her husband live with a widowed daughter and two grandchildren. The patient cares for the home and prepares the meals. Her daughter is employed outside the home.

The patient has travelled considerably, and has visited two of her sons living in New York and Chicago.

The Patient as a Physical Organism

Clinical Findings

Medical: The record of this patient in the Out-Patient Department revealed the following findings: labyrinthine vertige, renal glycosuria, haemorrhoids, menopausal syndrome, senile vulvitis and vaginitis, leucorrhoea, constipation, virus pneumonia, hypertrophic arthritis, chronic follicular tonsilitis, cartilaginous rest or cyst of right scapula, anxiety neurosis, thickening of right pleura, A-T and A-5 heart disease, hernia. Findings at the Geriatric Clinic: (1) Angina pectoris, (2) Nodule of right lobe of thyroid. This lady has attended diabetic clinic for years because of the fear of

diabetes. Re-assured re absence of diabetes.

Psyshiatric: Oriented in time and place. There is some difficulty regarding the important data of her life. Does not feel well, sometimes headache, heart trouble. Fell three months ago - pain left hip, feels weak. Does not stand or walk properly. Not depressed, according to her situation. Not afraid, does not sleep well, no important disease in own history or in family history.

Neurological: Pupils not remarkable, fundi not remarkable. E.D.M. not impaired. Left mouth corner right. Tongue to left. Deep reflex on right upper extremities left. Maze right left. Abdomen right left. Knee and ankle jerk nearly equal, perhaps slightly more action on the right. No Babinski or Oppenheim. Sensation not impaired.

Psychological: This woman of low average intelligence has retained her capacity to function very well. She shows some concreteness in thinking, but is able to adapt to the demands of reality. She is self-conscious, but capable of good energy output and a degree of spontaneity. There is no evidence of breaks in control or impulsivity. There is a mild degree of tension and anxiety, but no significant psychopathology.

Stress in the Physical Area

Although there are positive clinical findings, the patient does not make any specific complaints, but claims that 'everything aches', and that she has difficulty in getting around. Her fear of diabetes is indicated by her long history of visits to the diabetic clinic. Reassurance that she does not have this disease is not very effective. Neurological findings indicate probable left cerebro-vascular accident.

Strengths in the Physical Area

Illness has not been an impairing factor in the patient's life functioning. She accepts the aging process as a natural course of events, causing a 'slowing down' of normal functions. The patient attends clinics in order to seek relief from her 'aching pains' and reassurance for her fears of illness.

Adaptation

The patient's adjustment is in terms of:

1. Realistic acceptance of the aging process and the limitations of her ailments.
2. A capacity to function adequately in spite of clinical findings.
3. Expressed concern and fear about her physical condition and the possibility of handicapping illness.

The Patient as a Personality Within a Culture

Findings in the Cultural Area

Immigration: As a result of the Russian Revolution, the patient states that 'life in Europe became unbearable - a question of life or death'. She spent several years in Roumania, Poland and Hungary until immigration to Canada became possible in 1924. At the time of immigration many of her compatriots also came to Canada. The patient immigrated with her family of marriage.

Recreation: The patient enjoys television, radio and movies. She borrows books from the Jewish Public Library and enjoys reading. The patient has also attended lecture forums held at the Library. She now attends them less often because she does not get around as well as she did.

Religion: The patient, as a member of an orthodox family, adheres strictly

to the laws of her religion. She attends synagogue regularly on Saturdays. In the winter months the attendance is reduced because the patient finds it more difficult to walk. The patient participates actively in preparing synagogue ceremonies.

Interpersonal Relationships: Years ago the patient was very active in a Parent Teachers Association of the school which her children attended. She belongs to a Golden Age Club at the present time, but attends infrequently in the winter. Many of the patient's friends who are also immigrants, belong to the same groups. The patient also has made many friends among her neighbours.

Stress in the Cultural Area

Although the patient is very interested in social activities she cannot attend them as frequently as she would like to because of the difficulty she has in getting around.

Strengths in the Cultural Area

The patient's adjustment to immigration was easy due to her relatively young age and the fact that she adapted together with many of her compatriots. The fact that the whole family immigrated together was also a supporting factor.

The patient's recreational and interpersonal relationships seem very satisfying and are appropriate for a woman of her age. Her strong religious ties and cultural pursuits have continued to be satisfying and are a suitable channel for her energy.

Adaptation

The patient's adjustment in this area is in terms of:

1. Ability to derive much satisfaction from social activities.
2. Capacity to establish meaningful social relationships.
3. Acceptance of the fact that the aging process has limited the the extent of her social contacts.
4. Capacity to adapt well to changing life situations.

The Patient as a Member of Society

Social Findings

Employment: The patient has always been a housewife and at present manages her widowed daughter's home. She cares for five members of her family, and states that she has always made it her business to be 'a good mother'.

Income: Income has always been adequate. The patient and her husband now receive the Old Age pension and partial financial support from their children.

Housing: The patient and her husband lived in their own home until eight years ago when their son-in-law died. They then came to live with their daughter and her young children. The patient stated that she would like to move into her own dwelling since her grandchildren have now grown up and have a different outlook on life from hers.

The present dwelling is a six-room apartment which is kept meticulously clean. It is located in a shopping area and transportation and the synagogue are easily accessible.

Family Relationships: The marital relationship seems always to have been a close and satisfactory one. The patient speaks affectionately of her husband and claims to have shared all aspects of life with him.

The patient is a mother - figure in the home of her daughter and is well accepted as such. In spite of differences in point of view her

relationship with her children and grandchildren is a close one and provide her main source of pleasure.

Stress in the Social Area

There appears to be a natural amount of tension stemming from the proximity of living arrangements with the patient's grandchildren. This appears to be due to the fact that the grandchildren have grown up and have different ideas from those of the patient. The patient has considered moving to her own home, but realizes that in this event income might become a stress factor.

Strengths in the Social Area

The patient derives much satisfaction from her role as a grandmother. She is partially independent and willingly accepts some assistance from her children.

Family ties are close and living arrangements have been adequate for the past few years. However, an indication of the patient's views on living arrangements for older people was obtained when she indicated that it would be desirable for the community to provide small bungalow dwellings for older people. If this were done the problem of walking stairs and cleaning large apartments would be eliminated, and people with similar interests could live in the same area.

Adaptation

In this area adaptation is in terms of:

1. Realistic recognition of her role and satisfaction in carrying it out.
2. Capacity to manage a large home adequately and gain respect of

family members.

3. Adequate perception of her present status.

CASE XIV

History

The patient is a 67 year old man of medium height and robust appearance. He dresses neatly and gives the impression of having come from an aristrocratic background. He looks his age, but in conversation exhibits a marked mental alertness in discussing political and economic affairs. He was born and lived in Budapest until his immigration in March 1955. He was a trained pharmacist and continued to practice throughout the war years and even after the Communistic regime took over. The patient's wife is a gynaecologist who was also able to continue in her profession during and after the war years. As a result the patient was able to maintain his house which was used at the same time as a clinic.

The main reason for immigration to Canada was that the patient's daughter and son-in-law both of whom are practicing physicians, were already established here. Another son was also in Canada, though in another city. An additional reason for immigration was the patient's dissatisfaction with the political situation in Europe which interfered with his personal freedom. The economic background of the patient indicates a high standard of living in his country of origin. He attended the clinic because of his complaint of bronchial asthma from which he has suffered for twenty years, but which he never considered as a serious physical handicap.

The Patient as a Physical Organism

Clinical Findings

Medical: Possible parasitic disease, occasional pains in lower neck. Always been healthy, except for chronic asthma for the past twenty years, with frequent attacks in the winter. No substantial pain in cardio-vascular system.

Neurological: Findings are negative, except for diminished deep reflexes on both lower extremities with decreased vibratory sense in left leg.

Psychological: Superior intelligence, no significant intellectual impairment. Personality adjustment suggests some impulsive characteristics. Fair degree of adaptability with good reality contact. Some compulsive characteristics - tendency to isolate and carefully control the environment as well as some concern over 'cleanliness'.

Psychiatric: Findings are normal.

Stress in the Physical Area

This patient's only complaint is his chronic asthma with frequent attacks in the winter. This however has never seriously handicapped him. He tends to minimize his physical complaints and even to deny the fact that he suffers from asthma. The psychologist's report indicates some compulsive trends. The fact that he does not see age as a barrier in re-establishing himself in his profession probably indicates some denial of the aging process.

Strengths in the Physical Area

The patient has always been relatively healthy and the psychological findings indicate little deterioration and good reality contact.

Adaptation

The patient's adaptation in this area is in terms of:

1. Tendency to deny chronic asthma as a somatic disease.
2. Tendency to deny the aging process.
3. Ability to function on a good physical level.

The Patient as a Personality Within a Culture

Findings in the Cultural Area

Immigration: The patient emigrated from Hungary for familial and political reasons, as already indicated.

Recreation: Prior to immigration the patient participated actively in the cultural and recreational life of Budapest. He attended operas and concerts, and was active in the proffessional circles to which both he and his wife belonged. At present he does not participate in these activities mainly because of his lowered financial and social status. While he misses the social contacts he formerly enjoyed, he has been able to find substitute enjoyment by listening to good music on the radio and to high fidelity recordings.

Religion: Identification with his Jewish culture in Budapest was mainly through active participation in the Zionist organization in which he held the position of chairman. This active and open participation had to be discontinued after the Nazis and Communists entered the country. However, he continued to carry on those activities in the underground organization. The religious life of the patient was a traditional one with occasional synagogue attendance during the year, but consistent attendance at High Holidays and festivals. At present the patient is unable to participate

actively in the Zionist organization because of the language handicap. He does, however, attend High Holiday celebrations and maintains his cultural identification by continuing to consider himself a Zionist.

Interpersonal Relationships: Friendships are reduced to contacts with the family and this represents a significant change from the patient's life prior to coming to Canada. On a few occasions he went to a newly established Hungarian club but did not find the desired satisfaction because he does not play cards and was not interested in conversing about casual daily happenings. He has failed to find in this country the level of interests to which he was accustomed in Europe.

Stress in the Cultural Area

Immigration has been a stress factor because it has removed the patient from the highly cultured pursuits and the professional status which he formerly enjoyed. At present his recreational life is inadequate and he expresses feelings of dissatisfaction with his lack of friends. His failure to be accepted in professional circles has aggravated his feeling of lack of status in the community.

Strengths in the Cultural Area

Although there are problems in adaptation, the patient has been able to evaluate his present situation realistically. In spite of missing his former assocations he recognizes the advantages of being with his family in this country.

Adaptation

Adaptation in this area is in terms of:

1. Realistic acceptance of partial social isolation and lack of status even though this creates manifest dissatisfaction.
2. Ability to substitute family values for former professional and social satisfactions.
3. Ability to verbalize hostility and disappointment concerning his present circumstances.

The Patient as a Member of Society

Social Findings

Employment: At present the patient works as a general helper in a grocery and vegetable retail store. He works twelve hours daily for five days a week and finds the work hard, unclean and unsatisfactory. Until his immigration he was self-employed as a pharmacist. Under the Communist authorities he was delegated to teach young professionals in his own pharmacy. The patient enjoyed the teaching aspect of his work since it indicated acceptance of his professional status. The loss of professional work has created a deep traumatic reaction and has not been completely overcome. The patient hopes to return eventually to his own field.

Income: The patient was not permitted to bring any of his savings from Hungary and at the present time he is largely dependent upon his daughter and son-in-law, both of whom are doctors. His present earnings are $20.00 per week which he contributes to the family budget. He feels that his earnings are not commensurate with the amount of work which he does. However, limitations such as age, language difficulties, and lack of professional certification make it impossible for him to find employment in his own field.

Housing: The patient and his wife share a five and half room apartment with the daughter's family. Though the arrangements are pleasant and acceptable, they are significantly different from the home which the patient had in Hungary which he describes as 'one of the most beautiful homes in Budapest'.

Family Relationships: The present relationships with the daughter's family are close and satisfying. His relationship with his wife was described as always having been a harmonious one. It is noteworthy that the whole family is an inter-dependent unit. The only criticism which the patient expressed in regard to his family is that they buy luxuries such as a car, a high fidelity set, television and furniture on the instalment plan. This North American pattern is strange to the patient, but he accepts it as being normal on this continent. A main concern in the family area is that the patient's only son, a graduate engineer from a European College, has been unable to find employment in his own field.

Stress in the Social Area

The entire social life of this patient has been affected by the recent immigration. Immigration has resulted in a new pattern of employment, a lower level of housing and the necessity of accepting assistance from the family. All these changes have been a trauma for the patient to which he has not completely adjusted.

Strengths in the Social Area

The fact that the patient has been able to find employment and to accept his present situation as well as he has, indicates a high level of adaptability, ego strengths, and an ability to accept reality. The

contribution to the family budget helps him to maintain his status within the family. The family solidarity also makes his sacrifices more bearable to him. Housing, though somewhat crowded, is nevertheless reasonably adequate.

Adaptation

Adaptation in this area is in terms of:

1. A high level of adaptability in adjusting to changed financial, employment, and social status.
2. Ability to fit into a new familial environment.
3. A high level of drive to improve present circumstances and to recapture former levels of achievement.

CASE XVIII

History

The patient is a 70 year old woman who looks younger than her stated age. She emigrated from Russia with her husband a few months after her marriage to escape religious and racial pressures. She had only one child who was born in this country. The patient worked as a dressmaker throughout her adult life and still continues in this occupation. Her first husband died of heart failure and the patient remarried shortly after his death. Six years later her second husband died of cancer. She is at present living with her widowed sister.

The Patient as a Physical Organism

Clinical Findings

Medical: The patient has been diabetic since 1942. She suffers from hypertension and underwent a cholectomy in 1948.

Neurological: Patient complains of being nervous. This is her only complaint.

Psychological: Better than average ability and intelligence. Deals with life realistically. Dependency needs evident, mild depression of mood. Difficulty in inter-personal relationships.

Psychiatric: No mental illness. Headaches. Memory failing.

Stress in the Physical Area

The patient suffers from hypertension and diabetes but is not incapacitated by her physical condition. She is under rather than over-concerned about her physical condition and takes on a great many social and

recreational activities in addition to her responsibility in her sister's home. Signs of memory failure were not noted in the interview.

Strengths in the Physical Area

The patient complains of being nervous, and finds an outlet for her tension in being active and busy. She states, 'If we let ourselves go we are nothing'. The amount and level of activity, both in her employment and social participation, are striking in view of her age.

Adaptation

The patient's adjustment to physical stress is in terms of:

1. Denial of physical symptoms, which the patient does not regard as being of any importance.
2. Denial of the aging process.
3. Acting out of tensions in creative pursuits which are somewhat excessive in relation to her age.

The Patient as a Personality Within a Culture

Immigration: The patient regarded immigration as a difficult experience. She came to Canada from Russia shortly after her marriage. Both she and her husband worked upon arrival. The patient stressed her economic difficulties and commented that she endured many more hardships than the immigrants of today.

Recreation: The patient states that she was always a 'sociable type'. Her contacts with people and groups have always been very meaningful to her. She attends a Golden Age club, the "Friendly Club", and the "Victory Club". She is also actively engaged in family social activities.

Religion: The patient used to belong to a synagogue and attended regularly

on the High Holidays. Now she rarely goes to synagogue and states that "you can do good deed without bowing before the altars". Religion now has meaning for her in terms of her personal philosophy of life. However, she maintains a kosher home, lights the Sabbath candles, and observes the festivals.

Interpersonal Relationships: The patient's friends are all from the same cultural background. She stated that her contacts with people were very meaningful and that she has always enjoyed company. It is interesting to note that the results of the psychological tests show a discrepancy here in that the patient was described as having difficulty in interpersonal relationships.

Stress in the Cultural Area

There appear to be few stresses in the patient's life situation. She emphasized the economic hardships and difficulties associated with her immigration. Further, her present pattern of group participation may be due to her unmet dependency needs for acceptance and support. This is in line with the psychologist's observations.

Strengths in the Cultural Area

Strength in this situation is revealed in the way in which the patient can meet her needs in a socially acceptable and productive way. While her pattern of over-activity may reflect underlying anxiety, it provides outlets which are satisfying to her.

Adaptation

The ego defenses operating here are:

1. Acting out of possible dependency needs through an over-activity pattern.
2. Ability to find satisfaction through inter-personal relationships.

The Patient as a Member of Society

Social Findings

Employment: The patient is at present working in her home as a dressmaker in order to supplement her Old Age pension. She shares an apartment with her sister, the rent for which is paid for by the latter. She has always worked as a dressmaker in her own home and her earnings were the mainstay of the family for many years after her first husband became an invalid.

Income: Income does not constitute a source of stress to the patient. She has her Old Age pension, her earnings, and some savings left by her second husband. The patient pointed out that she "could always look like a rich woman as she made her own clothes". In her first marriage the income was marginal and the patient claims that "she took it with a smile". At present she is managing adequately, and her income is sufficient to give her a feeling of economic security.

Housing: The patient is now sharing living quarters with her widowed sister who is deaf and who makes many demands on her. The patient expressed the desire to leave her sister, but is ambivalent about doing so as her sister needs her, and provides her with a home. The patient lived with her married son's family until eight years ago when they moved to California. The home is a four-room flat, located in a new and modern section of the city.

Family Relationships: All the patient's siblings live with their families

in Montreal. These relatives are close to the patient and contacts are frequent and meaningful.

Tensions as a result of marginal income, and illness were noted in the patient's first marriage. During the second marriage, the relationship appears to have been a close and interdependent one. Income was no longer a stress factor. The two children from this marriage did not survive. Her relationship with her sister is a source of conflict. She feels indebted to her and at the same time resents the demands her sister makes upon her. The sister appears to be passive and dependent, in contrast to the patient's outgoing personality.

Stress in the Social Area

The patient's present living arrangements are a source of tension. She is unable to deal comfortably with the demands made upon her by her sister. Her hostile feelings may be increased by her own underlying dependency needs.

Strengths in the Social Area

Throughout her life the patient has shown adaptability and an ability to assume responsibility which is demonstrated in her taking over the support of her family during her first marriage. The fact that she can supplement her income by dressmaking, gives her a feeling of security and self-reliance. Her frequent contacts with her family and a close relationship with her son are positive supportive factors in this area.

Adaptation

Defense mechanisms operating in this area are:

1. Positive adaptation to reality in terms of taking independent and responsible action.

2. Successful relationships with family members with the exception of her sister.
3. Reasonably successful defenses against her dependency needs in terms of over-independence considering her age.

Discussion

Stress

The patients in this group have minor physical complaints but they do not constitute the same degree of stress as they do for the patients in Groups I and II. The complaints include recurrent hepatitis, pain following an accidental fall, partial blindness and deafness, generalized aches and pains, possible parasitic disease, chronic asthma, hypertension, diabetes and colectomy. In general the patients are able to accept the limitations imposed by illness realistically and to function adequately in spite of them. In the cases of the three recent immigrants in the group, the difficulties of adjustment have been manifest in both psychological and somatic complaints. These take the form of mild depression and anxiety and psychosomatic conditions.

In the psychological area the patients in this group exhibit adequate patterns of adjustment and are in good contact with reality. In spite of minor physical and psychological difficulties, their functioning is not impaired and they are able to carry on a level of activity appropriate to their years.

In the socio-cultural area the patients on the whole are successful in coping with their environments. The three patients who are recent immigrants are experiencing difficulties in assimilation. All of these patients had formerly enjoyed many cultural interests in Europe. Here, where they have not yet found a place within the community, and where the opportunities for cultural outlets are more limited, their social participation is reduced, and this constitutes a source of dissatisfaction. For

the remaining patients in the group there is an interest in social and cultural activities which provides them with a level of satisfaction appropriate to their years.

In addition to difficulties in the cultural area, the recent immigrants are experiencing hardships in adjusting to their loss of status. The remaining patients in the group have immigrated more than twenty years ago. Two of the three patients did not find their immigration stressful; the remaining patient experienced economic pressures as a result of immigration.

For three of the six patients tension in the social area arises from their living arrangements. One patient is ambivalent about living apart from her son. One of the patients who is living with her children would like to move into her own home, but her dissatisfaction is not marked. The third patient, who is living with her deaf sister, finds it difficult to accept the demands made upon her by the latter.

Strengths

As has already been pointed out the patients in this group are accepting of their physical limitations and their level of productivity is high. The adjustment to the aging process is realistic.

In the socio-cultural area many strengths are evident in the adjustment patterns. For the three recent immigrants, in spite of difficulties in adaptation to a new country, there is a realistic acceptance and understanding of the need for adjustment.

All of the patients are able to verbalize their problems and are well motivated to seek suitable channels in the community for their interests and activities. The particular difficulties of adapting to the cultural life

of this city have already been noted.

For the older immigrant group, cultural activities are gratifying and have been reduced in keeping with the realistic limits of aging. All the patients in this group are moderately active and derive much satisfaction from group and recreational activities. Social contacts with friends are well maintained.

The patients in this group are on the whole strongly identified with their religion and culture. One patient derives much satisfaction from his pastime of studying the Talmud. Another patient derives much support from her strong belief in the coming of the Messiah.

Four of the six patients in this group are productively employed. Two of the women are housekeepers. This role affords them a sense of status and responsibility. Another woman is a dressmaker and cares for her deaf sister. One of the recent immigrants has accepted a lower level of employment than he had in his country of origin. While he is dissatisfied with both his earnings and the type of work it fulfills his need for productive activity and maintains his status as contributor in the home. The remaining two patients, one male and one female, while they are not employed, are performing minor household chores and enjoying a relaxed way of life. The patients who are not gainfully employed receive financial assistance with no apparent conflict.

The patients in this group contribute much to familial solidarity. They are fulfilling useful roles as head of their respective families. This role gives them status, a sense of responsibility, and a feeling of adequacy. Five of the six patients have grandchildren and derive much

satisfaction from them. Inter-familial contacts are frequent. One of the patients, who lost all her family during the war, derives satisfaction from a substitute family.

Adaptations

The adaptation patterns of the patients in Group III in the physical area indicate good ego strengths. All the patients are able to accept the limitations imposed by their physical conditions and are able to function in spite of their handicaps. Their daily activity in recent years has been slowed down in comparison with past patterns.

In the social area, the recent immigrants are accepting of the realistic social isolation imposed by their present status. In two cases there is expressed dissatisfaction with the present level of culture and social activity. In Case VII the patient finds substitute gratification by regression into the past and looking toward the future through her belief in the coming of the Messiah. Although her present satisfactions are limited this patient is able to derive some gratification from her close relationship with a substitute family.

The patients in this group all show a high level of adaptability to changing life situations. Underlying this capacity is the ability to find substitute satisfactions. The mechanisms of defense operating in this group are repression of a traumatic past, healthy rationalization of the aging process and of the limits which are thereby imposed, and over-activity which conceals a fear of increasing dependency with age.

The male patients have redefined their roles. Although most are still productively employed, all have been able to limit their activities

and interests to those appropriate for their capacity and age. The women patients in this group show an ability to maintain their roles as mothers and housekeepers through their contacts with their children's families. There is a strong feminine identification for all the women in this group. Evidence of this capacity is even to be found in Case VII where the patient assumes a grandmother role in a substitute family. The two male patients in the group demonstrate a capacity to fulfill a role as male figurehead in their respective families. For example, in Case VI the patient enacts the role of father in the household of his divorced daughter and is the patriarchal counsellor to the entire family. Although some tensions exist, family relationships are positive and the patients themselves have much to contribute.

In general, the adaptation patterns of the patients in this group reveal a good contact with reality. In most areas of life functioning the mechanisms are appropriate and indicate a high level of ego strength.

Summary

In summarizing the findings on the life situations and defence patterns of this group, the following observations may be noted:

1. Physical handicaps exist but are neither immobilizing nor incapacitating.
2. A high level of productivity is maintained.
3. Stressful situations are faced and dealt with in an appropriate way and the patients are able to verbalize their difficulties.
4. There is a good ability to cope with the environment and to reach out for social gratifications.
5. The aging process is well accepted and accordingly certain restrictions are placed upon the level of activity.
6. Familial solidarity and cultural idenfications are a source of strength and the level of interest in family affairs is high.
7. Good adaptive capacity is revealed in the ability to redefine social and familial roles in accordance with changing life situations.
8. In general, there is evidence of good ego resources and defense mechanisms are used in a healthy way.

CHAPTER VIII

Findings and Conclusions

Introduction

This study was undertaken by three student social workers with the purpose of examining the life situations and the adaptation patterns which influence adjustment in old age. It was based on an analysis of eighteen older patients who had been attending the geriatric clinic of the Jewish General Hospital since its inception in September 1955.

With the recent advances in both the medical and the social sciences, the concept that transactions take place among the various systems of organization by which man interacts with his environment has been emerging. According to this concept man's functioning as a physical organism, as a member of his social group and as a carrier of his culture are intimately inter-related. Further, the transactions which take place between these levels of organization are such that they tend to maintain the individual in a state of relative equilibrium. However, this equilibrium is maintained at the expense of stress which may reveal itself ultimately in physical malfunctioning or in psychological disturbance. According to authorities in the field stress is dependent, not only on situations in the environment, but also on the ego defenses of the individual which render him more or less successful in reconciling his internal needs with the realities of the life situations in which he finds himself. This

thesis has been concerned with discovering the nature of these transactions as they occur in the lives of the patient group under study.

Old age is a period of life which is potentially stressful to every individual because of the many new adjustments which it demands. Our culture is one which until recently has neglected the needs of the older person and which has minimized the role he can play in society. Along with this attitude of devaluation of the older person there are realities in the social sphere which also put strain on the individual. These social realities include retirement from active life on the part of men, and loss of the mother role on the part of women, reduction of income, the death of the spouse and other supporting figures, and changes in familial and social relationships. In the physical area also there are changes attendant on the aging process to which the older person must adjust. These cover such changes as gradual decrease of physical vigor and intellectual capacity, decline in sexual functioning, incapacity due to illness, and fear of helplessness and death. In all of these related areas the older person has increased demands made upon him which call for a high level of ego resources and adaptability if he is to meet them successfully.

In approaching this study of transactions between the various systems of organization the case material on the eighteen patients has been analyzed intensively in order to evaluate adjustment in the physical, cultural, socio-economic, and familial areas. In the analysis of the cases the data obtained from the geriatric records of the hospital were included in order to broaden the basis for evaluation, and to relate the writer's findings to those of the other disciplines. In defining the area for research it has been deemed

within the scope of this study to consider the life situation, the definition of the situation in terms of stress and strength, and the adaptation patterns of the patients. It was not deemed within the scope of a social work study to explore the linkage between adaptation patterns and the etiology and course of physical and emotional illness. This latter type of research would properly fall into the field of the medical and psychiatric disciplines. However, it has been possible to relate physical malfunctioning to adaptation patterns and to the total life situation. It is hoped therefore that this thesis will have value in pointing the way toward further multi-discipline research.

Although use was made of the findings from other disciplines, the main source of data was the material obtained through the interview. It has already been pointed out that the interviewing was shared equally by the three writers and that the data from the interviews were assessed jointly in order to minize the element of bias. Similarly, the establishment of criteria for the three levels of functioning (Groups I, II and III) and the assignment of the patients to one of the three groups was done by the evaluation of all the writers.

The theory has been advanced that the definition of the life situation is comprised of interactions between external factors in the environment and the ego functioning of the individual. Situations are seen as supportive or stressful according to the particular reaction pattern of the individual, a reaction pattern which is based on his previous life experiences. The main emphasis of the study, therefore, has been upon the definition of the situation for these patients in terms of stress and strength, and upon the

particular reaction patterns which result in relatively successful and relatively unsuccessful adjustment. Further, since the study is concerned with the life situations and ego adaptations of patients in old age, there has been an attempt to assess them as they apply to this group.

No criteria have been established for what is "normal" adjustment in old age. Therefore it has been possible to draw conclusions only from what is known concerning adaptation in general and what may be gleaned from the literature in the geriatric field. It is well established, for example, that there is a slow deterioration in physical and mental functioning and an exacerbation of already existing physical complaints as the individual advances in years. Successful adaptation would seem then, to lie in the ability of the individual to function within these limitations, and unsuccessful adaptation in the extent to which he uses regressive and self-defeating mechanisms. Similarly, old age brings a need for adaptation because of changes in the social, cultural and familial roles in which the individual finds himself. Successful adaptation in these areas would then be evaluated in terms of the ability of the individual to find new roles and substitute activities and gratifications. Unsuccessful adaptation would be evaluated in terms of withdrawal from active participation and regression into earlier patterns of adaptation which are inappropriate to the new situation.

It has been pointed out in Chapter I that there have been a number of limitations in the study. The most obvious of these is the size of the sample. This means that any conclusions drawn on the basis of

this group cannot be said to be definitive for the older person in general. The fact that only one interview was held with each patient has also been noted as a limitation. Within the scope of one interview it was not always possible to obtain complete factual information concerning life events or material of significant emotional depth in all areas. Nevertheless, the readiness of the patients to discuss their life situations made it possible for the writers to gain insight by implication into life patterns which the patients did not always discuss directly.

It was decided at the outset that the writers would not interview family members because of the difficulty in obtaining a comparable family member for each patient, and because the focus of the study was on the way in which the patient himself evaluated his life experiences. In ten cases where the interview took place in the home of the patient it was not possible to avoid the presence of family members during the interview. As a result it was possible to gain a more comprehensive picture of the family relationships. On the other hand in the presence of family members it was felt that the patients were less free in discussing their feelings. In those cases in which the patients were seen in the hospital, it was not possible for the writers to have an actual picture of the housing accommodations.

It has also been noted that no attempt was made in the study to obtain a complete life history on each patient. It is felt that data on childhood experiences would have made possible an analysis of greater depth. However, such an analysis was not possible within the time which the writers had at their disposal.

The fact that there was marked variation in the length of time that the patients had been in this country has been a limitation in that the group was not homogeneous in this respect. However, this variation provided an opportunity for comparing the adjustment of the recent immigrant with that of the immigrant of longer residence.

General Findings

In discussing the findings from this study it should be kept in mind that the patients all belonged to a particular minority group. Though the findings are significant only for this group they nevertheless throw light upon the problems faced in general by the aging population.

A common feature of the patient group is that all of the sample with one exception came from Eastern Europe. The length of residence in this country varied markedly, ranging from less than ten years for five patients, twenty to thirty-five years for eight patients, to over forty-five years for five patients. In spite of this great variation in length of residence in this country the reasons for immigration were similar. In many cases the patients immigrated in order to join family members in this country. However, those who came in their young adult life did so in order to better their circumstances in the new world, while the later immigrants came in order to be united with younger members of their families. Familial reasons for immigration were closely related to a desire to escape from the political and racial persecution attendant upon two world wars. In the recent immigrant group three patients had suffered extreme hardship resulting from World War II in order to come to Canada.

It was difficult to obtain precise data concerning the experiences resulting from immigration for the patients who had been in this country for more than twenty years. It may be assumed, however, that immigration brought many hardships that the patients found it difficult to recall after the lapse of so many years. Although the men in the study apparently had no difficulty in establishing themselves in employment, a number of patients stated that they had financial difficulties following their arrival. For the recent immigrants the problem of having to adjust to a completely new way of life is aggravated by the patients' advanced years, physical limitations and the fact that employment is not readily available.

In the sample group there are two distinct Jewish cultural patterns. On the one hand there is the pattern of strict adherence to the Jewish code of ethics, and on the other there is the assimilated pattern of adherence to some of the traditional practises. However, these patterns cannot be sharply defined since there is much overlapping in the observance of religious traditions and in cultural attitudes. However, in all the patients there is a strong identification with Jewish culture and with the Jewish way of life. This strong cultural identification is one of the most striking findings of the study. It would seem that this identification, deeply rooted in childhood, has given to the individual a sense of security and self-hood which has been a source of strength and which has enabled him to adapt to the viscissitudes of his later life experience.

Closely related to the pattern of identification with Jewish culture are the strong kinship ties which are characteristic of the Jewish family group. In general it was found that recreational and social activities were

limited in nature and passive in type. While activities outside the home were not on the whole of primary importance to the patients, the social life was centered largely within the family. The sense of family solidarity was evident in all areas of the patients' lives - in the extent to which living accomodations were shared, in the measure of economic support which was given, and in the way in which the children, in spite of some family tensions, accepted the responsibility for their parents' well-being.

For the newer immigrant group the level of participation in social and cultural activities within the community had been higher in their countries of origin. Since their arrival in this country this level had decreased due to the fact that they no longer had an established place in the community, and considerations of language and finances prevented their taking advantage of available resources. This lack of cultural outlet was a source of dissatisfaction to this group and is related to the fact that some of these patients had been assimilated in their countries of origin and found it difficult to adapt to the narrower Jewish community in this city.

For the male patients in the study, lack of employment and loss of role as breadwinner added to the difficulty in adjustment to the aging process. These difficulties were further aggravated by loss of status within the community and a feeling of being unwanted and rejected. It has been found that marital tensions in some cases developed or were accentuated as a result of loss of role within the family. The pattern of rather narrow recreational activity in adult life created further difficulties in that

there was no established pattern for substitute outlets.

For the most part the women in the sample group were able to sublimate their loss of mother role by assuming the role of grandmother. Loss of employment was less serious for the women patients since they continued to carry out household tasks which were similar to those carried out in middle life. Even though seven of the women in the study were widowed, they continued in their role as housekeepers and derived satisfaction from the ability to maintain their status and to fulfill a useful role.

To some women the loss of the support of their husband was more traumatic than for others. Three of the women under study had not made a satisfactory adjustment to this loss. On the whole it may be said that on the basis of this study the loss of employment and its accompanying loss of status is more traumatic for men than for women.

None of the patients were experiencing severe financial deprivation although reduced income was of concern in that many of the patients had to adjust to a lower level of expenditure. As was pointed out earlier the responsibility which the families of the patients assumed helped to alleviate financial difficulty.

Findings Relating to the Adaptation Patterns of Groups I, II and III

In the physical area there was a wide variety in the illness patterns and in the way in which the patients used illness as a mechanism of adaptation. In Group I illness tended to be long-standing and chronic, and was severely incapacitating. It influenced the entire life functioning of the patients. At the same time there was an inability to accept the

aging process. It was only because of the sheltered environment and the support offered by family members that these patients were able to function in a very limited way. The adaptation patterns of this group in the physical area were generally inadequate and took the form of regression into illness, rebellion against the aging process, depression, suppression of aggressive and hostile feelings, dependency conflicts, living in the past, and self-depreciation.

Comparing the findings of Group II with those of Group I it was found that there was a history of long-standing physical illness which interfered with daily activity but was not as immobilizing as for the patients in Group I. There was a reduction in the level of mental functioning and illness appeared to be related to traumatic life experiences. Illness was used as an attention-getting mechanism. There was some regression into illness, over-concern with physical complaints and over-compensation on the part of the males in terms of enaggeration of physical ability.

In contrast to Groups I and II the patients in Group III were able to accept realistically their physical limitations. Although they all had physical illnesses they were able to function adequately and were accepting of the aging process. The adaptation patterns in general showed a high level of ego strength and good reality testing.

In general, although the writers cannot make a judgment as to the relationship between inadequate ego defenses and the etiology and course of illness, they can state, on the basis of the findings in this thesis, that the incapacity due to illness exists concomitently with regressive

adaptation patterns.

In the socio-cultural area the patients in Group I exhibited a borderline adjustment. In general there was a low level of motivation for social and inter-personal relationships and an ability to relate to others which resulted in a high degree of social isolation. Recreational life was passive in nature and relationships with friends afforded little satisfaction. It was significant that none of the patients in this group were employed, and that their inability to adjust to lack of employment had influenced their functioning in all other areas. It may also be said that there was a relatively high degree of family and marital tension. In spite of these tensions family members had been able to accept the limitations of the patients and support them in their limited functioning. The identification with their own culture has proved to be a further support to this group. Adaptations in this area were in the form of social isolation, withdrawal, and failure to find substitute activities and gratifications.

The patients in Group II exhibited in the socio-cultural area, similar patterns of limited ability to participate and to reach out into the community for social and recreational activity. Contributing to this inability were mental and physical disabilities and the realistic narrowing of the older person's world. The patients generally fulfilled useful roles and were productive to a limited degree within their homes or sheltered settings. Religious and cultural identification were a great source of strength to these patients. Close family ties and acceptance by family members as well as cooperative planning were additional sources of support. Though the patients expressed a desire to overcome

their inadequacies, there was a lack of sufficient ego strengths and motivation which would enable them to succeed.

In the socio-cultural area the patients in Group III revealed a relatively high level of functioning. In the cases of the three recent immigrants in this group, their ability to adapt was all the more striking in that they had to make a complete readjustment to a new cultural environment. Although they were experiencing difficulties in assimilation which were expressed in somatic complaints, anxiety, and depression all the recent immigrants were able to verbalize their problems and showed an awareness of the need to make an adjustment.

The older immigrants who did not have the additional problem of adjustment to immigration showed a realistic acceptance of the aging process and had maintained their activities in accordance with their more limited capacity. It is noteworthy that four of the six patients in this group were productively employed, even though in most cases the employment was of a different nature than it had been in former years. This reflects a similar adaptability to that which has been noted in other areas. In general, these patients exhibited a high degree of interest in the world around them and derived satisfaction from relationships with friends and group and cultural activities.

The family relationships of the patients in this group continued to be a source of satisfaction and there were few family tensions. It should be noted that it is only within this group that most of the patients were able to assume a role of leadership within the family which gave them a recognition and status due to age and experience, and which

accorded them a position of dignity within the family group.

In general, in spite of some less healthy defense mechanisms the ego adaptations of this group were adequate. All patients showed a high level of adaptability to changing life situations and were able to find substitute satisfactions within their present circumstances. All the women in this group had a strong feminine identification which corresponded to the ability of the men to fulfill their roles as the male figureheads within the family group.

Conclusions

This study was based on the assumption that transactions take place among the various systems of organization by which man interacts with his environment and that his functioning in the physical, social and cultural areas is intimately inter-related. The findings outlined earlier in this chapter which compare the life situations and adaptation patterns of the patients in the three groups substantiate the validity of this assumption. The patients who were poorly adjusted in one area showed evidence of limited adaptation in all other areas of life functioning. Similarly, those who were well-adjusted were able to function reasonably adequately in all areas.

Another assumption underlying the study was that stress and strength in adaptation patterns is dependent not only on situations in the environment but on the definition of the situation for the individual. This definition is dependent upon the nature of the ego adaptations which have been developed through previous life experiences. The findings of the study bear out the fact that the nature of the ego resources within the individual are the primary determinants of successful or unsuccessful life adaptation. While environmental situations influence individual response, the appropriateness of the response depends upon the success with which the individual has responded to life situations in the past.

Old age has been found in the study to make many new demands for adjustment on the patients in the sample group. These demands were found to exist in all areas covered by the study, and included the need to adapt

to lessening physical and mental capacity and increased disability, the loss of former roles in employment and in the family, and fewer opportunities for social participation. While these demands for adjustment were common to all the patients, it was found that the patients varied in their ability to meet these demands in accordance with the emotional homeostatic capacities which had been developed through past experience.

In adapting to changing situations the individual calls into play a certain pattern of response which results from previous experiences. If the situation is particularly stressful for the individual, and ego resources are weak, unhealthy defense mechanisms come into play. On the other hand, if the individual's ego resources are strong the response is appropriate, and defense mechanisms are healthy. For a particular individual a defense mechanism may be appropriate in a given situation, whereas for another person in the same situation the same defence patterns may be inappropriate. In this study it was found that the most commonly used defense mechanisms which were inappropriate in meeting stress were, living in fantasy or in the past, regression into illness, withdrawal, self-depreciation and self-pity, denial of the reality situation and unrealistic rebellion. The more appropriate defense mechanisms in the face of stress were mobilization of ego strengths to meet new situations, ability to reach out for meaningful relationships and to derive substitute gratifications, ability to verbalize unresolved fears, acceptance of the reality situation, ability to make constructive use of leisure time and the ability to assume leadership and fulfill a useful role.

Life situations demand particular adaptive patterns. In this study it was found that the reaction to immigration reflected the patient's ability to meet new situations. For the most part all of the patients were able to adjust adequately to immigration and with the passing of time they were able to achieve a new status. It is significant that three of the recent immigrants fell into Group III, thus indicating their strong ego resources.

The patients' membership in the Jewish minority group revealed significant findings. All patients are closely identified with their culture which gives them a sense of identity and self-hood. Although the extent of orthodoxy varied among the patients, cultural identification was on a high level. While familial tensions were found to exist for the patients under study, a striking finding was the importance placed upon and great satisfaction derived from a strong sense of family solidarity. It is noteworthy that familial tensions were high for all the patients in Group I and for some in Group II. For the patients who fell into Group I and for some in Group II, family solidarity had meaning in that the patients were able to obtain care and support from their families. The patients in Group III, on the other hand, were able to contribute much to family life.

In this thesis the writers have undertaken to study the adjustment patterns of a particular group of patients. Their findings in general have led the writers to conclusions which bear out the basic postulations set forth in Chapters II and III. In addition the findings throw some light upon the adaptation patterns of a particular minority group and reveal the importance of strong cultural and familial ties in the process of adjustment to the aging process.

APPENDIX A

APPENDIX A

INTERVIEW SCHEDULE

A. The Cultural Area

1. Religion & Ethnic origin	Hebrew? Country of origin Countries of residence Immigration to Canada - if so, at what age?
2. Use of Time: recreational life	
a) Interest in hobbies (present)	Handicraft, games, gardening, radio and television, reading, etc. (extent and level of interest in these).
b) Interest in hobbies (adult life)	What interests did the patient have? Are there differences in the present pattern? Has the patient developed new and satisfying interests?
c) Level of interest (present)	In terms of little interest, moderately, satisfying.
3. Interest in sports	
a) Interest in sport (present)	Does patient take any interest in sports, active walking, spectator, through radio?
b) Interest in sport (adult life)	Types of participation and in what? Active Spectator.
c) Level of interest (present)	In terms of little interest, moderately, satisfying.
4. Social Group Activities	
a) Participation (present)	Clubs, church affiliations informal social activities, old people's clubs, church groups (note extent of participation) family social events. Attendance at taverns. Inter-familial, extra-familial? Mixed or one sex?

b) Level of satisfaction	In terms of good, mediocre and poor group adjustments.
c) Above points in relation to adult life	Note changes in the group adjustment pattern.
d) How big is the problem of language in the cultural adjustment. What languages do they speak?	
5. Nature of friendships	
a) Present	Origin of friends. Number of extent of social contacts (many, few). Nature of relationship with friends (casual, meaningful).
b) Past	As above, with changes in pattern to be noted.
6. Religion	
a) Present	Religious affiliation - synagogue. Religious activities - attendance, other religious groups.
b) Past	Attitude to organized religion - negative, positive, indifferent. Changes in pattern to be noted.
7. Immigration (of patient)	Reaction to displacement - does patient see this as easy, difficult. If difficult, where were their tensions? Economic. Employment. Family life. Adaptation to new forms of culture through illness.
If patient was young	What were the tensions created in the family group?
8. Extent of identification with culture	In all social and recreational activities has this patient remained closely identified, casually identified or showed conflicts over cultural identification.

b) Level of satisfaction	In terms of good, mediocre and poor group adjustments.
c) Above points in relation to adult life	Note changes in the group adjustment pattern.
d) How big is the problem of language in the cultural adjustment. What languages do they speak?	
5. Nature of friendships	
a) Present	Origin of friends. Number of extent of social contacts (many, few). Nature of relationship with friends (casual, meaningful).
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6. Religion	
a) Present	Religious affiliation - synagogue. Religious activities - attendance, other religious groups.
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7. Immigration (of patient)	Reaction to displacement - does patient see this as easy, difficult. If difficult, where were their tensions? Economic. Employment. Family life. Adaptation to new forms of culture through illness.
If patient was young	What were the tensions created in the family group?
8. Extent of identification with culture	In all social and recreational activities has this patient remained closely identified, casually identified or showed conflicts over cultural identification.

B. The Physical Area

Illness Pattern of Patient	What illnesses or complaints has patient suffered since coming to clinic? In medical history (as noted). Length of clinic attendance .
Past	
Present	Present physical illness or complaints. Medical diagnosis . Psychologist's report . Psychiatrist's report . Extent of physical and mental incapacity in terms of functioning .
Meaning of Illness to Patient	Precipitating factors in terms of traumatic events. Mental deterioration - duration and event. Nature of adjustment - appropriate, over-concern, under-concern. Extent of regression into illness.
Importance of illness in adult life	Has illness been a significant factor in life functioning? Has patient responded to stress by illness? Has patient always regarded himself as healthy or sick? Has he been over-concerned, under concerned or realistically concerned over illness?
Attitude to loss of physical strength	Defenses against aging process . Realistic acceptance. Regression . Over-dependence . Rebellion . Living in past.
Illness in Family of origin and family of marriage.	Stress related to illness and death of significant family members.

C. The Economic Area

1. Employment

1. Present employment	If any, of what nature? (housekeeping, if any)

2. Reaction to loss of employment or role of mother in family	Was this traumatic? Was this adjustment easy, difficult, moderately difficult?
3. Employment in adult life	1) Laborer - unskilled, semi-skilled. 2) Clerical or "white collar" worker. 3) On own account - eg. merchant, restauranteer, etc. 4) Professional. 5) Housewife.
4. Stability in employment	If any changes, note over work span How many years (roughly) in each type of employment? Changes from one job to another (i.e., in terms of different employers).
	Trends in employment - up or down.
5. Satisfaction in working life	Was patient indifferent, satisfied or dissatisfied? Were patients main interests and satisfactions in the job area? Has patient worked overly hard, moderately hard or been overly casual in attitude to work?

2. Income

1. Income	Sources of income (OAP, savings, relatives, amount of present income, attitude of present income.
Present	Is it a stress factor? How?
Past	Get some idea of level of income in the past - did patient consider it adequate to his needs for himself and family? Has it always been a stress factor? Has income been a source of tension in the family through middle years. If so, in what ways?
2. Financial dominance	Has patient been the financially dominant member of the family. In terms of contribution, in terms of budgetting, shared dominance.

3. Meaning of money to patient and family	
Present	How does it affect present status? Present security?

3. Housing

1. Nature of present housing	Roomer, home owner, living with family, renter .
2. Adequacy of present housing	In terms of space, in terms of facilities (bathroom and kitchen) in terms of location (basement, attic), neighbourhood, etc. i.e., shops, transporation, synagogue, in terms of cost (in relation to income), in terms of physical ability to manage?
3. What stresses are there in housing in addition to above	Relationships with others, over-crowding, landladies, children, etc.

D. The Familial Area

1. Present family	Present family members living - is patient within or without a family? Significant family members to patient? If living with family, what members? If not living with family - extent of contacts.
2. Quality of marital relationship	Close, mutually inter-dependent, unsatisfactory - many tensions nature of some tensions - if so, what?
Present marriage (if spouse is living)	Same as above - tensions due to illness, incapacity of patient or spouse, etc.
If past marriage	Same as above.
3. Breaks in marital relationship	Death, separation, divorce.
4. Age of marriage?	

5. Age of spouse at marriage?	
6. Dominance in marriage	Patient dominant, spouse dominant, dominance shared.
7. Attitude to loss of former family roles, supporting figures	Defences used. Use of regression in memory and fantasy. Fear of helplessness and dependency self-belittling. Protection on to others.
8. Relationships with children (present)	Close, dependent, over-dependent, tensions in relationships.
9. Attitude of children or other family members to patient? (from patient's point of view)	Do children have hostility over giving care or financial support? Do they resent parents in the home? Are there problems over grandchildren? What in general are attitudes of children to patient?
10. Substitute families from patient's point of view	If the patient is living in a substitute family, what responsibilities does family carry for patient? What is the patient's feeling toward family? In what ways does this family fill the role of family?

APPENDIX B

APPENDIX B

SAMPLE INTERVIEW

Patient's Name Address Telephone Number Age Clinic Number

Interviewing Date: March 29, 1956. Worker Language Place

Description of Patient

An older lady with white hair, well-dressed and looking a little younger than her actual age was opening the door for me when I arrived. She had expected me due to the fact that I had called this evening to ask her permission to see her in connection with our study. The patient was dressed nicely and neatly. Patient was very cooperative in sharing information. It seems that her cooperation was due to the fact that she was interested in relating to me some of the feelings she had about older people, and the services which the community should provide for them. Her husband was bedridden and did not participate in the conversation. The interview took place in the living room. I got the impression that this home is very well kept, nicely decorated and I was impressed with the good condition.

A. Socio-Cultural Area

1. Hebrew -- Patient comes from Russia, immigrated to Canada in 1924 after having lived several years in Roumania, Poland and Hungary. Patient and family left Russia shortly after the revolution, due to the persecution which they suffered and this in turn was the result of the war and the Bolshvist uprising in Russia.

2. A) Patient enjoys going to the movies. They have a television set, and she also listens, frequently, to the radio. She borrows books from the Jewish Public Library, in which she finds much interest and also reads the Daily Jewish papers, at the library. In the past few years she has attended lectures at the Jewish Public Library and discussion groups but has gone to them more sporadically in the last year, due to her general weakness. Also, during the summer she attends these lectures

more frequently than during the winter months when it is difficult for her to get outside.

B) During adulthood, patient participated even more in lecture forums and cultural activities. She does, however, mention that this participation had to be refused due to the fact that she cannot get as much walking done as in her earlier years. In the past she and her husband have travelled frequently to the United States, New York and also Chicago, where one of her sons lives.

C) It seems that she gets a great deal of satisfaction out of these recreational activities, even though they are more limited today than they were in earlier days.

3. Not applicable.

4. A) Patient has participated frequently in the activities of the Golden Age club, and these too had to be limited during the winter months, due to the difficulty of her getting to the meeting places. She goes to the synagogue, especially on the High Holidays, and Saturday morning, accompanying her husband, who goes twice, daily, to the synagogue.

B) It seems that here too she has made satisfactory adjustments.

C) Years ago patient was very active in the Parents Teachers Association of the "Folk Shulla", but this as well as the discussion which had taken place, at the school, had to be relinquished, due to the fact that patient cannot get around as much any more, and does not have as much interest in the activities because her children have grown up and she in turn has not kept up with the new educational methods. Patient does, however, accept these limitations as normal ones.

5. A) The friends are composed of two categories, one being the friends who came from the "Old Country" and with whom contacts have been maintained; the other group are the neighbours who live either in the vicinity of the present home or those who lived near the districts in which the patient has resided previously. These friendships are very meaningful and fulfill most of the social contacts and to a large extent the recreational activities.

B) There are no noted changes in the pattern, as a matter of fact the same friendships as in the past are maintained and nurtured.

6. A) The patient as a member of an orthodox family adheres very strongly to the laws and regulations of the religion. The patient goes to synagogue regularly at least every Saturday, but during the winter months this is reduced to only occasional attendance. Patient is also active in the activities of the synagogue, helping out at celebrations.

B) In the past the patient's participation was more active, because "I could get around easier". But nevertheless the attitude the patient has was always a very positive one. She does, however, accept the fact that young people, like her own children and grandchildren do not use the synagogue as a centre of cultural and religious activities.

7. The Russian Revolution and its effects were the reasons for immigration. In Europe life had become unbearable and it was a question of "life and death". The patient also spent several years in Roumania, until finally they could immigrate to this country. The adjustment is seen as fairly easy, especially because of the younger age at which immigration occurred. Also because many of her "Landsman" came at the same time, and they all helped each other to adjust to Canada.

8. The patient has remained very closely identified with her culture in the social, recreational and group activities.

B. Socio-Physical Area

1. Dizziness, anxiety neurosis, menopausal syndrome, ovis hiatus hernia.

2. The patient accepts the aging process as a natural happening, however, says that "everything aches" and she is going to the clinic to hopefully get some relief from these aching pains. There is no mental deterioration of any degree.

3. Illness has not been a significant factor to life functioning, it has only slowed down the speed of the normal functioning; this too is accepted by the patient as being relatively normal to old age.

4. The patient accepts the loss of physical strength realistically. There is no dependency since the patient continues with all previously accepted functions.

5. Not applicable.

C. Socio-Economical Area

1. The patient has always been a housewife and continues in that capacity at the present time. She is in charge of a five person household, after she and her husband had moved in with her daughter and her two children some eight years ago. The patient also claims that, at times, a char woman helps with the chores in the household. The daughter works in a factory, and the older grandchild is employed as an office girl.

2. Not applicable.

3. The patient has always been a housewife.

4. Not applicable.

5. The patient always enjoyed the role of a housewife and follows the pattern which was known to her in the "Old Country". She has never worked outside of her home and always tried to be a good mother.

6. The sources of income for this couple are the Old Age pension and some support from the children. One son lives in Montreal with his family. One married daughter lives in Chicago. The daughter with whom this couple lives seems to share in the economics of the home. Income is only a stress factor, in so far as this couple would like to move into their own home, now that the grandchildren have grown up. However, the patient relates that this might be difficult due to the economical aspects. The patient also relates that it would be desirable if this community could provide small bungalow dwellings for couples or single people, where the problem of walking stairs and cleaning large apartments could be eliminated, and where people of similar interests could live together. It seems that this family has always been in the middle income class, and that there has been no significant change in the economical status.

7. The patient is, as mentioned earlier, living with her daughter and two grandchildren. It is a six-room apartment with lovely kitchen facilities, kept meticulously clean and the patient does all the cooking for the family.

8. The apartment is located in a central shopping area and is easily accessible to transportation. The synagogue is just around the corner. It seems that the living conditions are not stress-producing factors, but on the other hand, there are indications that this might change if the couple will have to move and make their own living arrangements.

D. Socio-Familial Area

1. The patient is living with her daughter and two grandchildren. They came to Canada after two brothers and one sister had made their domicile in this country. However, all three siblings are dead now. There seems to be a close relationship between the children of this patient.

2. The marital relationship seems to have been and still are very satisfactory. The patient spoke very affectionately of her husband.

3. Not applicable.

4. Approximately 20 years of age.

5. Approximately 25 years of age.

6. Dominance in the marriage was shared. The patient relates that her husband's family and her family knew each other in the Old Country, and in this way "their marriage was arranged".

7. Not applicable.

8. Relationship with children is very close, but definitely not over-dependent. The patient indicates that her main source of pleasure is obtained from the grandchildren. It seems, however, that the grandchildren, even though they live in the same home as their grandparents, live quite a different life. This became particularly obvious when the patient mentioned that it would be much better for grandparents to live in their own apartment, now that the grandchildren have grown up.

Summary

This patient is very well adjusted in all areas. She functions most adequately as a mother figure in her daughter's home, where she does all the housekeeping. She is alert and has many satisfactions, particularly from familial life. When weather permits she participates in group and social activities and has numerous friends. Her interests in communal affairs are broad and she is aware of current social problems, particularly pertaining to old age.

APPENDIX C

JEWISH GENERAL HOSPITAL
3755 ST. CATHERINE ROAD
MONTREAL

You have been coming to the Geriatrics Clinic of the Jewish General Hospital for some time. As you know this Clinic was established last September. The doctors, other staff members of the Hospital and the community at large are interested in learning more about your problems and difficulties as an older patient.

A special study to inquire into these areas is being made by the McGill University School of Social Work in co-operation with the Hospital. Since you are attending this Clinic, any information you could give us would be most valuable, and we hope you will give us your cooperation. We assure you that all such information will be kept strictly confidential.

_____ of the McGill School of Social Work will be getting in touch with you in the near future.

The McGill School of Social Work, the Hospital and I personally would appreciate your help with this project.

Yours sincerely,

W. R. Platkoff
Medical Director.

JEWISH GENERAL HOSPITAL
3755 ST. CATHERINE ROAD
MONTREAL

עס אי"ז שו"ן א צ"ם וי" אי"ה קומט ארי"ן און דער ספעצי"אלער
קלי"נ"ק פאר קראנקהי"טן פון עלטערע מענשן פון דעם "די"שן
שפי"טאל. וי" אי"ה וי"סם אי"ז די" דאזי"גע קלי"נ"ק עטאבלי"רט
געווארען דעם לעצטן סעפטעמבער. די" דאקטוי"רים און אנדערע
באאמטע פון דעם שפי"טאל וי" או"ך די" קהלה אלס גאנצעס זי"נן
פארי"נטערעסי"רט צו וי"סען מעהר וועגן א"ערע פראבלעמען און
שוערי"גקי"טן אלס אן עלטערער פאצי"ענט.

א ספעצי"עלע וי"סענשאפטלי"כע אוי"ספארשונג וועגן דעם וועם אי"צט
געמאכט פון דער שולע פאר סאצי"אלע ארבי"ם פון דעם מעקגי"ל
אוני"ווערזי"טעט צוזאמען מי"ט "די"שן שפי"טאל. אזוי" וי" אי"ה
באזוכט די" קלי"נ"ק, וועם די" אי"נפארמאצי"ע וואס אי"ה קאנט אונז
געבען זי"ן זי"ער וי"כטי"ג און מי"ר האפען אז אי"ה וועם מי"טארבי"טן
מי"ם אונז, מי"ר פארזי"כערן אי"ך אז די" אי"נפארמאצי"ע וועט געהאלטען
ווערען שטרענג פארטרוי"לי"ך.

פון דער שולע פאר סאצי"אלע ארבי"ם
פון מעקגי"ל וועם זי"ך שטעלען אי"ן פארבי"נדונג מי"ט אי"ך און
דער נאהנסטער צי"ט.

די מעקגי"ל שולע פאר סאצי"אלע ארבי"ם, דער שפי"טאל און אי"ך
פערזענלי"ך וועלען אפשאצען אי"ער הי"לף אי"ן דער דאזי"גער ארבי"ם.

מי"ט כבוד

W. L. Platkoff

מעדי"צי"ני"שער די"רעקטאר

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