For now, however, my life is very much in process, full of opening new doors while looking back at old and treasured experiences. My past gives my present a richness and a backdrop for the exploration which is happening in the present. Almost every value and belief I have held is up for reexamination and reevaluation.

In speaking of my old age, I once declared with some disappointment that I have not miraculously arrived at a state of grace or of wisdom, that I am still in process. This, then, is perhaps the greatest miracle of all. That so long as there is life, there is the possibility of growth and change. Old age provides no guarantees but death. However, it does provide us with a special gift, the final challenge and the final opportunity to grow up.

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The Myth of the Golden Years: One Older Woman's Perspective

Marcelle R. Adolph

SUMMARY. Adjusting to old age requires more than coming to terms with eventual physical decline. It also demands accepting the permanent loss of loved ones. This autobiographical account describes both positive and negative experiences during the seventh decade of life. My coping skills have been enhanced by previous employment as a mental health professional. As an older woman, I have been forced to become my own social worker, acting on my own behalf with medical and other bureaucracies. And, as a retired social worker, I have the ability to evaluate the skills and limitations of those care providers who have been called upon to assist me in coping with the problems of old age.

According to the popular press, the Baby Boom Generation perceives age 40 as "over the hill." Inspection of contemporary greeting cards confirms this impression. Cards for 16 and 21 year olds suggest that these birthdays are cause for celebration; those for the middle-aged and elderly allude to failing memory, decreased sexual abilities, and diminished vigor and attractiveness, all in the guise of humor. Clearly, ours is a culture which considers getting older to be a cause for mourning.

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Being told you look young is a compliment whereas wrinkles and sags are cause for depression. I can recall when one of my close associates in a women's organization told me that she could not believe that I was in my late 70s. After overcoming her shock, she told me that perhaps my curly hair made me look "younger than my years." I later learned from a mutual friend that this woman had coped with aging by having a face lift. A related experience took place at my orthopedic shoe store. While trying on oxfords, another older woman complained about the "ugliness" of comfortable shoes. She remarked: "My husband wouldn't let me in the house with these shoes; How could I wear these grandma shoes?" The poor woman had hobbled into the store with a cane, wearing silly little pumps. Her ankles, instep, and lower limbs were puffed up like balloons. She had been willing to cripple herself for the sake of appearing youthful.

Lest I give the impression that I am free of internalized ageism, I must admit that I continued to see myself as a middle aged woman (certainly not elderly) until I was in my 70s. Even now, I am reluctant to seek services or activities that are designated specifically for elderly persons.

When did I first come to terms with aging? When did I first realize my needs had changed? Age-related changes first became obvious when I retired from my career as a psychiatric social worker on my 70th birthday. Looking after myself and my husband became a full-time job; my life and self-image underwent enormous changes. What had once been identified as just normal aches and pains now was diagnosed as arthritis. Cataract surgery was necessary so that I could maintain my vision. I began to move more slowly; my sleeping patterns changed. The most enormous and traumatic change in my life was the onset of serious illness in my husband–a fast-moving, painful, and debilitating form of cancer which resulted in his recent death.

MOURNING AND THE AGING PROCESS

Prior to my husband's death and my 77th birthday, I had noticed that my arthritis had taken a turn for the worse. My internist prescribed a medication which combined a tranquilizer with a pain killer. The drug failed to relieve my symptoms. I then sought the assistance of a rheumatologist who diagnosed my condition as Polymyalgia Rheumatica. What a romantic-sounding name for a crippling disease! I could no longer climb stairs or turn in bed. My mobility was greatly impaired. Every part of my body ached; the pain was frightening. My late husband had to pull me out of bed and out of chairs. I was afraid I would end up either bedridden or in a wheel chair.

Shortly after a new medication enabled me to recover from a severe bout with my arthritic condition, my husband developed several medical symptoms. I was deeply concerned. He no longer seemed to have an appetite, coughing constantly and appearing to choke while eating. My husband was unable to swallow normally. His rapid onset of symptoms was swiftly followed by excessive weight loss. Always reluctant to seek medical assistance, I finally convinced my husband to be evaluated by a physician. He was hospitalized immediately, diagnosed with endema carcinoma (cancer of the esophagus). I asked my daughter to fly to Chicago to help us out. I was in shock, distressed about his rapidly deteriorating condition and worried about our future.

The medical team informed us that my husband had a very serious form of cancer and that death would be both imminent and excruciating without immediate treatment. Surgery was recommended but the prognosis was guarded. The typical patient with the kind of cancer my husband had lives only one or two years after removal of the esophagus.

According to the surgeon, my husband's operation was "a great success." He was told that he was fortunate to be able to return home in less than three weeks and was led to expect that he would be able to eat and swallow in a nearly normal fashion after a short period of time. I arranged for help from an agency that provides home care for chronically ill patients. Every day, a certified nursing aid came to our apartment to assist my husband and me. Care was expensive, and my daughter wondered out loud how long my husband and I could afford this service. The extended family was also anxious because before his illness, my husband had assumed many household duties that I was unable to do because of my arthritis. It became clear that I needed to employ a housekeeper regularly as well as maintaining the nursing aid service. All of this placed additional strain on my limited finances.

Within two weeks of his return from the hospital, my husband's distressing symptoms returned. He lost weight, no longer had an appetite, and began to choke and cough for hours at a time. He was unable to sleep sufficiently as a result of his deteriorating health. My nights were sleepless, too, as my husband needed constant care, and the nursing aid service was limited to the daytime hours.

The surgeon examined my husband once after his return from the hospital. He was diagnosed as having pneumonia but the medication he was prescribed only made him worse. Later, my husband visited his personal physician from our health maintenance organization (HMO). Although he was all skin and bones and could barely catch his breath, the internist declared enthusiastically: "Mr. Adolph, you look just wonderful!" I could hardly believe my ears. "My husband has pneumonia," I insisted. "Oh no," she replied following the most superficial chest exam, "He just has a touch of bronchitis."

I could hardly wait to get out of her office. Later, the internist called me at home to apologize. She had checked out my husband's condition with the surgeon and realized she had made a diagnostic error. I was enraged and wanted more than anything to tell this woman off. But, I bit my tongue, and politely thanked her for calling. This was one of many instances in which I experienced anger because the needs and insights of elderly persons seemed to be overlooked by those who controlled the health care system.

My husband's condition worsened. Instead of coughing up phlegm, he began to cough up vital fluids, bits and pieces of his own body. He suffered from terrible diarrhea and was humiliated by his inability to take care of himself. Finally, the Sunday before my husband's death, I called the emergency services of our HMO in desperation. I described my husband's continued deterioration. I finally reached his internist, doing my best to convince her of my husband's need to be hospitalized. In the background, my husband shouted, "I won't go to the hospital; don't make me go!" Instead of acknowledging that these were the words of a frantic man who never sought medical attention even when he needed it the most, the internist acted as if my requests for help lacked legitimacy. "There's your answer," she replied. "Clearly, your husband does not want to go to the hospital." It appeared that the economics of the HMO carried greater weight than did the medical and psychological needs of the elderly persons served by that organization. It simply wasn't cost-efficient to hospitalize my husband.

I could not accept the indifference of my husband's physician. I continued to argue with her, explaining that I could not manage him at home any longer. Finally, she agreed to allow a home care nurse to evaluate my husband's condition the next morning. The nurse arrived after another frantic night of caring for my desperately ill spouse. As I expected, the nurse knew she had to arrange for an ambulance immediately. After one quick look, my husband was on his way to the hospital. Never again to return home, he died four days later.

How can I describe the anguish and pain of seeing my life-long companion suffer and die so painfully? Had he lived a short time longer, we could have celebrated our 50th wedding anniversary and his 75th birthday. We held each other in his room; he comforted me while he lay there dying.

My husband's death came so quickly that our daughter was unable to fly back to Chicago in time to share her love and final farewell. At first, all I could do was talk to her on the phone. The hospital staff called me at 2 a.m. to tell me that my husband had died. They demanded that I come there immediately to help them with the necessary bureaucratic paperwork. Going there for the final time was terrifying. And everyone was so distant and professional, the setting so sterile and cold. I was asked to sign forms for death notices and other papers. No one was there to provide me with emotional support. But, at least I had a chance to see my beloved husband once more, to kiss him once more, to tell him how much I adored him, to say goodbye to someone I never imagined living without.

The next day I had to arrange for funeral services. To add to my pain and distress, my husband's sister announced that she would not join our immediate family in mourning. Extremely orthodox in her religious beliefs, she had decided that we (as Reform Jews) would not mourn my husband properly and therefore elected to "sit shivah" (or pray for him in the Jewish tradition) in her own home, with her own friends at her side and my immediate family left out of the picture entirely. I felt abandoned.

SUPPORT SYSTEM

During the funeral and afterwards, my daughter, brother, and his wife were very supportive. But, eventually they had to return to their homes in distant cities. I wasn't sure how I would handle my grief and new responsibilities without their assistance.

True, I still had a local support system. I received a great deal of continuing affection and assistance from close friends in Chicago, some of whom have been in my life for many decades. But, all their support didn't seem to be enough. I didn't think I could ever get over my grief. It didn't seem possible to go on without my husband.

I became extremely depressed, chronically anxious, almost in shock. I experienced an inner numbness, anger, loneliness. I didn't know how to fill my days at the same time that my life seemed overwhelmed with daily tasks. I was having difficulty coping. I was afraid of losing my sanity. I lost 25 pounds, was unable to sleep, frequently felt dizzy, and had a wobbly gait.

SPIRITUAL GUIDANCE

I was fortunate to have a compassionate and intellectually gifted rabbi speak at the services honoring my husband. My daughter convinced me to join his congregation to help me deal with my grief and loneliness. For the first time in my life, I attended religious services regularly. Judaism provided comfort as I began the mourning process, helping me renew commitment to life, assisting me in extracting a sense of meaning from the death of my beloved.

At first, the temple was the only place in which I could feel balanced and whole. I looked forward to shaking the Rabbi's hand at the end of each Friday service; his warmth, as he greeted each worshipper, was sustaining. After one particular service, I asked the Rabbi if he knew of a widow's support group. He was able to provide the name and telephone number of a social worker who anticipated beginning such a group.

I attended three sessions of the widow's group, but unfortunately, sciatica set in and I was unable to complete the six-week series, confined to my apartment by extreme pain. In hindsight, the missed sessions were not a complete loss. Group process had been disappointing. I was the most recent widow in a group which included women who had lost their partners one or more years ago. Initially, I had the fantasy that more experienced widows would show me how to regain good psychological adjustment. I was wrong. Apparently there is little truth to the cliche, "time heals all wounds." All around me were terribly unhappy women. Where were the role models I needed?

Religious services continued to challenge me psychologically and spiritually. I found myself becoming very depressed during one Friday night service. It had been a struggle to travel to and from the temple. It was cold and bleak; the rain had been pouring down in a deluge. After the Kaddish (the part of the service during which dead loved ones are recognized), I began to lose emotional control. It took all the strength I could muster to sit through the entire service. When the Rabbi asked how I was feeling at the end, I could barely speak. Tears rolled down my cheeks as I suppressed sobs. Rushing out of the Temple, I grabbed my very wet raincoat and hat. I simply could not control myself any longer. My stomach tied in knots, I screamed out my pain during the three block walk home. Crying profusely, I cursed my husband for leaving me to fend for myself in a lonely, cruel world.

I wanted to get through this pain on my own. So, when I got home, I elected not to call family, deciding instead to watch a frivolous movie on television about Knute Rockne, the famous football player and coach. Somehow, it was comforting to remember that Rockne had been a student at my high school. Oddly enough the film served a therapeutic end. I realized that I could nurture myself; I slept well that night for a change.

CRISIS

My life took a turn for the worse when an attack of sciatica incapacitated me just two months after my husband's death. On top of polymyalgia rheumatica (my form of arthritis), I now had additional pain. I could hardly move. Sobbing on the telephone, I cancelled a Thanksgiving trip to see my daughter a day before departure. Nothing could stop me from sinking into depression.

Thanks to two long-term women friends, I did not spend the holiday alone. But, after a delightful Thanksgiving dinner with their loving extended family, it was back to the reality of my aching body and empty apartment. Worse yet, I was too weak and disabled to be able to see my new therapist, a warm, skilled clinical psychologist employed part-time by my HMO. Home visits, even appointments longer than one half hour, were ruled out by budgetary restraints. Here as throughout the American health care system, economic priorities prevailed over the psychological needs and physical limitations of elderly patients like myself.

I was unable to walk to religious services, shop for myself, or attend organizational meetings. My telephone and the television became my sole source of social interaction. All the gains I had made in recent weeks seemed to erode before my eyes. Alone, I lost additional weight and slept poorly. I rarely ate a decent meal, becoming increasingly obsessed with my misfortunes. I found myself calling my daughter and brother more frequently, often several times a day and late at night. Although I sought their advice, their words failed to comfort me.

I was frightened, confused, and indecisive. I began to think about suicide. How could I go on without my husband? How could I manage with physical immobility and relentless pain? Didn't anyone care what happened to me?

Terrified, I called my daughter early one morning to tell her how upset I was. She recommended a brief stay in a psychiatric hospital to help me get out of my depression and begin to put my life back into perspective. I was very disappointed and let her know it. Initially, I had wanted her to fly back to Chicago immediately to be at my side. I knew she was very busy with her college teaching, but I couldn't help but feel abandoned. Didn't she know what an emergency this was for me?

In time, I came to terms with my depression. The belief that my daughter's personal presence would magically make my problems disappear was soon replaced with a more realistic one. I accepted

my need for professional psychiatric help. This is no easy insight for a retired mental health professional!

I will never forget the Monday that I sought psychiatric in-patient status. The day proceeded like a black comedy. I was so helpless and distracted that my daughter had to repeatedly tell me exactly what to pack just in case I was admitted. My dear friend, another older woman, finally arrived to take me to the hospital. Because she had poor vision and could not drive on expressways, it seemed to take us forever to get to the emergency room. When I finally arrived, the nursing staff was unaware of my daughter's many long-distance telephone calls, informing them of my condition and anticipated arrival. Nobody seemed prepared to help me.

Staff at the very hospital I had served as a psychiatric social worker made it clear that since I was affiliated with a HMO, I would have to undergo several hurdles before I could be considered a potential psychiatric in-patient. First, I had to be relocated to another part of the hospital to be evaluated by a psychiatrist who was employed by my HMO. Before transport, they locked me in an isolation room without a chair to sit on. What a stressful place for an elderly woman who was crippled with arthritis and sciatica! As I was too shaky to walk to my interview, they had to escort me to my appointment with the psychiatrist by ambulance.

I began to cry profusely, complaining bitterly to the guard that I was being treated more like a prisoner than a patient. My bladder felt full. I asked to go to the washroom. But, the security guard insisted that I could not leave the room. I cried and moaned but to no avail. Finally, the guard looked at me anew and said, "I think I know you." Yes," I said, "I worked here for 19 years." When I explained I was a former employee, the guard relented and permitted me to go to the washroom.

Next, I learned I was completely on my own for the duration of this ordeal. The friend who had brought me to the hospital needed to return home. After a 15 minute wait, a psychiatrist called my name. Showing empathy for the stresses that I faced as a widow, he seemed to understand how difficult it was to live alone for the first time in my life, to be isolated from my closest relatives. He actively listened to my angry feelings.

Frequently, I was asked if I had a plan for ending my life. Although I was very emotional, I had to admit that my suicidal ideation was somewhat vague. "No, I didn't have a plan. No, I had never made an attempt on my life." Instead, I explained that "I just didn't seem to have a reason to go on living, that life without my husband was unbearable." I shared my death fantasy: somehow, painlessly, it would be possible to go to sleep and never wake up again. As depressed as I was, my capacity for rational thinking must have come through. "Mrs. Adolph," the psychiatrist explained, "You are not disturbed enough to be a psychiatric in-patient." Apparently, my HMO wouldn't pay for hospitalization unless I was stark-raving mad, dangerous to myself or others.

The psychiatrist suggested medication to alleviate my depressive reaction and suicidal thoughts. I was prescribed a low dose of Elavil. After our meeting, I felt much better. The emotional catharsis had a healing effect. I called my daughter to inform her that I had returned home, proud that I had managed a cab ride by myself despite the traumas of the day.

The night after my vain attempt to get hospitalized, I slept well. My conditioned worsened after I began taking Elavil, however. Soon, I found myself to be quite agitated; I could barely contain my rage. I pounded the bed and pillows with my fists. I was verbally abusive to my brother and daughter, calling them to inform them that they had completely failed me. The medication was making me crazy.

Somehow, I got the energy to complete needed errands, depositing and cashing checks and shopping for groceries. When I got home, I was still very agitated. I decided to wait it out. Again, silly television programs had a therapeutic effect. After two hours of viewing I was in control. I called my psychiatrist to inform him that I could not continue using the medication he prescribed. I was beginning to come out of the depression on my own; I preferred my own resourcefulness to the chemical complexities of medication.

SELF-HEALING

I don't want to give a falsely negative picture of what it means to grow old and especially to be widowed. The crisis of my depression was the precursor to a healing process. I have regained a sense of

control and pride. I can see a purpose to living, loving, and relating as a newly single, older woman. Although my health problems and financial limitations cannot be ignored, they need not deny me access to independence or happiness.

I realize now that I was wrong to expect others to drop everything to look after me. I am at a point where I can accept help from friends and family while continuing to see myself as a resourceful person in my own right. How grateful I am for the love and assistance I get and receive from my warm support system. I think about one friend I have known for over 50 years in particular. When I was ill, this loving woman shopped for me, visited, and called regularly despite her own chronic health problems, restricted mobility, and economic limitations.

I am grateful, too, for everyone in my support system: the delivery man who brings me the groceries I can no longer carry home on my own, my landlords who look after every need of daily living and provide me with the continuing warmth of friendship, my many friends and loving relatives, and my vivacious cleaning lady who keeps my house tidy while rewarding me with ample hugs and kisses.

It is exciting; I am learning new things. For the first time in my life, I am in charge of finances. I am grateful to my daughter who helped me develop an efficient system for paying bills while arranging for a financial advisor to help me make prudent decisions regarding investments.

Various bureaucracies continue to present me with challenges. First, there has been the long process of negotiating with insurance companies and changing bank and credit accounts to my name. More frustrating is the continued deluge of bills and correspondence regarding my husband's medical treatment. Fortunately, my training as a social worker helps me deal with these hassles.

Writing this article has been therapeutic too, as have been continuing sessions with my clinical psychologist and psychiatrist. Although starting the paper felt like getting my teeth pulled without benefit of anesthesia, getting my experiences down on paper has facilitated insight and personal growth. I am glad that my daughter hounded me to write this; I am grateful to her for typing and editing my work.

Some of my memories are so painful and fresh. I have spent several sleepless nights as a result of writing–recalling the death of my beloved husband, my loneliness, and the pain of my illnesses. But, each day I mourn a little less and feel a little more alive. I realize now that loving and honoring my husband does not require me to give up the possibility of happiness. My background as a social worker helps me appreciate my struggles with aging, failing health, and loss. I am committed to the good fight of working through my grief while embracing life anew. Now, more than ever, I understand that activities, interests, and doing things on my own behalf are essential. I have rediscovered the pleasure of my own company and that being alone doesn't mean I have to be lonely.

Body Image Issues of Older Women

Joan C. Chrisler
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SUMMARY. Psychological researchers have all but ignored body image issues of mid-life and older women, and medical researchers have limited their concern to the impact of surgery or chronic disease on body image. The purpose of this article is to point out that body image concerns are not restricted to eating disordered clients and can occur in women of any age. The impact of various aspects of aging on body image is described, and implications for the practice of feminist therapy are discussed.

Body image can be defined as "an individual's appraisal of and feelings about the body and its function" (Cornwell & Schmitt, 1990); it is the "internal, subjective representation of physical appearance and bodily experience" (Pruzinsky & Cash, 1990). Body image is an important part of our self-concept and, as such, provides a basis for our identity. It acts as a standard that influences not only the way we think of ourselves, but also our ability to perform various activities and the goals we set for the future (O'Brien, 1980). Although body image does not alter from day to day, it should not be considered "fixed or static" (Pruzinsky & Cash, 1990). It develops throughout life as a result of sensory and behavioral experience, physical appearance, somatic changes, societal norms, and the reactions of other people (O'Brien, 1980).

In recent years body image has become a hot topic in both the

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