SOCIAL ASPECTS OF AGEING AND SENILITY.*

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THE object of my study was an attempt to discover what social factors might be said to contribute to either mental health or mental ill-health in old age. I studied the histories of four groups of 50 aged in four different settings which in retrospect might be said to form a spectrum. That is to say that each subsequent social background seemed to be more conducive to normal ageing than the preceding one. The actual sequence of the whole investigation, for technical reasons, was, however, as follows: In the first place I made contact with patients in Tooting Bec Mental Hospital; as a second group I chose people in a Club for Old Age Pensioners in Streatham; thirdly, I visited old people living by themselves in Fulham; and finally, I interviewed a group who are living on an Estate at Mill Hill, the Estate being maintained by the Society of Linen and Woollen Drapers. In all but the last sample I studied the cases of 25 men and 25 women.

I shall talk in greater detail about the first of these groups, and give my general impressions of the findings of the three remaining samples. The method of study employed in the Tooting Bec group differs in one essential point from that used with the aged living in the ordinary community. As the majority of the mental patients were too ill to give information themselves, their life-histories had to be pieced together from such heterogeneous sources as wives, husbands, relatives, landlords, relieving officers, hospitals and public assistance institutions. In the three other groups the old people themselves were the sole informants. The Tooting Bec sample consisted of 50 patients consecutively admitted during the period between November and December, 1943. The investigation was begun almost immediately after admission, and the cases were followed up for four months. With the exception of one younger man, the ages ranged from 65 to 87 for the men and from 68 to 91 for the women. Fifteen cases had been diagnosed as suffering from uncomplicated and 15 from complicated senile dementia, 13 from arteriosclerosis and hypertension, 6 from confusional states and 1 from pellagra. Twenty men and 12 women had evidence of generalized arteriosclerosis.

The basis for the inquiry was the scheme for social histories in use by psychiatric social workers. For obvious reasons more detailed data were available only for the later years of life. I followed up the progress of the patients with the help of the nurses, personal interviews and observation.

The basic assumption of the inquiry was that apart from organic cerebral changes incident to old age, social influences operate which are directly related

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to senility and senile psychoses. The data were analysed with reference to a schedule, the items of which represented my hypotheses regarding the importance of certain social factors. The social factors which are dealt with in the following account are:

1. *Social integration* as it is affected by (*a*) war conditions, (*b*) by a general change of attitude of children towards their parents, (*c*) by temperament and character, and (*d*) by excessive consumption of alcohol.
2. *Previous occupation and present activities.*
3. *Financial security.*
4. *Diet.*
5. *Infirmities, and the incidence of social integration.*
6. *Nationality of patients.*
7. *The effect of air raids on physical and mental health, and the effect of air raids which resulted in change of habits and accommodation.*
8. *Critical occurrences not due to bombing.*
9. *Previous mental history.*
10. *Ultimate social failure.*

Now to the first item of the schedule, namely *social integration*. It was assumed that old people, like every other age-group, have basic needs which, if they are not satisfied, lead to mental ill-health. The most important of these seemed to me to be normal human contacts and the feeling of being a useful member of society. This was termed social integration. Social integration was taken to have been achieved in cases in which at the time of the onset of the mental illness husband and wife were living together, or if widowed, they lived with children or relatives. In the case of single women and men, they were considered to be socially integrated if they formed part of the unit in which they found themselves. Non-integration, on the other hand, was supposed to be present if single women lived by themselves, against their own wishes. 36 per cent. of the women were single, 8 per cent. married, 8 per cent. separated and 48 per cent. widowed. 24 per cent. of the men had remained single, 28 per cent. were living with their wives, 8 per cent. had been separated for long periods of time and 40 per cent. were widowed.

I distinguished three categories of integration. Only 20 per cent. of the women patients and 28 per cent. of the men patients could be considered as socially integrated. 12 per cent. of the men and 12 per cent. of the women were to a limited extent integrated into the life of the community. They were tolerated by their children with whom they lived, but did not enter into the young people's activities. (More detailed descriptions and examples of the patients investigated can be found in an article by A. J. Lewis and H. Goldschmidt* in *The Sociological Review*.)

Among 68 per cent. of the women patients and 60 per cent. of the men, social integration was to a large extent lacking. Before their admission to Tooting Bec Hospital they were either living alone or in Public Assistance and

* Lewis, A. J., and Goldschmidt, H., "Social Causes of Admissions to a Mental Hospital for the Aged," *The Sociological Review*, **35**, Nos. 3 and 4, July–October, 1943.

other Institutions, and in lodging-houses of the Rowton House and Salvation Army variety. It should be noted that patients do not enter Public Assistance Institutions with enthusiasm. This is partly due to the popular conception about them, but is also based on the knowledge that their social activities would be curtailed and restricted, even though a group of contemporaries would be living under the same roof. Hence they only enter Public Assistance Institutions when no other alternative is available, when in fact their integration in the community outside is non-existent.

The adverse effect of the War on social integration was demonstrated in only two cases. 32 per cent. of the women and 28 per cent. of the men who lived by themselves might conceivably have lived with their children. The majority of the children, who were of the working class, did not consider that they could be expected to support their parents, in view of the higher cost of living of this generation. This attitude seems to indicate a growing tendency for the aged not to be supported by their own families, and it is a matter for further investigation whether the facilities provided by the community for the care of its aged can compensate for the loss of the emotional satisfaction of being part of a family unit. I will discuss this point further when I talk about the Club in Streatham.

Another very important factor which adversely affects social integration is character and temperament. Of 15 men living alone, 10 had personality difficulties, and of 17 women, 12 showed similar defects of personality. Such difficulties, besides preventing a successful integration into the family, may also, according to some authorities, point to a tendency towards senile psychosis.

Some of the cases were known to have consumed alcohol to an immoderate degree. Their children were ashamed of their parents' weakness, and were not willing to have it known that there was a close relationship between them.

In 17 cases of men and in an equal number of women little or no interest was shown in their welfare by other people. It would seem, therefore, that social integration was markedly absent in the group studied.

We now come to the second item—*previous occupation*. It was thought that it might be found that physical disability comes on sooner in manual workers than in the more privileged classes of the population. The majority of the male workers in our sample had pursued occupations in the lower income class; 9 who were unskilled had worked as carmen, stevedores, dustmen, navvies and the like; 12 semi-skilled workers had been employed as shop-assistant, publican, etc., and 4 skilled workers as clerks and foremen. Our findings did not indicate that there was a relationship between the age of retirement and the skilled or unskilled nature of the work.

A further possibility was that termination of active work often leads to impaired mental and physical function. There did not seem to be a close association between the beginning of the mental illness and the date at which the individual ceased work, except in three cases. These three patients seem to have suffered in facing the fact that they had to make way for people younger than themselves.

The men's activities and interests after they had given up full-time employment were then examined in the light of the hypothesis that to maintain

mental health, every person must at all times have some form of worthwhile activity. Only 20 per cent. of the men had performed certain duties, but none of them had belonged to any club or taken part in social or religious activities. Only one man was known to have gone to the cinema. 72 per cent. of the women had been employed in some form or other of domestic service, and all but two, who had been in Public Assistance Institutions for long periods, remained active in their homes until their admission to Tooting Bec Hospital. Three had been interested in Church activities. It was apparent, therefore, that after regular work had ceased, the majority of the patients had no other activities to take its place.

The next basic need investigated was *financial security*. The criterion of insecurity was that an individual's income at the outset of the mental illness was considerably less than during the previous decade, or that he or she had been entirely dependent on the support of another individual, a dependence which they were known to have resented. For all the patients the difference between their working income and the old age and supplementary pensions was negligible, as they had been earning small wages. Nevertheless, the change from earned to unearned income created a difficulty, mitigated, no doubt, by the fact that the pension was theirs by right and would continue whatever happened. 20 per cent. of the women were financially insecure, and 40 per cent. had no income other than old age and supplementary pensions. Economic difficulties were present in two of these cases. 36 per cent. of the men were financially insecure, and half of these had felt keenly their dependence on others. 20 per cent. of the men, apart from those in pensionable employment, had made some provision, albeit inadequately, for their old age. Taking the group as a whole we find that 25 per cent. were financially insecure.

Closely linked to financial security or insecurity is the individual's *diet*. Of the six patients whose diet was deficient, four reported that this was due to a shortage of money, and two, it appeared, had deteriorated mentally to the extent of neglecting to feed themselves. Two of the women showed signs of malnutrition.

The question of the patients' *infirmities* was considered to be another important factor in the possible causation of their mental illness. 28 per cent. of the women were either totally blind or had progressive loss of sight, and 20 per cent. of these were not socially integrated. The effect of this infirmity on their personality was very considerable.

Three of the women had had a hemiplegia, two were epileptics, four were severely handicapped by deafness and two by arthritis. With the exception of two, all of these lived alone.

The proportion of infirmities to non-integration among the men was somewhat more favourable. 20 per cent. of them were blind or nearly blind, and 12 per cent. of these had been adequately cared for. The same was true of the seven men who had hemiplegia. Only one of the three men who had become deaf had no one to look after him.

It is reasonable to consider foreign nationality amongst the aged, as having results similar to an infirmity. This is particularly noticeable when communication of ideas is made almost impossible because of language difficulties.

One patient of Greek nationality showed this " infirmity " to a marked degree. The stress caused by the non-acceptance of the foreigner in the English community was an even greater difficulty in five patients. Prior to their entry into the Mental Hospital some of these had been compelled to live in Public Assistance Institutions, away from their own small community which spoke their own language. We find, therefore, that 66 per cent. of the total number had an infirmity other than their mental illness.

With regard to *the effect of War conditions*, three men and three women seemed affected by the raids, but all the three women had previously been treated in mental hospitals. Injuries sustained during bombing had indirectly led to admission in three instances. The dislocation due to the loss of home and other changes caused by bombing were a disturbing factor in 12 per cent. of all cases.

It will be realized that as the investigation took place in the fifth year of the War, when London was relatively free from air raids, fewer factors directly connected with the War had affected the conditions of the patients. Other " critical occurrences " had included change of accommodation not due to bombing, loss of spouse and close friends of similar age.

Before discussing the ultimate social failure which made admission to Tooting Bec Hospital imperative, I want to refer briefly to the ***previous mental health*** of the patients. As already mentioned, three women and two men had previously been treated in mental hospitals. Defects of personality reported by the relatives of the patients on numerous occasions fell into two categories, the domineering and the over-timid personality. 52 per cent. of the men and 56 per cent. of the women had shown one of these characteristics, and it became plain that the majority had been ill-adjusted and difficult people. Many of the patients had been of a distorted and psychopathic personality the greater part of their lives. As they grew older those around them noticed the usual signs—poorer memory, garrulousness, a tendency to reminisce and so on. There was no appreciated need to intervene in the patients' affairs until they did something which indicated gross psychological deficiency and it became evident that they could no longer be tolerated in a normal society. Various social lapses were responsible for the decision to place them in a mental hospital. Six patients (4 women and 2 men) who previously lived in Institutions became a nuisance by getting into each other's beds. Nine men and two women caused annoyance to neighbours by accusing them of murdering someone, by damaging property, shouting and shifting furniture in the night. Wandering, often coupled with restlessness at night, was responsible for the admission of eight men and eight women. Three men and one woman had attempted or seriously threatened suicide ; in some instances this was associated with homicidal inclinations. Four patients got into trouble for indecent behaviour. Violence was reported in five cases. In the case of one other man who had been punished for trespassing on a number of occasions, the final misdemeanour was defrauding the railway of his fare. While on remand he was found to be suffering from cerebral arteriosclerosis. 28 per cent. of the male patients died within 6–25 days of their admission to the Hospital, and 12 per cent. of the women died within 3–46 days. Of the 32 per cent.

of the male patients whose condition improved greatly in Hospital, 20 per cent. had been living alone; so had the three women who improved appreciably. 24 per cent. of the men improved slightly, and of these 20 per cent. had been living alone. Of the 40 per cent. of the women in this category, 16 per cent. had been socially integrated. The condition of four men and nine women remained stationary or deteriorated. Two men left hospital again during the study; one of them had not improved, and one woman who was discharged had at that time no symptoms. It follows, therefore, that it would be a mistake to infer that because patients are admitted to Tooting Bec Hospital, the prognosis must invariably be unfavourable. In some cases the improvement, especially in their social attitudes, is such that they are enabled to leave hospital and to resume their lives outside.

The setting of the next group of aged, which I studied in the Darby and Joan Club for Old Age Pensioners in Streatham, seemed to me to provide one answer to the question of "how to add life to years as well as adding years to life." The sample was similar to the Tooting Bec group, not only in social and occupational status, but in many social, material and psychological privations, which in some degree face all ageing people in a changing society. In this sample and in the two subsequently studied I tried to obtain information on the social and medical history, as well as statements on the old people's attitudes towards social aspects of ageing and old age proper. I shall not be able in the time at my disposal to discuss the findings in detail, and will therefore only refer to the characteristics of each sample.

The Club consists of 1,100 members and is open six days a week. It provides meals and has facilities for recreational and occupational activities. I visited the Club fairly regularly for about five months, and came to the conclusion that the concept of social integration as defined in the Tooting Bec study must be broadened, to include integration into a community such as is presented by the Club. In many instances where family relationships were either strained or non-existent, the emotional cross-currents which it was possible to develop in the Club seemed to compensate and more than substitute for family ties. The beneficial effect of the Club atmosphere was particularly noticeable in those few cases in which there was evidence of a certain amount of mental deterioration combined with personality difficulties, the latter being largely responsible for lack of integration in their homes. The Club had obviously had a delaying effect in the one case in which a mental breakdown occurred during the study, necessitating admission to Tooting Bec Mental Hospital. When I visited the man in Hospital he at once identified me as the lady who had catechized him, and said he longed to be back at the Club.

People in the Club can function on their own level, and are not compelled to compare themselves constantly with people of a younger generation. I must state here that the Club members had at first been reluctant to join because of the effort needed to make new contacts, but they soon perceived that the Club provided what they needed most, the background for a satisfying way of life in which they could find self-expression. That this Club fulfils a real need was exemplified by the conduct of many members, but one case seems to me particularly relevant:

A lady, aged 85, severely handicapped in walking by an inoperable hernia, which was very noticeable, and further enfeebled by heart trouble, made her way to the Club regularly every day, in rain, hail or snow, and during the flying bomb attacks, which were particularly fierce in this neighbourhood. She had a tram ride of at least 15 minutes to reach the Club. To see her smiling face in the Club one need never have known that when at home she suffers acutely from the fact that she is unwanted in her son's family, and not allowed to venture forth from her room into the family circle.

Even more striking was the fact that the Club could transform—if only while in its precincts—the outlook of its members towards their material problems, making them seem less acute. This is best illustrated by the case of—

Mr. H—, who was infirm because of gastric and bronchial disease and double hernia. When interviewed in the Club, he declared himself satisfied with life. His cheerfulness and popularity in the Club would have rendered any other conclusion unlikely. When he was subsequently seen in his own house he talked of little else but his difficulty in making ends meet, and the strain imposed upon him by his complaint.

The attitudes expressed by the Club members, like those expressed by people in the other samples, threw many an interesting light on the social problems of ageing as seen by the ageing people themselves. Of particular significance seemed to me their reaction to present employment and retirement policies which are based on chronological age alone. Their attitude can partly be summarized by the vivid statement made by George Lawton* that amongst the peoples of the world the treatment of the aged varies. In some countries the aged are actually killed when they show signs of incompetence ; in other parts of the world indifference is shown towards them and their problems, and some peoples provide them with a degree of social care. The attitudes reflected by these types of behaviour towards the aged co-exist in our society. When men and women reach a given age they are executed vocationally and socially, not because they are incompetent, but because it is assumed that senility starts punctually when they reach their 65th birthday. When they are figuratively speaking " dead," society's attitude changes from indifference to solicitude about their welfare.

I will now refer to only one other of the attitudes expressed by the people in the Streatham sample, that towards housing and life with children and relatives, because these social aspects are inseparably linked with social integration. 68 per cent. of the men and 76 per cent. of the women did not wish to live with their children or relatives, and preferred to live either alone or in a Hostel. In the statements of almost all of these people there was an undertone of inadequacy in relation to their children. The old people recog nized the importance of being young, and " they seemed to have grown accustomed to contrasting old with ' young ' instead of with ' new '." But one could not escape the impression that what the people felt about living with their children was coloured by their Club membership, which had given them a new independence, and changed their views regarding their own isola-

* Lawton, George, " Psychological Guidance for Older Persons." Cowdry, *Problems of Ageing*, 1942.

tion. It is likely that the wish to live in a Hostel, apart from being the result of unsatisfactory housing conditions, was also a reflection of the happy relationships which they experienced in the Club with people of their own age.

The keynote in this sample, as well as in the ones subsequently studied, was the need for personal freedom and independence. Some thought that life in a Hostel might encroach upon this freedom and preferred living by themselves. This was forcibly expressed by—

Mr. E—, aged 69, an ex-prison warder. In Hostels, he said, there is always a certain amount of regimentation. I have been bossing people all my life and would not like to be bossed myself now.

I will now briefly consider the group of elderly studied in Fulham. In many respects the conditions under which they were living closely resembled the pre-hospital existence of the Tooting Bec patients. I asked myself often what it was that made life worth living for these people who lived entirely alone in surroundings which were anything but inspiring. Inspiring, indeed, seems an irrelevant term when one thinks of the hovel in which Mr. M— insisted on staying.

He described his profession as "fiddling"; this means he had a succession of jobs of dubious legality. He looked a perfect tramp without the healthy appearance which often goes with the life of a vagrant. He was dirty and unkempt, and lived in a room which contained nothing but a bedstead covered by filthy rags. I visited him in the winter when his attempts to light a fire had miserably failed. He remained adamant when the Institution was described to him as an ideal alternative. He said: "I want to be free to do as I like. I will not go to the 'House'."

In this case, as in every other one which I visited, the old people were holding on to their freedom as something very precious which compensates for many privations. But in almost all cases I discovered that they had one vital link with the outside world in the form of a much loved child, a relative or a devoted friend. Here again the paramount importance of social integration becomes evident. One case stands out in my mind in which the need for independence is demonstrated by a continuation of the life's work, and which offers a perfect illustration of social integration which transcends the local community and includes a wider social group:

An Irishman, aged 74, a widower living alone in his tailor shop, finds that his business is deteriorating progressively. He applies for the Old Age pension, which he is refused whilst living on these premises. He is advised to go to live in one room, which he flatly declines. Determined to remain a functioning personality in the community he struggles on, obviously unaware that his clothes are neglected and his shoes in shreds. He is much more interested in the welfare of his home country Ireland, and takes an active interest in all its concerns. He has taught himself to compose, and dedicates his songs to Ireland and to a daughter of his who lives abroad.

I found also that in cases in which gross mental deterioration was noticeable, personal contacts were conspicuously lacking. Of all the four groups which I studied, there was least pre-selection in the Fulham sample. Names and

addresses were obtained from sanitary inspectors, house agents, rehousing centres and priests. I also made contact with old men who congregated in the local market and recreation grounds, as it was difficult to find the requisite number of men living alone.

The Mill Hill sample, by comparison, was much more selected, as admission to the Estate was subject to the possession of a minimum income, to certain requirements of health and past connection with the drapery trade. The ratio of women to men on the Estate was two to one, and the majority of the people interviewed there were women. From the point of view of housing conditions, care and nursing in times of sickness, the Mill Hill Estate is nearer to the more ideal background for normal ageing than any of the others which I have discussed. The adjustment, however, which the people on the Estate make to inevitable concomitants of ageing and the happiness they experience under comparatively sheltered conditions is a function of their personality. Quite a number of the people complained that they were being looked down upon by the neighbouring community of Mill Hill because they lived on the Estate; but whenever this statement was made it was found to be related to a lifelong sense of personal inadequacy. There was also evidence of some financial insecurity, but not in the limited meaning of the concept as defined in the Tooting Bec study. Compared to the Mill Hill sample the Tooting Bec patients had led a hand-to-mouth existence, and the old age pension gave them a measure of security. The Mill Hill population, however, had maintained a high standard of living throughout their lives, and very few of them had anticipated life on the Estate, which to most of them represents a charitable institution, despite their own violent efforts to refute this. One lady made it quite clear to me that her only reason for allowing me to interview her was to "disabuse me of the notion that the Estate is a charitable institution."

What was striking in the Mill Hill sample was that their conscious feeling of social integration did not arise out of their propinquity with the other people on the Estate, but through contacts maintained with relatives and friends outside and their activities for the benefit of the larger community.

In summing up I would say that the Tooting Bec sample was too small to justify definite conclusions, particularly as no control group was available. The study did show, however, that in many instances patients might have remained in the ordinary community had social conditions been more favourable. It was encouraging to note that some patients who had broken down socially did improve in Hospital, and became capable of living again in the community. But efforts have to be made to rehabilitate them, socially and emotionally, and the milieu into which they return has to be favourable to their re-integration. Further research needs to be done in this field in order to find out how this rehabilitation can best be achieved.

It further emerged that although infirmities, disease, idleness, undernourishment and poverty had all contributed to the patients' failure, the lack of social integration was most powerfully averse to mental health. One might say that social integration is the "*leitmotiv*" which significantly recurs in each of the four studies. Although one must recognize that deteriorating mental health made people especially prone to the above privations, and that

the personality of an individual determines the extent to which worthwhile contacts can be maintained, the Club experience showed that personal relationships can be fostered. There are obviously definite limits beyond which Club life cannot succeed in preventive or remedial efforts.

The study showed further that the separation of ages, both physically and emotionally, has gone far, and a closer association of age and youth in larger households might be a move in the right direction. Perhaps this will seem to you as futile as making an attempt to " put the clock back." I can visualize, however, a non-residential advisory centre for the ageing and aged, staffed by doctors, psychologists and social workers, familiar with the problems of this period of life, very much on the lines of a child guidance clinic. One of the functions of the centre could be to interpret the particular needs of the old to the young and vice versa. The success of such centres will be bound up, however, with the wider measures the community takes to cater for the special needs of the elderly, such as provision for adequate housing, care in sickness and infirmity, and facilities for contributing their services to some socially useful end. As long as people live, some kind of accomplishment is open to them, or as Lawton put it: " Our life is not a book, with old age the last chapter; rather a series of books, a sequence of short stories—each with its own adventures, its own consummations."

General Discussion.

The President (Lt.-Col. A. A. W. Petrie) said that four very interesting papers had been read, though only just at the end was the matter of treatment touched upon, a matter on which some of them would like to hear more. Actually, of course, treatment rested somewhat with the individual concerned. One had heard of notable people who lived hard and died hard too, and who had declared that they would sooner live a brief but full life than the careful life with the prospect of a pleasant and happy old age. A careful and ordered life without stress was obviously one of the ways of living to an extremely old age.

The point that Dr. Richter had made was a very good one indeed, namely, that the physical life was not worth preserving if the mental life was virtually finished. Dr. Lewis had raised a number of questions about which one would have liked to have asked him at the time. It must be fully appreciated that there were a number of factors not quite comparable. What were the criteria for admission? He would have thought that the criteria for admission might vary in different classes of society. Probably the more prosperous sections of the community tended to keep their aged people with them in the home, possibly because they were supporting themselves. That was brought home in the paper which dealt with the social aspects. Generally speaking, the people who got into the poorer type of institution did so for some specific reason, such as faulty habits, or because their failing memory had become dangerous, causing them, for instance, to leave taps on about the house. In a considerable number of cases there were short episodes of confusion, which frequently cleared away, and their dementia was then found to be not of anything like the extent which had been assumed when these patients were admitted. Possibly it was some arterio-sclerotic episode which cleared up, leaving them mildly deteriorated.

The American figures were so much higher than our own that he was led to ask whether there was an equivalent of Tooting Bec in New York or Massachusetts. He had visited these areas, and had not come across such an institution; nevertheless, it might exist. The specialized accommodation in London had been recognized as of great value. Indeed, in the Joint Memorandum some specialized place for old people had been recommended. Mental statistics generally, not only those relating to Tooting Bec, were rather modified by the fact that there

were a very large number of people in public assistance institutions in London—the only area with which he was really familiar—for whom there was no room in special institutions. The London County Council, before the war, was intending to establish another institution because of the demand for this class of accommodation, a demand exceeding the supply. In London observation wards one was asked not to recommend to Tooting Bec because it was so full that they could not be taken in within less than six weeks or so. Thus a considerable surplus of people suitable for that hospital were retained in the wards of public assistance institutions. This to some extent invalidated the statistics, and if these factors were taken into account they would probably bring the London statistics much more into co-ordination with the American figures.

With regard to the social aspects, the various ways in which old people deteriorated had been brought out in the paper. To judge age from the appearance of the person was often quite misleading. He recalled a laundryman who had given his age as 57, but stated when he departed that he was really 85; he was a wonderfully preserved old gentleman, and had been able to get away with such an obvious inexactitude. The Darby and Joan Clubs and the "Granfer" Clubs had been very successful; there was one of these in Sutton. The old people were made to feel that they were not a burden to others, but could move at their own pace. Whether these clubs were residential or not, they did help to solve some of these social problems.

He did not know whether there was any relation between the irritability so common in arterio-sclerotic dementia and the irritability found in the domineering people referred to in the paper by Miss Goldschmidt. An open question was as to the age at which senescence could be said to begin. Degeneration in the eyes, beginning with Descemet's membrane, started in the early twenties, yet people in the early twenties—except for some outstanding examples shown in the war—were not yet necessarily at the highest point for running the world.

Prof. D. K. HENDERSON said that all the papers had points of great distinction about them which had been well worth emphasizing at a meeting such as that. He did not want to go through them *seriatim*. Dr. Aubrey Lewis had given a very interesting historical summary, and had produced figures which he thought amply showed the very great social significance of this problem of the aged. All of them associated with mental hospital work were feeling this burden, not only from the medical but from the nursing point of view, very seriously. In the limited field of some work carried out at Edinburgh in 1944 a review of many senile patients had been made, and bore out very strikingly what Dr. Lewis had said, that the admission-rate had increased within the last ten-year period. It had, in fact, practically doubled itself so far as the aged members of the population were concerned. That fact alone, taken in conjunction with the ageing of the population generally, constituted a very important social problem which should be investigated a little more fully.

Taking the groups, he had always been very much interested in the Alzheimer-Pick group of cases. That group, in his experience of the last few years, had increased tremendously in the mental hospital population. He had no explanation to offer for it, but in consultation work to-day as well as in mental hospital work he noted a very large rise in this so-called presenile or, as it was generically named, Alzheimer-Pick group of disturbances. Whether this was a toxic condition or due to some other cause was very difficult to understand, but he thought it was a matter for very much more intensive investigation by mental hospital workers than had been given to it in the past.

The other point in which he was interested—and which he was sorry had not been mentioned—was in connection with the hereditary aspects. This was a very striking factor. They saw family group after family group who, for one reason or another, irrespective of occupation or anything else, seemed to show striking early degenerative changes, about which a great deal more should be known. While these investigations were proceeding at Tooting Bec, with a population which was so accessible, it might be well to make some studies of the hereditary constitution of the people who were tending to come into these institutions. For all he knew, such studies might be in progress, but he just wanted to emphasize the need for them.

Dr. F. A. PICKWORTH congratulated Dr. Richter on the careful work he had done, and said how easily these results were to be correlated with the changes of

the blood vessels, on the scheme he had put forward at the last meeting. Vitamin C was now known to be concerned with the cement substance of the capillaries which concerned their permeability.

Dr. D. R. McCALMAN asked whether any recognition had been given to the fact that out-patient departments up and down the country, and especially in America, must be beginning to play a part in this question of senility; though he was not quite sure whether these out-patient departments tended to encourage admissions, or had the effect of enabling these people by social and psychiatric care to remain longer in the community than would otherwise be possible. He did not know whether Dr. Lewis could comment on the probable influence of these clinics now and in the future.

Dr. LEWIS replied that no doubt these out-patient activities had an increasingly important effect. In some cases perhaps the patients tended to gravitate to unsuitable places. On the other hand, he did not think it could be doubted that out-patient activities, particularly if they were specially organized, would have the effect of delaying onset of conditions which called for admission. In answer to the President's question, in New York they had no "Tooting Bec," and he did not think they had in Massachusetts. The Commissioners in New York had expressed the strongest wish that something of the kind might be provided, though the need there was not as great as here because in New York State there was an admirable system of family care. But even if they had a Tooting Bec in New York State, it would not bring the figures of hospital admissions to the same proportions as their own. If all the admissions to Tooting Bec were added to the total admissions, it would only bring the mental hospital population up to 91 per 100,000.

Dr. GORDON MASEFIELD said that in New York and Massachusetts all elderly cases were admitted without legal formality, whether or not they came under the type of certification that was necessary in this country, and which still carried with it a certain stigma. If they could be admitted without the legal formality he could understand the increasing number. He very much liked the phrase "moderate senility," which was an admirable one. He desired to ask with regard to Tooting Bec why arteriosclerosis was eliminated, and how, if it was eliminated, cerebral arteriosclerosis was dealt with.

Dr. RICHTER replied that arteriosclerosis was not eliminated; it was one of the factors which could not be eliminated.

The PRESIDENT, in reply to a question, said that his impression was that most of the people at Tooting Bec were admitted under Sect. 25 of the Mental Treatment Act. The general idea with regard to Tooting Bec was, as far as possible, not to use the Lunacy Act.

Dr. LEWIS said that under a special instrument they were allowed to admit under Sect. 25—also under Sect. 24, but the bulk of the admissions were under Sect. 25.

Dr. E. C. DAX asked whether certification was a deterrent to treatment in senility as in psychoses generally. Out of 400 cases over the age of 65 admitted between 1939 and 1945, one-sixth died within a month of admission, one-quarter within three months, one-third within six months, and one-half within a year. Of this number 60 per cent. were certified, as against 30 per cent., taking the figure for all admissions. With regard to administration of the seniles, one pictured a large senile observation ward attached to mental hospitals, where cases could be sorted out before being placed in homes to which they could go more naturally.

Dr. ARTHUR POOL viewed with some concern the recommendation of the Joint Committee of the B.M.A. and the R.M.P.A. that these senile cases should be segregated. He realized that there might be something to be said in its favour, but he would like to learn from some medical officer of Tooting Bec what it was like to be a medical officer in an institution which dealt solely with senile cases. His impression was that it was not very attractive. After all, they had to consider the medical personnel as well as the patients. He personally felt there was a great deal to be said for having a representation in their hospitals of all sections of the community rather than the segregation of an aged community.

Dr. W. J. T. KIMBER said that he hoped they would not lose sight of the fact that there were many sections of the general public who were considering the welfare of these old folk. There were many old folk's committees up and down the country with very definite views regarding the care of old folk—views which would not generally favour the establishment of a large special institution such as the Bec,

but rather the prevention of these people from going into an institution at all. He wished to emphasize the point that they should concentrate on the care of those people who were showing any symptoms of breakdown. Psychiatric social workers were probably doing valuable work, not only in looking after the old people when discharged, but in seeking at the out-patient clinics, possibly in conjunction with the Welfare Committees, to prevent the admission of these old people. He thought they should be committed far more to the avoidance of further institutionalism. It might be very satisfactory to committees to have plenty of bricks and mortar and to administer their institutions, which they did very satisfactorily, and say, " Yes, this is a magnificent show. Look at the people who want to come into it." Of course the people would rather go to Tooting Bec than be certified, but much more would they appreciate it if they could be dealt with without being institutionalized at all. He begged those present to give attention to the preventive aspect of the problem.

Dr. IVISON RUSSELL remarked that it seemed unlikely that they would be able to prevent themselves from growing old, and he thought the question they really ought to ask, when considering the most suitable way of treating old people, was as to what sort of institution they themselves would want to go into. His own choice would be for a small place, not a large one. From what he had heard that day the only thing he could see very much in favour of a large institution was that it was administratively convenient, and that it collected together a wealth of clinical material under one roof, which was of great advantage to research workers. Yet the same research could be carried out by hiring a fleet of motor-cars in which research workers went out into the country and saw these people in small houses.

The PRESIDENT said that the institution which the L.C.C. was proposing to put up before the war was to be one of 600 beds.

Dr. M. B. BRODY did not think that Mrs. Eysenck had sufficiently emphasized the fact that in the studies which had been carried out the intelligence had been conceived always in terms of the young person. That explained in a large measure why the old person was showing up so badly. They would have to come to some agreement on what they meant by intelligence before such a test was taken. The mental aptitudes of the young and of the old were very different. The test of intelligence which was designed for young people should not be used for old. Indeed he thought they might very well get away from talking in terms of intelligence and concentrate more on emotional and conative factors. One of the most serious things in senility was what had been called " emotional apathy." The latest work, by the way, showed very little correlation between cerebral change and observed dementia.

The PRESIDENT said that the effect of malnutrition had been stressed by one of the openers. He would have thought this was a factor likely to affect the younger groups rather than the older.

In brief replies,

Dr. RICHTER said that " cerebral arterio-sclerosis " was not a precise term. All manner of vascular changes were included under it.

Mrs. EYSENCK said with regard to intelligence tests for young adults and old, in the present state of knowledge they could only take such intelligence tests as were available, without differentiation on the ground of age. " Otherwise where were they ? "

Miss GOLDSCHMIDT said that some cases of the confusional type cleared up symptomatically fairly soon after admission to an institution, so that their stay there became no longer necessary. These people could lead more useful and less restricted lives in a smaller institution.

Dr. AUBREY LEWIS said that he was not aware of any valid evidence on the point of malnutrition as affecting the aged. He agreed with what Dr. Kimber had said as to the value of preventive measures—or, rather, not preventive in the absolute sense, but measures which would prolong the process as much as possible. By all means there should be concentration on these.

The Vote of Thanks to the openers, proposed from the Chair, concluded the proceedings for the day.