

UPDATE

WHAT IS MIDLIFE?

How much consideration have you given to midlife — your own or your patients'? Probably not much, and yet experience it you will for the 20 years between 40 and 60. You will feel its inevitable physical and psychological effects, and will either deny it at your own peril or change with it and grow in wisdom and stature. You'll either experience it unconsciously and perhaps foolishly as the butt of midlife crisis jokes, or handle it with some measure of grace. And what are you advising your patients about the transitions in themselves and their relationships that characterise this stage of life?

Very little has been known about midlife because until the developments of modern medicine a fairly small proportion of the world population experienced it. Up until the mid-1940s, when antibiotics were developed, the average person still expected to die in his 60s. The mandatory retirement age in the USA for Social Security purposes was established at 65 years old only in 1935 and is now up for review as people wish to work longer. Now in 2006 in the First World the life expectancy has risen to approximately 79 for men and 82 for women, with the over-85 group the fastest growing segment of the population. It is of course much harder to discuss life expectancy in sub-Saharan Africa with the diverse population groups and the scourge of AIDS. Suffice it to say, though, that trends in sociological, psychological and medical research have been strongly influenced by the emphasis in the First World. Midlife has only recently been in the sight of those establishing societal institutions and influencing attitudes in the North as well as here.

Until very recently a person was considered old at 40 and expected to die in his or her 60s — the very years that we now think of as middle age. Until the mid-20th century there were few distinctions made between what we now consider the three stages of adulthood (roughly 20 - 40), midlife (roughly 40 - 60) and seniority (60+). The least understood has been midlife, with no defined characteristics or roles for women above childbearing age or for men who have lost some of their physical prowess yet are too young to retire.

In South Africa we are still influenced by Western societal institutions that were developed in the First World decades ago to handle the needs of the average person. The institutions of Europe are undergoing the strains of an ageing population. However, in South Africa we are adding into the mix the pressures of affirmative action with very little intelligent consideration of cultural differences let alone of

age or life stage. In my executive coaching, I find that in corporate and governmental institutions it is not uncommon to find black women in their late 30s forced to compete with 60-year-old white men with no consideration of their comparative energy levels, acquired wisdom or perspective of their ages.

Consider that in the social institution of marriage, people make vows that commit them 'until death do us part'. This was easy to do when at least one of the spouses was likely to be dead by 50! We still make the same vow and hardly question the overwhelming probability of divorce, considering we now live 20 - 30 years longer. As we adjust our one-size-fits-all approach to the 60+ years of adulthood, we also need to re-order our expectations and prepare ourselves for three stages of marriage. Either we need to learn to make the transitions in our relationships from one life stage to another, or we need to be prepared to be married to three different spouses!

In counselling adults and couples, I address daily the issues of midlife with many of my clients. In my research and in practice I have identified two transitions or 'crises' that occur during midlife, the first being the transition into midlife around 40, but sometimes as early as 38, which mostly affects us psychologically, and the second menopause or andropause, which we experience when the hormonal and biochemical shifts reach a critical point around 50. In the next two articles in this series I will go into greater detail about the psychological characteristics of these changes.

In his book, *The Middle Passage: From Misery to Meaning in Mid-Life* (1993), Jungian analyst and midlife expert Dr James Hollis says that the midlife transition occurs when the 'provisional personality' — shaped by our parents and the requirements of society — is forced to make way for the coming forth of the 'authentic or inherent self'. Our sense of self and the seat of authority shift from outside us to within. The parental voices we have internalised in adolescence have begun to sound more like critical tyrants than like a helpful conscience we relied on in our youth. A crisis is experienced as the familiar manner in which we have handled things in our lives no longer works for us. We begin to feel restless, discontent and we naturally begin to 'soul search'.

The midlife hormonal changes are accompanied by changes in the psyche with corresponding behavioural changes. While medical research shows that this is true for both women and men, popular thinking still associates the irritability-anxiety-depression syndrome associated with hormonal changes with female menopause. This popular belief is sustained because the changes in women are more physi-

cally evident with the rapid decline in oestrogen and the cessation of menses. Hundreds of studies document both the physical and psychological symptoms of menopause and perimenopause. Perhaps because men have been so reluctant to admit to the effects of the gradual loss of their testosterone, which they associate with their image of manhood, medical research has been slow in studying what is popularly called 'andropause'.

But the well-documented psychotropic effects of testosterone in relation to sexuality, aggression, performance, cognition and emotion are affected as the testosterone levels are gradually lowered during middle age. According to Jed Diamond, author of the popular *Male Menopause* (1997), men make a terrible mistake by ignoring or denying hormonal changes or their effects. The effects on relationships, career and general wellbeing can be dramatic. He cites studies that link the lowering of testosterone levels with stress, depression, anxiety and a decrease in self-esteem. Alcoholism, violence and suicide rates are much higher in men in midlife than in women.

Genetic inheritance, temperament, brain characteristics, hormones and conditioning from family and society are all involved in determining the way individuals will experience the changes in midlife. Any thorough understanding of patients undergoing this stage and its transitions will take them all into consideration. However, there are obvious things I look for and will share in the following articles in this series. I will also mention the effects on relationships that either undergo a dramatic transformation or end in divorce in midlife. In the last article, I will also suggest a number of supports that can be provided beyond the obvious HRT and antidepressants that medical practitioners typically prescribe.

MARY OVENSTONE

Mary Ovenstone is a Canadian-trained psychotherapist. She specialises in couples and individual counselling and executive coaching. E-mail: ovenmits@iafrica.com

ALLERGIC RHINITIS, OR HAY FEVER

Allergic rhinitis, better known as hay fever, is an IgE-mediated rhinitis that is characterised by seasonal or perennial sneezing, rhinorrhoea, nasal congestion and itching around the nose, eyes and mouth. Allergic conjunctivitis and pharyngitis often accompanies this.

True hay fever, also called polinosis, is the acute, seasonal form of rhinitis. It is usually caused by wind-borne pollens. Grass pollens are also highly allergenic to some people. Occasionally, hay fever is caused mainly by airborne fungal spores. The main symptoms are itching of the nose, the roof of the mouth, the pharynx and the eyes. The onset may be gradual or abrupt. As the hay fever progresses

the nose runs and sneezing starts. Some people get frontal headaches and become irritable. Rarely, anorexia, depression and insomnia occur. Itching eyes are common, with swollen conjunctiva, and the nasal membranes are also swollen and red. Some people develop asthma.

Diagnosis is largely by history and examination. Eosinophils may be found in the nasal secretions and skin tests can be used to determine the specific pollens that are causing the allergy. Symptoms may be reduced by avoiding the precipitating pollen, although this is usually all but impossible. Oral antihistamines often provide relief. Topical nasal sprays containing antihistamines may be useful and the antihistamine may be combined with a sympathomimetic. Nasal symptoms that are not relieved by an antihistamine generally respond to an intranasal glucocorticosteroid spray, which can be used twice daily initially and the dosage reduced as symptoms settle. When used in this way there are few side-effects.

Perennial rhinitis is non-seasonal rhinitis, which may or may not be allergic. It is sometimes complicated by sinusitis, nasal polyps or sensitivity to aspirin or other NSAIDs. The symptoms vary in severity throughout the year. Symptoms such as conjunctivitis are uncommon, but chronic nasal obstruction is common and may extend to the eustachian tube. In children this can result in hearing difficulty.

A positive history of atopic disease supports the diagnosis, as does the characteristic inflamed, red nasal mucosa, numerous eosinophils in nasal secretions and positive skin tests, particularly to house dust mite, animal dander or fungi.

Some patients with negative skin tests, but with eosinophils in their nasal secretions, suffer from chronic rhinitis, sinusitis and polyps, called eosinophilic non-allergic rhinitis. These patients are not atopic, but are sensitive to aspirin and other NSAIDs.

Vasomotor rhinitis is characterised by a mild, but annoying, chronic continuous nasal obstruction or rhinorrhoea with no obvious allergy, polyps, infection, eosinophilia or drug sensitivity. Another group of patients are those who have chronic nasal obstruction as a result of overuse of topical decongestants – so-called rhinitis medicamentosa.

Treatment is similar to that for hay fever if specific allergens are identified. Surgery is sometimes tried if allergies have been ruled out, although there are no good data that show that surgery is effective for perennial rhinitis *per se*. Patients with eosinophilic non-allergic rhinitis usually respond best to a topical glucocorticoid. Patients with vasomotor rhinitis should avoid topical decongestants, which produce rebound congestion if used continuously for a week or more and may perpetuate chronic rhinitis.

BRIDGET FARHAM