Lifelong Learning Network, Inc.

FUND RAISING PROGRAM FOR CATHOLIC SCHOOLS

SAMPLE ARTICLES

TOGETHER WE CAN!
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GETTING BACK ON TRACK: A 3-DAY PLAN TO SHAPE UP YOUR DIET AFTER THE HOLIDAYS  

by Susan Witz and Alex Panozzi

The winter holiday season is usually a tale of two states: the state of overeating and the state of undereating. Either you're indulging in chips and dip at a party and baking five types of cookies at home, or you're skipping meals to make time for everything from decorating the house to making and shopping for gifts.

Now that January is here, it's time to start some good eating habits. Here's a three-day plan that helps you start the New Year by eating right. It contains daily menus that incorporate great-tasting, low-fat dishes, most of which are easily found in vegetarian cookbooks. Look for recipes with nutritional analyses, and choose ones that go light on fat. To whet your appetite, we've included some good, staple recipes (marked with an asterisk). You can continue eating this way every day by adapting these menu ideas to include your favorite foods.

**Breakfast**
- 4 oz. orange juice
- 1 Heartland Muffin*
- 1 Tbs. fruit spread
- 8 oz. skim milk (or 6 oz. soymilk)

**Lunch**
- 1 Pita Pocket with Hummus*
- 1 cup raw vegetables
- 1 pear
- No-calorie beverage

**Snack**
- 3 cups air-popped popcorn

**Dinner**
- 6 oz. vegetable juice
1 serving Hearty Vegetarian Stew with Burgundy Sauce*
1/2 cup couscous
1 cup steamed broccoli
1 serving Apple Strudel with Cinnamon Sauce*
No-calorie beverage
Total Calories for Day 1: 1,489

Heartland Muffins
1 1/4 cups whole-wheat flour
1/2 cup oat bran
1/2 cup wheat bran
2 tsp. baking powder
1 Tbs. vegetable oil
1/4 cup honey
1 whole egg or two egg whites, beaten
2/3 cup skim milk or soymilk
1/2 cup unsweetened applesauce
1/2 tsp. vanilla extract
2 medium, very ripe bananas, mashed or pureed

Preheat oven to 350 degrees and lightly grease muffin tins. Sift together dry ingredients. Set aside.

Cream oil and honey. Whisk in eggs, milk, applesauce and vanilla. Stir together dry ingredients and wet ingredients until just moist, leaving some lumps. Gently fold bananas into batter. Immediately spoon batter into muffin tins and place in oven. Bake for 20 to 30 minutes until just beginning to brown. Serve warm.

Makes 12 muffins. Variations:
Instead of bananas, substitute the following: 2 cups blueberries, or 1 cup chopped cranberries and 3 tablespoons granulated sugar cane juice.
Per muffin: 120 cal.; 3g prot.; 2g fat; 23g carb.; 18mg chol.; 71 mg sod.

Pita Pockets with Hummus
2 cloves garlic, minced
1/2 cup finely chopped green onions (tops and bottoms)
2 tsp. vegetable oil
cup chopped green bell pepper
3 Tbs. chopped fresh parsley
1 Tbs. sesame seeds
tsp. dried oregano
tsp. dried mint
1 15-oz. can garbanzo beans, rinsed and drained
Dash salt (optional)
Dash hot pepper sauce (optional)
2 whole-wheat pita pockets, halved to make 4 pockets
2 small tomatoes, cut into 4 slices each
1 small onion, sliced
4 leaves romaine or other lettuce
1 cup alfalfa or other sprouts
1 cup shredded low-fat monterey
jack or soy cheese  (optional)

Saute garlic and green onions in oil over medium heat until onions are transparent. Add pepper, parsley and sesame seeds. Cook until pepper is soft. Add oregano and mint and saute 1 minute more. Put vegetable mixture and garbanzo beans in food processor and process until smooth. Add salt and hot pepper sauce if desired.

Stuff mixture into pita pockets. Garnish with tomatoes, onion, lettuce, sprouts and cheese if desired. Serves 4.

Per serving: 276 cal.; 13g prot.; 7g fat; 42g carb.; 0 chol.; 220mg sod.

Hearty Vegetarian Stew with Burgundy Sauce

This stew is so substantial that you need only serve it with bread. It's also good over whole grains.

Burgundy Sauce:

1 1/2 tsp. extra-virgin olive oil
3/4 cup chopped onions
1 medium carrot, chopped
3/4 cup chopped celery
cup chopped leeks
2 cloves garlic, chopped
1/3 cup tomato paste
1 large bay leaf
1/2 tsp. dried thyme
1/2 tsp. dried basil
2 2/3 cups burgundy wine
5 1/3 cups vegetable stock
6 peppercorns, cracked
7 Tbs. whole-wheat or unbleached white flour
1 Tbs. vegetarian worcestershire sauce

Stew:

2 Tbs. extra-virgin olive oil
2 cups sliced onions
6 medium carrots, peeled and cut into chunks
4 parsnips, peeled and cut into chunks
2 large cloves garlic, pressed
5 cups quartered mushrooms
2 medium red potatoes, cut into large chunks
1 cup peeled and diced turnips
1 1/4 cups chopped green peppers
4 cups vegetable stock
1 Tbs. dried sage
10 oz. seitan
1 cup frozen peas
Freshly ground black pepper to taste Pinch salt (optional)
Chopped parsley for garnish

Burgundy Sauce: In a soup pot, heat oil over medium heat. Add onions, carrot, celery, leeks and garlic. Cook, stirring frequently, until soft. Add tomato paste, bay leaf and herbs. Stir to coat. Cook gently, stirring, until tomato paste begins to brown.
Stir in wine. Add stock and peppercorns. Bring to a rapid boil and cook for 20 to 30 minutes, until reduced to approximately 4 cups. Strain.

Dissolve flour in worcestershires sauce and a small amount of water or stock. Whisk flour mixture into sauce. Simmer for 15 minutes, until thickened. Set aside.

Stew: Heat oil in large, heavy pot. Sauté onions, carrots and parsnips over medium-high heat until they begin to brown; stir frequently. Add garlic, mushrooms, potatoes, turnips and peppers. Stir and cover. Cook 5 minutes, stirring periodically. Add stock, scraping bottom of pan with wooden spatula to remove any brownings. Add sage and seitan.

Stir in Burgundy Sauce and simmer about 30 minutes. Add peas. Turn off heat and allow stew to sit 5 minutes before serving. Add desired seasonings and garnish. Serves 10.

Per serving: 264 cal.; 10g prot.; 6g fat; 35g carb.; 0 chol.; 208mg sod.

Apple Strudel with Cinnamon Sauce

Strudel:
- 8 medium granny smith apples, peeled, cored and sliced
- cup raisins
- 2 Tbs. granulated sugar cane juice or honey
- Cinnamon and nutmeg to taste
- 6 sheets phyllo dough, partially thawed and covered with a damp, clean towel to retain moisture

Cinnamon Sauce:
- 2 cups apple cider
- 4 tsp. arrowroot or cornstarch
- Cinnamon and nutmeg to taste

Strudel: Preheat oven to 400 degrees. Mix sliced apples and raisins with sweetener; sprinkle with cinnamon and nutmeg. Lay 1 sheet of phyllo on a greased cookie sheet. Spray phyllo with vegetable oil spray or a mist of water. Lay another sheet of phyllo on top of the first one, spray with oil or water and place a third sheet on top.

Place half of apple mixture on phyllo and roll up lengthwise, turning in the ends to enclose filling. Cut 1/4 of the way through the roll to make 7 servings. Repeat procedure with the other 3 sheets of phyllo and the remaining apple mixture. Bake 15 to 20 minutes, until lightly browned.

Sauce: Combine all ingredients in a small saucepan. Whisk thoroughly. Heat to a boil, stirring constantly.


Per serving with 2 tablespoons sauce: 105 cal.; 1g prot.; 0.2g fat; 24g carb.; 0 chol.; 38mg sod.

Breakfast
- 1/2 grapefruit
- 3/4 cup oatmeal with 2 Tbs. raisins
- 8 oz. skim milk (or 6 oz. soymilk)

Lunch
- 1 serving Split Pea Stew with Chunky Vegetables
- 1/2 cup leftover couscous 2 crackers
- 2 tangerines No-calorie beverage
Snack
   1 large rice cake
   2 Tbs. Peanut-Ricotta Spread*

Dinner
   Tossed salad with 2 Tbs. no-fat Italian dressing 1 serving Low-fat
   Fettucini Alfredo*
      1 bread stick
      1 cup fresh pineapple chunks No-calorie beverage
Total Calories for Day 2: 1,159

Peanut-Ricotta Spread
This spread will stay fresh until the expiration date on the ricotta cheese.
   1 15-oz. carton low-fat or nonfat ricotta cheese cup peanut butter
   1 Tbs. honey
   1/4 tsp. almond extract
   1/4 tsp. vanilla extract
   1/4 tsp. cinnamon
Combine all ingredients in a food processor or blender. Blend until smooth. Store spread
in the refrigerator. Makes 2 cups. L Variation: This spread also makes a good frosting.
Per 2-tablespoon serving: 70 cal.; 5g prot.; 4g fat; 4g carb.; 10mg chol.; 57mg sod.

Low-fat Fettucini Alfredo
This version is much lighter than the original classic, but it loses none of the rich
character.
   12 oz. dry fettucini, preferably whole wheat
   2 cups evaporated skim milk or low-fat soymilk (or cups powdered
      skim milk mixed with cups water)
   4 cloves garlic, minced or pressed
   6 Tbs. grated parmesan cheese
   cup chopped fresh parsley
   Freshly ground black pepper to taste
   2 cups chopped and steamed vegetables of choice. carrots, green beans,
zucchini, onions, broccoli or peas
Cook pasta according to package directions. Drain. Place pasta in a large nonstick
saute pan along with milk and garlic. Bring to a simmer, stirring frequently. Add cheese.
Continue cooking until cheese melts and sauce thickens. Stir in parsley and black pepper.
Add steamed vegetables and toss gently. Serves 4. L Variations:
Flavor the milk with 1 teaspoon curry powder; proceed with recipe.
      Chill dish and serve as a cold pasta salad.
      Add a splash of wine to the sauce before heating.
Per serving: 179 cal.; 15g prot.; 4g fat; 23g carb.; 11 mg chol.; 320mg sod.

KEY TO RECIPE CODES
OL Ovo-lacto: contains dairy products and eggs. L Lacto: contains dairy products. v
Vegan: contains neither dairy products nor eggs (may contain honey).

Breakfast
   2 stewed prunes
   1 whole-wheat bagel
   1 tsp. margarine
8 oz. skim milk (or 6 oz. soymilk)

Lunch
1 serving Mexican Tofu Salad* with Mock Sour Cream*
1 large apple
No-calorie beverage

Snack
1 Heartland Muffin*

Dinner
8 oz. won ton soup
1 serving Vegetarian Chop Suey*
1 serving Banana Ice Dream* with Chocolate Sauce*
No-calorie beverage

Total Calories for Day 3: 1,270

Mexican Tofu Salad
4 corn tortillas
1 lb. finn tofu, drained and crumbled
1 Tbs. chili powder
1 tsp. ground cumin
1 Tbs. ground coriander
tsp. salt (optional)
2 tsp. corn oil or other vegetable oil
6 cups shredded romaine lettuce
4 medium tomatoes, quartered
1/2 cup shredded low-fat monterey jack or soy cheese (optional)
4 Tbs. Mock Sour Cream (see recipe) (optional)

Preheat oven to 350 degrees. Place tortillas on a dry cookie sheet and bake in oven until crisp, about 15 minutes. Crumble into small pieces and set aside.
Mix together tofu, chili powder, cumin, coriander and salt if desired; saute in oil for about 5 minutes or until mixture is dry. Remove from heat; cover to keep warm.
Arrange lettuce on four plates and sprinkle with roasted, crumbled tortilla ps.
Cover with warm tofu mixture. Add tomato wedges. If desired, garnish with cheese and Mock Sour Cream. Serves 4. L/V

Per serving: 201 cal.; 12g prot.; 8g fat; 23g carb.; 0 chol.; 46mg sod.

Mock Sour Cream
This recipe is also perfect as a low-fat topping for a baked potato or a bowl of chili.
1/2 cup low-fat or nonfat yogurt
2 tsp. lemon juice
Dash salt

Mix together all ingredients. Store in refrigerator. Makes 1/2 cup. L Per tablespoon: 9 cal.; 0.8g prot.; 0.3g fat; 1 g carb.; 1 mg chol.; 44mg sod.

Vegetarian Chop Suey
If you're short on time, use a packaged frozen vegetable medley for some of the fresh vegetables.
2/3 cup chopped onions
3 cloves garlic, minced
2 tsp. freshly grated ginger root
1 Tbs. toasted sesame oil
1/2 cup diagonally cut carrots
1/2 cup diagonally cut celery
2/3 cup sliced mushrooms
1 cup sliced bell peppers
2/3 cup coarsely shredded red cabbage
2 cups diagonally cut zucchini
2/3 cup mung bean sprouts
2/3 cup sliced green beans
2/3 cup pea pods
2/3 cup bamboo shoots
2/3 cups sliced water chestnuts
1 cup sliced tomatoes
1 cup water
2 Tbs. low-sodium soy sauce
3 Tbs. arrowroot or cornstarch
3 cups cooked brown rice

Saute onions, garlic and ginger root in oil. Add carrots and celery, and saute for 5 minutes. Add mushrooms, peppers, cabbage and zucchini, and saute 3 minutes more. Add bean sprouts, green beans, pea pods, bamboo shoots, water chestnuts and tomatoes, and saute 3 minutes more. Stir together water, soy sauce, and arrowroot or cornstarch; pour into vegetable mixture. Cook until the sauce is thickened and all vegetables are tender-crisp. Serve over rice. Serves 4.
Per serving: 329 cal.; 9g prot.; 5g fat; 63g carb.; 0 chol.; 158mg sod.

30-MINUTE SKILLET DINNERS

by Marla Edelstein

Give yourself a break! When you're looking for a really easy way to get dinner on the table, try one of our all-in-one-skillet dinners. To make things even speedier, we incorporate convenience foods, then add fast, fresh-tasting touches like herbs, garlic, and lemon juice. These tasty combinations of protein, starch, and vegetables provide a balanced meal without the bother of having to prepare three separate dishes. Another added bonus: These one-pan meals are a snap to clean up.

Spanish-style Chicken
Cumin, a spice available in seed and in ground form, has recently gained in popularity. Widely used in Spanish, Mexican, and Chinese cooking, it has a pungent, aromatic taste.
Preparation time: 10 minutes.
Cooking time: 16 minutes.
1 tablespoon butter or margarine
1 clove garlic, crushed
4 boneless, skinless chicken-breast halves
1/2 teaspoon ground cumin
1/8 teaspoon pepper
2 1/2 cups water
1 package (4.4 ozs.) Spanish-flavored rice and sauce
1 cup frozen peas, partially thawed
1 cup frozen whole-kernel corn, partially thawed
2 green onions, sliced
1 tablespoon finely chopped cilantro (fresh coriander) (optional)
4 slices tomato
1. In 10” skillet melt butter over medium heat. Add garlic and cook about 30 seconds until golden. Sprinkle chicken breasts with 1/4 teaspoon of the cumin and pepper. Cook 3 to 4 minutes per side until cooked through and golden brown. Remove chicken from skillet and set aside.

2. Gradually add water to skillet. Stir in Spanish-flavored rice and sauce, peas, corn, green onions, and remaining 1/4 teaspoon cumin. Bring to boil. Reduce heat and simmer 9 minutes, stirring occasionally, or until rice is almost tender. Stir in cilantro, if desired. Put chicken breasts back into skillet, and top each with a slice of tomato. Cover and cook 1 minute or until chicken is heated through and rice is tender.

Yield: 4 servings.

Nutrition per serving: 332 calories; 33 grams protein; 5 grams fat; 38 grams carbohydrate; 658 milligrams sodium; 66 milligrams cholesterol.

Pork Lo Mein Pronto
Many supermarkets have a stir-fry section in the meat department where you can find pork, along with chicken and beef, precut into strips. The different meats can also be alternated to vary the taste of this dish.

Preparation time: 8 minutes.
Cooking time: 12 minutes.

1 tablespoon peanut or vegetable oil 3/4 lb. boneless pork, cut into strips 3 green onions, thinly sliced 1 clove garlic, crushed in a garlic press 1/2 teaspoon freshly grated pared gingerroot (see note) 2 packages (3 ozs. each) pork-flavor dry oriental noodle soup 2 1/2 cups water 1 red bell pepper, cored, seeded, and sliced 1/4 lb. fresh snowpeas, trimmed, or 1 box (6 ozs.) frozen snowpeas, thawed 1 can (14 ozs.) fancy mixed Chinese vegetables, drained

1. Heat in 10” skillet over medium-high heat. Add pork and cook 1 minute, stirring. Add green onions, garlic, and ginger and cook 1 to 2 minutes, stirring frequently, until pork is cooked through. Remove pork mixture from skillet. Set aside.

2. Remove flavor packets from noodle packages. Add water, contents of flavor packets, and noodles to skillet. Bring to boil, stirring twice. Reduce heat to medium, cover, and cook 4 to 5 minutes until noodles are tender. Add bell-pepper strips, snowpeas, Chinese vegetables, and pork. Cook 2 to 3 minutes, stirring occasionally, until heated through.

Note: You can substitute 1/8 teaspoon ground ginger for fresh gingerroot.

Yield: 4 servings.

Nutrition per serving: 392 calories; 25 grams protein; 19 grams fat; 30 grams carbohydrate; 1,042 milligrams sodium; 51 milligrams cholesterol.

Golden Scallops and Rice
Scallops are great to use when you're in a hurry, because they cook quickly and there are no shells to peel, as with shrimp.

Preparation time: 5 minutes.
Cooking time: 25 minutes.

1 envelope (1.3 ozs.) golden onion-soup mix 2 1/2 cups water 1 tablespoon butter or margarine 1 cup uncooked converted white rice 1 package (10 ozs.) frozen asparagus spears, partially thawed, cut into thirds 1 lb. bay scallops 1 jar (4 ozs.) pimiento pieces 2 green onions, sliced 1 tablespoon lemon juice

1. In medium bowl stir soup mix into water. Melt butter in 10” skillet over medium heat. Stir in rice. Cook 1 minute or until slightly browned. Add soup. Bring to boil. Reduce heat to low, cover, and simmer 18 minutes or until rice is almost tender and most of liquid is absorbed.
2. Stir in asparagus and cook 1 minute. Increase heat to medium. Stir in scallops, pimientos, green onions, and lemon juice. Cook, covered, 5 minutes or until scallops are tender.
   Yield: 4 servings.
   Nutrition per serving: 359 calories; 25 grams protein; 5 grams fat; 52 grams carbohydrate; 635 milligrams sodium; 37 milligrams cholesterol.

Skillet Turkey Pot Pie
If you have any leftover Thanksgiving turkey, give this dish a try. You can also use chicken or ham instead of turkey.
Preparation time: 5 minutes.
Cooking time: 12 minutes.
2 tablespoons butter or margarine 1 medium onion, chopped 1 package (12 ozs.) frozen hash-brown potatoes (3 cups) 2 cups milk 1 envelope (1.8 ozs.) white-sauce mix 1/2 teaspoon dry mustard 1 package (16 ozs.) frozen mixed vegetables such as broccoli, cauliflower, and carrots, partially thawed 2 cups cooked, cut-up turkey 1 cup low-fat shredded cheddar cheese, divided 2 English muffins, split and toasted
   1. Melt butter in 10" skillet over medium heat. Add onion and cook 3 minutes or until almost tender. Add hash-brown potatoes and cook 5 minutes, stirring occasionally, or until tender.
   2. Stir in milk, sauce mix, and mustard until blended. Add vegetables and bring to boil.
   3. Stir in turkey, cover, and cook over medium heat 2 minutes or until vegetables are tender and sauce is thickened. Set aside 2 tablespoons of the cheese. Sprinkle remaining cheese onto turkey mixture and cook 1 minute, stirring, or until cheese is melted and blended.
   4. Meanwhile, sprinkle reserved 2 tablespoons cheese onto toasted English muffins. Place in toaster oven or under broiler to melt cheese.
   Yield: 4 servings.
   Nutrition per serving: 569 calories; 39 grams protein; 24 grams fat; 48 grams carbohydrates; 906 milligrams sodium; 91 milligrams cholesterol.

Kielbasa and Kraut
Preparation time: 5 minutes.
Cooking time: 20 minutes.
1 lb. kielbasa sausage 1 medium onion, thinly sliced 1 lb. sauerkraut, drained 1 can (16 ozs.) whole potatoes, drained and halved 1/2 cup apple juice 1 large tart green apple, halved, cored, and sliced
   1. Cut kielbasa into 1/2" pieces. Brown on all sides in 10" skillet over medium heat, about 3 minutes. Add onion and cook 5 minutes, stirring occasionally, or until onion is tender.
   2. Stir in sauerkraut, potatoes, and apple juice. Cover and bring to boil.
   3. Reduce heat and simmer 5 minutes, stirring occasionally. Add apple and simmer another 5 minutes or until apple is tender.
   Yield: 4 servings.
   Nutrition per serving: 456 calories; 17 grams protein; 31 grams fat; 27 grams carbohydrate; 1,477 milligrams sodium; 76 milligrams cholesterol.
ACCIDENT PREVENTION AND SAFETY PRECAUTIONS
by Kenneth C. Fine

* A child should never be permitted to use a power mower.
* Always wear safety goggles when using a power mower, weed cutter, trimmer, or other tools that may kick up stones, twigs or other objects.
* Never try to free an object from a mower blade or snow blower while the motor is running.
* Never leave a power mower unattended while the motor is running, even momentarily.
* Always wear protective gloves and goggles when using a power saw. Follow manufacturers' instructions and make sure the saw is in proper working order and that the blades are sharpened.
* When not in use, a garden hose should be rolled up and stored. It should never be left lying in the grass where someone may stumble over it.
* Garden tools should be put away after using. A grocery carton can be used, or they can be hung individually on a wall. Hoes, rakes, and other such tools should never be left lying on a lawn where someone may step on them.
* Pesticides should be used with extreme care and always sprayed downwind. They should not be decanted into unlabeled jars; leftovers should be discarded according to instructions, and not tossed in the garbage or flushed down the toilet.
* The cover on a well, septic tank, or cistern should be sufficiently secure at all times so that it cannot be removed by children.
* Garage doors should be easy to open both from inside and outside. If electronic power lifts are used on a garage door, there should be another exit that can be used in case of power failure.
* The driveway should always be clear of bicycles, motorcycles, children's wagons, and other obstructions. Also, children should be warned not to play in the driveway.
  * Don't wear loose clothes or flowing sleeves when cooking on an outdoor grill.
  * Cancel a backyard barbecue if there's a high wind.
  * Never attempt to pour starter or other flammable liquid onto burning or smoldering charcoal. Use an electric starter instead.
  * Have a fire extinguisher nearby whenever cooking out. When using a campfire or grill in the woods or open area, dig a fire pit first and make sure that the fire is thoroughly extinguished before leaving it.

IMPROVE AGING SKIN WITH WRINKLE CREAMS
by Maria Liberty

The age of your skin depends not only on your actual age, but also on your health and genetic potential. Signs of aging such as wrinkles can be delayed somewhat if you follow basic precautions. The aging of the skin is due to four factors:
  * The skin cells become toxic. The cells cease to allow the oxygen to pass through the exchange of waste gasses and life-giving oxygen is slowed.
* Poor circulation prevents the proper delivery of oxygen. Any organ that doesn't receive enough blood will not function correctly and will eventually wither.

* Cells become dehydrated. Skin is approximately 70 percent water and must remain moist in order to function properly. Aging is almost always accompanied by cellular drought.

* Skin tissues shrink. The deterioration of the firm fat and tissue under the skin leaves the outer skin with less support and without that support the skin ages rapidly. The loss of elasticity of the size and number of active muscles in the muscle mass also leads to a loss of tone. Expression lines deepen without cushioning under the skin. Sun, wind, time and other environmental agers are always working, weakening your skin and making the surface rough and dry. But defensive and offensive weapons are available.

Besides some well known remedies to delay wrinkles, other innovative weapons are available. Natural cosmetics can assist in this battle. Researchers recently found that the extract of a rare flower growing wild on Spanish hillsides can help reduce the appearance of lines and wrinkles caused by stress and environmental factors such as the sun and pollution.

The flower, chamomile, is an age-old remedy to soothe the skin. Levomenol is the active ingredient that gives chamomile its soothing properties. At the University of Bonn's Dermatological Clinic in Germany, two controlled studies found that skin cream containing chamomile extract smoothed skin and reduced wrinkles.

In the first study, women applied the chamomile preparation. In three days, the researchers found a smoothing effect with a reduction of fine lines and wrinkles caused by ultraviolet (UV) rays. Within seven days, the skin returned to its healthy appearance.

In the second study, similar results occurred on skin damaged by chemicals and that which mimicked the effects of harsh pollutants. After 10 days, researchers found visible, measurable smoothing effects from the use of the chamomile preparation.

The researchers tested the same cream base with and without the chamomile extract. Test results proved that the skin improvement and wrinkle reduction was attributable to the levomenol-rich chamomile and not to the cream base itself.

Glycolic acid, also known as hydroxyacetic acid, is the simplest form of a group of naturally occurring acids collectively known as alpha hydroxy acids or AHAs. These acids are found in natural sources such as fruit and other foods. Glycolic acid, for example, is found in sugar cane.

Fruit acids include citric acid from citrus fruits, malic acids from apples, lactic acid from milk and tartaric acid from grapes.

Glycolic acid is now used in a variety of natural skin moisturizers and creams to help improve the texture of the skin and also to reduce fine lines and wrinkles. It has also been used successfully in a skin peeling procedure, which improves such skin conditions as age spots, acne and wrinkles.

Glycolic acids are by no means a new discovery. In ancient Egypt, Cleopatra knew of the benefits of the alpha hydroxy acids or fruit acids. She used them to smooth her face and bathed in them to soothe her body.

Ancient Roman women saved the thick layer of acid that formed at the bottom of wine barrels while the wine was aging. They then applied this acid to their face to soothe their skin.

Glycolic acid has the greatest penetration level of all the alpha hydroxy acids.
because of its small molecular size. It is also thought to have the greatest benefit to the skin.

Studies show that glycolic acid helps to loosen or break up the thick, outer horny layer of the skin where excessive buildup of dead skin occurs. This loosening or breaking up of the outer skin layer leads to a sloughing off of dead skin cells that has proved effective in smoothing fine lines in aging skin and smoothing the texture of sun-damaged skin. A natural, cruelty-free wrinkle cream is a must for a regular skin care program for anyone over 25.

Here are some other weapons that help fight off aging skin:
* Sleep. It is vital because the nutrients that help new skin cells to form are not assimilated properly without sleep. Oxygen is also brought to the skin during sleep.
* Calcium. This mineral helps promote a soothing alkaline-acid balance in the blood and allows you an undisturbed, restful sleep. If calcium supplies fall below normal, the nerves become tense. Without enough calcium your muscles contract as you sleep, causing spasms. In addition, if your body is not getting sufficient calcium, it simply leaches the mineral from your bones, which can lead to osteoporosis.
* Vitamin C. This nutrient encourages healthy connective tissue which binds all the individual cells together. Vitamin C helps the red blood cells to carry hydrogen and other ingredients needed for metabolism and nourishment of the skin's tissues. The juice of a lemon can encourage new skin growth by encouraging the skin to shed and replace old cells.
* Water. All ancient people included a water ritual in their rites. Fresh, pure water is perhaps the only true fountain of youth. Drink at least eight glasses of water a day.

For a wide assortment of creams and lotions that reduce the appearance of wrinkles, visit your health food store. There you will find an array of products using aloe vera, jojoba, chamomile, bee products, the juice of loofa vines, essential oils, vitamin E, vegetable enzymes and many others.

REFERENCES:

WHEN AIDS TAKES A LIFE

by Victor M. Parachin

After three years of marriage, Linda and Ron gave birth to a healthy baby boy. When their son was 6 months old, the parents became alarmed because he began to lose weight. More alarming was the fact that the infant began to need smaller diapers rather than larger ones. Initially their pediatrician was baffled. After extensive testing...
doctors determined the little boy had AIDS. When the parents were tested, they learned that Linda, the mother, also had AIDS. Their son died at 14 months. Linda's health continued to deteriorate for nearly three years before her life ended at age 32.

Despite the fact that shortly before her death Linda was an emaciated 60 pounds and had become completely blind, her diagnosis was kept a secret from family, friends, and colleagues. Even at the burial all but one brother and sister believed that Linda had died of cancer.

Unfortunately, there is still a major social stigma attached to AIDS patients. As a result, those who grieve an AIDS loss are afraid to acknowledge their grief publicly. When there is an AIDS-related death, survivors will need all the help, support, and ways to help AIDS survivors heal.

Respond with compassion. The AIDS crisis has presented not only a medical challenge but also a theological one. Religious groups are confronted by the fact that in many cases AIDS was contracted through drug use or numerous casual sexual relations, both of which violate traditional Christian teaching.

In spite of that reality, all AIDS patients and their survivors must be treated with unconditional love and acceptance.

Be sensitive to hidden grief. Dr. Alan D. Wolfelt, a grief specialist and director of the Center for Loss and Life Transition in Fort Collins, Colorado, reminds caregivers that AIDS survivors are "disenfranchised" because they feel the need to hide their grief. He states: "Disenfranchised grief is experienced when the death of someone loved is not acknowledged or socially supported. Unfortunately, many survivors of AIDS deaths are disenfranchised. Because of the social stigma surrounding the disease, survivors of AIDS deaths feel the pain of loss yet may not know how or where or if they should express it."

This pattern of sheltering feelings and hiding the true nature of the illness often begins when AIDS is first diagnosed. One example is that of Elizabeth Glaser and her husband, Paul, Hollywood director and former star of the TV series Starsky and Hutch. In 1981 Elizabeth was infected with the AIDS virus through a tainted blood transfusion. Unknowingly, she passed the virus on to her two children.

Ariel, their eldest daughter, was diagnosed as HIV positive at age 4. Although the couple decided to confide in only a few of their closest friends, the impact was extremely negative. "At first no one would allow their children to come and play at our house," Elizabeth Glaser writes in her book In the Absence of Angels.

"Some friends refused to let my kids come to their homes at all. Some said their children could continue to play with mine, but only at the park. Some dropped out of our lives. We asked a therapist to see if a child psychiatrist would work with Ari when and if we felt it was appropriate. I was later told that psychiatrists would not see my child because they were afraid if word leaked they would lose too many other patients."

Unfortunate experiences such as those of the Glasers force AIDS patients, their families, and close friends to engage in a conspiracy of silence. A healthy grief recovery hinges on the freedom to express feelings openly and honestly. "Just like other bereaved persons grieving the loss of someone loved, AIDS survivors need to talk, to cry, sometimes to scream, in order to heal," says Dr. Wolfelt.

Work to be well informed Because of inaccurate information and fear associated with AIDS, there is a continuing need for education and information. Be informed so you
can inform, educate, and reassure others about AIDS issues. Some people hesitate to visit surviving family at a funeral home, fearing they will contract the virus themselves simply by shaking hands or embracing family members. The national Funeral Directors Association recently published a helpful booklet titled A Caring Response to an AIDS-related Death. That brochure is effective in dispelling myths about contracting AIDS during a funeral visitation.

Accept the intensity of AIDS grief. The harsh negative response from society toward AIDS patients and families creates a more intense grieving process. "Sometimes when I am alone in my car," Glaser says, "I scream, /If You are there, God, I hate You!"

While such intense and angry expressions can be unsettling to a listener, the bereaved need to get those feelings out. Dr. Wolfelt advises, "Accept that survivors may be struggling with explosive emotions, guilt, fear, and shame well beyond the limits experienced in other types of deaths. Be patient, compassionate, and understanding."

Be aware of support groups. One of the most effective sources of help to AIDS survivors is a support group. There they can meet with people who have had a similar loss, see others coping successfully, and share their feelings without fear of rejection or ridicule. A practical act of mercy on the part of a caregiver would be to take the time to locate a group--noting location, dates, and meeting times, and giving that information to the bereaved.


PERSONALITY CHARACTERISTICS OF ADOLESCENTS WITH ALCOHOLIC PARENTS

by Martina Tomori

This study examined personality traits frequently encountered in children in families with at least one alcoholic parent. The sample investigated included 63 adolescents (32 males and 31 females) ranging in age from 12 to 19 years. Twelve self-image variables and eight aggression and anxiety variables were assessed using a battery of psychodiagnostic instruments. The results were compared with those obtained in a control group of 321 age-matched adolescents (160 males and 151 females) growing up in nonalcoholic families. Statistically significant differences between the groups were found in eight self-image variables (impulse control, emotional tone, vocational and educational goals, sexual attitudes, family relationships, psychopathology, and adjustment and depression), in six aggression variables (assault, indirect aggression, verbal aggression, irritability, suspicion, and feelings of guilt), and in both anxiety variables (i.e., anxiety as a state and anxiety as a personality trait). The findings can be functionally applied both to clinical work and to prevention programs for adolescents at risk.

INTRODUCTION

Investigations of various factors known to increase the risk of alcohol addiction in adolescents have invariably stressed the association between the personality traits of
prospective alcoholics and their dysfunctional family. The unsatisfactory social context, which aggravates the adverse effects of those factors, is commonly determined by parental alcoholism, which significantly affects the dysfunctional family dynamics. The studies addressing the issue of alcohol abuse in adolescents deal primarily with the following clusters of risk factors: parental influence, peer influence, social context of adolescent involvement in alcohol, and personality characteristics of adolescent misusers (Mayer, 1988).

Our clinical and research work has indicated that in adolescence the above-mentioned factors are most closely interrelated and highly interdependent. Since personality traits are formed within the family, family relations and family dynamics represent, in addition to a number of subjective and objective factors, important determinants of the adolescent personality profile. Similarly, social behavior characteristics, which are so intimately connected with self-image and the process of separation and individuation, reflect all strong and weak points of the family process. Several researchers have identified high levels of depression, anxiety, low self-esteem, and low educational goals as common personality characteristics of adolescent problem drinkers (Lisansky & Gomberg, 1982; Mayer, 1988). These characteristics are in many aspects determined by the parental abuse of alcohol and the deleterious effects of alcoholism on the family. Unassertive parents are unable to enhance assertiveness in their children, nor can they promote their uneventful and trauma-free experiences separation process, one of the main axes of adolescent psychodynamics.

Feelings of being rejected and constant fear of emotional loss, which accompany children of alcoholic parents throughout their childhood, tend to culminate in adolescence, a time when the feelings become even more destructive and are further intensified by the adolescent's need for independence. Feelings of inferiority additionally impede separation of children from alcoholic families. Their loneliness provides an ideal breeding ground for the accumulating anxiety, self-rejection, and mistrust of others. Hostility associated with these feelings may assume various forms of aggression. Such adolescents use alcohol to relieve anxiety, reduce dissatisfaction and mistrust, and give vent to accumulated aggression. In adolescents brought up in alcoholic family environments, alcohol, entering through several receptor sites, fills many gaps left over from the development period prior to separation. Their parents--either the alcoholic parent, or the partner living with him/her in co-dependency, or both of them--who are themselves filled with distress, depression, and anxiety, usually cling to their children while at the same time manifesting overt signs of resentment and rejection. In this state of pathological ambivalence, they both reject their children and try to tie them to themselves, thus seriously hindering their separation. As a result, many children of alcoholic parents develop defensive aggression or passive resistance, or take recourse to some other inappropriate patterns of defensive behavior. Their negative self-image, rendered even more somber by the feeling of shame caused by the alcoholism of their parents, only adds to their loneliness and low sense of well-being. They have no opportunity to learn how to cope with anxiety and depression. Encouraged by the disinhibiting effects of alcohol, they find it easier to enter the world outside their family borders in search of relief and self-assertion (Berlin, Davis, & Orenstein, 1988).

Filled with feelings of inferiority, such adolescents cannot or dare not seek accomplishment in a healthy peer group, although their need for social approval and their
wish to be accepted as part of the group is much stronger than in their peers who are growing up in a supportive and affectionate family environment. Thus, they are even more vulnerable to influences of delinquent adolescent groups. The use of alcohol relieves stress, regulates moods, and enhances communication skills and relations with peers whose approval boosts their low self-esteem (Thompson, 1989). Drinking compensates for the lack of social skills which cannot be learned in an alcoholic home, and at the same time acts as an anxiolytic drug (Smith, Canter, & Robin, 1989). To such adolescents, socialization enhanced by the use of alcohol is more easily accessible than other healthier patterns of the socialization process. Adolescent children of alcoholic parents are therefore more vulnerable to early alcoholism than are their peers from nonalcoholic homes. Alcohol abuse, however, is not the only hazard that threatens these adolescents to a much greater extent than it does their peers from healthy families.

Authors who have investigated personality characteristics of adolescents with alcoholic parents portray them as having difficulty with issues of self-esteem, depression, ego control, and feelings of guilt (Tweed & Ryff, 1991). Also, they are found to have higher somatization scores, poor self-concept, inability to develop emotional and intimate relationships, and a low level of resistance to illness and stress (Whipple & Noble, 1991; Wagner-Glenn & Parsons, 1989). Not only are children of alcoholics more vulnerable to use alcohol and other drugs, they are to a greater extent also exposed to other psychosocial risks (Chassin et al., 1992). These findings stress the need for the identification of protective factors which would reduce these hazards to their mental and physical health. By establishing and developing such factors, we could contribute to more effective prevention of alcohol and drug abuse and other psychosocial disturbances.

METHOD
Sample
The sample investigated included 63 adolescents (32 males and 31 females), aged 12 to 19 years. In the alcohol treatment center, alcohol dependence was diagnosed in either one or both of their parents. A control group consisted of 321 same-aged adolescents (161 males and 160 females) from nonalcoholic families. Informed consent was obtained from the subjects, all of whom had volunteered for the study.

Psychodiagnostic Procedures
The following psychometric instruments were used in all individuals in the study: Offer's self-image questionnaire (OSIQ), which assesses impulse control (PS-1), emotional tone (PS-2), body image (PS-3), social relationships (SS-1), morals (SS-2), educational goals (SS-3), sexual attitude (SX), family relationships (FS), external locus of control (CS-1), psychopathology (CS-2), optimal adjustment (CS-3), and depression (DEPR); Aggression Questionnaire (Buss-Durkee) which assesses physical aggression (assault) (A), indirect aggression (IA), verbal aggression (VA), irritability (IR), negativism (NG), resentment (R), suspicion (SU), and feelings of guilt (G); Spielberger's State-trait Anxiety Inventory (STAI), which assesses anxiety as a state (STAI X-1) and anxiety as a trait (STAI X-2).

Data Analysis
The data obtained were analysed using the Statistical Package for the Social Sciences. The following statistical methods were employed: determination of statistical parameters; the F-test and t-test for determining the significance level; the one-way analysis of variance; the Pearson correlation coefficient; and the Kendall Tao correlation coefficient. Only relevant data are presented in the tables.
RESULTS

The observed differences between the control and the study group were highly significant (at the 0.01 level) in the following self-image variables: impulse control (PS-1), family relationships (FS), and optimal adjustment (CS-3). Low impulse control scores in the study group suggested that they had great difficulty controlling internal impulses. This characteristic is manifested in uncontrolled reactivity, weak impulse control, and inability to control external and internal pressures in a rational way (characteristic of the very high inner tension in adolescence). Differences in family relationship scores indicated that adolescents from alcoholic homes hold a very negative view of their family and experience a high degree of uncertainty about their role in the family. The resulting feelings of insecurity constitute an equally important part of their self-image.

Adolescents from alcoholic homes had significantly lower adjustment scores; since in a disrupting alcoholic environment they are frequently faced with various stressful situations, their inability to adapt to stress is a particularly severe handicap.

The groups differed significantly (at the 0.05 level) regarding their vocational and educational goals (SS-3). Adolescents with alcoholic parents scored lower on the scales for these goals as compared with their peers from nonalcoholic families. They also showed very low aspirations and invested very little energy in making plans for the future.

Group differences were statistically significant (at the 0.1 level) regarding emotional tone (PS-1), sexual attitudes (SX), psychopathology (CS-2), and depression (DEPRES). These scores reflect emotional instability, inability to control emotions, confusion about sexual role, and viewing oneself as being different from others in terms of psychopathology and increased depression. The latter is not manifested as a disorder of mood, but as a tendency toward withdrawal and defeatism, as a derogatory attitude to oneself and other people, as well as increased uncertainty and apathy. Aggression (Results of the Buss-Durkee Questionnaire)

The most significant differences between the groups were noted in their irritability (IR) and verbal aggression (VA) scores. Adolescents with these traits are more likely to engage in conflicts when feeling frustrated or when under subjective or objective pressure. Increased urges to quarrel and uncontrolled and loud outbursts of anger adversely affect both the adolescent and his/her environment. Adolescents from alcoholic homes score significantly higher than do controls on the scales of assault (A), suspicion (CU), and intense feeling of guilt (G) (at the 0.05 level). Also, they are quick to react by assault, show high levels of destructiveness, and are mistrustful of others. They have a very low opinion of themselves and are filled with feelings of guilt. They also differ from control peers in their level of indirect aggression (IA) (at the 0.1 level).

Anxiety (STAI Results)

A comparison of anxiety scores for adolescents in both groups showed that children of alcoholic parents had significantly higher scores for anxiety as a state (STAI X-1), which is manifested in acute feelings of anxiety and worry as well as anxiety as a personality trait (STAI X-2), expressed by uncertainty, pessimism, feelings of constant inner tension, and a tendency to be on the alert for threats. In addition to acute feelings of anxiety, they demonstrated high levels of anxiety which constituted a constant component of their personality profile and profoundly influenced their self-concept and attitude.
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**DISCUSSION**

The objective of this study was to determine the personality characteristics of adolescents with alcoholic parents which distinguish them significantly from their peers from nonalcoholic families. Since previous studies have suggested that children from families with at least one alcoholic parent are more likely to develop various forms of psychopathology, including problem drinking (Marston et al., 1988; Wagner-Glenn & Parsons, 1989; Pardeck, 1991), this study was undertaken to find out which psychodynamic pathways and social processes placed so many children of alcoholic parents at similar risks. The study focused on the adolescent self-image for two reasons: self-concept plays a key role in the development of adolescent psychosocial disturbances; and self-image is strongly influenced by the family environment. Many studies dealing with children of alcoholics have suggested that there is an increased rate of alcohol use and early problem drinking, often followed by alcohol dependence (Thompson, 1989; Englander-Golden et al., 1989; Walfish, Massey, & Krone, 1990; Page, 1990; Page & Cole, 1991; Cole, 1991; Thorlindsson & Vilhjalmsson, 1991; Martin & Pritchard, 1991) in this group. Further, the identification of risk factors for drinking would throw more light on protective factors which could be included in alcohol abuse prevention programs, as well as in treatment of alcohol-dependent adolescents.

**Self-Image**

Compared to their peers from nonalcoholic families, adolescent children of alcoholic parents are more likely to be described as impulsive, nonconforming, and depressed. Their role in the family is often conflicting, they are confused about their sexual identity, and have very low educational aspirations. Each of these traits is basic to the adolescent personality structure, and taken as a whole, they predict a higher rate of problems, conflicts, and traumatic experiences in the course of their personality development.

Poor self-concept predisposes adolescents to development of inappropriate, even destructive, defense mechanisms, and in many ways determines the development of pathological responses and somatic problems. Such emotionally unstable adolescents show poor self-control and view themselves as incompetent and unaccepted. Uncertainty about the sexual role, which is characteristic of adolescence, increases vulnerability in several ways. Such adolescents are especially prone to adopt maladaptive ways of self-assertion and tend to resort to deviant and harmful behaviors in order to relieve their emotional distress.

**Aggression**

A comparison of adolescents from alcoholic families and their peers from nonalcoholic families showed that the former scored higher on aggression leading to conflicts. These conflicting situations increase their low opinion of themselves and mistrust of other people, and increase their dissatisfaction. The intensity of their feelings of guilt further raises the destructive effects of these conflicts on their self-concept.
Anxiety
Feelings of intense anxiety are an integral part of the personality structure of adolescents with a family history of alcoholism, and discriminate them significantly from their peers from nonalcoholic families. Since severe and uncontrollable anxiety is basic to most neurotic disorders and other forms of psychopathology, these adolescents appear to be at a particularly high risk.

Each of these characteristics originating in the alcoholic family, is likely to predispose the adolescent to the development of various disorders, including alcohol and drug abuse. Thus, professionals involved in clinical evaluation and therapy of children with a family history of alcoholism should pay attention to their specific personality constellation.

There is no doubt that certain weaknesses, personality traits, or disturbed mental functions may be the key factors which predispose these adolescents to problem drinking and alcohol dependence. The correlation between personality characteristics and involvement in alcohol is confirmed daily in our clinical practice. The dynamics of psychoactive substance abuse is closely connected with other issues, including negative self-concept, depression, anxiety, dissatisfaction with the role in the family, and uncertainty about the sexual self.

Involvement in alcohol and other drugs is not only a major element of the individual's pathology, but forms part of a larger social context of adolescents. It is closely linked with their social habits and their feeling of being part of the group; it increases their assertiveness and enhances their social skills and peer relations, thus contributing to the development of their social self--an essential part of one's self-image.

Self-confidence and readiness to accept different, sometimes negative views and responses of others, coupled with the ability to cope with occasional refusals or failures, are the key characteristics that help adolescents adopt healthy patterns of social behavior. Adolescents must show at least some predictability, self-control, and inner strength in order to be able to view their relationships with peers as a supplement to what they had been given by their family, rather than as compensation for what was missed as a child. Adolescents who come empty-handed from their dysfunctional families badly need to be accepted by peers, yet new social experiences, instead of helping them develop their social role in a constructive way, further increase their emotional distress. Such adolescents resort to drinking in order to relieve depression and feelings of insecurity. The disinhibiting influence of alcohol enhances their sociability and makes them feel in control, yet the cumulative effects of alcohol and high levels of aggression--which they somehow manage to restrain when sober--are most often detrimental both to the drinker and to the environment. Because of their unhappy and deprived childhood, adolescents from dysfunctional families show increased inclination toward alcohol misuse, greater susceptibility and vulnerability to the adverse effects of drinking, and therefore are at higher risk for developing alcohol dependence than are their peers from nonalcoholic families.

The results of the study can be applied directly to our clinical work with adolescents and their families. Our comprehensive therapeutic approach includes training courses in assertiveness and social skills, provides adolescents with the tools for more effective control of inner tension, and teaches them how to give vent to their aggression in less destructive ways. Psychotherapy focuses attention on the development of a
realistic self-image, self-confidence, trust in others, and healthful sexual attitudes. All of these elements used in psychotherapy need to be included in alcohol and drug abuse prevention programs designed for adolescents at risk for developing alcoholism and other psychosocial disorders.

REFERENCES


ADAPTOGENS: ALL-PURPOSE HERBS

by Christopher Hobbs
James Ryan grew up California's Central Valley as a farmer's son. As a child he loved to stand by the fields and watch the biplanes fly over, trailing white clouds of pesticides that filled the spaces between the rows and engulfed the plants in a thick fog. At times the wet spray would land on his skin and hair. After twenty-five years of exposure to agricultural chemicals and exhausted by the rigors of running a large commercial farm, Ryan was so debilitated that he could no longer meet the challenges of everyday life. He suffered from periodic bouts of dizziness, some so severe that he would nearly collapse. On the advice of a Chinese herbalist, he began to take an herbal tea that included eleuthero, astragalus, and reishi. These substances, which some herbalists now call "adaptogens," have played a central role in his recovery. Adaptogens are a recently identified class of herbs that can help strengthen our bodies' ability to adjust to the rapidly changing conditions of our lives.

The word adaptogen was coined by the Soviet scientist N. V. Lazarev in 1947. According to Lazarev, a substance must fulfill three criteria to be classified as an adaptogen:

* Cause only minimal side effects
* Increase the body's overall immune function by a wide range of actions rather than by a specific action
* Restore to balance all bodily systems while aggravating none

Although Lazarev conducted his original studies of adaptogens using synthetic chemicals, it was his student, I. I. Brekhman, M. D., who changed the focus of adaptogenic research to natural substances. Brekhman noticed that many Russian doctors, especially in the outlying districts, prescribed herbs in their practices. Brekhman first studied Panax ginseng, a popular Chinese herb commonly prescribed for longevity.

But its availability was limited, and it was too expensive for daily use. So he began to test other members of the ginseng family. In 1959 Brekhman discovered that Siberian ginseng (Eleutherococcus senticosus), which was more common and less expensive than Chinese Panax, had even stronger adaptogenic qualities.

Since then, Brekhman and many other researchers have conducted thousands of scientific tests on eleuthero, as Siberian ginseng is commonly called, as well as on other herbal adaptogens. They have proved to be remarkably effective in preventing a variety of stress-related ailments and in increasing stamina and athletic performance.

In general, adaptogens work as follows:

* Support adrenal function and thus counteract the debilitating effects of stress.
* Increase the concentration of enzymes that help produce energy in the body's cells.
* Help cells to eliminate waste byproducts of the metabolic process.
* Provide an anabolic effect that helps build muscle and tissue.
* Help the body use oxygen more efficiently.
* Enhance the regulation of biorhythms.

Although mainstream medical practitioners often doubt that a single remedy can exhibit all these benefits, the concept behind the general tonifying effects of adaptogens is familiar to Western medicine. Until about fifty years ago, doctors commonly prescribed medicines known as roborants (strengthening substances), tonics (which restore normal tone to tissue), and alternatives (which improve the processes of nutrition...
and repair). For example, bitters such as gentian and quassia were widely used to improve digestion, and strengthening foods such as oatmeal and yams were prescribed for convalescents. What we now call adaptogens combine at least some of the major functions of roborants, tonics, and alternatives. Indeed, some herbalists are beginning to classify many of these general acting herbs as adaptogens, including the wellknown immune-tonic echinacea and golden seal, a bitter herb.

The majority of today's studies on adaptogens have been conducted in the Soviet Union. Researchers there have identified several herbs that I will call primary adaptogens. These herbs were among the first to be studied as adaptogens and are the most powerful. They include: eleuthero, schizandra (Schizandra chinensis), and reishi (Ganoderma lucidum).

There are also what I will call secondary adaptogens, or herbs that have shown some normalizing activity, especially on the immune, nervous, and hormonal systems, but which may not have been studied extensively for their adaptogenic qualities or may not support the adrenal system. Secondary adaptogens include: ashwaganda (Withania somnifera), gotu kola (Centella asiatica), wild oats (Avena sativa), astragalus or huang chi (Astragalus membranaceous), fo-ti or ho shou wu (Polygonum multiflorum), burdock (Arctium lappa), and suma (Pfaffia paniculata). There are probably many other herbs, and even foods such as seaweeds and leafy greens, that fall into this second category of adaptogens, but those mentioned above are the best studied and most readily available ones in this country. You can incorporate adaptogenic herbs into your daily nutritional regimen as you would any general supplement. Adaptogens have few contraindications or cross reactions with other supplements. They can be taken as tinctures, capsules, or teas.

There are three ways to evaluate the effectiveness and safety of an herbal remedy: first, by its history of use; second, by what scientific research can document about its effect, its active constituents, and its toxicity; and third, by the results of its use in clinical practice. In the case of eleuthero, its effectiveness has been documented by all three methods.

Eleuthero has been known in China for thousands of years, where traditionally it has been used to counteract general debility and weakness. In the Soviet Union, millions of people take eleuthero daily, among them mountain climbers, sailors, and factory workers, who all use the herb to increase endurance and to reduce the frequency of illness. The Soviet Olympic team uses eleuthero, especially weight-lifters and runners.

The American researcher Norman Farnsworth collected and translated many of the original Soviet studies on eleuthero of the sixties and seventies, and published them in Economic and Medicinal Plant Research, vol. 1 (Academic Press, 1985). Although many of these studies were not double-blind experiments, their results do offer insight into how adaptogens work and what benefits they might offer. These studies found eleuthero's major physiological effects to be as follows:

* Protect against environmental pollutants and radiation
* Normalize body temperature
* Regulate blood-sugar levels
* Protect the liver and enhance its ability to eliminate drugs from the body
* Improve the body's ability to resist infection
* Optimize adrenal function

Eleuthero also increases endurance and the capacity to do work by improving the
cells’ ability to use phosphorus-containing energy molecules and to dispose of lactic acid and other byproducts of metabolism. Finally, eleuthero has been shown to increase semen output and reproductive capacity in men.

The active constituents of eleuthero are natural plant steroids called eleutherosides, which are concentrated in the root bark. Eleuthero products made from root bark alone are much more potent than those made from the whole root, but such products are rare and prohibitively expensive. The original research on eleuthero was conducted with tinctures of whole roots that contained approximately 35 percent alcohol.

For those interested in using herbs to improve general immune function, eleuthero is probably the place the start. Its strengthening and endurance building capabilities make it suitable for busy people everywhere. For general maintenance, to help cope with stress, or to support a physical training program, many individuals take one dropperful of eleuthero tincture before breakfast. (When the drops are placed in a cup of warm water or tea, most of the alcohol will evaporate.) To increase performance in athletics, on the job, or at school, many individuals take a second dropperful in the evening about an hour after dinner. During times of heavy stress or change (new job or living situation), three droppersful of the extract (either two in the morning and one in the evening, or one in the morning, at noon, and at night) are often recommended. Every ten days many users take a two-day break with no eleuthero, then repeat the cycle and continue for up to nine months—or longer under supervision.

The following is a list of primary and secondary adaptogens, their effects on the body, and how they often are prescribed by trained herbalists:

**PRIMARY ADAPTOGENS**

**Schizandra Berry (Schizandra chinensis)**

In the American horticultural trade, schizandra is called magnolia vine, and indeed botanically it is closely related to the familiar magnolia tree. Schizandra has been an important ingredient in traditional Chinese tonic formulas since antiquity; the small red fruits of schizandra are considered to balance all bodily systems because they have all of the five flavors Chinese herbalists use to classify medicinal herbs: sour, salty, bitter, sweet, and acrid.

In the West, schizandra is often combined with eleuthero in adaptogenic formulas, and it has been studied extensively in this form in both Sweden and the Soviet Union. It is also included in commercial anti-stress, weight-loss, and sports formulas in this country. Scientific studies support these uses of schizandra as well as the herb’s liver-protecting and strengthening capabilities. The liver is a vital "adaptogenic" organ, because it helps to regulate blood sugar and hormone levels, and because it is the main detoxifying organ of the body.

Schizandra is suitable for those who wish to support liver function, who have difficulty digesting fatty foods, or who have skin problems such as acne. It can be taken as a tea (added to eleuthero with a little licorice and ginger), or it can be purchased in a wide variety of commercial preparations, such as tinctures and powdered extracts in tablet form.

**Reishi (Ganoderma lucidum)**

Reishi mushrooms are one of the most revered of the adaptogens. There are stories of people in Japan traveling on foot for hundreds of miles to pick them in the hopes of curing some chronic condition or incurable disease. Reishi has shown a wide
range of adaptogenic properties, including blood-sugar regulation, immune support, anti-cancer properties, the ability to oxygenate the blood efficiently, faster than normal regeneration of the liver, free-radical and radiation protective effects, reduction in sensitivity to allergens, sedative and anti-hypertensive effects, and cholesterol lowering properties. Reishi should be considered when deep immune support is needed.

Ken Jones and Terry Willard, in their book Reishi Mushroom: Herb of Spiritual Potency and Medical Wonder (Sylvan Press, 1990), quote clinical studies in China where ninety coronary-disease patients in several different hospitals were given oral preparations of reishi over a four-month period. Reishi relieved feelings of weariness in about 78 percent of the patients, feelings of cold extremities in 74 percent, and insomnia in 78 percent.

Reishi mushrooms can help strengthen those who are recovering from chronic illnesses, especially when general weakness is a problem. Children seem to respond quickly to reishi.

SECONDARY ADAPTOGENS

Ashwaganda (Withania somnifera)

Ashwaganda is an herb from India, where it has been used since antiquity. The plant is a member of the usually narcotic nightshade family, whose other safe members include the potato, tomato, and eggplant. This small shrub is widely cultivated throughout India, and it plays a central role in traditional ayurvedic and folk medicine. People in India use all parts of the plant, but it is the roots of the ashwaganda that are considered to be medicinal. Traditionally, ashwaganda roots have been recommended for indigestion, heart disease, arthritis, lumbar pain, and fevers, and it is used as a general strengthening medicine for children and for those recovering from illness. Recent clinical and laboratory experience has shown ashwaganda roots to have a strong tumor-inhibiting activity in humans as well as a marked anti-inflammatory effect, which supports its traditional use for arthritis. The extract proved to be without side-effects, unlike hydrocrotisone, a synthetic drug often prescribed for arthritis.

Ashwaganda root can be taken as an herb tea or purchased in a variety of commercial products. The tea is made by simmering one part of the root in ten parts water for half an hour. The tea is taken twice daily, about 1/2 to 1 ounce at a time.

Gotu Kola (Centella asiatica)

Although gotu kola looks nothing like parsley or angelica, it is a member of the parsley family. It is a common weedy plant throughout Asia, often growing in drainage ditches. It likes wet, rich soil and is a common orchard weed in Hawaii. I grow the plant in pots on my back porch, so I always have a supply of the tasty, kidney-shaped leaves. According to legend, if you eat a leaf of gotu kola each day, your lifespan will be extended to one thousand years! I don't expect to be around in my present form for quite that long, but if gotu kola adds a few healthy years to my life, well, so much the better.

Ayurveda, the ancient East Indian system of medicine, recognizes gotu kola as an important brain and nervous-system restorative. Modern science has shown it to have adaptogenic properties and strong wound-healing capabilities. It is used in many cosmetic preparations, helping our sensitive hides to adapt to insults like sunburn. If you wish to try gotu kola, make sure to purchase the fresh liquid extract or grow the plant yourself and take it fresh. I have found that gotu kola loses its properties rapidly when
dried.

**Astragalus (Astragalus membranaceous)**

One of the gems of traditional Chinese medicine, this root from the pea family is sometimes stir-fried in honey to enhance its tonic properties. Astragalus is considered a powerful deep immune strengthener. Its long history of use and extensive laboratory testing have proven its adaptogenic and normalizing effects on the nervous, hormonal, and immune systems.

I learned of astragalus during my first visit to a Chinese acupuncturist and herbalist. The doctor's name was Dr. Yau—which made me worry a bit about his needling technique—but he turned out to have a very gentle hand. I was feeling anxious and fatigued after two years of pre-med classes, and Dr. Yau prescribed astragalus. I experienced splendid results.

Since then, I have designed many effective formulas using this remarkable herb, and I have developed an especially healing relationship with astragalus by growing it from seed in my herb garden.

**Fo-ti or Ho Shou Wu (Polygonum multiflorum)**

Chinese herbalists consider this member of the buckwheat family to be one of the best adaptogenic and longevity herbs. Fo-ti is considered a good cardiovascular herb. Studies have shown it to be effective at lowering serum cholesterol. It also contains bioflavonoid-like compounds that help protect and dilate blood vessels, increasing blood flow to the heart. The root of fo-ti is said to take on magical powers when it is old, and has several interesting names applied to it, depending upon its age. According to the ancient herbalist Li Shih-chen, at fifty years fo-ti is fist-size and is called "mountain slave"; taken at this time, the herb "will preserve the black color of the hair and moustache." A 100-year old root is as large as bowl and is called "hill-brother"; taken at this time the herb will preserve "a cheerful countenance." A 150-year-old root is the size of a basin, and if taken at this time, "the teeth will fall out and come afresh." At 200 years fo-ti is called "hill father," and if taken at this time "the countenance will become like that of a youth, and the gait will equal that of a running horse."

I've started growing fo-ti in my garden, but so far it is only two years old. My hair is showing a few strands of gray, but I have hope.

**Wild Oats (Avena sativa)**

This herb grows as a common grass throughout many parts of the world. Most herbalists feel that a tincture or powdered extract of wild oats is helpful for those recovering from addictions. For instance, several studies suggest that it may reduce cravings for nicotine. Wild oats is also recommended as a nerve restorative when there is trauma or nerve weakness. It should be taken for a long-period of time to be effective, at least one dropperful of the liquid extract or one tablet of the concentrated extract two to three times daily.

**Burdock (Arctium lappa)**

Burdock is a close relative of such well-known herbs as echinacea, dandelion, and feverfew, although it does not currently share their popularity. Burdock root, greens, and seeds were known to the ancient Greeks as healing remedies, and in Western herbalism, they were important foods and medicines throughout the middle Ages. Their nutritional content is high, yet even more interesting is their rich complement of active medicinal compounds. Modern research has isolated chemical constituents from burdock that have
proved to be antibacterial, anti-fungal, and, most important, tumor-protective and desmutagenic (inhibiting of cancer-causing agents). Burdock roots are commonly found in supermarkets and natural foods stores in many parts of the country and can be prepared by boiling, sautéing, or deep-frying. I enjoy thinly sliced roots stir-fried in olive or sesame oil with garlic, greens (such as kale), red peppers, and tofu. The crisp, firm roots can also be added to soups of all kinds.

**Suma (Pfaffia paniculata)**

This herb is native to the Amazon and has been used in South America for generations as a heal-all. In Spanish it has been called "para todo," because of its wide range of applications. Modern research suggests that suma may be an effective adaptogen. Prescribed in Brazilian hospitals for cancer and diabetes, it is given as a tea, two or three cups daily are recommended. The American herbalists Janet Zand and Michael Tierra recommend suma for its strengthening properties, especially for women who suffer from fatigue and hormonal imbalance. Tierra claims that, "to obtain the maximum benefits, one has to take it as a 'food tonic', for instance start with two to four capsules of the powder or up to a teaspoon of the powder (as a tea or in food) three times a day and gradually increase the frequency until you are taking the herb every waking hour and continue for up to a month or more." After this period, Tierra has seen a smaller dose (one does three or four times a week) have the same effect. He cautions, however, that some people may experience nausea, in which case it is best to reduce the dose (perhaps by a third) until the nausea disappears. Tierra also suggests that those with inflammatory conditions, like colds and other infections, should not take it.

Not only do adaptogenic plants contain important nutrients, such as iron, magnesium, and germanium, but their steroid-like compounds may also prove to be essential dietary ingredients. Although scientists have yet to set "daily minimum requirements" for these adaptogenic compounds, we may yet find that the lack of them in our modern diets is a contributing factor in the rise of stress-related and immune-based chronic illness.

It is certain that nature herself is our most powerful ally in our quest for health and longevity, but herbs are not the only adaptogens available. Saunas and cold water treatments can be adaptogenic in their effects, as can all forms of exercise, if practised wisely. Also, as Norman Cousins has so eloquently said, laughing is a deeply healing activity and is, seriously, one of the greatest adaptogens.

**CHRISTOPHER HOBBS** is a fourth-generation herbalist and botanist. He is on the board of directors of the American Herbal Products Association and is a consultant to Rainbow Light Custom Extracts.

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**THE CUTTING EDGE OF ALTERNATIVE CANCER THERAPIES: LEADING CANCER DOCTORS DESCRIBE THEIR PROTOCOLS**

by Charlotte Gerson, Stanislaw Burzynski, Michael B. Schachter, Keith I. Block and Rudolf E. Falk

The diversity of cancer treatments available today is truly mind-boggling. We asked five leading doctors who are successfully using holistic nontoxic therapies with
cancer patients to describe their protocols.

Charlotte Gerson continues to carry on the revolutionary healing therapy developed by her father, the late Dr. Max Gerson. As president of the Gerson Institute in Bonita, CA, she lectures widely and acts as a consultant on the Gerson Therapy to physicians who operate Gerson Therapy Clinics.

The Gerson Therapy is an intensive, non-specific, nutrition-based medical treatment. Its objective is to help the body rid itself of disease by supporting the metabolism and defense systems.

This is achieved by flooding the body with nutrients from 20 pounds of organic foods daily, most of them processed into fresh, raw juices. The main features of the diet are: sodium, fat and (temporary) protein restriction, and potassium supplementation. It is high in vitamins, minerals and micronutrients and rich in fluids.

Although some cooked foods are allowed, great emphasis is placed on the consumption of unaltered foods. Fresh, raw fruits and vegetables are the source of all micronutrients in their pristine organic composition--and they supply even those health-promoting factors not yet appreciated by science.

The medications and supplements used in the Gerson Therapy are materials of organic origin which occur naturally in the body and are given in therapeutic amounts. An important treatment is the frequent detoxification of tissues and blood by coffee enemas, which stimulate the enzyme systems of the gut wall and liver and promote excretion of toxic bile.

Stanislaw Burzynski, M.D., Ph.D. has been awarded 21 patents for his antineoplaston treatment. Clinical studies on this nontoxic cancer therapy are underway in Japan and Poland and were scheduled to begin in the summer of 1992 in the U.S. under NCI sponsorship. The Burzynski Research Institute is in Houston.

For over 25 years my research has been inspired by the philosophy of Hippocrates to "first do no harm." True to this philosophy, my clinical research has been based on his discovery that the body itself has a treatment for cancer: a separate biochemical defense system completely different from the immune system, with growth-inhibiting substances that actually control some types of cancer, not by destroying cancer cells, but by correcting them.

Normally developing new cells become specialized to serve specific purposes. Once specialized, they no longer divide to from new cells. However, some cells seem to lose their way, never specialize, and continue dividing, overwhelming the normal cells. This neoplastic process, called cancer, is a disease of cell differentiation.

According to my research, the biochemical defense system protects us by reprogramming, or normalizing, defective cells. Errors in cell programming may lead to such diverse disorders as cancer, benign tumors, certain skin diseases, and AIDS.

The chemical components of this system are peptides, amino acid derivatives, and organic acids, a group of substances which I have named antineoplastons due to their activity in inhibiting neoplastic, or cancerous, cell growth. In 1967 my initial research indicated that cancer sufferers typically have a lower level of these substances in their blood than healthy individuals. Since 1977 I have treated over 2,000 advanced cancer patients and within the last two years I have also begun treating HIV infection and AIDS with these nontoxic peptides and amino acid derivatives.

Michael B. Schachter, M.D. has practiced nutritional medicine since 1974 in
Suffern, NY. He is a founder and vice President of the Foundation for the Advancement of Innovative Medicine (FAIM).

Until recently traditional medicine regarded cancer as a foreign body that had to be removed either by surgery, radiation or chemotherapy.

Our approach rests on the assumption that cancer is a systemic and not a local disease, even before it reaches advanced stages. Therefore, our strategy is to support and enhance the body's defenses utilizing many of the following methods: dietary recommendations, nutritional supplements (such as vitamin A, beta-carotene, vitamin C, bioflavonoids, vitamin E and other anti-oxidants, B complex vitamins, proteolytic enzymes and a variety of herbs), fresh air and exercise as tolerated; mobilization of internal healing forces utilizing psychosocial methods; and various detoxification procedures to help rid the body of toxic substances as the body breaks down cancer cells. Patients are sometimes given homeopathic medications designed to synergistically enhance the body's own defenses.

We frequently recommend injection programs including intravenous infusions of ascorbic acid. In addition to the IV program, we often recommend staph phage lysate (SPL), which is given intradermally and/or subcutaneously, intranasally or orally. This preparation is a potent stimulator of the immune system.

Hydrazine sulfate, a relatively nontoxic form of chemotherapy, which has been researched extensively and is now undergoing phase III trials in the U.S., is often used by patients to improve appetite and bring about both subjective and objective improvements in the patient's condition. When patients begin therapies that are available outside the United States, we are available to help administer these therapies and support and monitor such patients.

All these methods may be used alone or in conjunction with more mainstream approaches administered by other physicians.

Keith I. Block, M.D. is the medical director of the Cancer Treatment Program at Edgewater Medical Center in Chicago. He is a clinical instructor at the University of Illinois College of Medicine and has served as medical consultant on nutritional-oncology research for the Office of Technology Assessment.

Cancer treatment is concerned with more than just removing tumors by surgery, radiation, or chemotherapy. It also involves preventing recurrence of primary tumors; preventing or inhibiting the metastatic process; strengthening the immune system (a salient goal for cancer patients); and attenuating the noxious side effects of widely used therapies. Proper diet can usefully support all these areas of cancer treatment.

As a clinician, I believe that nutrition must be seen in the overall context of my practice, which marshals a range of other services and support systems that have produced remarkable results for an array of ailments. Central to the practice is a fundamental knowledge of who the patient is, not merely what he or she has. Together with other specialists, I have developed a systematic stress-management program that includes group support, biofeedback, cognitive work, and counseling in the reduction of life stresses and psychological vulnerabilities. We now know that the immune-suppressing effects of psychological stress are of major importance.

Exercise regimens, part of my physical conditioning program for the bedridden to the athletic, are designed to raise cardioaerobic competence and maintain muscle mass. Where appropriate, selected nutritional and botanical supplements are given. We have
begun an in-hospital program and a facility offering nutritious meals to be taken home or to the hospital, for patients and families who can't cook at home.

The goal of all these programs is to arouse in each patient a life-affirming and healing attitude. This is imperative in all medical care, but especially so in cancer treatment. My ongoing work and research in nutrition and diet, then, are part of a larger picture—that of fulfillment at the physical, biochemical, psychological and emotional levels, both for people combating cancer, one of the most stressful of medical experiences, and for those hoping to prevent it.

Rudolf E. Falk, M.D. founded The Falk Oncology Centre in Toronto in 1985, which is dedicated to the development of innovative therapies for cancer patients. He is a Professor of Surgery and Immunology at the University of Toronto.

Over the past two decades, a cancer patient's excess prostaglandin production has frequently been shown to be a significant contributor to tumor growth. Yet, the conventional treatments used to curb prostaglandin proliferation have serious drawbacks. Corticosteroids suppress the immune system and, to be effective, nonsteroidal anti-inflammatory drugs (NSAIDs) must be given in intolerably high doses.

At the Falk Oncology Centre, we have developed a carrier vehicle—hyaluronic acid—which can be used with a variety of drugs. Hyaluronic acid, which is nontoxic at any dose level, can be administered intravenously, intramuscularly, or can be injected directly into the tumor. When administered in hyaluronic acid, NSAID drugs, Ketorolac and Diclofenac can be given at two to four times the usual dose without major gastrointestinal, hepatic or renal side effects.

We have found that intravenous cytotoxic chemotherapy mixed in hyaluronic acid shows enhanced targeting to tumor tissue in patients with recurrent and/or metastatic cancer. Furthermore, we have developed a topical gel which utilizes Diclofenac in hyaluronic acid. When applied topically, this gel has proven to be effective against basal cell carcinoma.

Over the past two years, we have evaluated 90 patients with advanced cancer including colorectal cancer, non-small cell lung cancer, breast cancer, malignant melanoma, and a variety of other malignancies. Of the 90 patients treated, 80 still survive either in a stable condition or in partial or complete remission. Of this group, there are 30 patients, or one-third of the original group, who are now in complete remission.

ANCIENT HERBAL COSMETIC FORMULAS WORKED WONDERS FOR CLEOPATRA - HOW ABOUT YOU? AGE-OLD RECIPES HELP YOU PUT A NEW, NATURAL FACE ON BEAUTY

Age-Old Recipes Help You Put A New, Natural Face On Beauty

Half a century ago American archaeologists excavated the tomb of Helep Heres I, the mother of the pyramid-builder Cheops. Among the treasures which had been placed in her grave they found a beauty case full of cosmetics. And Cleopatra's cosmetic concoctions were legendary. It would seem that beauty has always needed a helping hand.

But what is quite new is the amount of money being made by commercial cosmetic firms who frequently package simple substances in exotic pots, bottles and
boxes, and who, with the help of advertising, have built up a huge and very lucrative industry.

Unfortunately, some of the chemicals used in commercial products can have the opposite effect to that which was intended. Allergic reactions can be caused by certain perfumes contained in "beauty" preparations, by irritants in hair dyes and by detergents contained in some cleaning creams. Even more distasteful is the use of hormones, sometimes extracted from placenta and not completely free of health risks. Another undesirable aspect of some commercial cosmetics has been pointed out by anti-vivisectionist: the development of some beauty preparation has involved experimentation on animals.

The exaggerated claims used to sell these products will, no doubt, give hope to every Cinderella. But let's face it: No antiwrinkle cream will give you back your youth and no bust lotion will turn a Twiggy into a Jayne Mansfield. The contents of those thick glass bottles and false-bottomed pots can only help make the best of what is already there.

Natural cosmetics cannot work any miracles either, but they do provide an alternative way to care for your appearance without the disadvantages of commercial preparations. Moreover, they can be made at home with very little trouble at less cost. Some recipes are quite complicated, needing many ingredients and a certain amount of time and effort. Others are as simple as making a cup of tea or picking a flower.

The various fats and oils, such as sweet almond oil, can be bought at most drugstores. If you go when they are not busy, many druggists will weigh small and exact amounts for you. The herbal infusions of witch hazel and rosewater are also available at drugstores. Dried herbs, herbal oils, mixtures and concentrates can often be bought from health food shops and homeopathic drugstores, but the specialist herbal supplier will stock the widest range of products.

Many of the herbs and plants can, of course, be grown easily in the garden or window box, for example, sage, rosemary, lavender, fennel, garlic, cornflowers, etc. Others like celandine, speedwell, elder and hawthorn, grow in abundance in the countryside.

Choose the herb which is most suitable for your hair or skin type and most easily obtainable. Then choose a cream or lotion and replace the simple oil by an equal quantity of essential oil of herb. Distilled water or rosewater can be replaced by an equal quantity of herbal infusion. In the case of hair tonics, the alcohol ingredient may be replaced by the same amount of herbal tincture.

Another way of adding herbs to cosmetics is to pound a quantity of fresh herb directly into your creams. This has to be done very thoroughly and require a lot of energy! A pestle and mortar are essential for this. It is also possible to add plant or fruit juices directly to the creams and lotions. Use a blender.

The following guide will help you decide which herbs are most suitable for your particular skin or hair type:

Astringent herbs: The most important are plaintain, lemon, hazel and bilberry.

Witch hazel has also very important astringent properties.

Herbs for softening and moisturizing are marsh-nallow, cucumber, camomile.

Skin tonics are used to remove excess oil from the skin. They are refreshing,
stimulating and will tone up the complexion. Tonics are often used after a cleansing lotion to remove the last traces of dirt and grease from the face, but they can also be used by themselves to clean the face.

**WITCH HAZEL AND ROSEWATER**

This is the simplest and one of the best skin tonics. Mix 2 parts rosewater to 1 part witch hazel. These proportions are for a normal to greasy skin. Those with a very oily skin can increase the proportion of witch hazel and those with drier skin should increase the rosewater.

(Astringent skin tonics all contain alcohol and are not suitable for people with very dry or sensitive skins.)

**ORANGE AND LEMON TONIC**

3 Lemons 1 Cucumber 1 Orange 3 tbsp. Rosewater 30 grams Alcohol Extract the juice from the orange, lemons and cucumber and mix this with the other ingredients. This makes a potent lotion, good for skin color, and for those who suffer from blackheads.

**CUCUMBER TONIC**

1 Cucumber Elderflowers Distilled water Brandy

Peel the cucumber and slice thinly. Put it into a pan and add enough water to cover it. Simmer until the cucumber is soft. Mash it and put in a muslin cloth to drip. Press as much of the juice through the cloth as you can. Add 1 part brandy to 2 parts cucumber juice. Prepare an elderflower infusion with 3 flowers to 1/4 liter distilled water. Add 1 part elderflower infusion to 2 parts cucumber and brandy mixture. This makes an excellent lotion to clear a troubled skin.

**ORANGE BLOSSOM TONIC**

60 g Orange blossom infusion 35 g Alcohol 2 g Glycerine

Prepare the infusion with 1 tbsp. dried orange blossom to 1/4 liter distilled water. Filter this well and shake it together with the other ingredients. A simple and soothing mixture.

**ROSEMARY TONIC**

1 small bunch Rosemary 1/4 liter Distilled water 1/2 measure Brandy Simmer the bunch of fresh rosemary in the mixture of distilled water and brandy for 20 minutes. Filter this mixture for an excellent mild face tonic.

**WHEN YOUR CHILD NEEDS ANTIBIOTICS**

by Janet Zand and Paul M. Fleiss

If your child's physician has prescribed antibiotics, do not be discouraged. A course of the right medicine begun at the right time can be highly effective. Sometimes an infection attacks so strongly that a child's body cannot fight back without significant assistance. In certain of these instances, antibiotics can be of great help.

If your child appears to be suffering from such an infection, make no assumptions. Instead, rely on your pediatrician to confirm a diagnosis--person-to-person. In these days of food-to-go, we have become accustomed to phoning in our children's symptoms the way we would order a take-out pizza. In reality, children who are sick enough to seemingly need a course of antibiotics are sick enough to be seen by a doctor.
If antibiotic therapy is advised, know that you can join in the healing. You can learn about antibiotics and how they work. You can be on the lookout for any imbalances they may create. And you can provide restorative and preventive care by augmenting the prescribed treatment with natural remedies. Here are some pointers to help you on your way.

Antibiotic Properties, Origins, and History

What is an antibiotic? It is a substance derived from living organisms, usually bacteria or molds, and it is able to kill microorganisms or inhibit their growth. In fact, the word antibiotic means "life destroying." Whereas antibiotics were originally grown from natural components for use in the treatment of parasitic diseases, today they are often synthetically produced to help combat bacterial infections.

The curative power of moldy and fermented substances has a long history. Early medical records from China, Egypt, and Mesopotamia, dating back to at least 1500 BC, mention the use of animal dung and soybean curd in the treatment of wounds and infected swellings. Similar practices were in effect around the world for more than 3,000 years, with surprisingly few refinements. The development of antibiotics as we know them did not occur until scientists began investigating the causes of infectious disease.

In the late 1800s, chemists Louis Pasteur and Jules Joubert observed that spore-producing parasites known as anthrax bacilli failed to grow in cultures contaminated with airborne molds. The chemists understood that their findings might well have significant therapeutic implications. Nevertheless, advances were delayed nearly half a century while the focus of infectious-disease research shifted to immune serums, vaccines, and other chemical agents.

In 1928, Alexander Fleming noticed that the pus-producing bacterium Staphylococcus aureus stopped growing wherever the airborne mold Penicillium notatum had begun to grow. Fleming, in an unsuccessful attempt to reproduce the contaminant, named it "penicillin."

Two decades and many scientists later, penicillin was finally produced for military use. The year was 1943. And the material was so scarce that the urine of treated individuals had to be collected so that the excreted penicillin could be recrystallized and used again.

Then, in 1957, laboratory scientists found a way to synthesize penicillin. Immediately, the industrialized nations witnessed a veritable explosion of semisynthetic (part mold, part synthetic) penicillins. By the 1960s, a wide variety of laboratory-designed antibiotics had hit pharmacy shelves. And, as it turns out, for good reason. The ready availability of antibiotics had sparked not only widespread use, but rampant abuse—and, consequently, the need for a diversity of antibiotic therapies.

The indiscriminate use of antibiotics continues, posing one of the greatest challenges modern medicine has yet to face: infections that are becoming increasingly more difficult to treat. Many strains of bacteria have grown smart and have adapted to the commonly prescribed antibiotics. In short, bacteria that could at one time be easily killed by reliable antibiotics are now fighting back. In his book When Antibiotics Fail, Marc Lappe, MD, points out that by 1960, about 80 percent of tested staphylococcal organisms demonstrated resistance to three of the most popularly prescribed antibiotics—tetracycline, penicillin, and chloramphenicol. Today, penicillin is effective against only 10 percent of all Staphylococcus aureus, a parasite that once succumbed in large
Antibiotic Know-How

If your child's physician has prescribed antibiotics, do not be discouraged. A course of the right medicine begun at the right time can be highly effective.

In a fascinating study of children with acute middle ear infections, two Dutch physicians set out to compare the effects of early versus late versus no antibiotic therapy. Of a total of 3,047 children, 1,680 were treated with antibiotics, and 1,367 received no antibiotics. The researchers arrived at the following conclusions:

- When antibiotics are begun on day one of the disease, the frequency of recurrence is 2.9 times higher than when no antibiotics are given. When antibiotics are begun after the eighth day, the rate of recurrence is only 1.3 times higher.
- Antibiotic therapy does not shorten the disease process.
- Antibiotics should be reserved for instances in which complications are present.
- Of all children with otitis media, 88 percent never need antibiotics.
- Antibiotics are most effective when treatment is delayed and antibiotic therapy is generally infrequent.[1]

If the antibiotic prescribed for your child is ineffective against the existing illness, or if bacterial resistance is present, you will probably know it. Should you observe any sudden deterioration in your child's health, notify your pediatrician immediately. A different medication may be in order.

To know what symptoms to look for, do some fact finding in advance. Ask your pediatrician about the possible side effects of the antibiotic prescribed. Also ask the pharmacist for a copy of the descriptive insert that accompanies the medication.

Above all, let the doctor know if you plan to give your child natural remedies along with the prescribed antibiotic. Natural remedies--administered both during and after a course of antibiotic therapy--can help counter many of the adverse effects associated with these medicines. In fact, postantibiotic treatment goes a long way toward reestablishing well-being and preventing a recurrent infection.

Common Side Effects of Antibiotics

- Constipation or diarrhea.

Antibiotics diminish the number of beneficial bacteria in the bowel. As a result, antibiotic therapy may interfere with the thorough digestion of food and lead to constipation or, more commonly, diarrhea. Upon completion of a course of antibiotics, bowel disorders typically subside. In some cases, though, they last a very long time--especially among children who have been treated with several different antibiotics. If your child is experiencing post-antibiotic constipation, try one of the following natural remedies:

- Acidophilus or bifidus culture helps restore bowel flora. These supplements, given two or three times a day can offer dramatic results after one week of treatment.
- Flax seed tea acts as a demulcent that both soothes and "greases" the bowel. This is the recommended treatment for children whose stools have become very dry from antibiotic therapy. To make the tea, simmer 1 teaspoon of flax seed in 1 cup of boiled water for 5 minutes, then strain. The brew may be added to applesauce or juice, if preferred. Offer 1/2 cup twice a day, increasing the amount as needed if the stool remains dry.
- Licorice root, in tea or tincture form, is the demulcent of choice for children...
who have taken antibiotics for a recent lung infection. The herb has antibiotic properties and is soothing to both the bowel and the lungs.

If your child is experiencing post-antibiotic diarrhea, consider these options:

* Acidophilus or bifidus culture, two or three times a day, can help restore bowel flora and relieve antibiotic-related diarrhea after one week of treatment.
* Slippery elm tea is both soothing and healing to the irritated mucous membranes of the large intestine. Native Americans and colonialists used slippery elm as a curative for malnourished children and adults with chronic diarrhea due to infection.
* Echinacea-goldenseal combination, in tincture or tablet form, is helpful for children with sustained diarrhea due to a bowel infection that has persisted despite a full course of antibiotics.

Intestinal infection.

With the reduction in friendly bacteria L. acidophilus and B. bifidus, the intestinal tract may become susceptible to parasitic infection. Giardia lamblia, one of the 10 most common infections in daycare centers today, is known to be highly opportunistic following a course of antibiotics. Symptoms include diarrhea with fever, cramps, reduced appetite, nausea, weakness, abdominal distention, flatulence, belching, or vomiting. If your child exhibits any of these symptoms, notify your pediatrician.

Another parasite that can take hold after a course of antibiotics is Candida albicans, a yeastlike fungus that otherwise lives quietly in the intestines. As this organism reproduces and multiplies, it enhances a child's susceptibility to various allergies. Acidophilus, garlic, echinacea-goldenseal combination, a low-sugar diet, and homeopathic Arsenicum album (9c or 30x) can ease many of the symptoms associated with both giardiasis and candidiasis.

Dermatitis.

Some children develop an allergy to the antibiotic they are taking, in which case a skin rash may appear. Occassionally, infectious symptoms will abate after the rash appears, indicating that the infection is making its way out of the body. Other times, signs of illness will endure, signaling an allergic reaction and, hence, the need for a different medication.

If your child develops a rash, be sure to notify your physician immediately. If the rash persists after your child has switched to another antibiotic, try one or more of the following treatments:

* Echinacea-goldenseal combination, in tincture or tablet form, hastens detoxification of the blood, liver, and kidneys. The immune system, relieved of the burden of detoxifying, can then set about resolving the rash. The recommended treatment is one dose three times daily for three to seven days following antibiotic therapy.
* Burdock root--in tea, tincture, or tablet form--is specific to the skin. The recommended treatment is one dose three times daily for three to seven days following antibiotic therapy.
* Calendula, in cream or ointment form, is soothing and particularly helpful for rashes that are red and hot.
* Traumeel, applied topically in cream form, is a soothing balm for itchy rashes in which the skin has not been broken by relentless scratching.

Persistent mucus.

After antibiotic therapy, infectious residue is often left behind in the form of nasal
or lung phlegm. This is especially true among young children who are not yet able to blow their noses or cough up mucus. If your child has persistent mucus after completing antibiotic therapy, proceed with one or more of the following:

* Dietary reduction or elimination of milk, cream, cheese, fried foods, peanuts, bananas, and sugar can help reduce the amount of phlegm produced.
* Echinacea-goldenseal combination, in tincture or tablet form, assists in both clearing the mucus and eliminating the offending bacteria.
* Vitamin C helps speed up the recovery process.
* Homeopathic Hepar sulphuricum (6c or 12x). Use if the mucus is yellow, the sneezing has continued, and your child is irritable and perhaps chilly.
* Homeopathic Pulsatilla (6c or 12x). Use if the mucus is yellow, the phlegm is concentrated in the right nostril, and your child prefers to be outdoors.
* Homeopathic Kali bichromicum (6c or 12x). Use if the mucus is white and stringy, and your child complains of a full nose.

If none of these homeopathic remedies matches your child's symptoms, consult a homeopathic textbook--or better yet, a homeopath. If, on the other hand, your child's nasal passages are overly dry, try running a humidifier for a week or two.

Reactions to repeated courses of antibiotics.

Children who are given repeated courses of ampicillin or other broad-spectrum penicillins tend to develop more antibiotic-resistant Hemophilus influenzae than youngsters who have had little or no exposure to these drugs. And with antibiotic-resistant H. influenzae comes increased susceptibility to bacterial illnesses such as otitis media, throat infections, conjunctivitis, and occasionally, meningitis.

According to a report published in 1987, broad-spectrum penicillins together with sulfa-containing drugs account for about 65 percent of all antibiotics prescribed for the pediatric population the previous year.[2]

Preventing a Recurrent Infection

Although antibiotics can kill the offending bacteria, such drugs cannot restore balance to the body. After completing a course of antibiotics, a child can in fact become highly vulnerable to a recurrence of the recent infection. To help your child avoid a recurrent infection, offer one or more of the following preventatives:

* A week-long course of acidophilus or bifidus culture, whether your child is symptomatic or asymptomatic.
* A daily vitamin C supplement for a couple of weeks. The gentlest form of supplementation for a recovering child is a mineral ascorbate vitamin C powder that can be mixed into juice.
* A low-potency zinc supplement several times a week for a few weeks. Zinc supplements are best absorbed when taken at the start of a meal.
* A daily dosage of antibacterial-antiviral herbs for a full week following antibiotic therapy. Echinacea, for one, acts like a broom, helping to sweep the body clear of residual remnants of infection. Goldenseal, a strong herbal antibiotic, helps restore health to the mucous membranes, especially those of the nose and lungs.
* Small amounts of tonic herbs such as Astragalus membranaceous and American ginseng. These herbs blend well with soups and stews, and are ideal for children who are tired upon recovering from an infection.

Infectious diseases are a reality. The best rule of thumb is to find a physician who
will work with you and your child in preventive as well as curative approaches to illness. A second-best option is to provide the preventive and restorative measures on your own, with the help of a naturopathic physician, chiropractor, acupuncturist, or other natural practitioner experienced in child health. It is quite possible—even healthful—to mix allopathic and naturopathic approaches. While the diagnoses and treatments may differ, they are often compatible.

Notes

BEYOND GRIEF: A GUIDE TO RECONCILING LIFE AFTER LOSS
by Ardath Rodale and Sharon Stocker

For Kay Ferguson Bechtel, grieving started long before her father's death, during the 3 1/2 years of his illness. "It was a time when grieving seemed traitorous," she recalls, "like a failure of hope." When the end came, Kay was more sad and exhausted than she had ever been in her life. And the emotional road back was neither smooth nor predictable. "Grief doesn't proceed linear fashion," she explains. You feel better. You feel yourself heal. And then, wham! - you're back on your emotional knees. Still, as the days pass, the circles widen. When grief returns again, it finds you stronger."

Anyone who's ever lost someone dear understands the healing process Kay describes. But, while there's no one road map for grief, certain paths can help facilitate and quicken our journey through it.

Some say that the passage of time is the great emotional healer. In fact, it's what you do with that time that is important. In the initial phases of grief, time is necessary to acknowledge and assimilate the emotions, says Daniel Dworkin, Ph.D., affiliate professor of psychology at Colorado State University and co-author of Helping the Bereaved (Basic Books, 1992). Perhaps the most important step we can take toward healing is to grant ourselves time and permission to grieve.

"One of the major roadblocks to grieving is that many of us have abandoned the traditions that in the past gave us the opportunity to publicly share our grief," explains Dr. Dworkin. "As a result, we've had less and less permission to express it and be supported by the community."

In some cultures and religions, for example, the bereaved aren't supposed to do anything at all for a week or two, or even longer.
"In the Jewish religion, you sit shivah for a week and everyone else brings the food in," Dr. Dworkin explains. "You don't have to worry about the mundane, day-to-day kinds of things, and it's socially sanctioned, so it takes a lot of die pressure off."

In modern corporate settings, by contrast, employees are typically given just three days leave, even if it's a spouse or other very close relative who died. Then, employees are expected to go right back to work. "Of course you're not functioning anywhere near 100 percent, but the expectation is that you should be," says Dr. Dworkin.

Judy Tatelbaum, M.S.W., author of the classic, The Courage to Grieve
"Culturally, we place high value on maintaining an image of strength and fortitude in the face of hard times," she says. "The most effective way is to really let go and allow our feelings."

ACCEPTING THE PAIN OF HEALING

"Grief feelings are the hardest kind for us to deal with because they're very intense, and it's not usually just one feeling but many all at the same time," Tatelbaum explains. After the initial shock wears off, the emotional floodgates burst, releasing a torrent of feelings that can range from anger, guilt, anxiety and self-blame to longing, loneliness, sadness and even relief in the case of long illness. This deluge can be overwhelming and frightening - especially if we don't know that all of these reactions are normal.

"It's so much at once, it makes you feel out of control," says Tatelbaum. The fear of losing control permanently can lead us to shut down, suppressing the emotions to avoid feeling them. In fact, feeling our emotions is crucial to moving forward through the grief process.

Dr. Dworkin agrees. "If we cut our emotions off, we don't heal," he says. "In this society, we too often assume that if there's pain, that's bad and we should get rid of it as quickly as possible. We don't accept that part of the grief process normally includes a lot of pain, and we have to allow it."

"At first, it may seem like one step forward and 10 steps back because when someone starts to feel emotional pain, the natural tendency is to withdraw into depression or get really, really busy in a manic sense to avoid feeling altogether," explains Susan Kavaler-Adler, Ph.D., founding executive director of the Object Relations Institute for Psychotherapy and Psychoanalysis, in New York City.

"In order to tolerate the pain, you need a supportive environment in which you can feel safe expressing your emotions," she adds. "Over time, as you are able to speak your feelings, the pain gets converted into a tolerable sadness and a renewed sense of love for the lost person."

SEEKING A SUPPORTIVE LISTENER

Finding listeners with whom to talk can be difficult. Often, friends withdraw, paralyzed by the fear of doing or saying the wrong thing. Or, to avoid the discomfort of not knowing what to say, they may jump in and take the role of advice giver.

"People think they have to have answers, but what answer can you honestly have for somebody who's dealing with death?" asks Tatelbaum. "People back off if they feel they haven't any good advice to give." It's not that friends are unwilling to help, it's more often that they're clueless as to what to do.

"As the bereaved, you are really in the best position to tell people how they can help," explains Dr. Dworkin. "If you can, ask specifically by saying, /I need you to sit with me and just let me cry,' or, /Could you come and have dinner with me on Saturday night?" Most people will rise to the occasion."

What's most often the biggest help to a grieving person is very simple: just listening. "It's the most wonderful, generous gift anyone can give to a grieve," says Tatelbaum. But sometimes, listening is too painful or disturbing for friends or family who may be grief stricken, too.

You may really need to vent your anger at your deceased spouse for leaving you..."
right in the prime of life, for example," says Roberta Temes, Ph.D., author of Living With an Empty Chair (New Horizon Press, 1992). "You're furious for the unfulfilled dream of his promise to share the golden years together and for now having to be alone and sleep in the big empty house by yourself. "You can't automatically expect friends and family to understand that personal fury when they're upset and trying to sort out their own emotions," she says.

Often, it's people who aren't quite as close to the situation who can listen and really be there. That's why support groups can provide invaluable comfort. Many groups serve specific grief situations, like the death of a child or a suicide, and can create a highly resonant community of members. "One of the hardest parts of the grief process is feeling like you're alone with your emotions," says Dr. Dworkin. "If you can connect emotionally with other people and feel like they understand what you're going through, it really can help you."

Not only that, but fellow support-group members are potentially more supportive than friends or family of a griever's need to rehash the same material over and over.

"There's a lot of repetition built into the emotional catharsis phase in terms of talking about and experiencing feelings," says Dr. Dworkin. "That's normal and healthy. A healing transformation takes place internally through that repetition."

THE HEALING POWER OF NATURE

Sometimes, even with support and understanding, our thoughts still get stuck on "why?" - why me? why now? The mental frustration is, "I used to be able to explain to myself what was happening but now I'm at a loss for words." The intellectual mind does not have a way to grasp it. And the attempt is to grasp it - to make life coherent again.

When life feels out of control, spending time in the natural world gives a palpable sense of coherency. "Even though your life has felt chaotic, in nature, you begin to see yourself as orderly within the larger order," says Mel S. Bucholtz, a psychotherapist and director of the Returning to Earth Institute, which hosts wilderness trips. "There is an order, but it's not the limited one of the humanly imposed environment. It's on a much grander scale that you fit into.

"In this context, you see that death is not wrong, it's not bad," explains Bucholtz. "Neither is it wonderful. It's simply part of a natural process that happens during life, and we see our own experience reflected in that.

"Most of us who live in or around cities are so cut off from nature that we've forgotten the way the life cycle works," adds Dr. Dworkin. "And the way it really works has become a kind of affront to us. How dare this end! Nature permits the process; it makes loss acceptable. Instead of being angry at the reality of loss all the time, we can focus on healing."

We begin to see that we are analogous to life forms of the natural world," says Bucholtz. "Seeing this, we begin to feel that we're part of a much larger event that is like our own, and we feel embraced by it. Each of our experiences is no longer separate; we no longer feel isolated."

RECONCILIATION

"Once the bulk of emotion has been worked through, there's a cognitive shift that takes place," says Dr. Dworkin. "It's not actually recovering from the grief. It's reconciling to the new reality, because when someone close to you dies, you'll never be the same as you were before." You also begin to have more energy to put back into the
world and your daily activities. You start reaching out a little more in terms of your social contacts and caring about other people again.

"By mourning, you get to a place where you have a sense of the lost person and the lost relationship and can start to retain the positive and loving aspects of it," says Dr. Kavaler-Adler.

"Anytime you encounter one of these major life transitions, you have the opportunity to come out stronger if you embrace the process," agrees Dr. Dworkin. "The grief process naturally stimulates the development of emotional coping skills and a new awareness of life's priorities. It has the potential to make you stronger.

"That's not to say that you'll never feel grief again; that's not the measure of strength," he continues. "But you'll be able to move through it without losing your psychological and emotional bearings to such a great degree. It's painful, but at least you have a measuring stick for it. The next time it comes around - it will - you can move through it instead of avoiding it out of fear."

WE'VE BEEN HIT...

for Mama

We've been hit and we look it. We chill in the blue light of winter windows. And to us, life seems ferocious - too loud, too fast, too alive and he isn't. All of it, the dawn, the night, each breath a question. The cool curve of wealth, power, wit, the sun of kindness - these could not protect him. Out of their whorl he was dragged and finally lifted.

The stem cut, we mutter to him and ourselves, looking for the prayer that will close our chests. Is it yellow? red? stone? bone? We must close enough, palms pressing the cage of our ribs enough, to go on.

Here is a prayer. Thank God for this spirit - strong enough to see himself home and with us - before his last breath, a morning room soon filled with a clear victorious jig of air. Mama, anything can happen. February, cloud end. And out of the brown ground could come daffodils - all innocent, all full of light.

OVERCOMING GRIEF: A TRUE STORY

I felt like a young child again. The day was bright and shiny, the last warm day of fall. With springy steps, I took a walk over the farm. I was so glad to be alive, It was David's thirtieth birthday. Later he came to my office and I asked him how it felt to be 30. He replied, "Gee, Mom, I don't feel any difference." With a smile I answered, "Well, I can tell you one thing. Life gets better. I am so much happier now than when I was 30."

That night after dinner, he started to hyperventilate.

What could be wrong with David? As I looked at him in the next few days, a feeling of uneasiness began to creep into my mind and fear gripped my soul. in less than two weeks, he died from pneumocystis due to AIDS. He was diagnosed just two days before his death. I wasn't there when his time came. As I entered the hospital room immediately afterward, he looked so peaceful. My first reaction was not one of grief. Instead I felt overwhelming love for this wonderful son who I was so proud of. I though about bringing him into the world and I felt the urgency to somehow return him to my body. As I rubbed my hand over his still warm, strong arm, I prayed, "Thanks, God, for
the privilege to be David's mom. If only I could have had him with me a while longer." I realized that my terrible fear of death was all gone - and then the feeling of loss surrounded me like a tightening band.

The day after the service celebrating his life, there was a new snowfall. I walked the same path over the farm as I did the day of his birthday. The tears never stopped, and the wind was pushing me from behind. As I got to the end of the field and turned around to come home, my tears stopped and the wind was now pushing me from the front. I heard a voice inside of me saying, "First I'll help you and then you need to help yourself." I looked down at the new footprints in the snow and realized that my life was creating a new uncharted path. How could I manage without David? It was as if a part of me was missing. The anguish didn't stop. I feel that the hardest experience in life is the death of a child. The parent thinks of all the unfulfilled dreams that will never come to pass and the sorrow goes deep within the heart.

Healing from grief takes a long time. It begins with one step at a time. When I went back to work, I found it difficult to concentrate and often in a meeting, my mind would wander. It was hard to make decisions. When people would ask how I was doing, I'd reply "fine" and then there was a rush of tears. I asked myself, "Would other people understand and have patience with me?" One woman asked me to be an active part in a college meeting and I told her I couldn't because my grief was still too strong. She said to me, "You hold up well. To look at you no one would ever know." How could she be so insensitive! I was angry and then I realized she had never experience a death of a child. In my heart I forgave her.

One day in the midst of my tears, the doorbell rang and there were two little neighbor boys. They asked if they could come in. We got out my grandchildren's toys. As they were filled with wonder and excitement, sunshine came to my face. The power of children's laughter can be a healing balm.

David was an ardent collector of papers and things. Since his house was small, much of what he didn't immediately need was stored at our home. I asked my husband, Bob, what I would ever do with all the things. I felt exhausted. He said, "Just put it in a closet." When I finally did get around to putting his things in order, all the memories came flooding back and I was devastated. The biggest lesson I learned was never to clean out over any holiday. Grief at this time is a double whammy!

I realize more than ever that we are not islands in our lives. We are surrounded by many friends who love and care for us. They are there to share happiness or be sad with us. It was shown very clearly by the number of cards and letters that came in stacks delivered by the mailman. One day I sat at the kitchen table and sighed. I thought to myself, "I am breathing in all this love and health and as I exhale out goes all negative thoughts and disease." I was always a good giver, but never a good receiver and this was a time to learn. We are all there for each other to be an arm of support and love. As my son Anthony said, "We are all grieving, but Mom, remember that the rest of us are still here." As I was David's cheerleader in his life, his spiritual urging now became mine. I felt him encouraging me on to reach out to other people to help them understand about AIDS.

In a sense, his life was being carried on through me. My unconditional love for him helped to open up my heart. I like to think of healing from grief as the beginning of a tight bud. Gradually the petals unfold and with time, reach out to be a beautiful flower.
Four years after David left, my mother was dying. I had been reading a lot about how to say goodbye to someone you love. While her mind was still clear, I figured the time had come for me to tell her how much she meant to me. She listed for a while and then had the look of indignation on her face. She said to me, "Don't tell me when I am ready, I'll tell you." I laughed and said, "O.K., Mother." If I hadn't told her that day, it would have been too late. Another stroke left her innocent. Her process took three months and there were many days that we thought would be her last. I was with her when she died, stroking her forehead and saying over and over, "I love you, Mother."

I thought the circle of Mother's life was closed and that I had done all my grieving before she died. I went back to work immediately and had one accident after another. What I had to learn was that grieving doesn't end abruptly. While one life might be over, we need to treat ourselves with tender care. We are not machines at a time like this, but special, fragile human beings.

I believe that tragedy happens in threes. My husband, Bob, and I were both so busy. Our work was unified, even though it took us in different directions. I came home from one trip as Bob was ready to go on another. This time he was going to Russia to culminate a joint venture between Rodale Press and that country on agriculture. On the day he was due to arrive home I thought that it would be so wonderful to settle down together for a while. I was filled with excitement as I anticipated his homecoming. I wore a new red skirt. At noon, two of my daughters and one of the presidents of the company appeared at my office door and blurted out that Bob had been killed on the way to the airport to come home. I screamed, "No, no. Take it all away!" My mind held utter disbelief! It couldn't be true-but yes it was.

We got through all the plans and decided to have his service on the farm that he loved so much. Two thousand people attended his life celebration. When we came back from the cemetery, there were people walking and picnicking all over the farm and my thought was, "Wow, Bob would really love this!"

The days went by and I felt that I was in a fog. I still felt that Bob was away on a trip and would be home soon. I began to wonder why I didn't seem to have any feeling. Where was reality? I mentioned this to my son Anthony and he told me that I needed to see a counselor. He said that if he hadn't been having counseling when Bob died, he never would have made it. The counselor told me that I had too much sadness in a short period of time and this was nature's way of allowing me only that which I could handle at the time. She said that feeling would come back. It did, but not until I felt rebellion and probably suppressed anger at Bob, "How could you leave me?"

I have learned that we do have a choice on how we will deal with grief. If it is bottled up inside of us, we can become ill. We need to gradually let it go. It is not easy flow because it comes back in waves. With time we can be filled with calmness. I have worked hard on finding peace. When adversity comes, we need to rest a while, contemplate and allow quite time for gaining strength. True understanding comes about as we allow it to become part of us and realize that we can see that good can come through adversity.

I like to think of the story of the oyster. One tiny grain of sand can work its way into the shell and cause pain for the oyster, but the pain doesn't destroy it - instead over time it produces a beautiful pearl.

In the play, Zorba, the Greek, someone asks Zorba what he does when he is said.
His reply is, "I dance." For me I have learned to go out to do something for someone else who needs cheer and love.

Sometimes now I look at myself as a tree that has withstood many storms. I have bent with the stress of it all, but have always snapped back taller and stronger than before.

I would never trade my life for another. These special people in my life will always be warm inn my heart and if I am quiet, I hear them urging me to keep on helping others - to make a difference. Energy never dies. It becomes a starburst when it changes direction and it glows with a brighter light of understanding when it comes down to touch us all who are still here to carry on. I am thankful for life and each new day.

HOW TO GET SUPPORT

Support through the grieving process is crucial to recovery. Here's a list of potential resources"

* National Hospice Organization (800) 658-8898 (in the United States) provides brochures and referrals to local hospices, who can refer you to support services in your area. Write to them at: 1901 N. Moore St., Suite 901, Arlington, VA 22209.
* Hospice Foundation of America (800) 854-3402 offers information and a one-hour videotape entitled "Living With Grief: Personally and Professionally" for $12.50 (no postage and handling necessary). Send a check or money order to: 1334 G Street NW, Suite 605, Washington, DC 20005.
* Compassionate Friends (708-990-0010) is a self-help support organization for bereaved parents and siblings who have experienced the death of a child or brother or sister. They provide brochures and referrals to support groups in one of their 650 nationwide chapters. Write to them at: P.O. Box 3696, Oak Brook, IL 60522-3696.
* Widowed Persons Service of the American Association of Retired Persons (AARP) provides a free pamphlet, On Being Alone, and referrals to nationwide bereavement groups cosponsored by AARP. Write to them at: 601 E St. NW, Dept. PM, Washington, DC 20049.
* Grief Recovery Helpline (800-445-4808 in the United States, Monday-Friday, 9-5 PST; 519-650-5921 in Canada) is an educational service sponsored by the Grief Recovery Institute.

* Call your local hospital and inquire about bereavement programs.
* Call your local newspaper for support-group listings.

TAKING ADVANTAGE OF THE BODY'S HEALING POWER

by Darrell E. Ward

A QUOTE by 18th-century surgeon John Hunter hangs above the desk of Steven Rosenberg, chief of surgery at the National Cancer Institute: "Surgery is like an armed savage which attempts to get by force that which a civilized man would get by stratagem." That notion is one of the guiding forces in Rosenberg's research. His mission is to civilize the treatment of cancer; his stratagem is immunotherapy--the use of the immune system to destroy a malignancy.
"The chief advantage of immunotherapy is that it uses the body's own immune system, a system that evolved to detect exquisitely small changes in molecules to tell nonself from the body. If we can take advantage of that system, we're more likely to have a treatment that is effective and carries minimal side effects," he explains.

It is one of the newest and most exciting areas of experimental cancer therapy. Research in immunotherapy is producing and using the most current knowledge of the immune system and the latest advances in molecular biology and gene therapy. The field gradually is earning a place alongside surgery, radiation, and chemotherapy for the treatment of the disease. More than a dozen clinical studies under way at Ohio State University's Arthur G. James Cancer Hospital and Research Institute provide some form of immunotherapy to certain patients.

"In selected patients, immunotherapy works," notes Pierre Triozzi, associate professor of internal medicine and director of the Biological Response Modifier Program at The James. "We've seen good responses in 15 to 20% of patients we've treated."

Through the use of vaccinations, the immune system has been used very successfully by medical science to fight infectious disease. "And I don't think immune therapy for cancer is a pipe dream at all," says Julian Kim, clinical instructor of surgery at The James. "It's a matter of understanding cancer a little bit better to enable the immune system to target cancer cells."

The key to making immunotherapy succeed lies in helping the immune system to recognize malignant cells as defective tissue. The immune system does this already when cells are infected with a variety of viruses. There is circumstantial evidence that cancer cells form throughout life, but are destroyed by the body before they become dangerous. Yet, more than 1,000,000 Americans get cancer each year--obvious evidence that malignant cells somehow gain the upper hand and elude detection by the immune system.

The immune system is the body's first line of defense against viruses, bacteria, fungi, toxins, and foreign cells. It is fully capable of destroying tissue, which is what happens during rejection of a transplanted organ and during autoimmune diseases. In the latter, the immune system mistakenly kills normal, healthy tissues in the body. This occurs in rheumatoid arthritis and some forms of diabetes.

The fundamental job of the immune system is to distinguish what belongs in the body from what doesn't--to recognize self from non-self, as the scientists say. The work is done by white blood cells, including monocytes, macrophages, cosinophils, and basophils. The bulk of the immune response is carried out by the group of white blood cells known as lymphocytes.

Through a microscope, lymphocytes are medium-sized, round cells in which the nucleus is offset like the yolk in a hard-boiled egg. They all look alike, but, on closer inspection, using sensitive biochemical tests, important differences emerge.

For example, most immune cells fall into one of two main camps: B or T cells. B cells, which make up about 25% of immune cells, take their name from the fact that they develop and mature in bone marrow. Their job is to produce antibodies--proteins tailor-made to attach to an antigen, a molecule that identifies a virus, bacterium, or foreign cell as non-self. Each B cell can recognize only a single antigen.

Once activated, a B cell begins dividing and producing antibodies, churning out as many as 2,000 antibody molecules a second for several days. The antibodies are carried
throughout the circulatory system, binding to their antigens upon contact. In this way, they inactivate and destroy viruses, bacteria, and toxins, or mark the invader for destruction by other immune cells. Antibodies, though, can not reach viruses that have invaded cells—that's one of the tasks of T cells. T cells mature in the thymus gland, which lies on the heart. These cells are responsible for "cell-mediated" immunity. There are three varieties of T cells: killer, helper, and suppressor.

Killer, or cytotoxic, T cells bristle with receptors that detect the presence of antigens on other cells. An antigen fits into a receptor like a key fits into a lock. These antigens may come from viruses infecting the cell or from transplanted or grafted cells. When a killer cell detects an infected cell, it secretes a substance that eats holes in the infected cell, destroying it and the viruses inside. The same thing happens following skin grafts or organ transplants from one person to another, resulting in graft or organ rejection unless the immune system is suppressed.

T helper cells, on the other hand, play a key role in initiating an immune response. They serve as the master switches of the system and trigger the proliferation of B cells and T killer cells, which destroy body cells that have been invaded by certain viruses and parasitic fungi. Presumably, they also would destroy cancer cells. T suppressor cells' job is to prevent an immune reaction from getting out of hand. They slow or prevent the action of other immune cells.

A type found in both T cells and B cells is the memory cells. They are formed during the first encounter with a virus, bacteria, or other antigen; held on reserve, circulating in the bloodstream; and respond quickly when the body is invaded again by that specific antigen.

Distinguishing between normal and cancerous cells If the immune system notices that an infected cell is different from a normal one, why doesn't it recognize that a cancer cell is different? "That's the $64,000 question," Kim points out.

For a long time, researchers simply assumed that the immune system could not distinguish between normal and cancerous cells. They also reasoned that, since the immune system recognizes antigens and does not recognize cancer cells, the latter must not produce antigens. Today, however, "We now know that tumor cells do express antigens," Kim indicates.

The change from a normal to a cancer cell involves damage to genes—mutations—that control cell growth. Mutated genes often produce abnormal proteins, and these often can be recognized as antigens. In addition, cancer cells can produce abnormal proteins from normal genes. For instance, cells lining the colon make the protein mucin. When those cells become cancerous, they produce abnormal mucin even though the mucin gene is normal. That abnormal mucin can be recognized by the immune system as foreign.

No longer are the immune cells regarded as bumbling and passive, but otherwise passive, enemy within. Scientists now see the problem more as a game of cat and mouse. They think that cancer cells employ strategies that actively throw immune cells off the track. They still don't know how these strategies work, but speculate they range from camouflage and smoke screens to subversion and bait and switch.

Some cancer cells, for instance, seem to mask the expression of antigens, thereby rendering themselves invisible to the immune system. Others may overproduce antigens,
releasing them like a fog that overwhelms the immune cells' detection system. Some malignant cells might produce one antigen and, while the immune system focuses on it, switch to another.

Evidence also is mounting that cancer cells release substances which suppress the action of the immune system, or that some tumors produce cells that suppress the immune system. It is the task of immunotherapy to bolster the immune system and help it see past the smoke and mirrors set up by cancer cells.

The conviction that the immune system held the potential to fight cancer developed from the observation that tumors at times disappear on their own. Such cases have been recorded since the 1700s.

In the 1890s, a New York physician, William B. Coley, uncovered the record of a patient with an advanced, recurrent, inoperable cancer of the neck that suddenly disappeared on its own. It had been seven years, but Coley tracked down the patient and found him healthy and showing no sign of cancer.

The patient's record also told Coley that, just prior to the regression of the cancer, the man had suffered two acute attacks of erysipelas, a sometimes severe skin infection caused by the bacterium Streptococcus pyogenes. Reports of malignant tumors regressing after infections pre-dated Coley by a century.

Coley reasoned that, in the process of fighting the infection, the body also fought the cancer. He put his idea to the test by intentionally infecting some patients suffering from advanced cancer with a mixture of two bacteria. The treatment cured several of the patients. That mixture continues to be known as Coley's toxins. Other physicians tried his technique, but couldn't reproduce his success. His work was overshadowed by the introduction of X-rays and then chemotherapy, but his results still are studied and discussed by researchers today.

Like Coley, Steven Rosenberg encountered a patient who by any measure should have died from his cancer. At one time, the man had had a tumor the size of a fist in his stomach. Doctors had given him only months to live. Nevertheless, 12 years had passed when Rosenberg, then a junior resident in surgery, saw him in 1968, at which time there was no sign of the disease.

"This did not seem possible," wrote Rosenberg in his book, The Transformed Cell: Unlocking the Mysteries of Cancer: "... there had been only four documented cases--not four a year in the United States, but four, ever, in the world--of spontaneous and complete remission of stomach cancer."

Rosenberg concluded that the man's body had rid itself of the malignancy. "It was likely that his immune system, which defends the body naturally against disease, had reacted to the cancer and destroyed it. If we could somehow understand how this had happened, if we could somehow understand the mechanism, if we could somehow duplicate the mechanism in other patients.

The research of Coley and Rosenberg provides examples of the two methods used in immunotherapy to rev up the immune system to fight cancer. Coley's work is a primitive example of what today is known as active immunotherapy, wherein patients are given something designed to activate their immune system against cancer. That agent is called a cancer vaccine, although the term is a bit of a misnomer.

A cancer vaccine is different from the typical vaccine used to ward off infectious diseases. While the latter is given to people to prevent a disease from occurring, cancer
vaccines are given to individuals who already have been treated for the disease. All cancer vaccines are experimental, and none works well once a tumor is present, notes Pierre Triozzi. "They work best to prevent the disease from recurring." For this reason, "some people refer to them as therapeutic vaccines or theracines."

Their purpose is to prime the patient's immune system to recognize and attack tumor cells. They usually consist of killed cells or parts of cells from the patient's tumor. The goal is to give immune system cells--T cells--a target, an antigen, much like giving a bloodhound a sniff of something that belongs to the person it is tracking. While an activated T cell doesn't really follow a chemical scent to the tumor, exposure to the antigen allows the T cell to distinguish cancer cells from normal ones when it encounters them.

Other cancer vaccines are based on a molecule found on tumor cells and rarely anywhere else in the body. Such molecules make admirable antigens. At The James, Triozzi is working with a cancer vaccine that is based on the hormone human chorionic gonadotropin. HCG is a protein produced only by the embryo during development and by cancer cells.

Researchers are using HCG as an antigen that will help T cells recognize cancer cells. Since HCG by itself hardly causes the immune system to raise an eyebrow, they couple it with a diphtheria toxoid, a toxin that has been rendered harmless. Like a rap on a hornet's nest, the toxoid produces a swarm of immune cells. The theory is that the militant immune cells also will attack cancer cells with the HCG antigen.

Why would cancer cells produce a substance found only in an embryo? Scientists speculate that cancer is a regression in the life of the cell--that a cell at one time was specialized to perform a certain function in the body, but then reverts to an earlier and less specialized form. In this form, the cell grows uncontrollably and sometimes even produces proteins that normally are found only in the embryonic state.

Active immunotherapy relies upon methods such as cancer vaccines to stimulate the patient's immune system. A second form of immunotherapy, pioneered by Steven Rosenberg, is referred to as adoptive immunotherapy. It involves removing lymphocytes from the patient, training--or activating--them to identify and attack tumor cells, growing them in the laboratory until they number in the millions, then returning them to the patient. In military terms, these cells represent a contingent of highly trained reinforcements, tailored to identify, attack, and destroy tumor cells.

The cells are grown in a solution that contains the substance interleukin 2, a hormone-like chemical produced by immune cells. IL-2 is necessary for lymphocytes to develop and helps activate them to fight cancer cells. Some experimental immunotherapy treatment plans, also known as research protocols, include giving patients IL-2 after they have received their cancer-fighting cells.

A major difficulty in adoptive immunotherapy has been identifying those lymphocytes among all those present in the body that are most active against a tumor. A number of strategies have been tried, none of which has panned out as hoped.

Rosenberg first tried using lymphocytes removed from the blood and grown along with IL-2 and some of the patient's tumor cells. He named these T cells lymphokine-activated killer cells. Laboratory experiments showed that LAK cells would destroy a number of human cancer cells, including melanoma, colon cancer, and sarcomas. Best of all, they left normal cells untouched.
Encouraging results

Rosenberg first used LAK cells and IL-2 in humans in 1984 in patients with advanced cancer. By mid 1990, more than 300 patients had been treated with LAK cells plus IL-2 or with IL-2 alone. Of those receiving both LAK cells and IL-2, one-fourth had complete or partial regression of their tumors. (Partial regression means a tumor has shrunk by at least 50%.) Of those receiving IL-2 alone, 17% had complete or partial remission.

The treatments were most effective in patients with melanoma or kidney cancer, but they also exacted a price. The proliferation of lymphocytes in patients could impair the functioning of vital organs. Also, IL-2 caused fluid to leak from blood vessels into the surrounding tissue. These side effects cleared up quickly after treatment was stopped. Next, Rosenberg and his research team tried using T cells isolated from the tumor itself. Experiments in mice showed these cells, known as tumor-infiltrating lymphocytes (TILs) to be 50 to 100 times more effective at attacking tumor cells. It meant that 1-2,000,000 TILs could do the same job as 100,000,000 LAK cells. It also meant that less IL-2 could be given to patients, thereby reducing the treatment's side effects.

At The James, research in adoptive immunotherapy is under way for certain patients with advanced colon cancer. Triozzi, along with Ted Martin and Julian Kim, both surgical oncologists, are using T cells taken from lymph nodes that drain the tumor. Half the patients also receive low doses of IL-2.

The James' researchers chose not to use tumor-infiltrating lymphocytes for a good reason. "If the lymphocytes in a tumor were doing their job, the tumor wouldn't be there," Kim maintains. In fact, "they may be what's left of a failed immune response." It is too early to predict the effectiveness of this treatment because the study is in an early phase, but results so far have been encouraging.

Meanwhile, Rosenberg's lab is trying to improve the potency of TILs using gene therapy--taking a gene from one cell and transplanting it into another. Rosenberg has taken the gene for tumor necrosis factor, a cytokine that interferes with a tumor's blood supply, and inserted it into TILs. He hopes the TILs will home in on the tumor, then destroy it with the added firepower of tumor necrosis factor. He currently is working on ways to increase the number of TILs that find their way to the tumor and the amount of tumor necrosis factor they produce once they get there.

This work is only the beginning, according to Kenneth Culver, executive director of the Human Gene Therapy Research Institute at Iowa Methodist Medical Center. "Einstein once said that imagination is more important than knowledge. What we need now is to use imagination to find ways to deliver genes into cancers and other diseased tissues."

Culver, who did pioneering gene therapy research with Rosenberg and others at the National Institutes of Health, has started doing just that. Today, scientists are removing cells from the body, introducing an anticancer gene such as the one for tumor necrosis factor into them, then returning the cells to the body. The cells then deliver their toxic cargo to the tumor. Culver is developing ways to eliminate that messenger, to sidestep the use of T cells.

He is introducing a gene into brain tumors that makes them sensitive to the antiviral drug ganciclovir. The drug has no effect on cells without the gene.

Researchers insert copies of the herpes simplex thymidine kinase gene into a
retrovirus. The virus is grown in large numbers in mouse cells. Treatment begins when virus-laden mouse cells are injected into the brain tumor. There, the viruses are taken up by dividing cancer cells, but not by surrounding non-dividing cells. The ganciclovir then kills tumor cells, but leaves alone other cells in the brain that do not contain the gene. "Over the next 10 years, as we find ways to introduce genes into growing tumors, gene therapy is likely to become a standard means of cancer therapy," Culver indicates.

As experience in immunotherapy grows, researchers are finding that some tumors are more susceptible to it than others. It may be that some tumors have antigens that shine like 100-watt bulbs, while others have antigens that glow like night-lights.

"Before long," Pierre Triozzi predicts, "we will be able to identify people who are predisposed to cancer, and we'll be able to detect very early cancers. We'll treat those people with surgery or radiation to eliminate the primary tumor, then use the immune system to prevent recurrence."

What role will immunotherapy play in managing cancer? "The best strategy is prevention," says Triozzi. "The ability to harness the immune system as part of prevention is going to be a great help. That's the real future for immunotherapy."

PERFECT ROAST GOOSE
by Christine Smith Koury

The Christmast goose, immortalized by Charles Dickens in A Christ-Carol, is the traditional holiday fare in Europe.

Brought to America by the Pilgrims, the goose graced many a settler's table. Although no longer served here as commonly as in Europe, goose is a delicious change from turkey or other standard Christmas fare.

Holiday Roast Goose

Although geese are not bred to have a higher yield of meat and less fat, goose is still a fatty bird, so we prefer not to stuff it. Make a stuffing to serve separately if you'd like.

Buy a goose with the USDA Grade Shield. Available in sizes ranging from 6 to 18 pounds, with 8 to 14 pounds the most common, a large goose will eight to nine people. An easy buying guide: Allow three quarters of a pound of uncooked goose for each 4-ounce serving.

To thaw a frozen goose in the refrigerator, allow one to one and a half days for a 6- to 10-pounder; two to two and a half days for a 10to 14-pounder; and three days for any goose over 14 pounds.

Preparation time: 10 minutes.

Roasting time: 3 to 3 1/2 hours.

12- to 14-lb. goose 1 large orange, cut into chunks 3 cloves garlic, chopped 1 tablespoon olive oil 1 teaspoon dried thyme, crushed 1 teaspoon dried rosemary, crushed 1/8 teaspoon salt 1/8 teaspoon pepper

1. Heat oven to 400 DEG F.

Cut off string or rubber bands that hold legs and wings of goose in place. Remove neck and giblets from body cavity. Pull off neck skin and excess fat from body cavity. Rinse bird inside and out, under cold water, and drain well; pat dry.
2. Mix orange chunks and garlic, and place in body cavity. Place goose, breast side up, on rack in shallow roasting pan. Tuck wings under bird. With point of small sharp knife, prick skin of goose well. Combine oil with thyme, rosemary, sale, and pepper. Rub mixture over goose. Insert thermometer into inside of thigh muscle, being careful not to touch bone.

3. Roast goose according to the following chart:

<table>
<thead>
<tr>
<th>Weight</th>
<th>400 DEG F</th>
<th>325 DEG F</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 to 8 lbs.</td>
<td>45 min.</td>
<td>About 1 hr.</td>
</tr>
<tr>
<td>8 to 10 lbs.</td>
<td>1 hr.</td>
<td>1 1/2 hrs.</td>
</tr>
<tr>
<td>10 to 12 lbs.</td>
<td>1 1/2 hr</td>
<td>2 hrs.</td>
</tr>
<tr>
<td>12 to 14 lbs.</td>
<td>2 hr.</td>
<td>2 1/2 hrs.</td>
</tr>
<tr>
<td>Over 14 lbs.</td>
<td>2 1/2 hr.</td>
<td>3 hrs.</td>
</tr>
</tbody>
</table>

4. During roasting, spoon or siphon off accumulated fat every 30 minutes. After reducing oven temperature to 325 [degrees] F, continue roasting until thermometer registers 185 DEG F. Set aside goose and let stand to cool slightly before carving.

To carve, follow these easy steps:

1. Lay goose on cutting board. Remove wings and set aside. With legs turned toward you, hold the drumstick and gently pull the leg away from the body. Cut through the skin between leg and body, exposing the joint. Cut through the joint that connects the leg to the backbone. Cut both legs from body and set aside.
2. Cut down on one side of breastbone by inserting knife between meat and center breastbone. Continue cutting along bone to wing joint. Holding meat with a fork, gradually cut meat away from rib bones. Repeat with other breast.
3. Place breast meat on cutting board, and cut into slices.
4. To bone legs, place leg, skin side down, on cutting board. Holding the bone with your fingers, cut around it and remove. Slice remaining meat.

Yield: 16 4-oz. servings.

Nutrition per 4-oz. serving: 270 calories; 33 grams protein; 14 grams fat; 0 grams carbohydrate; 86 milligrams sodium; 109 milligrams cholesterol.

COMMUNICATING WITH CHILDREN

by Lendon Smith

I have often thought that God made children look like their parents so they would be more acceptable when they first come out in the world. Parents think their babies are cute if they look a little like themselves. ("This one's a keeper; he looks like grandpa." "Yeah, no teeth.") God also figured that if babies would smile broadly at age three weeks, the parents would melt with joy, forgive the night feedings and truly believe this baby is the best present they have ever received. I used to shine a light on my face at two in the morning when I was feeding our babies. Doing this assured them that I was a trustworthy father, and worth a smile.

The baby is rewarded for smiling, giggling and laughing. The parents cannot help but respond with smiling, giggling and laughing. This mutual love and trust helps develop a good self-image in this vulnerable infant that must last a lifetime. We feed,
bathe, cuddle and console this little one, wanting this child to grow up to take care of us when we need to be fed, bathed, cuddled and consoled in our vulnerable fragile years.

So how do we communicate the idea to this baby that we love, want and even need him/her? Feeding this baby when hungry is the most important thing we can do. However, putting the baby on that rigid four-hour feeding schedule when the poor tyke is hungry in two hours is a dirty trick, and may set up bad vibrations about you as a parent.

Breast feeding is the superior nutrition method. Someone discovered that the baby's ability to focus in those first few weeks is limited to about 12 to 14 inches away. This is just the distance from the mother's breasts to her face. The baby associates a warm, comfortable stomach with a smiling human face. Trust. Love. Those are the communication messages.

Much research has confirmed that a soft voice, and even a melody, along with a full stomach, and some full-body massage is the way to calm a touchy baby. You don't have to be opera-level material to sing to your baby. Just something soothing, or even poetry, or nonsense rhymes. How about rap? Make up your own.

Along with the full stomach that the parents are providing in those first few months is a running conversation with their baby. You are teaching that child all about the world. "This is a table. The sky is blue. Here is a chair. This is milk. We love carrots. They are carrotcolored."

We love carrots. They are carrotcolored.

Get those books that are made of plastic so the baby can chew on them. Read them over and over again. Keep inserting those good words into your conversation. "Love", "Sweet", "Beautiful", "Perfect", "Neat", "Okay". All the positive ones.

The trick is to get your baby to associate warmth, love and comfort with your calm voice and gentle hugs. That is communication in the first year. Then when this child stands up on her hind legs and gets into danger, your strident, anxious voice will be heeded. "Don't touch the hot stove!" It may be life-saving.

Somehow during those trying times when these gregarious twoyear olds are testing out the world, you must try to balance up the WELOVE-YOU's and the DON'T-DOTHAT's. They do need limits. But the positives should outbalance the negatives by about two to one.

Even though our children were tired and hungry (look out for low blood sugar surliness) by the time I got home for dinner, we tried to be civil as we sat around the table. I would ask, "What was the most fun thing you did today?" (Things like, "I pulled Barbara's hair," were not allowed.) It had to be positive. And dinner time is no time for correcting the day's social deviancies.

We tried Friday night surprises. Everyone had to bring something to the meeting that was creative. A mud-pie. A picture. A poem. A joke. A dance. Something artsy that he/she had done. The rule was that we had to display respect and wild applause.

We knew not to lecture our children, although we did. We tried to treat each as a dignified human being, but we often forgot that rule. We planned a special night out on each of their birthdays when they were young. Just one parent and the designated child would go out to dinner (hamburger usually) and then to a movie. I had a routine question I would ask each time I did this: "What do you want to be when you grow up?"

You don't have to have taken a course in psychology to rear your children with a good self-image. You should be thoughtful. You can read to them as they are falling asleep at night. Be a friend to your children. If you try, they will think you are okay when
THE WONDER OF COOKIES
by Miyoko Nishimoto

My mother and I were probably the first family in our small suburb of Tokyo to celebrate Christmas. Our "celebration" amounted to decorating an artificial tabletop tree, and the entire neighborhood came to stare at it in wonder. Of course, the event held no spiritual significance; we were Buddhists, but my mother was trying to initiate me into various Western customs because we would soon be leaving Japan and moving to America.

My mother was no expert on Christmas, and there were certainly no cookies at our Christmas celebrations. In fact, it wasn't until I was in junior high school in America that I learned of the existence of such delights. Naturally, I felt quite cheated. Why I wondered, had I been deprived of this singularly fun and delicious aspect of the holiday? I immediately set out to explore the magic of the cookie cutter.

My complete lack of a tradition to call upon-no grandmothers with zealously guarded family recipes, no memories of my mother baking innumerable batches of cookies-made me extra attentive to the types of cookies that other families prepared. What thrilled me the most was the variety. At no other time of the year could one enjoy so many different cookies, all home-baked and delicious. I even tried to create my own variations on other people's traditional recipes. I delighted in designing cookies that were small-so that one could keep indulging-and varied in shape, texture and flavor. I found that the simplest cutout sugar cookies could be made irresistible by adding a little spice or unusual decoration. The following recipes are the results of my experimentation: a blend of the traditional and new, made with the most wholesome ingredients possible.

Alas, 30 years after my mother introduced me to Christmas, Christmas cookies have yet to arrive in Japan. Instead, something called "Christmas Cake" is sold in every bakery at holiday time. These sugary cakes with white frosting, decorated with Santa and reindeer, are said to be indigenous to America, and the Japanese celebrate Christmas by lighting a candle and eating a slice of this cake. A new custom has been created and given the name of tradition. Perhaps one day I can do the Japanese a favor by introducing them to the truly traditional indulgence of the holiday: cookies.

Carob-Walnut Kisses

These cookies are rich and delicious without being overly sweet.

1/2 cup margarine
1/2 cup honey
2 heaping Tbs. instant grain-based coffee substitute
5 Tbs. carob powder
1 to 1 1/4 cups whole-wheat pastry flour
1/2 cup finely ground walnuts

Mix together margarine, honey, coffee substitute and carob powder until well blended. Add flour (1 cup will produce a delicate cookie, cups a firmer one) and walnuts. Mix until completely blended, but do not overmix or beat.

Preheat oven to 350 degrees. Place dough in a cookie press and pipe out into fat
kisses on a greased baking sheet. Bake for 12 to 13 minutes. Cookies will be very soft when they come out of the oven but will become crisp as they cool on the rack. Store in an airtight container. Makes 40 cookies.

Per cookie: 67 cal.; 0.8g prot.; 4g fat; 7g carb.; 0 chol.; 32mg sod.

Carob Glaze
2/3 cup carob chips, preferably unsweetened and dairy-free
1 to 2 Tbs. water

Store-bought sprinkles (optional)
Melt chips with water in a double boiler. Brush onto cooled cookies. Top with sprinkles while still warm if desired. Makes 2/3 cup.

Per teaspoon of glaze: 16 cal.; 0.1g prot.; 0.9g fat; 2g carb.; 0 chol. 0 sod.

Marzipan Horseshoes
These soft almond cookies, with a texture reminiscent of marzipan, can be served plain or decorated with brightly colored Fruit-Juice Glaze (see recipe).

1/2 cup margarine
2/3 cup honey
2 cups blanched almond meal
1 2/3 cups whole-wheat pastry flour
1 tsp. vanilla extract
1/8 tsp. almond extract

Preheat oven to 350 degrees. In a large bowl, cream margarine and honey until light and fluffy. Add remaining ingredients and mix well. Divide dough into 36 balls. Roll each ball into a log 3 inches long, then bend each lo into a horseshoe shape and place on a greased cookie sheet.

Bake for 6 to 8 minutes. Makes 36 cookies.

Per cookie: 127 cal.; 6g prot.; 6g fat; 13g carb.; 0 chol.; 36mg sod.

Chocolate Rum Pecan Cookies
1/2 cup vegetable oil
2/3 cup honey
3 Tbs. dark Jamaican rum
2 oz. unsweetened chocolate, melted
2 cups whole-wheat pastry flour
1/2 tsp. baking soda
1/2 cup chopped pecans

Preheat oven to 350 degrees. Combine oil and honey and whip until blended. Add rum and melted chocolate and mix well. In a separate bowl, sift together flour and baking soda, then add to the chocolate mixture and mix well. Fold in pecans. Drop by teaspoonfuls onto a greased cookie sheet and bake for about 8 minutes. Do not allow the edges to darken or burn. Makes 40 cookies.

Per cookie: 77 cal.; 1g prot.; 5g fat; 13g carb.; 0 chol.; 11mg sod.

Speculatius
These festive Scandinavian cookies are delicately spiced with cardamom. Traditionally, they are stamped with wooden molds and cut after baking, but the usual cookie cutter method also works well

2/3 cup margarine (preferably unsalted)
1/2 cup granulated sugar cane juice (or 1/2 cup honey)
1 1/2 tsp. egg replacer
2 Tbs. water
1 1/4 cups whole-wheat pastry flour
1 tsp. ground cinnamon
1/2 to 3/4 tsp. ground cardamom

Cream together margarine and granulated sugar cane juice or honey. Combine egg replacer and water, and mix into the margarine mixture. Sift together flour and spices and mix in well. Chill dough for several hours or overnight in the refrigerator.

Preheat oven to 350 degrees. On a lightly floured board, roll out dough to a 1/4-inch thickness and cut with cookie cutters, then place on a greased cookie sheet. (Or roll out to a 1/4-inch thickness on a greased cookie sheet and stamp with lightly floured traditional wooden molds to be cut after baking.) Bake for 10 minutes. Makes 48 small or 24 large cookies.

DOCTOR-PATIENT COMMUNICATION

by Tony Smith (British Journalist)

As a jobbing medical journalist I have a couple of appointments as medical adviser to consumer organisations. I get a steady trickle of letters from people with questions about their (and their relatives') illness.

Answering these queries is usually both easy and worthwhile; most inquirers simply want an explanation of what is wrong with them and a description of their treatment in words they can understand. In many cases their own doctors must have told them these facts, but the traditional medical consultation is an amazingly inefficient arrangement for transmitting information. Countless studies using video cameras and tape recorders have shown that most doctors believe they are better communicators than they are in practice; they use far too much technical jargon. And even the best communicators pour many of their words into the sand; anxious patients remember at best only half of what is said to them and often fail to comprehend what they do remember.

Little effort is needed to improve the dismal results of doctor-patient consultation. Patients who are given tape recordings of their outpatient consultations take them home and play them over and over again (and so do their relatives). Doctors who know that their words are going to be recorded are more likely to structure their advice. Doctors who go to the trouble of writing and printing simple advice sheets find they are very popular. Yet most do nothing. Their patients do not complain—they mostly suffer from that curiously English reluctance to ask their doctors direct questions. So they write to me, saying that they don't want to ask their own doctors "because they are so busy."

Busy at what? I suspect that apparent business is often a cloak for reluctance to talk about topics the doctor finds difficult. Shouldn't doctors make it clear to patients that they can always return for another consultation simply to ask questions?

Until this change in attitude occurs, however, I shall go on answering my "Aunt Peg" type questions. Most, as I say, are easy; some are difficult and disheartening. Patients with chronic disorders such as osteoarthritis and angina or those with disabilities...
after a stroke write asking for help because "my doctor says there is nothing more he can do." What a dreadful thing to say. A year or two ago the BMJ published a correspondence on heartsink patients--those with thick folders and unsolvable problems. There are heartsink doctors, too. They greet any fresh symptom from a patient with chronic disease with the defeatist response "we can't give you new lungs" (or joints or whatever). I suspect that underlying this response is disenchantment with the job. The middle aged doctor who has lost all enthusiasm for his work is, indeed, a sad figure--but his patients suffer as much as he does.

THE EFFECTS OF STRESS ON HEALTH
by Stanley S. Heller and Kenneth A. Frank

PERSONALITY AND STRESS
IN RECENT YEARS, a good deal has been written about the possible role of personality type in disease. Much of this stems from the research and writings of two San Francisco heart specialists, Drs. Meyer Friedman and Ray Rosenman. By interviewing heartattack patients, Drs. Friedman and Rosenman began to see a behavior pattern, which they called "hurry sickness." Later they described this as a "chronic, incessant struggle to achieve more and more in less and less time." The Type A person always tries to do more than one thing at a time and is impatient with slowness in others. He or she is likely to behave competitively in situations that do not call for competition. Type A's have their own pattern of speech: They talk fast, interrupt others, and finish sentences for those who speak more slowly. They may be quick tempered, compulsive, suspicious, and hostile.

In contrast, Type B behavior is more relaxed, less competitive, and not so driven by time and the need to succeed. Drs. Friedman and Rosenman found that people with this personality type did not seem to be as susceptible to heart attacks as Type As. Over the last 25 years, the question of personality and heart disease has been the subject of continuing research and controversy. Some studies seem to indicate that it is a major factor, while others do not. Studies at Duke University and elsewhere have attempted to identify those components of Type A behavior that may be the most detrimental. Two longterm Duke studies pinpointed hostility as a key factor:

People who tended to be suspicious and hostile had a higher incidence of heart attacks, as well as a higher death rate from other causes.

Why should Type As be more disease-prone than the calmer Type Bs? This important question has not been fully answered, but a growing body of evidence seems to point to many of the same physiologic changes that are produced by stress. In Type A people, the levels of stress-related hormones are higher than normal; conceivably, this could produce the same detrimental effects on blood pressure, blood vessels, blood lipids, and other systems.

Type A Women
Until recently, men have been the focus of most studies relating personality and disease. But, according to Drs. Friedman and Rosenman, there are Type A women, but they are different from Type A men. Women, for example, are more likely to turn their stress inward on themselves rather than release it in sudden outbursts of anger, which is
typical of Type A men. In fact, Type A women often come across as excessively polite, when, in fact, they are only hiding feelings of anger or hostility. Type A men tend to be very driven and focused on a single goal; in contrast, women have difficulty setting priorities, assigning equal rank to career, family, marriage, and home, resulting in incredible pressure and feelings of guilt and overload. Studies have found that even women who have achieved executive rank or high professional status are likely to devote 40 or more hours a week to managing a household and caring for a family. It is little wonder that working women are experiencing an increase in stress-related illness.

Type A Children

Studies have found that children as young as 3 years exhibit the behavior patterns typical of Type A personality. Whether this is an inherited characteristic or one molded by environment is open to debate; there is mounting evidence to support both theories, indicating it may well be a combination of factors. Dr. Karen Matthews, a psychologist at the University of Pittsburgh, did one study in which a group of toddlers were instructed to stack blocks on top of each other in the presence of their mothers or other women. The women, regardless of their own behavior patterns, tended to encourage the Type A children to do more, while they expressed praise and satisfaction for the performance of the Type B children. Dr. Matthews theorizes that Type A children are more emotionally responsive than others, and therefore elicit the very behavior that urges them on. Dr. Friedman, for his part, believes that Type A behavior can grow out of a child's feelings that parental love depends on what he or she does-getting high grades, winning at sports, excelling in any assigned task-rather than for who the child is.

In contrast, there are a number of studies linking the behavior pattern with consistently higher levels of stress-related hormones, and hormonal responses to stressful situations seem to be excessive in Type A people. Given the fact that the Type A profile can be detected in children barely old enough to talk, it is a distinct possibility that it is not fundamentally a behavioral problem, but instead, the product of an inborn, physiological syndrome, interacting with life's conditioning experiences.

Modifying Type A Behavior

Regardless of the roots of Type A behavior, one important question is whether or not attempts should be made to modify it. Again, there is no clear agreement among the experts. Some people feel that there is not enough evidence to indict Type A behavior as a cause of disease; therefore, attempts to change may be just another stress without beneficial results. Also, ours is a success-oriented, competitive society, and the Type A person is rewarded by achieving many of the goals that we hold in such high esteem: money, status, and power, among others. Add to this the fact that many, if not most, Type A people enjoy their hectic, fast-paced lives and have no desire to change. What's more, studies have found that many either deny or overlook the more undesirable facets of their behavior. Most prefer to think of themselves as competent and competitive rather than compulsive and hostile; as conscientious and productive rather than time-slaves and workaholics; as verbal and self-assured rather than loud-mouthed and overbearing. In any event, in Western society Type A drive is more likely to succeed. One recent study from Canada showed that about 60 percent of the top corporate executives have Type A behavior. (In contrast, in Japan, where corporate philosophy is more cooperative than competitive, the Type A pattern is far less prevalent than in North America.)

Some experts assert that it is futile, and perhaps contrary to the best interests of
the person involved, to try to force a Type A to become a Type B. The people who seek professional help because of stress related to this behavior pattern are often the families or close associates of Type A people rather than the individuals themselves; many Type As don't want to change their way of life, they simply want to avoid the detrimental effects. One of the more successful treatment strategies is to identify those specific Type A characteristics that seem to be the most damaging and then to try to modify them, rather than undergoing a complete revision in behavior. Thus, someone who harbors excessive hostility may enter an anger management program aimed specifically at overcoming this facet of behavior. A person who consistently hyper-responds may benefit from relaxation therapies, such as meditation. Exercise and biofeedback training are still other therapies that have proved useful in modifying detrimental behavior traits. Several of the techniques outlined later under "Techniques to Overcome Stress" have also been utilized effectively to help Type As to diminish the stress component of the Type A behavior pattern, e.g., time urgency. In addition, a number of strategies have been suggested to help Type A people gear down to a less-pressured pace. These include:

* Avoiding situations that evoke hostility. If standing in line at the bank or post office is a source of annoyance, either send someone else on the errand or time such visits to avoid peak hours when there are likely to be lines.
* Scheduling true work breaks. Instead of eating at your desk or scheduling a business lunch, do something entirely different that is not job-related: jogging in the park, visiting a book store or art gallery, exploring a different neighborhood, doing a crossword puzzle. Even an hour spent in a totally unrelated pursuit can be a revitalizing force that, in the long run, will increase productivity and feelings of well-being.
* Learning how to manage time. Many Type A's constantly overbook themselves, scheduling back-to-back appointments, and then allowing themselves to be interrupted with other business, guaranteeing that they will soon be off-schedule. Little wonder they become compulsive clock watchers.
* Penalizing Type A behavior. Making a list of "hurrying habits" and then consciously extracting a penalty for succumbing to them is an effective behavior modification technique. For example, crossing a street against the light to save a few seconds can be penalized by waiting for the next light, crossing back, waiting again, and then crossing with the light. Speeding to make a yellow light can be penalized by having to drive around the block 2 or 3 times.

SELF-TEST FOR RISK OF CORONARY HEART DISEASE
Agreement with the following nine statements is associated with a greater risk of coronary heart disease:

1. I have often met a lot of so-called experts who are less informed than I.
2. When men are with women, all they usually want is sex.
3. It's very satisfying to cheat a cheater.
4. People who are rude or annoying deserve to be treated roughly.
5. When I dislike or pity someone I don't try to cover up my feelings.
6. My employers often foist their mistakes off on me, but don't give me credit for the work I do.
7. I have often worked for people who were incompetent.
8. Some of my friends and relatives have irritating habits that annoy me very much.
EXERCISE REDUCES HEART DISEASE RISK
by Maureen Sangiorgio, Greg Gutfeld and Linda Rao

Exercise may block damage of a harmful personality
We know exercise can help improve even the most harmful of physical problems. Now a new study suggests being physically fit may erase the effects of a toxic temperament.

Researchers looked at the association between levels of aerobic fitness among type-A personalities--people often characterized as hostile, drive and aggressive--and levels of a clotting chemical in their blood called thromboxane. The type-A pattern of behavior has been implicated as an independent risk factor for coronary heart disease.

After putting 97 male students through blood, fitness and psychological tests, researchers found that thromboxane production was highest in unfit type A's. Thromboxane is a clotting chemical that strongly promotes platelet stickiness in blood, which can trigger heart attacks.

The type A's who were physically fit, however, had the same thromboxane levels as the type B's--people with calmer, less hostile personalities. This may mean that aerobic fitness helped make the angry blood chemistry safer (Behavioral Medicine, Spring 1992).

"People who appear to be type A show pretty high levels of thromboxane production," says Jon M. Gerard, Ph.D., from the department of pediatrics at the University of Manitoba, Winnipeg. "Right now it's speculation, but exercise may block that chemical, potentially preventing these men from having heart attacks."

This study was the first to tie behavior to a specific blood element known for boosting heart-disease risk. "It may be that this striving, competitive type-A personality is associated with a release of hormones and neuro-chemicals in response to a stressful lifestyle," says Dennis Dyck, Ph.D., professor of psychology at Washington State University, Medical Lake. "This hormone release may then harmfully act on thromboxane and other chemicals in a way that leads to a greater risk for clotting."

POSTINFECTIONOUS FATIGUE: PROSPECTIVE COHORT STUDY IN PRIMARY CARE
by S. Wessely, T. Chalder, S. Hirsch, T. Pawlikowska, P. Wallace and D.J.M. Wright

Summary The idea that chronic fatigue has an infectious origin has become popular, but the main evidence for such an association has come from retrospective case-control studies, which are subject to ascertainment bias. We report a prospective study of the outcome of clinically diagnosed infections in patients presenting to UK general practitioners.

Questionnaires assessing fatigue and psychiatric morbidity were sent to all
patients aged 18-45 years in the study practices. The prevalence of chronic fatigue and chronic fatigue syndrome was then ascertained among 1199 people aged 18-45 who presented to the general practitioners with symptomatic infections and in 1167 people who attended the surgeries for other reasons. 84% were followed up at 6 months. 9.9% of cases and 11.7% of controls reported chronic fatigue (odds ratio 1.0 [95% CI 0.6-1.1]). There were no differences in the proportions who met various criteria for chronic fatigue syndrome. No effect of infection was noted when we excluded subjects who reported fatigue or psychological morbidity at the baseline screening. The strongest independent predictors of postinfectious fatigue were fatigue assessed before presentation with clinical infection (3.0 [1.9-4.7]) and psychological distress before presentation (1.8 [1.2-2.9]) and at presentation with the acute infection (1.8 [1.1-2.8]). There was no effect of sex or social class.

Our study shows no evidence that common infective episodes in primary care are related to the onset of chronic fatigue or chronic fatigue syndrome. Lancet 1995; 345: 1333-38

Introduction

The problem of excessive fatigue has attracted much interest in the past few years. Special attention has been paid to the possibility that the condition has an infective origin, and the term postviral fatigue syndrome has become popular. Although the subject of chronic fatigue and infection has a long history,[1] this renewal of interest was stimulated by studies in the 1980s linking chronic fatigue syndromes with Epstein-Barr virus[2] and the enteroviruses.[3] The majority of patients seen in clinics specialising in chronic fatigue syndrome report that their problems began with a viral infection.[4-8]

Difficulties with this simple story soon became apparent. Markers thought to indicate recent infection with Epstein-Barr virus or enteroviruses were found to be poor guides.[9,10] Epidemiological difficulties include reliance on retrospective case-control studies to determine exposure to an infective agent often reported as occurring several years previously. One group defined cases of postviral fatigue as "fatigue starting after an acute, apparently viral, infection".[3] However, the average adult in the UK experiences four or five symptomatic viral infections per year. 30% of a population sample[11] answered yes to the question "Have you suffered from a virus in the last month?" Chance associations between chronic fatigue and viral infection must be common. Retrospective case-control studies of postinfective fatigue are subject to ascertainment bias, since identification of a case (postviral fatigue) has been made by knowledge of exposure (viral infection), which violates the condition that cases be selected independently of exposure for valid case-control studies. There are psychological reasons why patients might attribute symptoms without a definitive biomedical explanation to a viral cause, thus contributing to recall bias and search after meaning.[12]

To overcome these difficulties, we carried out a study of chronic fatigue that was population based, involved ascertainment of exposure to infection and psychological vulnerability unbiased by the onset of chronic fatigue syndrome, and used controls not exposed to infection recruited at the same time and place.

Subjects and methods

Stage 1 - Before the main study started we sent two questionnaires to all individuals aged between 18 and 45 years registered with the study general practices. Recruitment of the practices has been described elsewhere.[13] Fatigue was assessed by a
self-report questionnaire (fatigue questionnaire), which was developed for a hospital study of chronic fatigue syndrome[4,14] and refined in primary care.[15] It consists of eleven items covering physical and mental features of fatigue, duration of fatigue, the proportion of the day during which the respondent felt tired, and muscle pain at rest and after exercise. Respondents were also asked why they felt tired. Psychological morbidity was assessed by the twelve-item general health questionnaire (GHQ).[16]

Stage 2 - The study then followed the traditional design of a cohort study. The exposed cohort were patients aged 18-45 who attended the study general practices with suspected infections. Identification of an infection was at the discretion of the doctor, but guidelines were provided. Local infections such as conjunctivitis, cold sores, fungal nail infections, and vaginal candidosis were not included. Most patients presented with "flulike" episodes or infections of the upper respiratory tract. Each subject for the non-exposed cohort was the next person within the appropriate age range who entered the general practitioner's surgery with any complaint not related to a possible infection. All subjects were asked to see the research nurse, who was available in the surgery at the same time. The nurse explained that the study was about the effects of common infection, and obtained written consent. Patients then completed the questionnaires listed on the figure, and blood samples were taken from members of the exposed cohort. (Ethical approval for samples to be taken from non-exposed subjects was not given.) Viral symptoms (including runny nose, phlegm, sore throat, fever, cough) were assessed on the 26-item checklist used by the MRC Common Cold Unit.[17] Each symptom is rated on a 6-point scale. The nurse recorded demographic details, resting pulse rate, and body temperature. Other psychological assessments and allergy questionnaire results will be reported elsewhere.

Stage 3 - All subjects were sent the general health questionnaire and fatigue questionnaire 6 months after attendance at the general practitioner's surgery. The criterion for cases of chronic fatigue was excessive fatigue throughout the preceding 6 months. Subjects who met this criterion were classified as fatigue cases or fatigued controls, depending on whether they belonged to the exposed or non-exposed cohorts.

Stage 4: nested case-control study - All fatigue cases and fatigued controls were asked to return to the general practitioner's surgery for further investigation and assessment. The same assessments were also carried out in a sample chosen from subjects without fatigue in the two cohorts - equal numbers matched by sex and age to the nearest 5 years (matched controls). The chronic fatigue syndrome questionnaire,[18] a 24-item scale, was used to assess the presence and severity of physical, cognitive, behavioural, and affective components of fatigue. Psychiatric illness was ascertained by the Revised Clinical Interview Schedule (CIS-R[19]), which was designed to record psychiatric morbidity in primary care. It is intended to be used by non-psychiatrists, and has a low observer bias. It was completed by the research nurse after appropriate training. It was scored without the fatigue items.

Functional impairment was assessed by the Medical Outcome Study 20-item questionnaire (MOS short form[20]), scored on a scale of 0-100. We also used a checklist of 32 somatic symptoms, modified from the Somatic Discomfort Questionnaire[21] and previously used in hospital-based studies of chronic fatigue syndrome.[4,14] Methods of Coping questionnaire, Life Events inventory and the Hospital Anxiety and Depression scale were also applied. Blood samples were taken from exposed subjects.
Outcome measures
The Oxford,[22] Australian,[6] and USA Centers for Disease Control and Prevention (CDC) 1994[23] criteria for chronic fatigue syndrome were used. The CDC 1988 criteria closely followed the original case definition,[24] with the exception of the physical criteria. No measures were made of lymphadenopathy, fever, or pharyngitis because of doubts about reliability.[23]

All general practice records were searched for records of any psychiatric admissions, prescriptions of psychotropic medication, and any current medical problems. The number of visits made to the surgery in the year before recruitment to the study was also recorded.

Laboratory investigations
Tests on blood samples were not intended to provide laboratory verification of acute viral exposure, but to study possible viral persistence. All fatigue cases and their stage-4 matched controls were screened with liver and thyroid function tests, haemoglobin, urea, electrolytes, and C-reactive protein.

Statistics
Likert scoring for GHQ and fatigue questionnaires produces a normal distribution in population samples, so parametric statistics can be used. MOS short-form scores produce skewed distributions,[25] but these approximated to a normal distribution after log transformation, as did the number of visits to general practitioners. GHQ, CIS-R, and fatigue scores were entered into regression models as continuous variables, but odds ratios are given for categorical variables for ease of comprehension. Social class was entered as a stratified variable with five levels. Parametric comparisons of means were made by t tests, nonparametric comparisons by the Mann-Whitney test, and comparison of proportions by the [X.sup.2] test.

The study power was adequate to detect a clinically meaningful difference in the risk of chronic fatigue between cases and controls. With p=0.05, the study had 80% power to detect a relative risk of 1.4 between cases and controls. With the same [alpha] and [beta], the figures for more stringent categories of chronic fatigue syndrome were 1.8 (CDC 1994), 1.9 (Oxford), 2.2 (Australian), and 2.4 (CDC 1988).

Results
Response rates
Response rates for stage 1 have been reported elsewhere.[13] 15 283 replies were received, an overall response rate of 48%. The response rate adjusted for inaccuracies in the inner city practice registers was 67%.

1167 (97%) of the 1199 exposed subjects and 1160 (98%) of the 1177 non-exposed subjects recruited at stage 2 completed all or nearly all of the questionnaires. More refused the blood test. Only 5% refused to be interviewed by the research nurse, usually because of pressure of time. 752 (63%) exposed and 792 (68%) non-exposed subjects had previously completed stage-1 measures. Those recruited at stage 2 who had not replied at stage 1 were slightly younger (33.4 vs 31.5 years for the responders), and a larger proportion were male (24.7 vs 18.2%, [X.sup.2] test, p=0.0004).

At stage 3, 1985 completed questionnaires were received, a response rate of 84% (exposed 84%, non-exposed 83%). 155 patients had moved, 21 refused, and no information was available on 215. Non-responders were more likely to be male (35.8 vs 29.7%, p=0.01), and at stage 1 more likely to score above the cut-off defining a case for
both the GHQ (48.0 vs 38.9%, p=0.02), and the fatigue questionnaire (46.8 vs 42.0%, p=0.23).
Of the 214 subjects who met the criterion for chronic fatigue, 185 (86%) were interviewed - 89 (89%) exposed and 96 (84%) non-exposed. Of the 214 matched controls, 193 (90%) were interviewed - 95 (95%) exposed and 98 (86%) non-exposed.

All patients who met the criterion for chronic fatigue at stage 3 were matched by age and sex with a non-fatigued subject from the same cohort. More than 80% of the matched non-fatigued control subjects were successfully interviewed at the first attempt. Matched controls who could not be contacted were replaced with another. Thus, every fatigued subject interviewed at stage 3 was successfully matched with a control for whom full interview data were obtained.

Clinical diagnoses

The commonest symptoms in the exposed cohort were sore throat (66%), cough (57%), headache (57%), aching muscles (53%), runny nose (49%), fever (38%), and chills (36%). The month of onset followed the expected seasonal distribution for common viral infections. The mean duration of symptoms in the cases was 8 days. The general practitioners' clinical diagnoses are given in table 1. In the non-exposed cohort the reason for attendance was recorded as related to the reproductive system (25%), musculoskeletal (17%), skin (11%), routine (insurance medicals, repeat prescriptions, &c: 9%), respiratory and cardiovascular (7%), ears, nose, throat, and conjunctivitis (6%), digestive (5%), other eye problems (4%), mental illness (4%), lifestyle advice (4%), nervous system (2%), psychosocial (2%), fatigue (2%), urinary (1%), and endocrine (1%); no reason was recorded in 2%.

<table>
<thead>
<tr>
<th>General practitioners' diagnosis</th>
<th>% of exposed cohort</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sore throat</td>
<td>33</td>
</tr>
<tr>
<td>Influenza</td>
<td>19</td>
</tr>
<tr>
<td>Cold</td>
<td>16</td>
</tr>
<tr>
<td>Gastroenteritis</td>
<td>6</td>
</tr>
<tr>
<td>Chest infection</td>
<td>4</td>
</tr>
<tr>
<td>Tonsilitis</td>
<td>4</td>
</tr>
<tr>
<td>Sinusitis</td>
<td>3</td>
</tr>
<tr>
<td>Middle-ear infection</td>
<td>3</td>
</tr>
<tr>
<td>Chickenpox</td>
<td>1</td>
</tr>
<tr>
<td>Glandular fever</td>
<td>1</td>
</tr>
<tr>
<td>Urinary tract infection/cystitis</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>6</td>
</tr>
<tr>
<td>Missing</td>
<td>2</td>
</tr>
</tbody>
</table>

Stage 2 sample

The exposed and non-exposed cohorts did not differ in sex distribution; there were more women than men in both cohorts (68%, 70%). The mean age was lower in the exposed than the non-exposed cohort (32.7 [SD 7.5] vs 33.5 [7.5] years); this difference was significant because the sample was large, but it is probably unimportant.

There was no difference between the exposed and non-exposed cohorts in the mean fatigue score or the proportions who scored above the cut-off for fatigue cases at stage 1 (before recruitment to the study; 42.4 vs 42.7%, p=0.8). However, there was a slightly higher proportion of GHQ cases at stage 1 in those later recruited as non-exposed.
subjects (37.6% exposed vs 42.1% non-exposed, p=0.08). By contrast at stage 2, 63.5% of exposed subjects scored above the cut-off for fatigue on the fatigue questionnaire compared with 36.1% of non-exposed subjects (p<0.001); a greater proportion of the exposed than the non-exposed cohort had psychiatric morbidity according to the GHQ (43% vs 36.1%, p=0.001).

**Postviral fatigue**

Similar numbers of exposed and non-exposed subjects complained of fatigue at follow-up (table 2) and similar numbers met criteria for chronic fatigue, scoring above the cut-off already validated in primary care for the previous 6 months (100 vs 114). The combined prevalence of chronic fatigue was 10.8%. As we introduced more stringent criteria for chronic fatigue syndrome, the difference in the likelihood of the syndrome between the non-exposed and exposed cohorts increased, although did not reach significance for any set of criteria (table 2). The most likely reason for the slightly higher rates of fatigue in the non-exposed cohort was the slightly higher rates of fatigue and psychological morbidity at stage 1 in that cohort. Separation of fatigue into physical or mental symptoms\[4,15\] revealed no differences between the groups.

Since previous fatigue was strongly associated with subsequent chronic fatigue, it is possible that any association between infection and fatigue was obscured by the high rate of preinfection fatigue in the study sample. We therefore repeated analyses for those without previous fatigue only. Eligibility was defined as a low fatigue score at stage 1, rather than stage 2 since many patients were fatigued at stage 2 because of the acute infection. Even among subjects with no history of fatigue, there was no evidence that infection at stage 2 was associated with chronic fatigue or chronic fatigue syndrome. Another confounder is the possibility of further infections during follow-up. 36% of those interviewed at stage 3 recalled such an infection, but there was no difference between exposed and non-exposed cohorts. We restricted analyses to subjects who recalled no infection (no further infection for exposed subjects) during the 6 months of follow-up, and again found no increase in the risk of chronic fatigue in the exposed subjects. 37 (40%) of 93 exposed subjects and 56 (48%) of 118 non-exposed subjects who recalled no infection during follow-up had chronic fatigue (odds ratio 0.7 [95% CI 0.4-1.2]). The odds ratios for other definitions of chronic fatigue syndrome were 0.6 (0.2-1.5) by Oxford criteria, 0.5 (0.1-1.7) by Australian criteria, and 0.2 (0.1-0.8) by CDC 1994 criteria. Thus, there was no difference in the pattern-of-results, but a slight loss of power reflected in the wider confidence limits.

Stratification by sex, age group, social class, pre-existing psychological morbidity (stage 1 or stage 2), or pre-existing fatigue (stage 1 or stage 2), made no difference to the pattern of results. The stratified (Mantel-Haenzel) odds ratio for the effect of viral infection adjusted for sex was identical to the crude odds ratio shown in table 2. Adjustment for the number of visits to the general practitioner during the year before recruitment also had no effect on the odds ratio for chronic fatigue syndrome.

There were no differences between the exposed and non-exposed cohorts for other outcome measures at stage 3. The proportions who had psychiatric morbidity on the GHQ were similar (49 vs 51%) and the mean GHQ scores were identical. More detailed information was available on the subset recruited for the nested case-control study. There were no differences at that stage between the exposed and non-exposed cohorts in the
number of somatic symptoms, depression and anxiety scores, psychiatric disorder assessed by direct interview, previous psychotropic drug use, or previous psychiatric history. (Details will be reported elsewhere.) The only difference between the cohorts at 6-month follow-up was in the total physical limits determined by the MOS short form; the score was greater in the non-exposed cohort (3.5 vs 2.8, p=0.04). Belief that fatigue at stage 2 was due to a physical cause did not influence the risk of subsequent fatigue (odds ratio 1.0 [0.7-1.5]), nor did attribution to a physical explanation for catching the virus (0.8 [0.4-1.4]).

There were no significant differences in the number of symptoms between exposed and non-exposed subjects at stage 3, with the exception of stiffness, palpitations, and tremor, which were commoner in the non-exposed cohort. This may be a chance finding.

Significant variables were entered into a stepwise multiple regression model, with the dependent variable chronic fatigue at stage 3. The data set was the 671 subjects from the exposed cohort with complete data at all three stages of the study. Previous fatigue (scoring above the predefined cut-off on the fatigue questionnaire at stage 1) was the strongest independent predictor of fatigue after viral infection (p<0.001). Logistic regression was used to obtain more meaningful measures of effect size with categorical predictor variables (table 3). Independent contributions were made by both fatigue and psychological distress before presentation with the clinical infection, and by psychological distress at the time of presentation. Belief that fatigue was due to a physical cause was not a significant predictor of fatigue (odds ratio 1.6 [0.8-3.3], p=0.21).

Acute viral symptoms

Subjects in the exposed cohort who satisfied criteria for chronic fatigue 6 months later were more likely to say that they had most of the general symptoms on the viral checklist when recruited at stage 2. These symptoms included headache, aching muscles, insomnia, joint pain, heaviness of the legs, physical weakness, sore eyes, chills, racing heart, anxiety, tearfulness, sensitivity to noise, sensitivity to light, poor concentration, and poor memory. On the other hand, there was no difference between those who developed chronic fatigue and those who did not in the proportion reporting local symptoms on the checklist (sneezing, runny nose, production of phlegm, earache, hoarseness, nasal stuffiness, sore throat, fevers, sweating, and cough), either in prevalence or severity.

Viral symptoms and psychological morbidity

The association between viral symptoms and postviral fatigue was further explored by studying symptoms experienced during the acute infection and psychological morbidity measured at the same time by the GHQ. Every symptom listed under the viral checklist was commoner in subjects who scored higher than the GHQ cut-off (GHQ cases) than in those who were not cases, except for sore throat (odds ratio 1.0). However, there was a difference between local and general symptoms. Local symptoms that were not associated with the subsequent development of chronic fatigue all had odds ratios of between 1.2 and 1.7. Of those that were associated with chronic fatigue, only chills (odds ratio 1.9) and joint pain (1.9) had odds ratios under 2.0; in most the odds ratio was more than 3.0, which indicates a very strong link.

A similar pattern was observed for the influence of previous (stage 1) psychological morbidity. There was no statistical association between being a GHQ case at stage 1 and ten of the viral symptoms (sneezing, runny nose, phlegm, sore throat, hoarseness, nasal
stiffness, cough, fever, chills, and earache), all of which had odds ratios between 0.8 and 1.2. The other symptoms were all significantly associated with previous GHQ scores. Insomnia, heavy legs, tearfulness, sensitivity to noise or light, poor concentration, weakness, joint pain, fatigue, headache, and memory loss all had odds ratios of more than 2.0, and only racing heart (1.3), sweating (1.5), sore eyes (1.5), and aching muscles (1.9) had significant odds ratios less than 2.

This pattern was confirmed by studying the stage-2 symptomatic profile in subjects without pre-existing psychiatric morbidity (ie, not GHQ cases at stage 1). The power of the study was reduced, but symptoms with odds ratios of over 2.0 (statistically significant) were again general rather than local symptoms.

Discussion

We found no evidence to suggest that in primary care common viral infections are associated with chronic fatigue syndromes.

The study has several limitations. First, only patients with symptomatic infections were recruited; symptomless infections and those not diagnosed as infections by the general practitioner would be missed. However, most patients seen in specialist care with the diagnosis chronic fatigue syndrome recall a symptomatic episode.[4-8,26] Second, patients with infections who never presented to their general practitioners would be excluded, although such cases might be expected to be less severe. The cohort design permits study of the outcome of infection and the results can be applied to the general population, unless there is evidence of a selection bias in the choice of cohort. A bias would occur if infections that are associated with chronic fatigue syndrome are also less likely to be seen by the general practitioner. This idea seems implausible. Another possible bias would occur if subjects vulnerable to postinfective fatigue syndromes were unlikely to present to the general practitioner with acute infection. In the self-help literature on chronic fatigue syndrome, sufferers are characterised as overachievers reluctant to seek medical help. Adjustment for numbers of visits to the general practitioner did not, however, reveal any effect of infection.

Third, as the study progressed some exposed and non-exposed subjects reported new episodes of infection, although there was no difference between the two cohorts in the rate of such infections. However, subjects in the non-exposed cohort who experienced a new infection followed by chronic fatigue would not be false-negatives on follow-up, since they would not be able to complain of the full 6 months of fatigue, and thus would not satisfy the criterion for chronic fatigue cases. Exclusion of subjects who developed further infection revealed no suggestion of any effect on infection on the risk of fatigue or chronic fatigue.

Two internal biases should be considered. The exposed (infection) cohort reported substantially more fatigue at stage 2 than the non-exposed subjects. This difference is almost certainly due to the acute response to infection. At stage 1, before the infection, fatigue scores were identical in the two cohorts, and there was a slight tendency for those who later developed infections to have less psychological morbidity. A more likely source of response bias is the finding that non-responders at stage 3 had slightly higher psychological morbidity at stage 1 than responders. The association between previous psychological distress and postinfectious fatigue may be slightly stronger than that we report.

These criticisms should be set against the strengths of the study design, which are
its general practice base, prospective design, and high rates of follow-up. We know of only three similar studies.[27-29] Imboden et al[27] found that among patients who had developed influenza after the 1957 epidemic, psychological vulnerability predicted delayed recovery at 6 weeks. By contrast with our findings, White et al[28] found an increase in postinfectious fatigue syndromes, but only in patients with Epstein-Barr and non-Epstein-Barr glandular fevers, not other viral infections. Epstein-Barr virus is, however, a rare cause of acute viral infection in primary care (only 1% of symptomatic infections in our cohort), and commonly causes no symptoms. Thus, our findings and those of White et al[28] accord for upper respiratory tract infections.

Cope and colleagues21 Studied subjects defined by a general practitioner as having acute viral infections, but had no control group. At 6 months, 17.5% remained chronically fatigued, a slightly higher proportion than that in a cross-sectional survey of attenders in a single general practice recruited in an earlier study. Our acute infection cohort is similar to that of Cope et al[29] in sociodemographic variables and duration and range of presenting symptoms. Cope et al[29] acknowledged the need for their results to be confirmed with a control group of non-infected patients. With such a control group recruited prospectively in the same practices and at the same time as the exposed cohort, we found no evidence of any postinfection fatigue effect at 6 months.

The different symptom patterns noted during the acute infection also suggest that acute infection is not an important mediator of chronic fatigue. Local symptoms were common in the acute cases, but did not predict the subsequent development of chronic fatigue. By contrast, general symptoms did predict chronic fatigue. These symptoms were also associated with both current and previous psychological distress, unlike the local symptoms. There are several possible explanations. First, the symptoms may predate viral exposure, but may be confused by the patient with the symptoms of viral malaise. Second, the symptoms may develop during an acute infection because of an underlying trait of somatisation. Cope et al[29] reported that somatisation (defined on the basis of attributional style) predicted postviral fatigue. We found no evidence that attribution of the cause of viral infection predicts postviral fatigue, perhaps because we used a cruder measure of direct attribution rather than the measure of global attributional style used by Cope et al. Third, general symptoms represent a general response to acute infection mediated by cytokine release (as opposed to the local symptoms directly related to viral involvement). This mechanism would not explain the firm association with premorbid psychological morbidity. We believe that the different pattern of symptom associations is consistent with the overall lack of an effect of acute infections on the risk of chronic fatigue.

Can these results be applied to chronic fatigue syndrome outside primary care? We believe they can. Most people presenting with chronic fatigue syndrome who claim an infective onset to their symptoms do so without laboratory confirmation at onset, not surprisingly, since most diagnoses of common viral infections are made without laboratory investigation.

We conclude that common infections play little part in the aetiology of chronic fatigue in primary care. This conclusion does not exclude a role for less common infections, caused by Epstein-Barr virus, toxoplasma, or cytomegalovirus, for example. Nor does it exclude a rare complication of a common infection. The study power was adequate to detect small differences in the risk of chronic fatigue, but it had only a 50%
power to detect a relative risk of 1.5 for the latest CDC criteria for chronic fatigue syndrome.[23] Overall, we conclude that the population attributable risk of acute infections on the prevalence of chronic fatigue syndrome is low.

Instead, our results suggest a link with previous fatigue and previous psychological disorder. The strong association between previral fatigue and both idiopathic chronic fatigue and chronic fatigue syndrome contrasts with the findings of Cope et al.[29] The differences may reflect the limitations of reliance on retrospective reports of fatigability, rather than prospective assessments carried out before the subjects presented with viral infections. Retrospective accounts of previous fatigability, a necessary part of all the case definitions of chronic fatigue syndrome (which require that fatigue must be of new onset), are likely to be even less accurate in the patients with long-standing fatigue who make up most specialist samples of chronic fatigue syndrome. The pilot phase of this study was supported by the North West Thames Regional Health Authority. The main study was supported by Linbury Trust, with additional support from Private Patients Plan, and BUPA.

References

GARLIC: FANTASTIC HEALTH AID
by Rob McCaleb

In June 1991, I sat in a Food and Drug Administration conference room with Peggy Brevoort, president of the American Herbal Products Association, and our attorney Bill Pendergast. Across the table was Dr. Fred Shank, director of the FDA's Center for Food Safety and Applied Nutrition. Dr. Shank is in charge of all matters relating to food at the Agency, which governs the food industry.

We were discussing the health protective effects of foods, supplements and herbs...
and what claims might be allowed by the FDA under the Nutrition Labeling and Education Act passed by Congress in 1990. Congress and the Administration had taken a bold step, directing the FDA to come up with rules allowing health benefit claims on the labels of food products which could be shown to reduce the risk of cancer.

We visited the FDA to find out how receptive they would be to health benefit claims for herbs, and we proposed to offer funding from the industry and professional expertise from the Herb Research Foundation to help them evaluate such claims for herbs. Dr. Shank told us he expected that getting a claim approved, for any food or supplement, would be very difficult.

Dr. Shank referred to the 10 specific areas Congress had directed the FDA to investigate for potential health claims, and asked if I thought there were any herbs which would fit into one or more of these specific categories. I responded that, yes, there are many examples; herbs that have cholesterol-lowering effects like fiber; antioxidant effects like certain vitamins; and protective effects against all four of the leading causes of death: heart disease, cancer and respiratory and liver diseases.

We were not ready to discuss any specific, and this brief meeting was hardly the place, but I mentioned one example of a well-researched herb: garlic. A recent study published in the National Cancer Institute's journal showed a direct protective effect of garlic against stomach cancer in humans. Dr. Shank, apparently aware of that study, immediately interjected, "That would not be nearly enough to approve a claim."

So, unfortunately for the American public, the FDA intends to be typically repressive. Doctors and scientists, Congress and the Administration are all increasingly receptive to the idea of preventive medicine, and to the benefits of healthful foods and supplements. The FDA seems intent on continuing to require decades of research and hundreds of millions of research dollars before allowing Americans to be informed about even the simplest known health benefits of foods and supplements. After all, the FDA still hasn't made up its mind about fiber, after more than 40 years of study and literally billions of dollars worth of research.

The benefits of garlic on health have been researched through modern scientific experimentation for more than 30 years. Numerous human clinical studies confirm the safety and effectiveness of this remarkable food.

In 1989, the internationally renowned cancer journal Oncology published research from the Department of Biochemistry, Kyoto Prefectural University of Medicine in Japan. Garlic extract, they found, was able to inhibit one of the earliest events in the development of chemically-induced cancer.

The study involved both laboratory experimentation and animal studies. The first showed that garlic extract prevented the earliest chemical reactions involved in the process of tumor formation. The animal study demonstrated that the garlic extract caused a complete inhibition of the first stage of skin cancer development. That same year, researchers at the New York University Medical Center reported in the Journal of Biochemistry and Toxicology that garlic and onion oils had numerous chemical compounds which inhibited the enzyme lipoxygenase. The authors conclude that "the inhibition of lipoxygenase may be involved in anti-promotion tumors."

An article in Planta Medica, one of the world's most respected plant medicine
journals, discussed how garlic protects liver membranes from oxidation damage (lipid peroxidation), thereby increasing the useful life and function of the liver cells and detoxifying carcinogens.

For those unfortunate enough to already be under treatment for cancer, this study in Nutrition and Cancer in 1990 is important. Researchers at the Amala Cancer Research Center in Kerala, India, discovered that garlic extract reduces the toxicity of the cancer therapy drug cyclophosphamide. The garlic extract increased the life span of mice treated with cyclophosphamide by more than 70 percent. It also reduced the level of lipid peroxidation in the liver caused by this toxic chemotherapy drug, and "did not interfere with the tumor-reducing activity of cyclophosphamide."

This is an remarkable finding, that something as safe as garlic can dramatically reduce the toxicity of chemotherapy agents, without reducing their effectiveness. This has a tremendous potential to benefit cancer patients undergoing chemotherapy. Unfortunately, there will likely be no interest in this activity from drug companies or the FDA.

In May 1990, the Indian Journal of Experimental Biology reported that garlic extracts could prevent chemically-induced skin cancer. The amount of the chemical carcinogen used in this study was enough to produce tumors in 100 percent of the control animals, while a garlic extract protected 57 percent of the test group against skin cancer. When a lower dose of the carcinogen was used, enough to cause tumors 74 percent of the time, the amount of protection afforded by garlic extract was still 57 percent. The Cancer Biology Laboratory of the Jawaharlal Nehru University in India conducted this study.

The Institute of Experimental Cancer Research at the University of Innsbruck, Austria, found the free radical scavenging effects of garlic constituents "might be responsible for the inhibitory effect" against mutation induced by radiation.

Garlic also protected against mutation caused by peroxides and two other chemical mutagens. The research started with salmonella and coliform bacteria, then confirmed its results on hamster ovary cells, to demonstrate that the effect was not confined to bacterial cells but also worked on mammalian cells.

Cancer Research published results from the University of Texas' Anderson Cancer Center showing a major flavor component of garlic, diallyl sulfide (DAS), inhibits colon cancer and also reduces damage to the colon caused by gamma ray exposure. Thus, in addition to reducing the incidence of cancer and the toxicity of cancer chemotherapy drugs, garlic may also reduce damage from radiation treatments of cancer.

The Journal of Mutagenesis Research reports that a water extract of garlic bulbs markedly suppressed mutagenesis in several bacterial mutagen assays. The garlic extract appeared to inactivate the mutagenic chemical used in the test, which was conducted by Zheijang Medical University in China.

Scientists at the Tri-Service General Hospital in Taipei, Taiwan, described the inhibitory effect of topical garlic extract on oral cancers. They concluded that "garlic could be developed as a potential chemo-protective agent for oral cancer." Their study was reported in Nutrition and Cancer.

Also in that journal, Kansas State University researchers studied the effect of garlic and onion oils on all stages of skin cancer in mice. They found an inhibitory effect in every stage in the development of skin cancer and concluded that "onion and garlic oils inhibit all stages of mouse skin tumorigenesis."
Studies in 1991 include research at California's Loma Linda University, published in Cancer Letters, which found a protective effect of a constituent of garlic against the most powerfully known natural carcinogen, aflatoxin B1. Aflatoxins, sometimes present in most nuts and peanuts, as well as corn, wheat and other grains, was unable to affect the DNA of animals treated with the garlic compound.

Also published in 1991 was an article in Biochemistry and Pharmacology about experiments at the University of Miami School of Medicine which confirmed the anticancer effect of the garlic compounds DAS. This study found a significant increase in activity of a liver enzyme responsible for detoxifying carcinogens.

The garlic compound increased the activity "in a dose-dependent manner" in the stomach and in the lungs. The authors suggest that some of the anticancer activity of garlic may be the result of this enzyme-activating effect. The same University of Miami oncology department reported in Cancer Letters that DAS does inhibit cancers in specifically the same organs -- the stomach and lungs -- in which it was shown to affect enzyme activity.

These are only the most recent of the hundreds of studies that have shown anticancer effects of garlic. This, combined with the many other benefits of garlic, makes it small wonder that millions of Europeans take garlic tablets every day. And both Europeans and Asians include large amounts of it in their daily diet. It's small wonder too that Asians and Europeans consistently have a lower incidence of cancer than Americans.

It is tragic that the FDA refuses to allow manufacturers of garlic products to tell their customers about the benefits of these products. Fortunately, consumers do have access to information provided by magazines like this one. Only through widespread education can Americans improve their health and longevity through the informed use of herbs and other dietary supplements.

For information about how you can help increase Americans' access to this kind of information, contact the Herb Research Foundation in Boulder, Colorado at 303-449-2265.

REFERENCES:


HOW TO GROW A MEDICINAL HERB GARDEN
by Karen Baar

While Dried herbs are a godsend in terms of convenience, growing your own healing herbs is an endeavor well worth considering. Not only does an herb garden provide a treasure trove of sensory pleasure--with its bright colors and pungent aromas--you'll reap health benefits by having herbs with medicinal properties more potent than the dry herbs you can buy in the store. "When who buy bulk herbs, as with any product, you don't know them, how long they've had [the who has been handling herbs!, or how old the herbs are," says Jim Sensenig, N.D., a naturopath in Hamden, Connecticut. "The operating principle le with herbs is that as you move away from fresh plants, the herbs in potency The exposure to oxygen and light will deteriorate some of the essential components and diminish the herb's effectiveness. For the casual herbalist using fresh [herbs] is preferable, and drying your own is the next best thing."
I've been gardening for ten Years now and still love to go out in the early morning when dew has just dried. The sun isn't yet enough to cause the plants to sag and some of the flower buds are just beginning to open. I have also found that this is the perfect time to harvest herbs, bringing them into the house to create simple, useful home remedies. When my daughter had die flu and couldn't sleep, I used chamomile leaves from MY garden for a tea to ease her restlessness. And in the spring, I have found that fresh dandelion leaves, plucked from MY backyard, are a tasty way to deal with premenstrual bloating.
Best of all, these benefits are surprisingly easy to come by since many herbs are easy to cultivate. The following seven herbs are particularly adaptable to a variety of soil
types and climates. These herbs, however, are only a beginning; once you start growing your own, the only limitation is the size of your garden.

SEVEN EASY HERBS

These medicinal herbs are nontoxic, easy to use from the first year you grow them, and are also pretty enough to be used as cut flowers. Most can be started from seed directly in your garden; follow the instructions on the seed packet for planting depth, spacing, and precise timing. After planting any seeds, it is crucial to keep them moist until they germinate. The first two leaves that appear, known as cotyledons, are food-storing tissues and not "true" leaves; once the second set of leaves appears, however, you can thin or transplant your seedlings. And although most herbs need at least five hours of full sun a day, some win tolerate partial shade, and many are drought resistant too.

PREP THE SOIL

When growing perennial herbs, be sure to devote some time to preparing the soil. Most important is good drainage because excess water can cause poor growth in summer and failure to survive the winter. If possible, get a soil test from your local cooperative extension service, which is listed under state agencies in your telephone book; the results will help you adjust the pH (most herbs prefer a neutral soil) and guide whatever other adjustments you may want to make. If your soil is sandy or claylike, add organic matter: leaves, leaf mold, rotted hay, or compost. Aim for a loose, loamy mixture. Once you've established a bed with good garden soil, frequent fertilizing is unnecessary; in fact, too much feeding reduces the amount of essential oils the herbs produce. A yearly addition of compost or well-rotted manure is sufficient.

CALENDULA

Calendula officinalis

Pot marigold

Growing Information: The bright yellow-orange flowers of calendula, a striking annual, bloom all summer and well into fall. You can easily grow pot marigolds from seed. Simply sow the seeds as soon as the ground can be worked in early spring; they germinate in ten days to two weeks. The flowers, which reach about two feet in height, thrive in full sun and tolerate partial shade; they also self-sow and may spread. Collect them as they come into bloom during the summer. Dry calendula carefully to avoid bleaching the flowers; once they are dry, separate and store the petals.

Uses: Calendula flowers, especially the petals, are used to heal wounds. Use a calendula infusion as a mouthwash to treat mouth ulcers and gum disease. It will also ease menstrual cramps and soothe digestive ulcers. Externally, try calendula on local injuries and irritations; it is astringent enough to stop bleeding, and a compress--a clean cotton, linen, or gauze pad soaked in the warm infusion--can be applied to slow-healing cuts, burns, and minor infections as well as to sprains and bruises.

CHAMOMILE

Matricaria recutita German or Hungarian Chamaemelum nobile Roman or English

Growing Information: Both species of chamomile--German and Roman--are used medicinally and are good plants for the home garden.

German chamomile is an annual, one to two feet tall with finely cut, fragrant leaves. Its many tiny flower heads have yellow disks surrounded by white rays. Sow the seeds directly in the garden in early spring; they will germinate in a week to ten days. German chamomile needs full sun. It will tolerate many soils, but a light, sandy soil is
best. These plants may become leggy by late summer; they will also self-sow freely.

Roman chamomile is a perennial, a low growing, creeping herb that requires full sun and good drainage. This species doesn't thrive in very hot areas, but it is often used as a ground cover in cooler spots. Roman chamomile has downy gray-green leaves and fewer flowers than its German cousin. You can start this herb from seed directly in the garden, or buy small plants from a nursery.

To harvest chamomile, gather flowers in spring and summer as they come into bloom, then dry and store. Uses: A tea made from chamomile flowers is frequently used for ailments of the digestive tract. Its anti-inflammatory properties ease such conditions as diverticulitis, gastritis, and flatulence. Chamomile relaxes the gut wall, relieving spasms and diarrhea. For digestive problems, try drinking an infusion after meals. The tea is also a gentle sedative, useful when anxiety and nervousness cause insomnia. And it is safe and effective for children and cranky or teething infants.

Note: In rare cases, chamomile can cause contact dermatitis.

DANDELION

Taraxacum officinale

Growing Information: Despite their reputation as intrusive weeds, dandelions, which are hardy perennials, are attractive and highly useful plants. You can sow their seeds after the last frost in spring; they germinate in seven to twenty-one days. The plants are adaptable but grow best in rich, deep, moist soil. If you're sure that no pesticides have been used, you can collect dandelion leaves or seeds from the wild plants in your yard and neighborhood. You can harvest them any time, but they are best in early spring before the flower buds appear. Uses: This discussion is limited to dandelion leaves, although all parts of the plant are useful. Dandelion leaves are a powerful diuretic. Unlike many pharmaceutical diuretics, however, which can cause the body to lose potassium, dandelions have a high potassium content. To use them, puree the leaves and use the juice, or eat them whole in a salad. You can also dry dandelion leaves and use them as an infusion to stimulate digestion.

FEVERFEW

Tanacetum parthenium

Growing Information: Feverfew is a perennial herb with light, aromatic, yellow-green leaves and numerous white daisylike flowers from early summer trough fall. It's a good plant for the front of a border because it grows only one to two feet high. You can start feverfew in the spring, sowing seed directly in your garden after all danger of frost is gone; it germinates in ten to fifteen days. Or you can plant cuttings in spring or fall. Feverfew grows in average soil in full sun to partial shade. To encourage bushier growth and more leaf production, pinch back the flowers as they begin to form. Harvest the leaves throughout spring and summer; just before the plant flowers is the best time. Leaves can be dried or frozen.

Uses: Because feverfew relaxes blood vessels, you can use it to prevent migraines. Try eating one large leaf or several small ones daily. The fresh leaves can cause mouth ulcers in some people, however; if this happens, try sauteing the leaf in a bit of oil before chewing it. Feverfew also stimulates the uterus, so an infusion can ease menstrual pain.
and sluggish flow.

Note: Avoid this herb during pregnancy or if you are taking blood-thinning drugs.

MARSHMALLOWS
Althaea officinalis

Growing Information: Six feet tall with branched stems, gray-green leaves, and pale, lilac-pink flowers tucked into the upper leaf axils, marshmallow is a pleasing addition to any garden. This hardy herb flowers all summer and into early autumn. You can sow seed directly into your garden, where it will take about thirty days to germinate, or you can buy plants from a nursery. Marshmallow is easy to grow in average, well-drained garden soil in full sun or partial shade. Collect and dry the leaves in late summer after the plant has flowered.

Uses: Marshmallow is highly mucilaginous, so it is used as a demulcent--to soothe and protect irritated tissues. Make an infusion with the leaves for bronchial disorders or as an expectorant for dry coughs. The tea also soothes urinary tract disorders such as cystitis. Marshmallow can also be used to soothe bruises, muscle aches, sprains, and burns; to do so, make a poultice by chopping up the fresh herb and applying it to the affected area. Put a bit of oil on the skin first to prevent the herb from sticking, and use gauze to hold it in place. You can use dried marshmallow leaves if you boil them for a couple of minutes and squeeze out any extra liquid.

ST. JOHN'S WORT
Hypericum perforatum

Growing Information: St. John's Wort is a many-branched perennial. It grows one to three feet tall with pale green leaves and star-shaped golden flowers that bloom all summer. St. John's Wort grows in average garden soil in full sun or partial shade. Seeds take a long time to germinate, so it is quicker to start with plants. St. John's Wort grows wild throughout much of North America and can become invasive in your garden, so keep an eye on it and pull out any unwanted volunteers. Uses: St. John's Wort oil reduces swelling; use it as an anti-inflammatory for sore joints or muscles, such as tennis elbow, and to speed the healing of sores and bruises. To make the oil, collect the flowers when they are just open, cut or crush them, and cover them with olive oil (or cold-pressed safflower, walnut, or sunflower oil) in a glass container. Let them ferment in a warm place or in the sun for several weeks, shaking the container daily. When a bright red liquid has formed in the bottom, strain it through muslin or cheesecloth, and it's ready to use. Store the oil in a well-sealed, dark-glass container.

You can make an infusion of St. John's Wort from the dried aerial parts--the entire above-ground portion of the plant--collected when the herb is in flower. Drink the tea to soothe nervous tension, anxiety, or the symptoms of PMS or menopause. You can also use the infusion to bathe wounds, skin sores, and bruises.

Note: If taken internally, St. John's Wort can cause photosensitivity, a dermatitis that comes with exposure to the sun, it also occasionally causes contact dermatitis if you work with it when it is wet.

YARROW
Achillea millefolium

Growing Information: Yarrow is a hardy, feathery-leaved perennial that grows three to four feet high. Its flower heads, which are available in a variety of appealing colors, are flat clusters about three to four inches in diameter; they bloom all summer long.
sown in your garden, yarrow seed will germinate in ten to fourteen days. Or, if you prefer; you can start with small plants. Yarrow needs full sun and average soil; it is highly drought resistant. To harvest yarrow, gather the aerial parts when the plant is in flower, then dry and store. Uses: When used as an infusion, yarrow promotes sweating and helps reduce fever. Drink hot tea made from the aerial parts hourly until the fever breaks.

Externally, yarrow can be used as a styptic to stop bleeding; try putting a poultice of fresh leaves on cuts or grazes. And a fresh or dried leaf inserted into your nostril will stop a nosebleed.

Note: Avoid yarrow during pregnancy because it stimulates the uterus. Occasionally, but rarely, yarrow can also cause a skin rash.

RELATED ARTICLE: From Garden to Good Health

PICKING HERBS

When picking any herbs, harvest them on a clear, sunny day after the morning dew has dried but before the sun gets too hot since this may evaporate the essential oils.

DRYING HERBS

Dry herbs in a warm, dry, shady spot; be sure to have good air flow over and around them. You can spread flower blossoms and leafy parts of herbs on racks covered with muslin or newspaper; turn them every day to ensure even drying. Or tie leaves and stems in small bunches (a handful) and hang them. Most herbs will dry in several days or, at the most, a week.

You can also dry herbs in the oven. Preheat the oven to its lowest setting and place the herbs on a cookie sheet; dry with the oven door wide open. Once dry--they will feel crisp--store the herbs in airtight containers in a cool spot out of direct sunlight.

BREWING HERBS

An infusion or tisane is a tea made with the leaves or flowers of a plant. When making an infusion, it's essential to keep the volatile oils from escaping, so keep the tea completely covered while it steeps. Pour one cup of simmering (not rapidly boiling) water over either two teaspoons of the fresh herb or one teaspoon of the dried; cover and let it steep for ten minutes. If you're brewing a small amount in a cup, cover the cup with a saucer; when using a teapot, cover the spout. Strain the tea before drinking. Drink it hot or cold, and although you can make enough to last a few days, it is best to make the tea fresh each day.

Karen Baar writes on a variety of health subjects.

GOOD MARRIAGES MAKE HAPPY CHILDREN

by Harville Hendrix

As awareness settles in, partners look at each other in a different light. They view each other no longer as "intimate enemies," but as fellow pilgrims on a journey toward emotional healing and spiritual wholeness.

Most couples who unearth the roots of conflict in their relationship make a surprising discovery: the trial to understanding the sources of the struggle leads to a reservoir of unmet childhood needs. Viewing their marriage through one lens of childhood reveals direct parallels between the way they feel in their marriage and the way
they felt as children. The other lens reveals aspect of their parents' marriage that they have unconsciously re-created with their partner. The model of marriage they tried to escape has followed them to their own bedroom where they, like programmed robots, behave with each other as they behaved with their parents.

At some point, enlightened couples ask: Why are we doing this? The answer that finally emerges is that they are trying to work out with their partners the problems that remained unsolved with their parents. Such an awareness often leads to remarkable changes in attitude. Instead of blaming their parents, they see them as wounded children suffering the parenting failures of their mothers and fathers. Couples get to learn experientially what marital and family therapists have been talking about for years: unresolved childhood problems are handed down from generation to generation.

As this awareness settles in, partners look at each other in a different light. They view each other no longer as "intimate enemies," but as fellow pilgrims on a journey toward emotional healing and spiritual wholeness. The relief this vision provides, however, may be distributed by the anxiety it raises about the emotional welfare of their own children.

What We Saw As Children

In a recent couples workshop, Mary, in tears, asked, "Are we doing to our children what our parents did to us?" Although the truth hurt, the answer was: "Yes. Just as your model of marriage came from your parents, so did your model of parenting. During childhood, you took in the way you saw yourself being treated as the way to treat others; and you now refer to this early inner experience unconsciously, as your blueprint for the way to behave with your spouse and your children."

George, Mary's husband, asked, somewhat fearfully, "Does that mean we have already hurt our children?" Again the answer was: "Yes. The internalization of models begins in early childhood. With their first experiences, children create a picture of the outside world. Simultaneously, in the course of interacting with their parents, they create an image of themselves. The world is 'safe' for children if their needs are met; if those needs are frustrated, the world is 'dangerous.' The corresponding image of the self is 'secure' or 'insecure', depending on the availability or reliable warmth. So, to the extent that your conflicts have created tension in the home and diverted your attention from your child, he or she has been emotionally injured.

"During a child's first six years, the images of world and self are flexible and can be changed. Between ages 7 and 10, a child will respond to improved conditions in the environment. Once adolescence begins, however, change is more difficult because the child is well accustomed to a stressful environment and the child's behavior is more rigid. Changes in adolescence require radical alterations at home--an endeavor that may call for professional help, yet is certainly worth the effort. Why? Because whatever is not resolved in adolescence reappears in marriage and forms the basis for a power struggle."

Then came the big question: "Is there anything we can do to keep our children from having the kind of marriage that we have, or that our parents had? Can this chain of pain be broken?" The answer I gave was: "The best gift you can give your children is a good marriage."

The idea that the quality of your marriage has a direct influence on the quality of your child's future marriage may be as alarming to you as it is to couples in my workshops. The fact that your relationship with your parents is the culprit in your
marriage may be equally distasteful. It is certainly one of the most unwelcome ideas I have ever encountered.

Nonetheless, the evidence mounts. I have seen thousands of couples, and family researchers have studied thousands more, who are grappling with a marital conflict that can be traced back to childhood. The evidence goes even further. All our close relationships in adult life—at work, with friends, in organizations, in politics—are viewed through the screen of childhood memories. In every area of life that entails emotional involvement with others, we are repeating our childhood experiences or trying to work them out. And this struggle in adulthood to come to terms with childhood is a direct outcome of the quality of our parents' marriage, their early relationship to us, and the relationships we had with other significant people. Our children cannot escape this fate. It is a reality we must face.

What Children Need Most

What kind of marriage must children witness to become healthy adults and create a happy marriage of their own? Until recently, we did not know the answer to this question. Now we do. And it is quite simple: children need an environment infused with reliable warmth, a free flow of communication, and protection from injury. So say development psychologists John Bowlby and Mary Ainsworth, who for 30 years studied children interacting with their parents both at home and in laboratory settings.

In the course of their studies, Bowlby and Ainsworth identified three basic types of children: "secure," "insecure," and "avoidant." The secure children, who had reliable warmth and protection during the first two years of life, developed a "secure emotional base." From there, they set out to explore their environment, evolving through the stages of childhood with a positive self-image, confidence in themselves, a positive attitude toward the outside world, and good relationships with others. According to follow-up studies, the secure children learned well in school, made friends, had few illnesses, were liked by their teachers, expressed their feelings freely, knew how to get comfort when they needed it, and were involved in many activities.

The parents of these children all had good marriages. They expressed affection toward each other, solved problems well, showed respect for their children, and considered each other their "best friend." These marriages were also distinguished by a free flow of communication between partners. Everything was open to discussion. The researchers concluded that parents who are not distracted by unexpressed anger, tension, and distrust between themselves are available emotionally to their offspring. Such relationships provide children with good role models that they can internalize and take with them into their adult lives.

Most children are not so fortunate. Their parents, stressed by life circumstances as well as tensions in their relationship, and lacking good role models themselves, are less apt to provide reliable warmth and protection—or, as I call it, "consistent availability." Some parents are immediately available on some occasions and not others. Some parents, while physically present, are insensitive to their children's signals of distress. Their responses may be delayed or inappropriate to the situation, or they may initially reject their children and then become excessively indulgent.

According to Bowlby and Ainsworth, such children become "anxious and insecure." Uncertain that their parents will be available if called upon, they turn into "clingy and whiny" children who are uncomfortable about going to school, and often do
not do well in class. Some are prone to tics or frequent stomachaches; others get more than their fair share of colds and flus. Some are impulsive and easily frustrated; others are tense and constantly seeking attention, either by crying or by entertaining their parents.

These children share another striking feature: the absence of a free flow of communication. They do not readily share their feelings or experiences with their parents. And when they do talk, they change subjects frequently, too anxious to concentrate on any topic for a significant period of time. When these children are away from their parents, they constantly ask about them; whey they are with their parents, they frequently check to see if they are accessible.

The insidious aspect of this pattern of behavior is its persistence. Peter and Susan interrupted their therapy session one day to discuss their teenage son. He had unexpectedly come home from college and taken the family car to another city. When he failed to return home that night, his parents grew frantic. Finally, he phoned and said that he did not think they would notice his absence, and even if they did, they would not care. At the time of the session, he was still away, staying with his aunt. When Susan and Peter asked what to do, I insisted that they get in the car and go to him at once, express concern about his feelings of not being loved, and bring him home.

Later that day, another couple discussed their teenage. Anxious about going away to summer camp, she had cried during the night. And when they went to comfort her, she said, "I am afraid I will never see you again."

Both couples mentioned that their adolescents had been whiny and clingy as young children. Marriage during those early years, they reported, had been difficult. Susan had been depressed when her son was young, primarily because she believed that Peter did not love her. He was so involved in his business that she seldom saw him; and when they were together, they alternated between feeling extremely close and engaging in vicious fights. "Nothing seemed stable," she said. "When we were close, I knew it would not last. Peter could not stand the intimacy. As soon as we made love, he would withdraw emotionally or physically. During these times, I felt so confused. And when the children came around, I had no energy for them, so I acted mechanically. But when things were good between Peter and me, I enjoyed the children and eagerly involved myself in their activities."

When asked about her childhood, she said she did not know if her parents loved her. She could never tell. Sometimes things seemed wonderful, and then everything would change; or they would fight, and before she knew what was going on, the house would fill with an appalling silence. She recalled feeling nauseous a lot and being sick. Based on her recollections, Susan parents her children the way her parents parented her, and, not surprisingly, her feelings toward Peter echo the way she felt toward her parents. Without some dramatic change in her marriage, her son may well feel insecure in his marriage and repeat the intergenerational pattern of marriage and parenting.

What about the avoidant child? On the surface, say Bowlby and Ainsworth, avoidant children look great. They are fiercely independent and appear self-sufficient in every way. They neither cling to their parents nor seem concerned if they are not present. When parents return from an absence, these children do not run the them for hugs; in fact, they show little interest.

The researchers found that when avoidant children initially approached their parents, they were rebuffed or ignored. The parents, for their part, were unavailable and
rejecting. Even stressful crying could not attract their interest. Only when crying became unbearable did they respond--mechanically and coldly. Eventually, these children ceased to show distress when their parents left them.

Convinced that when they need care, their parents will not be there for them, avoidant children learn to keep their distance from mom and dad. At school, they often show hostility, bullying other students and sometimes teachers are well. These children are adept at getting negative attention while hiding their desire for love and support. They also avoid engaging in a free flow of information while conversing with parents and other adults. When discussions touch on personal feelings, they are likely to change the subject. While they appear emotionally isolated from their own feelings and those of others, emotions that do come to expression are acted out, rather than articulated. Instead of using words to express anger of frustration, avoidant children would sooner strike out at someone or run to their rooms.

The Chain of Pain

In my relationship therapy practice, I see grown-up versions of insecure and avoidant children. Now they are clingy and emotionally distant adults. Often, they are married to each other and have children of their own. The insecure partner clings and complains. The avoidant partner, fiercely independent and beholden to no one, minimizes their marital struggle and their children's problems as "normal."

Susan, after tearfully describing years of emotional abuse and lack of closeness, became stiff with rage when she heard her husband Clarence say: "It isn't that bad. Everyone has problems. Things would be OK if yo did not complain so much. That's what bothers me ... You are always so emotional--climbing the walls."

When asked if he could comfort his wife through her tears, her replied: "No, I see that all the time. It's just a game. We didn't do that in my family. If we did, we would be beaten or sent to our rooms."

"What happens inside you when Susan cries?" I asked. "Nothing," he answered. "I just go numb and want to leave the room. That's what I would do if I weren't here."

Not only did Clarence struggle to remain in control of his feelings, but he also tried to gain control of therapy by redirecting the conversation to the welfare of the children. By then, Susan had stopped crying and had withdrawn, defeated again in her attempt to elicit a positive emotional response. At that point, she meekly acquiesced to talking about the children.

Susan and Clarence have two teenage children. Their 17-year-old daughter is doing well in school, does not complain about anything, and has never asked for help with schoolwork. She has many acquaintances and few friends. Although she has begun to date, she has never brought home any of her boyfriends. When Susan discovered that her daughter had broken up with a recent boyfriend, all she would say was, "It's nothing. I didn't expect anything, anyway." Her earlier years included a period of unbearable crying, which had been diagnosed as colic, and an otherwise quiet childhood. In the words of her father, she was "always independent," someone who "knew her own mind" - - ominous indications of an environment that did not foster open relationships and the sharing of feelings.

Their 15-year-old son had always been demanding, had had bouts of depression, and was unable to sustain friendships for any period of time. He had tried some drugs for a while, and gave them up after developing a relationship with his first girlfriend.
Although he was smart, his grades were poor and he engaged in few after-school activities. In contrast to his sister's pseudoindependence, he had little interest in going to camp or getting a summer job; his preference was always to be at home. As a young child, he would often try to sit on his mother's lap, only to be criticized by his father. And when he would try to horse around with his father, they would end up in a fight.

Stirred by the specter of this pained husband and wife replicating themselves in their children, I began to feel alarmed about the future of our society. This couple's struggle, after all, represents the struggle of the human family. Their story is my story. It may be your story. While some details are unique and some stories are more painful than others, the patterns are all the same: the wounds of childhood are passed on through the generations. The past is transmitted through the present to the future.

In most instances, we become a problem only to ourselves and our families. We adapt to our pain and live out our lives in quiet or noisy desperation. In other instances, we become a problem to society. We fill hospitals with psychosomatic illness, mental institutions with confusion and despair, prisons with anger and revenge, divorce courts with destroyed families and more inured children, and streets with homeless men, women, and now families. Some of us become candidates for houses of prostitution; others become customers of the drug cartels of Colombia and the breweries of Kentucky. A few, seeking a way out, show up at meetings of Alcoholics anonymous or other self-help groups; fewer still appear in the offices of psychiatrists or other mental health professionals. We also seek answers through religion and social causes. We are the walking wounded—victims of failed parenting and troubled marriages.

This need not be a continuing chronicle, however. Hope for a new future rests with good marriages. Enough evidence is now in to show that whereas children who are deprived of consistent availability and reliable warmth lead problematic lives, happy children explore the world with a burning curiosity as well as care and respect for nature. Free of the stresses posed by insecurity, they experience less illness, better functioning immune systems, and longer lives. Free of the need of focus on their pain, they have the energy to create good marriages and produce happy children who will in turn contribute to the social good.

Healthy marriages must become our number one national priority. Government and private enterprise need to join hands and bring this vital area to national consciousness. Surely, if we can go to the moon and peer into the infinite reaches of the universe, we can educate ourselves about how to be married and rear children who are emotionally healthy and spiritually whole. They will create a society worth living in.

Rather than spend precious resources repairing human wounds—and yes, fighting drugs, waging war, and solving social problems—let us invest in preventing them. No further research is needed. We already know what to teach. The key to improving the human condition has been with us for thousands of years: we must learn to love, not as a moral ideal, but as a pragmatic necessity.

CULTIVATE HEALTH WITH HERBS

by Christopher Hobbs
The use of medicinal plants for the relief of the common ailments to which the flesh is "heir" is of very ancient origin. In fact, more than 5,000 years ago, many herbs, like ginger, garlic, and cardamom, were recommended by physicians and used by people for many of the same health imbalances for which we use them today. This safe history of use is reassuring in an age when we are warned about the side effects of dozens of new synthetic drugs that come on the market every year.

Today, herbalism is in the process of rediscovering its "roots." The chemical compounds found in these traditionally used plants are ones that we co-evolved with over many thousands of years. The use of medicinal herbs is also prominently mentioned in most spiritual works throughout the world, such as the Bible and the Hindu RigVeda. Herbs are not just a collection of active chemical compounds that simply affect the dynamic biochemical balance of the body; they can also play an important part in our spiritual and emotional well-being. This aspect of herbalism is often emphasized by today's herbalist, who honors the blessings of the herbs, or "green people."

A new world herbalism is evolving from the various healing cultures, especially Ayurveda (from India), traditional Chinese medicine (TCM), and traditional European medicine.

The following list reviewing the traditional uses of herbs is based on three generations' and my 20 years' experience with herbs. I have drawn on the experience of many North American and European herbalists (including my mother and grandmother) whom I honor as my teachers.

All the herbs mentioned can be found in natural food stores, herb stores, or by mail-order throughout the country, either in bulk form, tinctures (herbal extracts in an alcohol or glycerin solution), extract tablets or capsules, or in whole-herb powder form.

Herbs are ideal for medical self-care, but the material that follows is not intended as a substitute for diagnosis and treatment by a qualified health-care professional.

Upper Respiratory Tract Conditions
Colds
Colds are a natural part of the human life cycle and, paradoxically, offer us valuable protection. A number of viruses, such as Rhinovirus, play a key role in causing colds. The average person in the U.S. has 2.4 colds a year--which adds up to a whopping 576 million cold cases overall. Despite the transitory misery, colds have a strong positive side--they increase elimination, both by sweat and through the copious discharge of mucus from the nose; they reduce our feeling of well-being, encouraging us to rest; and, like a fire drill, they activate and exercise many immune functions.

In traditional Chinese medicine, colds are usually separated into wind-cold and wind-heat types. Wind-cold types often result from exposure to a cold-wind, or prolonged chill. Wind-heat colds are often seen in the spring or summer, and can arise in people who are easily overheated. In TCM, unlike in Western medicine, a cold is not just a cold. Separating colds into two types makes it easier to treat the condition and restore proper inner harmony.

In systems of traditional healing, colds are not considered serious for instance, in Chinese medicine. They are considered "surface" phenomena. If we rest and drink cleansing teas and immune activators, the miserable feelings should be minor. In fact, we have the opportunity to feel better after the cold because of the excellent healing and environmental "adjustments" our bodies have accomplished.
Colds are often characterized by an early-warning signal in the form of a slight sore throat and can often be bypassed entirely by immediately taking full-dropper doses of echinacea tincture every two hours. If the sore throat is particularly severe, a half-dropper of propolis (a honeybee product) or usnea tincture could be added as well. Echinacea accomplishes some of the same benefits as the cold itself, such as activating our immune system's phagocytes, or "garbage elimination" system.

For a runny nose, goldenseal reduces mucus discharge.

A classic soothing tea for colds that aids the release of heat from the body and also supports the body's efforts to eliminate accumulated toxins can be made by mixing equal parts of peppermint leaf, yarrow flowering tops, and eider flowers. Use 1 teaspoon of the mixture per cup and steep 20 minutes. Drink several cups of the mixture throughout the day and get plenty of rest.

Further herbal remedies for this common ailment can be found under Fevers, Coughs, Sore Throats, and Sinus Infections.

FEVERS

Besides the peppermint, yarrow, and eider tea (mentioned above) for reducing heat in the body, try adding 4 drops of lavender oil to a bowl of tepid water and sponging on the hands, feet, and forehead.

For another excellent remedy, steep common honeysuckle (Lonicera japonica) flowers (or fresh or dried eider flowers) in hot water for 20 minutes, let cool, add the juice of 1/2 lemon and a teaspoon of honey. Let the mixture cool and drink several cups of it as needed.

If a fever persists for more than a few days, it may indicate a more severe problem that needs the attention of a qualified natural health practitioner. Remember that children's fevers often exceed those of adults by a few degrees.

COUGHS

Coughs that produce white or clear sputum, especially when chronic, usually result from what in traditional Chinese medicine is considered a colder condition than yellow or green mucus, which means there is more heat.

My favorite cough remedy is a tea of 2 parts organic lemon peels, 1 part garden sage (Salvia officinalis), and 1/2 part thyme. Add the herbs to boiling water, remove from the heat, cover, and steep for 15 minutes. Add the juice of 1/2 lemon and 1 tablespoon of honey, and drink 2 or 3 cups during the day as needed. Over the years, I have found this blend to be delicious and effective.

Another tea for coughs that also relaxes the upper respiratory tract includes plantain leaves (1 part), coltsfoot (1 part), thyme (1/2 part), marshmallow root (1/4 part), and licorice (1/4 part). Make the tea using a tablespoon of the mixture per cup of hot water and drink freely throughout the day. In addition, full dropper doses of echinacea can be taken every 2 hours to stimulate immune activity and eliminate wastes in the bronchial area.

For chronic coughs of long-standing, expectorant herbs (which eliminate mucus) are traditionally recommended. A good expectorant tincture might include herbs such as grindelia, yerba santa, and balm of gilead. This mixture can be used also as a tea, adding some of the herbs for coughs due to heat (mentioned above).

SORE THROATS

For sore throats the natural antibiotic usnea works well either singly or in formulations,
both as a gargle and internally in tincture form, 10 drops mixed with water, 3 times daily. White sage tea, 1 teaspoon in 1 cup water steeped for 1 minute and mixed with lemon juice and honey, is antiseptic. Green tea is another option since it contains tannins, which are astringent and antibacterial and help to eliminate mucus and reduce the infection. Herbal immune activators and antiseptic herbs like echinacea or propolis can be added to the tea, as can soothing anti-inflammatory herbs like licorice or marshmallow root. Antibiotic tinctures can be added to this soothing tea base.

**FLU**

Like a cold, influenza is a viral condition. Although more severe than a cold, the two are often difficult to tell apart.

The aches and pains, fevers, and congestion that accompany flu are all addressed in the following blend of herbs for tea--boneset (2 parts), eider (1 part), peppermint (1 part), echinacea (1 part), and yerba mansa (1 part). Drink it warm and freely.

Other known flu herbs are garlic, which I sometimes take by cutting up a clove or two into pill-size pieces and swallowing with tea, and antiviral herbs like lemon balm, St. Johnswort, baptisia, or thuja. Lemon balm makes a delicious lemony tea and the active ingredients are water-soluble. St. Johnswort is best taken in a tincture form (a good quality tincture will have a ruby red color), 1 dropper (40 drops) three times a day, or in a standardized extract form (1 tablet three times daily). Baptisia or thuja are available in tincture blends or formulas, often mixed with echinacea. Follow the directions for St. Johnswort tincture.

If digestive symptoms, such as diarrhea and abdominal tension or soreness occur, try marshmallow root, lemon balm, or black walnut in tincture or tea form. If there is fever and nervousness, try lemon balm or blue vervain in tea form.

**SINUS INFECTIONS**

For reducing infection and excess heat in the sinuses, echinacea (3 parts), usnea (1 part), and goldenseal (1 part) work well in combination, either in capsule (2 every 4 hours) or tincture (40 drops of echinacea, 15 drops of usnea, and 15 drops of goldenseal every 4 hours). A mild goldenseal tea used as a nasal wash can speed up the process. (Close one nostril and sniff tea up open nostril until it trickles down the back of the throat.)

To help relieve stuffiness and promote drainage, put 4 drops of eucalyptus oil in a bowl of boiled water, put a towel over your head, lean over the bowl, and inhale for a few minutes.

**ASTHMA**

Teas or extracts of the following herbs can help alleviate the frightening symptoms of breathlessness and wheezing common to asthma sufferers. Grindelia and yerba santa are more appropriate for asthma accompanied by heavy white sputum (both are expectorants and have antispasmodic effects on the bronchi). Coltsfoot, marshmallow root, mullein, and licorice are better for dry types of asthma (all are soothing and moisturizing). Ma Huang can dilate the bronchial tubes. Ma Huang is a stimulant and should not be used regularly. It sometimes helps to eliminate dairy products, which can promote an overproduction of mucus, for several months when one is experiencing symptoms of asthma.

Besides being influenced by heredity, asthma is affected by emotional factors, immune function, and everyday stress. Emotional upset and depression is aided by St. Johnswort standardized extract (1 tablet as needed) and anxiety by passion flower,
California poppy, and valerian (use the fresh plant tincture or extract). For immune weakness, use an astragalus and reishi mixture, and for stress, eleuthero and licorice support and protect healthy adrenal function.

Women's Imbalances

PREMENSTRUAL SYNDROME (PMS)
To help balance hormones, strengthen the reproductive organs, and lessen monthly emotional ups and downs, any of the following herbs may be used: vitex (chaste tree berries--essential in any PMS formula), black cohosh, false unicorn root, skullcap, and dandelion. Take in tea, extract, or capsule form, though because of their strong taste, most people usually prefer to take an extract or powder in tablet or capsule form. Begin taking the herbs twice daily 10 to 12 days before the onset of menstruation and continue until three days after.

Because the health of the liver is considered an important factor in PMS, dandelion root (tea or tincture) and milk thistle (standardized extract or tincture) can be added for additional support. In particularly difficult cases, the herbs should be taken as a tonic for several months or until the condition improves.

VAGINAL YEAST INFECTIONS
Many women have found near-miraculous relief from the burning and itching of yeast infections by douching with tea tree oil, 1/2 teaspoon in a quart of water. This mixture does not cause further irritation. If the condition is chronic and difficult to heal, it is essential to avoid hot, spicy foods and caffeine and refined sugar. In traditional systems of healing, spicy foods are considered irritating and heat-producing, thus they are best avoided when there is a chronic infection of the urinary, intestinal, or reproductive tracts.

Men's Imbalances

PROSTATITIS
As men pass the age of 50 or 55, testosterone levels start to decline, which can lead to an irritation or enlargement of the prostate gland as well as lowered sex drive.

Inflammation of the prostate gland can be treated by drinking a tea 3 times daily made with equal parts of the following herbs: saw palmetto (strengthens bladder and prostate), echinacea, nettle, and horsetail (anti-inflammatory, diuretic), buchu (urinary antiseptic and strengthener), and corn silk (soothing diuretic and tonic). The herb Pygeum africanum, or simply pygeum, is gaining in popularity as more clinical experience and scientific support accumulate. This herb is taken in extract form, and products are available in natural food stores. Pumpkin seeds, which are rich in zinc, are usually added to the diet to accompany the herbal program.

LOW SEXUAL DRIVE
A lack of sexual energy can sometimes be addressed by toning the body with these herbs: damiana, a stimulating nerve tonic; ginger, a popular herb for increasing warmth and circulation; ginseng, probably the most documented herb (by a long history of use and much laboratory work) for stimulating the production of testosterone in the body; saw palmetto, a nourishing tonic for the sex organs; and wild oats, an excellent nerve tonic, especially recommended for supporting sexual energy. Eleuthero is highly beneficial for supporting the adrenal system and increasing overall energy production in the body. Make a tea of equal parts of the herbs and drink 2 cups a day. A number of commercial products that contain some or all of these herbs are widely available in natural food stores.
Note: a number of herbs are often sold as sexual tonics and testosterone stimulants, including damiana, saw palmetto, sarsaparilla, and wild yam. These herbs, though they have their place in herbal therapy, are not documented either by history of use or scientific testing to replace testosterone or increase the production of testosterone in the body. Ginseng is the only herb that can stimulate testosterone in the body.

Yohimbe, the African plant widely known as an aphrodisiac, has been documented medically for its ability to relieve impotence resulting from a physiological difficulty in having or maintaining an erection. Yohimbine hydrochloride, an alkaloid derivative from the plant, is prescribed by doctors for this condition. Although yohimbe extract and powder can be purchased in natural food stores, it should be noted that the herb is a central nervous system stimulant and in its concentrated extract form can cause such side effects as nervousness, anxiety, and sleeplessness. Use the herb cautiously.

Digestive Disorders

STOMACHACHE

Stomachaches brought on by nervous tension or overeating can often be relieved by drinking a cup of tea made from 1 part chamomile, 1 part catnip, 1/4 part ginger, and 1/4 part licorice.

Other important digestive herbs, many of which are best taken in tea form, are fennel, caraway, peppermint, artichoke leaves, and gentian. A little experimentation will determine which herbs and combinations work best for you.

NAUSEA

Whether caused by overeating, motion sickness, hormonal imbalances, over indulgence in alcoholic beverages, or other factors, nausea can be relieved by a combination of ginger (either 2 capsules or 1 dropper of the tincture in a little water) and 2 drops of lavender oil in a cup of water. A tea of lavender flowers (1 teaspoon per cup) is also useful.

Great things have been said about a combination of powdered kudzu root and umeboshi plum. Mix 1/2 teaspoon of kudzu in a little cool water, then add the mixture to 1 cup of warm water to which an umeboshi plum has been added.

CONSTIPATION

This is often a chronic condition brought on by a combination of heredity, nervousness, overwork, lack of vigorous physical activity, and lack of fiber in the diet. Herbal laxatives, like senna or aloe, which add more moisture to the stools or stimulate intestinal contractions, are popular but should not be depended on for long-term use. They can be habit forming and further dissipate vital energy in the bowels.

Even the most intractable constipation is easy to remedy when a high-fiber diet is followed, along with a good program of physical exercise, coupled with stress-relief techniques. It is also wise to massage the abdominal area with a little flaxseed oil (or castor oil, if more stimulation is desired) in a clockwise direction for 10 minutes, morning and evening. Go in deep and try to work out any tender spots. Give the intestines a rest: in the morning don't eat until you have been active for at least 30 to 60 minutes; in the evening, don't eat after 7 P.M.

Safe herbal bowel tonics that can be used for up to a month or two, in tea, powder or extract form, include the following (in ascending order of potency, from least to most potent): dandelion burdock yellow dock cascara sagrada Chinese rhubarb--use small
amounts, for not more than two weeks, since it can over stimulate the bowels in sensitive people.

INTESTINAL GAS (Flatulence)
A fast-acting remedy is 1 to 3 drops of peppermint oil added to a cup of water. Or take 1/2 to 1 teaspoon of fennel or anise seeds, chew them up thoroughly and swallow with water or tea, a little at a time.

A useful tea blend can be made using 1 part chamomile, 1/2 part ginger, 1/2 part wild yam, and 1/4 part lavender. A strong tea of chamomile flowers is the universal remedy for bowel irritation and colic, with or without gas, both in children and adults.

DIGESTIVE AIDS
The liver is a vital organ for proper digestive function and plays a crucial role in energy storage and supply, as well as being the major organ of detoxification.

To help the liver function more efficiently, make a tea or take an extract of one or more of the following herbs, chosen for their bitter, toning, and bile-promoting properties: milk thistle (extract only), dandelion, skullcap, artichoke leaf, Oregon grape, gentian, cardamom, orange peel, or ginger. Drink a cup of the tea or take 30 drops of the extract in water 15 minutes to 1/2 hour before each meal. Many commercial preparations of these herbs are available under the general name "bitters." They promote proper liver function and help restore weakened digestive power.

Cardiovascular

HIGH CHOLESTEROL
Blood cholesterol is considered an important risk factor for heart attacks, stroke, and other cardiovascular diseases. While a few important herbs are considered useful for lowering blood cholesterol, they work slowly and must be used persistently over a period of months or years; ideally, they are coupled with a low-fat, high-fiber diet and proper vigorous exercise.

Garlic is by far the most widely documented and clinically useful herb and home remedy for lowering blood cholesterol. Cook with it, eat it raw (if you don't mind the odor), and take garlic supplements, many of which offer high quality and potency thanks to modern analytical methods. Other herbs to try include green tea extract, dandelion root (unroasted) taken daily as a tea or extract, alfalfa powder, and the "medicinal foods," oat bran and pectin (found in many fruits).

Immune Disorders

HAY FEVER
To combat the common symptoms of hay fever--itchy eyes, runny nose, and sneezing--it is important to begin herb treatment at least a month before the allergy season begins in earnest. The following Chinese herb blend for symptomatic relief of hay fever has turned many allergy sufferers into believers: 1/2 ounce pinellia, 1/2 ounce astragalus, 1/4 ounce Ma Huang, 1/4 ounce licorice, and 1/8 ounce ginger. Simmer the herbs gently in 4 cups of water for 45 minutes; drink one cup morning and evening. Because Ma Huang contains the stimulant ephedrine, it is not recommended for those with high blood pressure or weak digestion.

Other excellent hay fever herbs include stinging nettles (anti-inflammatory, antihistamine activity), eyebright (mild antihistamine), dong quai (immune modulator), and goldenseal (anti-inflammatory, mucous membrane tonic).
When one has extremely severe allergies, it is good to add so-called adaptogenic herbs, such as eleuthero (Siberian ginseng), licorice, reishi, or schizandra, that help support adrenal function, a weakness of which is often associated with hay fever. Adaptogens are a class of herbs that can strengthen and support adrenal and immune functions and help us to handle stress. Avoiding dairy products and possibly wheat during these times of seasonal discomfort can also be helpful since many people are allergic to these foods.

Bladder Imbalances

BLADDER INFECTIONS (Cystitis)

To soothe the burning sensation that accompanies bladder infections, make a cold-water infusion of marshmallow root by soaking 4 teaspoons of the herb in a quart of water and letting it sit overnight. Drink the preparation freely. One or more of the tinctures of usnea, sandalwood, goldenseal, or echinacea (1 to 2 droppers, three times a day) can be added in severe cases, for their antiseptic and antibiotic qualities. Where there is suppressed urination, pipsissewa, dandelion leaf, and parsley

Bladder infections are another instance where one should avoid cold drinks, spicy foods, refined sugar, caffeine, and alcohol. Soothing sitz baths are helpful for bladder infections, as they bring blood to the area and help flush out the infection. Alternate sitting in hot water for three minutes followed rounds in the evening.

Unsweetened cranberry juice is a classic remedy to accompany the herbal treatments, and having been written up in the New England Journal of Medicine, it is even recommended by doctors.

Skin Ailments

POISON OAK/POISON IVY

I usually throw caution to the winds, wading though poison oak in the fall looking for edible mushrooms, and one of the best remedies I've found is the following mixture: dissolve 1 teaspoon of salt in 1/2 cup of water, blending in 2 or 3 teaspoons of a fine cosmetic clay (preferably skin-colored). When the consistency is that of a thick paste, but is still spreadable, beat in 5 to 15 drops of peppermint oil. The salt and clay draw and dry, and the peppermint oil (due to its menthol) lowers inflammation and cools by stimulating the skin's "cool" receptors. The results with this treatment are almost miraculous. Grindelia tincture used externally and internally (20 to 30 drops, 2 to 3 times a day) can be helpful in stopping the itching and burning of poison oak. This sticky plant contains resins and when applied externally, reduces the irritation and can keep the rash from spreading to other parts of the body. If one gets poison oak around the eyes, it is good to use aloe vera in this sensitive area for cooling and drying up the rash.

BURNS

Keeping peppermint or lavender oil in a handy place in the kitchen is excellent burn insurance. Both of these oils, when applied promptly, work quickly to alleviate the pain of burns and aid healing. With any first or second-degree bum of localized extent, it is essential first to immerse the affected area (where possible) in cool water for 10 to 20 minutes. For more serious burns, seek medical treatment.

Another tried and true remedy for burns is the application of oils or salves containing St. Johnswort or calendula, the latter for its strong anti-inflammatory and immune-activating virtues and the former for its anti-inflammatory effect on the skin.

CUTS, BITES, STINGS
Small cuts can be easily cared for by washing the area with an herbal soap (containing echinacea or calendula) and then applying moist compresses of echinacea tincture, which can accelerate wound healing and protect healthy cells from invasion by bacteria or fungi.

Tea tree oil, a strong antiseptic, also works well and does not sting when applied. For more serious cuts, apply cayenne or yarrow leaf powder directly to the wound to staunch bleeding; this sounds like "heroic" herbalism, but the sting of the cayenne passes quickly.

The most time-honored remedy recommended by herbalists for cuts, as well as any kind of spider bites or bee stings, is plantain. Plantain is always available as a garden weed or waste-lot plant. There are two ways to prepare it: use the blender or trust to plain saliva. In the saliva method, thoroughly chew one leaf to make a mucilaginous paste and apply to the spot. This method is excellent for kids (who love the attention), for oneself, or family members. The blender method works for the more fastidious, but it takes longer and requires equipment.

I recently watched a plantain "poultice" heal a severe staph infection, where the whole forearm was swollen bright red. The treatment consisted of a plantain paste—which included 20 drops of echinacea tincture and 10 drops of usnea tincture--on the source point of the infection (in this case, the knuckle). The poultice was changed every few hours, and usnea and echinacea tinctures were taken internally, I dropper of each every 3 hours. By the next day, the swelling and redness had mostly subsided and antibiotics were avoided.

Fresh plantain is good for any kind of infection because its leaves contain the antibiotic aucubin.

Sports Injuries

STRAINS, SPRAINS

Sprains are best treated initially by soaking the affected area in cold water, followed by applying arnica compresses (30 drops of liquid extract in a bowl of water) to help reduce inflammation. (Caution: do not use arnica if the skin is broken because it can increase inflammation.) Repeat every 2 hours. After the first 24 hours, use warm arnica compresses.

BRUISING

A combination of arnica, calendula, and St. Johnswort oils is very effective for bruising. Apply the preparation as soon as possible to increase its effectiveness. (Do not use arnica if the skin is broken.)

LACK OF ENERGY

Herbs known for their potential to increase energy include damiana, Panax ginseng, eleuthero, wild oats, and rosemary (in either tea or extract form). These herbs are safe, do not contain stimulants (such as caffeine or ephedrine), and can be taken as needed, though ginseng might be too stimulating for some people and should be used moderately. Herbs that are stimulating to the nervous system but are known to have side effects such as nervousness and restlessness, possibly raising the blood pressure, include coffee, black tea, guarana, kola nut, chocolate, and Ma Huang (Epbedra sinensis). Although more than 120 million people drink coffee in this country, this and the other stimulant drugs should be used cautiously as they are possible risk factors for heart disease and, at the very least, nervous disorders.
Nervous System

STRESS RELIEF

What we call stress—the tensions, pressures, and upsets of daily life—is apt to weaken or unbalance our nervous systems, leading to symptoms such as anxiety or depression. It can also upset our immune and hormonal systems (which work together closely), resulting in lowered resistance to infections. Constant or long-term stress can also affect our digestion, leading to ulcers, constipation, or irritable bowel syndromes. To help relax a tense mind or body, a flavorful tea can be made by steeping 1 part each of chamomile, lavender, linden, and lemon balm and 1/2 part orange peel. This stress-reducing tea is excellent after dinner and has the added benefit of aiding digestion. For extra-strength stress relief, add equal parts of valerian (tincture or powdered extract from the fresh plant is best), passion flower, and California poppy to the above mixture—or take in capsule or extract form since the taste is not as pleasant.

To support adrenal function, herbs such as eleuthero, licorice, rehmannia, and reishi can be found in many commercial herbal products. For immune weakness astragalus, ligustrum, reishi, and shiitake are widely recommended. The herbs can be purchased in bulk in Chinese herb stores or many natural food stores. These can be added to soups and stews. At left is my recipe for "Wei Qi" (protective vitality) soup.

SLEEP DISTURBANCES

Drinking a cup of the following herb mixture can often ensure a restful night's sleep—passion flower, skullcap, valerian, hops, and California poppy. Steep 2 teaspoons of the mixture in 1 cup of water. These herbs can also be taken in extract form, 1 dropper 1/2 hour before bedtime. For children who don't sleep well at night, try giving them a prebedtime bath to which a handful of linden (leaves and blossoms) tied up in a muslin bag has been added.

ANXIETY

A combination of hops, California poppy, and hawthorn, either in tea or tincture form, may allay anxiety. These herbs are known to have a quieting effect on the central nervous system.

DEPRESSION

Herbs that traditionally have been used to lift depression include St. Johnswort, rosemary, lavender, wild oats, and damiana. Steep 2 teaspoons of the mixture (equal parts) in a cup of water and drink 3 times daily. A mood-elevating bath can be made by adding a few drops of lavender, rose, or orange oil to the water. The same oils can be added to sweet almond or apricot kernel oil to be used for massage.

St. Johnswort is the most commonly prescribed natural remedy in Europe for mild depression. Try 1 to 2 tablets of the standardized extract as needed, but not more than 4 in a day.

ADDICTION

For symptoms of drug withdrawal, whether from nicotine or alcohol, wild oats have been shown to be useful for their strengthening effect on the nervous system and for their antiaddictive properties. A tea can be made, steeping 1 teaspoon of herb in 1 cup of water, or a liquid extract can be used--40 drops 3 times a day.

HEADACHES

For headaches, try this "aspirin replacement" herbal blend (no side effects)—passion flower, periwinkle(Vinca major), wood betony, white willow bark (1 part each),
and lavender (1/2 part). Steep 2 teaspoons of the mixture in 1 cup of water and drink as needed. Various commercial preparations are available that contain one or more of these herbs. For migraine headaches feverfew is the herb of choice, and it has two double-blind studies demonstrating its effectiveness. Take 1 to 2 tablets of the powder, or 1 to 2 droppers of the tincture morning and evening. It may take from three to six months before its full effects are felt. Some people have experienced relief where nothing else has worked. The herb must be taken on an on-going basis.

SMART HERBS

- Ginkgo has a positive effect on cerebral circulation, glucose metabolism, and neurotransmitter balance, all of which can have a strengthening effect on memory as well as improving mental vigor. Take 1 to 2 tablets (of the standardized extract) or droppers of the tincture morning and evening.

- The traditional Ayurvedic herb, gotu kola, is also recommended by herbalists, especially as a fresh plant tincture, for maintaining strong mental vigor.

HERBS FOR DAILY USE

The following list of herbs includes ones that are the most commonly recommended by herbalists in this country, Europe, and other countries where Western herbs are used. They are herbs that have a long history of effectiveness and safety for their indicated areas of use and have supporting scientific studies to back up their traditional uses. These herbs were also chosen for their popularity and ready availability in natural food stores or herb shops. Many of the herbs can be found in local nurseries and grown in window boxes or in the garden and harvested for personal use.

- ARNICA--One of the best-known trauma herbs, used externally as an oil or liniment.
- ASTRAGALUS--The premier deep toning immune herb, used as a tea, tincture, or powdered extract.
- CALENDULA OIL--An excellent skin remedy, applied locally for burns, bites, stings, and other trauma.
- CALIFORNIA POPPY The extract (tincture or tablet form) is helpful for relieving tension, sleeplessness, and anxiety; safe for children.
- CHAMOMILE--A world-renowned herb for colic, bowel irritation, and general relaxation; safe for children.
- ECHINACEA--One of the best studied and clinically proven herbs for immune stimulation. Large amounts (1 to 2 droppers several times daily) are best taken in up to three 10-day cycles, then discontinued. Small doses (5 to 15 drops daily) can be useful as a mild immune tonic for longer-term use.
- ELDER FLOWERS--The flowering tops of blue or black elders make an excellent tea for reducing fevers and increasing elimination of wastes for colds and flus.
- ELEUTHERO (Siberian Ginseng) The best-researched "adaptogen," which helps us to adapt to stress by supporting adrenal function and increasing energy efficiency. Often used by weight-trainers and other sports enthusiasts.
- EUCALYPTUS OIL--The oil has strong antiseptic properties and is useful in steams for sinus problems to relieve congestion.
- GINGER--The best herb for supporting digestion, relieving nausea (from any cause), and generally stimulating circulation. Taken as a tea, extract, or as a powder in capsules.
GINKGO—One of the most interesting herbs of the last few years. Improves brain function, including memory and alertness. Protects blood vessels, improves circulation, and is a powerful antioxidant. Best herb for ringing in the ears (tinnitus).

GINSENG—The panacea herb of ancient China. Excellent for people over 50, to improve vital energy, sexual energy, and enhance digestive powers. Often blended with other herbs in formulas.

GOLDENSEAL—This North American native herb is widely known and used for colds, flu, sinus infections, and bladder infections. Lowers inflammation, helps cool infections of the mucous membranes. Useful when blended 1 part to 3 parts echinacea.

GOTU KOLA—The ancient Ayurvedic herb, thought to improve memory and mental vigor and act as an adaptogen. Preliminary research supports this view. The herb should be used fresh since the dried herb rapidly loses its potency.

GRINDELIA—A native of North America, this sticky yellow-flowered plant from the daisy family was a favorite Native American remedy for poison oak and other rashes. It was formerly included in the official United States Pharmacopoeia as an internal remedy for asthma, bronchitis, and other upper respiratory tract ailments.

HAWTHORN—The extract is well-researched and has a long history of use as the herb of choice for strengthening and protecting the cardiovascular system, especially the heart. To be used in extract form long-term, even over a number of years.

HOPS—One of the major flavor components of beer. An excellent digestive bitter herb that also works as a relaxant.

LAVENDER—A tea of the flowers or the essential oil is used internally to lift the spirits and allay nausea.

LICORICE—Licorice root is an important herb for flavoring and harmonizing herbal blends. It has proven antiviral and anti-inflammatory properties and is commonly used for upper respiratory tract, digestive tract and urinary tract irritation or infections. The herb has also shown benefits for healing ulcers and is considered an important adrenal support herb.

MA HUANG—This plant contains ephedrine, a stimulant and decongestant; it is used for colds, asthma, and hay fever. Not a mild herb.

MARSHMALLOW ROOT—This mucilaginous herb is used as a tea or liquid extract to soothe mucous membranes in the digestive, upper respiratory, and urinary tracts. Marshmallow has recently shown some immune-stimulating properties.

MILK THISTLE—The great liver protector and healer. Well-researched and clinically proven for hepatitis, cirrhosis, or for extra nutritional support for people who drink alcoholic beverages or use pharmaceutical drugs.

NETTLES—An excellent nutrient herb that has also shown antiallergic properties for hay fever and anti-inflammatory activity for enlarged or irritated prostate glands.

PEPPERMINT—The essential oil (in minute amounts) is one of the best home remedies for relieving intestinal gas, bowel inflammation, or irritation. A tea of the leaf is also widely used.

PLANTAIN—The ubiquitous weed that every herbalist loves. It has a high percentage of mucilage to soothe; allantoin to speed wound-healing; and aucubin, a strong antimicrobial substance, to prevent infections. Use fresh as a poultice, tea, or tincture, or the fresh juice internally or externally.

REISHI—A mushroom renowned for its powerful immune-strengthening activity.
It has also shown the ability to regulate blood sugar and may help lower cholesterol. Use as a tea, tincture, or powdered extract.

ROSEMARY--This common garden herb contains natural camphor, which helps energize the nervous system without overstimulating. It also contains powerful natural antioxidant properties and is a good digestive herb.

SHIITAKE--This common mushroom is as delicious as it is medicinal. One of its active constituents, lentinan, has shown antitumor, antiviral, and immune-strengthening properties. It is used in soups, stews, stir-frys and as a tea or extract.

ST. JOHNSWORT EXTRACT, oil--The extract of this common European and American weedy plant shows great promise as an antivital (against the AIDS virus) and anti-inflammatory agent. It has long been used as a remedy for mild depression. The standardized extract is used internally, and the oil is applied externally for burns and nerve pain or trauma due to tension or accidents.

TEA TREE OIL--An Australian import emerging as an important herb for fungal infections of the skin or nails, vaginal yeast infections, and gum inflammation or sores.

USNEA--Called the herbal antibiotic. In the laboratory, this common lichen has shown powerful inhibitory activity against strep, staph, and pneumonia infections. May work in combination with echinacea for strep throat or staph infections (such as impetigo).

VALERIAN--A traditional herb with a wealth of clinical evidence to support its use as a sleep, aid, nerve tonic, and relaxing herb.

VITEX--One of the best-known women's herbs, it was recommended by Hippocrates (450 B.C.) for the same purposes as today: menstrual imbalances and hormonal difficulties (PMS, menopause); also to bring on mother's milk.

Herbal Side Effects

A NOTE OF CAUTION

Although the charge is often made that herbalists say that all herbs are safe, no responsible herbalist would ever make such a claim. Herbs are often very safe--usually much safer than synthetic drugs, both for the person taking them and on our environment and energy resources. But they are complex mixtures of chemical compounds that can heal, change different body processes, and sometimes cause side effects, especially when overused or used thoughtlessly.

Below is a list of the best-documented possible side effects of the herbs mentioned in this article. Contraindications can be further researched in the books listed in the resource section.

ARNICA--Taking the herb, tea, or tincture internally may lead to severe gastrointestinal irritation. Using the tincture or oil on open wounds or scrapes might increase inflammation.

ESSENTIAL OILS (lavender, tea tree, peppermint, eucalyptus)--These plant essences are highly concentrated and should be used cautiously. Never use more than a couple of drops at a time and reduce dose if any irritation develops, either externally or internally.

GOLDENSEAL--People with weak digestion should use this herb sparingly. Do not use continuously for more than 10 days or 2 weeks. Large doses (more than 2 standard-size capsules or 15 to 25 drops of the tincture, 3 times daily) are not recommended. Because it stimulates the uterus, it is not to be taken during pregnancy.
LAXATIVES (aloe, senna, cascara, rhubarb)--Long-term use (more than 2 weeks) might lead to dependency, loss of bowel tone, and intestinal irritation.

LICORICE--For people with high blood pressure, edema, or electrolyte imbalance, long-term use (more than 2 weeks) of licorice root or its products can lead to sodium retention, excessive potassium excretion, and water retention. Moderate use is not considered problematic.

MA HUANG---This herb contains ephedrine, which stimulates the nervous system. Dangerous side effects include raised blood pressure, weakened digestion, sleeplessness, nervousness, and anxiety. Also can cause uterine contractions--pregnant women should avoid it.

PREGNANCY--Herbalists generally agree that herbs should be used more cautiously during the first trimester and perhaps the second trimester of pregnancy. The following is a list of the more agreed-upon herbs to avoid: black cohosh, cascara sagrada, coltsfoot, comfrey, dong quai, essential oils, feverfew, ginseng, goldenseal, Ma Huang, senna, yarrow. Avoid laxatives.

ST. JOHNSWORT--Large amounts might make the skin more sensitive to sunlight. For people whose skin is already sensitive, take extra precautions when using the herb therapeutically.

VALERIAN--Large amounts of the tea (more than 2 cups at a time) or powdered extract might cause headaches in some people. Some people who take valerian are stimulated rather than calmed by the herb, but this paradoxical effect is rare with the fresh plant tincture, tea, or extract.

VITEX--Not to be taken concurrently with birth-control pills.

THE SHELF-LIFE OF HERBS AND HERB PRODUCTS

The overall effectiveness of any herb or herb product is determined not only by the quality of the herbs that went into it, but also by the length of time it has been sitting on the shelf. Most herbs are best stored in their whole form, kept in amber glass jars packed as close to the top as possible, and stored in a cool place out of direct sunlight. Under normal circumstances, most powdered herbs will only retain their full potency for a matter of two or three months. If they are encapsulated and in plastic bottles, as many herb products are, one should not count on any more than a one-year shelf-life. Whole herbs, if stored correctly, may retain a fair quality for up to three years. Tinctures, herbal extracts in an alcohol or glycerin solution, may hold much of their activity for up to three years, if stored in a cool, dark place. Extracts in tablet or capsule form will last longer in amber glass jars than in plastic bottles, which will allow oxygen and moisture to enter.

WEI QI SOUP
1 gallon water
5-10 sticks astragalus
1-2 medium-size reishi mushrooms
1/4 cup ligustrum fruits
5-8 small to medium-size shiitake mushrooms
Assorted vegetables (such as carrots, beets, potatoes, yams, parsley, and celery)
1/4 cup barley (optional)

Fill a soup pot with water and add astragalus, reishi mushrooms, ligustrum fruits and shiitake mushrooms. Simmer the herbs for 30 minutes, then add vegetables. The addition of barley will make the soup thicker and is very strengthening
and soothing to the digestion. When the soup is done, drink the broth and eat the vegetables. Store in the refrigerator for several day's use. The more fibrous herbs such as astragalus are too tough to eat, so simply put them aside. The shiitake mushrooms, however, are delicious and fine-textured.

All herbalists agree that herb quality is a number-one priority. We are not satisfied when herbs are poorly grown, improperly harvested, dried, or stored. Fortunately, the proper techniques for ensuring the highest quality herbs are becoming better known and more closely followed. There are still some excellent quality and some poor quality herbs and products on the market. National organizations like the American Herbal Products Association (AHPA) and the American Herbalists Guild (AHG) are working hard to educate manufacturers and consumers about the importance of herb quality. For more information, write to and support the efforts of these organizations by becoming a member of the AHG, or see if the manufacturers of your preferred herbal products are members of AHPA—if not, encourage them to join.

To assure that you are getting the best quality herbs, look for "certified organic" products. When a company cares enough to pay more for these herbs, it will usually put more effort into the manufacturing process. Of special concern are the rapidly dwindling resources of some native plants, such as echinacea and goldenseal. We cannot afford to take these plants from the wild for much longer—so support organically cultivated herb products and ensure the continuation of our wild heritage.

American Herbal Products Association
Box 241 0
Austin, TX 78768
(512) 320-8555
American Herbalists Guild
Box 1683
Soquel, CA 95073

Books:

CHRISTOPHER HOBBS is a fourth generation herbalist and botanist with more than 20 years' experience with herbs. He is the founder of Rainbow Light Custom Herbal Extracts, vice president of the American Herbal Products Association, and a founding member of the American Herbalists Guild.

HAVE YOU CONSIDERED HERB SCHOOL?

by Judy Krizmanic

Maybe it was the first cup of chamomile tea you sipped to calm a queasy stomach. Or the echinacea tablets a friend slipped your way the winter you caught too many colds. Somewhere down the line, you tried an herb and it made a difference.
At Vegetarian Times, we get lots of requests from people who have had such experiences. They want to know how they can learn more about treating and preventing common illnesses with herbs. One good way to find concentrated information these days is through commercial courses in herbalism. Because there isn't an established standard for herbal medicine in the United States, you won't find an accredited herb college, but there are a number of courses that provide a starting point for understanding herbs.

A thorough herb education includes hands-on experience. For that reason, there's nothing like the schooling you'll receive at an on location herb school, or at least at herb seminars and workshops. Those who enroll in such programs swear by the completeness of the hands-on experience. "I learn better in a classroom setting:" says Susan Haupert, a former student of the California School of Herbal Studies and a registered nurse who wanted to be able to teach her patients about selfcare remedies. "I learned from both the teachers and the other students, and the school itself is in such a healing setting," she says.

Unfortunately, the selection of onsite herb schools is slim, and your enthusiasm for attending them will depend on your particular interests. Plenty of seminars and workshops are offered around the country, though, where you can work closely with professional herbalists. For a complete list of seminars and workshops, contact the American Herbalists Guild, Box 1683, Soquel, CA 95073.

If you don't have the time or the inclination to take an on-site course, consider a home-study correspondence course. It's the simplest, most affordable way to learn about herbs. Many of the premier herbalists in the country have courses that are perfect for beginners.

Although most correspondence courses focus on the fundamentals of Western herbalism, others introduce you to herbal systems from around the world. "Before taking any class, write for information," suggests Roy Upton, secretary of the American Herbalists Guild. "Ask for the overview of material covered and what books they require." You might not want to invest in a course that skims too many subjects or, on the other hand, is based on one or two books that you could easily read on your own. Some herbalists will even allow you to try a lesson before committing to the whole course. Whatever mode of herbal education you choose, it's wise to be aware of a couple of things.

First, because there is no standard for herbal education in this country, you're basically getting one perspective-that of the herbalist who teaches or wrote the course. Some instructors suggest that students take more than one course for a well rounded view.

Second, and perhaps more important, these courses don't prepare you to be a professional herbalist. There is no such thing as a licensed, certified or registered medicinal herbalist in this country. The only people who can legally dispense herbs are licensed M.D.s, osteopaths, naturopaths, chiropractors and acupuncturists. Restrictions on these practitioners vary from state to state. Legalities aside, herb courses don't even attempt to teach you medical diagnosis. Even if a course covers basic anatomy and physiology, it cannot provide the extensive information and clinical practice needed to understand the body and herbs well enough to diagnose and treat medical ailments. Instead, these courses are for lay people interested in using herbs for themselves or their families. That said, I was impressed by the sophistication of the courses offered. Here are
some of the most notable.

Classroom Courses in Herbolology

The California School of Herbal Studies, Box 39, Forestville, CA 95436; (707) 887-7457. If you have the flexibility to relocate and the interest to spend several uninterrupted months on an 80-acre nature sanctuary in northern California-just studying herbs-the California School of Herbal Studies (CSHS) is the undisputed best place to go. "I get a lot of people asking me how they can learn about herbs. If they are serious about it, I send them to the California School:' says Stephen Foster, herbalist and author of several books. Founded by herbalist Rosemary Gladstar Slick, CSHS is the closest thing there is to a "college" of herbalism. The school offers two major courses of study, both with hands-on emphasis: the five-month Foundations of Herbalism (ideal for beginners), and the more advanced, eight-week Therapeutic Herbalism course. Both are billed as intensive," meaning that you attend classes several hours each day, Monday through Friday.

The teachers at CSHS are topnotch. One faculty member is former American Herbalists Guild president and British-trained medical herbalist David Hoffman, author of the internationally acclaimed The Holistic Herbal (Findhorn Press, 1983). Fellow instructor Amanda McQuade Crawford has studied and taught about herbs in China, South America, Europe and the United States. Classes are generally small and each student works closely with the teachers.

The classes themselves are diverse and in-depth. The Foundations of Herbalism course covers identification and classification of herbs, harvesting, drying and remedy making. Students learn the basics of anatomy and physiology and learn how to set up a home herbal first-aid and medicine cabinet. They also learn about the ecological relationships between plants, humans and other animals, and are introduced to the financial and legal aspects of running an herbal business.

The Therapeutic Herbalism course covers 150 herbal remedies and presents case studies on treating various body systems with herbs and preventive herbal medicine. Advanced students attend the annual Breitenbush Herbal Retreat in Oregon. The tuition for Foundations of Herbalism is $2,495; Therapeutic Herbalism costs $1,975 and includes the cost of the Breitenbush retreat. Neither tuition includes materials. There are no on-site dormitories, but the school provides a list of housing locations around the area.

The Southwest School of Botanical Medicine, 1071/2 E. Broadway, Silver City, NM 88061; (505) 388-4411. Later this year, the school will move to Albuquerque.) This school is for those who have a real interest in working within the herb industry or at least want to learn about herbs from both medicinal and manufacturing perspectives. "It's the only 'trade school' for herbs in this country," says founder Michael Moore. Moore is author of several herbal books and articles, including Medicinal Plants of the Mountain West (Museum of New Mexico Press, 1979) and Medicinal Plants of the Desert and Canyon West (Museum of New Mexico Press, 1989). Many of the herb manufacturers in this country are Moore's former students.

The school offers an annual five-month-long course from February to June. Tuition is $1,200 and includes a three-week field trip. This year, the class's 30 students traveled around the mountains and deserts of the Southwest and West, attended the American Herbalists Guild Symposium in Boulder, Colo., and then headed to the Ozarks. The 1992 tuition will likely increase to $1,500.
The institute of Chinese Herbology, 1533 Shattuck Ave., Berkeley, CA 94709; (415) 649-1123. Short of attending a four year degree program, the institute's Comprehensive Practitioner Training program is the best beginning study program of Chinese herbs. No previous knowledge of Chinese medicine is required. The program is divided into eight courses: Course A, for example, introduces fundamental concepts of traditional Chinese medicine. Course B brings the theory to life as it discusses herbs, their properties, classifications and preparation. The remaining courses include discussions of the therapeutic principles of the Chinese system, case studies, and ways to continue to use and learn about Chinese herbs after the program is finished. The course is also available on 130 hours of audio tapes. Fee: $995 to $1,100, depending on payment plan. The institute also offers an advanced course.

Correspondence Courses:

The Next Best Thing to Being There

Therapeutic Herbalism by David Hoffman, 9304 Springhill School Road, Sebastopol, CA 95472; (707) 829-3451. David Hoffman is a member of Britain's National Institute of Medical Herbalists, former director of the California School of Herbal Studies and author of several herbal books. Of all the courses on Western herbalism, his is the most medically oriented. "It is for people who want to know how to use herbs for healing. There's nothing on growing or things of that nature," notes Hoffman, who corrects assignments and answers questions by mail. Hoffman has written more than 800 pages of text for this course. (He estimates it will take about 10 months to complete.) The lessons progress from an introduction to phytotherapy (the British term for herbal medicine) to details on specific body systems and herbs that strengthen or treat those systems. You'll explore almost 200 medical plants in detail, learning how to make herbal remedies and locate current research. Fee: $400. Text only: $150.

Herbal Studies Course by Jeanne Rose, 219 Carl St., San Francisco, CA 94117; (415) 564-6337. Jeanne Rose, one of America's best-known herbalists, may be the only correspondence course instructor to hold telephone office hours" to answer students' questions. Rose's course is an introduction to "all things herbal." It covers medicinal herbs for self-care, body care, animal care, herb rituals and aromatherapy. Rose has written a dozen popular herbal books and booklets, including her latest, The Herbal Guide to Food (North Atlantic Books, 1990). She also has created a line of herbal body-care products.

The course's 34 lessons are contained within five full-sized herb texts and two booklets. Approved for continuing education units for registered nurses and vocational nurses. Fee: $375; texts included. Rose also offers an advanced course for $275.

East West Course in Herbology by Michael Tierra, Box 712, Santa Cruz, CA 95061. In the herbal community, Tierra is well-respected for having fostered a union between Western herbalism and ancient herbal systems from India and China. His book, The Way of Herbs (Unity Press, 1980), provides the listings and explanations of remedies for the course. Tierra also wrote Planetary Herbology (Lotus Press, 1989) and has more than 12 years of clinical experience. "I especially like the East West course because it draws from so many cultural sources [and] deals with the whole person:' says Rosemary Gladstar Slick.

Tierra's home study course in herbal medicine introduces you to basic Chinese
and Ayurvedic principles, and teaches you how to make and use Western, Oriental and Ayurvedic herbal preparations according to these principles. Tierra offers his comments by mail on your homework.
The fee for the 12 lessons is $150. This course is a prerequisite for Tierra's more extensive course, the Professional Herbalist Course. Fee: $350. (Discounts available for enrollment in both courses.)

The Science of Art and Herbology by Rosemary Gladstar Slick, P.O. Box 420, East Barre, VT 05649; (802) 479-9825. Gladstar Slick, founder of the California School of Herbal Studies, has designed each of the 10 lessons in her course to be "like a day at herb school." The first lesson begins with a discussion of the nervous system, herbal preparation, and how to determine quality herbs. Each lesson thereafter explores a different body system and introduces topics ranging from harvesting, drying and storing of herbs, to herbs for women's and men's health. Gladstar Slick (who also cofounded the Traditional Medicinal Tea Co. and published the Sage Healing Ways pamphlet series) brings a wealth of knowledge about identifying and wild-crafting herbs, and adds her rich spirit with discussions of ceremony and Earth awareness.

Gladstar Slick emphasizes her desire to work personally with students in order to develop a course right for each one. She encourages students to use her course as more than a series of "read through" assignments and to actively participate in herbal projects. Fee: $300. First lesson only (to sample the course) is $20. Gladstar Slick also offers a seven-month apprenticeship program and several herbal workshops at her log cabin home in Vermont.

The School of Natural Healing, P.O. Box 412, Springville, UT 84663; (801) 489-4254. The School of Natural Healing was founded more than 30 years ago by the late John R. Christopher, America's leading herbalist and natural healer in his day. Today, his son David directs the school. The Herbal Home Study course includes 22 hours of instructional video and 10 hours of audio. The school also offers a Master Herbalist course, requiring attendance of a 100-hour intensive seminar at the school. Fee: $595 for the basic Herbal Home Study course; $1,095 for both Herbal Home Study and Master Herbalist courses.

Dominion Herbal College, 7527 Kingsway, Burnaby, British Columbia, Canada V3N 3CI; (604) 521-5822. Founded in 1926, Dominion Herbal College is the oldest herb school in Canada. Its Chartered Herbalist Course provides a good foundation in anatomy and physiology, both of which are essential for understanding how herbs work in the body. About one-third of the course's 60 lessons focus on these subjects. You'll learn about 200 herbs and how to make formulas with them. Lessons are corrected by Judy Nelson, a naturopath, chiropractor and teacher who has worked with the school for 10 years. "Everyone is encouraged to work at his or her own speed, but the course takes most people about six months to a year to complete," Nelson says. Fee: 900 (Canadian); contact school for payment plan and discount information. The school also offers a clinical course for advanced students.

Wild Rose College of Natural Healing Ltd., Suite 302, 1220 Kensington Rd. N.W., Calgary, Alberta, Canada T2N 3P5; (403) 270-0936. The college offers several courses for home study. Herbology I is taught by college director Terry Willard, Ph.D., a practicing herbalist who is well-known in North America and Europe. The course studies body systems, introduces folklore and modern herbal research, and examines popular
herbs such as ginseng and aloe vera. You also learn how to construct an herbal first-aid kit. Herbology II explains chemical properties and biological effects of herbs. More specific courses include topics such as Herbs for Female Health. Write for a catalog.

Wild Rose also offers a limited amount of classroom courses.
The Platonic Academy of the Herb Renoissance, P.O. Box 409, Santa Cruz, CA 95061; (408) 423-7923. Director Paul Lee, Ph.D., an internationally recognized scholar and educator in traditional herbal studies, offers a 10-lesson correspondence course giving a broad, comprehensive overview of the entire herb field," including herb cultivation, history and tradition, and legal concerns. The course text has more than 500 pages of material. Fee: $150. For $295 plus $8 shipping, you can purchase the course plus accompanying audiocassette tapes by Lee and herbalist Christopher Hobbs.

The American institute of Vedic Studies, P.O. Box 8357, Santa Fe, NM 87504; (505) 983-9385. The institute offers an Ayurvedic Correspondence Course by David Frawley, well-known in the United States and India. Here you learn about the oldest herbal medical tradition in the world, Ayurvedic herbalism, updated for modern times. The course text is 450 pages. Fee: $225.

Other Resources
The following schools offer herbal courses, some as a part of more varied curricula:
School of Natural Medicine, P.O. Box 7369, Boulder, CO 80306-7369; (303) 443-8284.
The Ayurveda Center of Santa Fe, 1807 Second St., Suite 20, Santa Fe, NM 87501; (505) 983-8898.
The Ayurvedic institute, P.O. Box 23445, Albuquerque, NM 87192-1445; (505) 291-9698. Of particular interest is Lessons and Lectures on Ayurveda by Dr. Robert Svoboda.
The Clayton School of Natural Healing, 1704 11th Ave. S., Birmingham, AL 35205; (800) 6384590. Herbology is one of the primary areas of focus. institute for Wholistic Education, 33719 116th St., Twin Lakes, WI 53181; (414) 877-9396. The institute has a course that covers the fundamental principles of Ayurveda and Ayurvedic herbs.

Herbal Home-Video Courses


Naturopathic physicians routinely prescribe herbs to treat disease or to maintain health; therefore, medical schools that grant Doctorates of Naturopathic Medicine (N.D.) require students to take several herbal courses. Although interest in naturopathy has grown in the past 20 years, only a handful of states license new naturopaths: Washington,
Oregon, Alaska, Hawaii, Arizona and Connecticut. There are three four-year colleges of naturopathic medicine in the United States and Canada:

Bastyr College, 144 N.E. 54th St., Seattle, WA 98105; (206) 523-9585. National College of Naturopathic Medicine, 11231 S.E. Market St., Portland, OR 97216; (503) 255-4860.

Ontario College of Naturopathic Medicine, 60 Berl Ave., Toronto, Ontario, Canada M8Y 3C7; (416) 251-5261 (licensure in Canada only). Herbal Conferences

A few times each year, professional herbalists gather to share their ideas, research and other herbal experiences. Several conferences have become tradition in the herbal community. Events vary, but usually include intensive seminars, herb walks and lectures.

Annual Symposium of Herbal Medicine, sponsored by the American Herbalists Guild, P.O. Box 1683, Soquel, CA 95073; (408) 438-1700, Ext. 273.


Sixth National Herb Growers and Marketing Conference, sponsored by the International Herb Growers and Marketers Association. This year it's co-sponsored by Purdue University and the University of Minnesota; call (708) 566-4566 for information. Held in Minneapolis July 19-22, 1991.

GROW FRESH HERBS ALL WINTER LONG: A GUIDE TO INDOOR CONTAINER GARDENING

by Julie Fanselow

FALL CAN BE A MELANCHOLY time of year for people who grow culinary herbs. Though the approach of colder weather brings the promise of rest in the wake of hectic summer gardening, winter often means the end of fresh-from-the-garden herbs for cooking.

This doesn't have to be the case, however. With a little bit of know-how, and perhaps a couple of grow lights, you can grow culinary herbs indoors throughout the winter by bringing some of your garden plants inside or by starting new ones from seed.

If you're like most people, space inside your home is limited. That means your first task is to narrow the list of herbs you want to grow. You'll find that some are much more suited to indoor gardening than others. Fortunately, you can grow most culinary herbs indoors without any problem, says Peter Borchard, president of Companion Plants, an Athens, Ohio, mail-order firm that sells about 600 varieties of herbs from all over the world.

Next, determine which herbs on your list are annuals and which are perennials. By fall, annuals such as basil and dill have nearly concluded their lifespan in your garden and aren't worth trying to bring inside, says Borchard. The best way to enjoy annuals throughout the winter is to start new plants from seed right now.
Perennials go through the cycle of new growth, flowering and fruiting for at least three years. They come in two varieties: tender and hardy. Tender perennials like rosemary are unlikely to survive the winter if left outdoors. By contrast, hardy perennials, including thyme, tarragon and chives, can show weaker growth indoors and can remain outdoors in a dormant state if properly mulched—but then you couldn't get them fresh during the winter.

STARTING NEW ANNUALS
GROWING ANNUAL HERBS from seed is easy; just be sure to plant enough. A couple of basil plants may look great on your windowsill, but they're not going to go very far in cooking.

To start an indoor garden, choose containers to sow your seeds in. Leftover two-inch flats from last spring's young plants work well, but you can use any two-inch-high tray with good drainage. Herbalist Steven Foster, author of Herbal Renaissance (Gibbs Smith, 1994), suggests cutting an empty gallon milk jug to a height of about two inches and punching drainage holes in the bottom. If you reuse containers, be sure they're sterile (this is also true when replanting perennials); a 10-minute soak in a 10 percent solution of bleach and water, followed by a thorough rinsing, should suffice.

Fill containers with growing medium to about a half-inch from the top. Foster favors a mixture of one part sterile potting soil, one part fine sand and one part peat moss. Plant seeds in rows two inches apart--do not crowd them--and cover with a thin layer of soil, then water, so soil is moist but not soggy. Cover containers with plastic wrap to retain moisture and place in an area where the temperature will not drop below 60 degrees (on top of the refrigerator is a good spot).

When the seeds have germinated (usually in just a few days), remove the plastic. Seedlings need at least 12 hours of light a day, making this a good time to invest in grow lights or fluorescent lights. You can set your herbs up on a table you've designated for herb-growing, which will also give you more space than if you cram plants on windowsills. If you use artificial lights, leave them on for 14 to 16 hours a day, and place seedlings four to six inches from the lights.

Be sure the soil remains moist, but not waterlogged--about as wet as a wrung-out sponge. When the seedlings show their first two true leaves, transplant individual seedlings to four-inch pots. (You may think the true leaves have appeared, when in fact what you're seeing are the cotyledons, the food-storing tissue of seeds. True leaves look like miniature versions of an herb's mature leaves and will appear after the cotyledons.) Plants in containers--both annuals and perennials--need plenty of water and food, because they can't send their roots very far in search of nutrients. Unless you know a particular herb prefers drier soil, keep the soil moist and feed your herbs an organic fertilizer every three or four weeks; a little bit of compost, if you have it, or liquid seaweed, available at gardening centers, both work well.

BRINGING YOUR PERENNIALS INSIDE
WHICH PERENNIALS you bring indoors from your garden will be governed largely by their size. You may desire the flavor and sweet smell of fresh sage, for example, but the herb's bushy shape and large size make it impractical for indoor cultivation. Mint, tarragon and thyme, on the other hand, are better candidates for a crowded windowsill or plant table.

Another factor to consider is how well a particular herb will survive the winter if
left outdoors. You can find a hardiness zone map in just about any gardening book or from your local university extension service; determine which of your perennials are not designated "winter hardy" for your zone. These are the plants you must bring inside; which of your other perennials you bring in is up to you.

The best time to bring tender perennials inside is after the fall harvest but before the first frost. If there are hardy perennials you want to take inside, Borchard recommends trimming back their top growth and leaving them outside through the first frost. "This fools them into thinking they've had a dormant period," Borchard says. "Then bring them inside and they'll be ready to grow."

First, prepare your pots. Make sure they have good drainage, so the roots won't sit in water and rot. You can use the same potting mix that you use to start annual seed, though you'll need to add organic fertilizer. Betsy Strauch, an herb gardener and writer from Lenox, Mass., likes to blend together equal parts peat moss, coarse vermiculite, perlite and compost a few hours before transplanting. Many gardeners prefer to just use their own nutrient-rich garden soil; if you go this route, sterilize it for 20 minutes in a 200-degree oven to kill any pests.

Dig up the herbs, being careful to keep the root mass as intact as possible. Trim off any rotten, dead or damaged roots, then trim back the top growth until its size is approximately the same as the root mass. Choose a pot slightly larger than the root mass and fill about one-third with soil. Gently place the herbs in their pots, then fill with soil.

Opinions vary on whether herbs must be acclimated to reduced lighting before moving indoors. Strauch favors acclimatization starting three to four weeks before the first frost. She moves newly potted herbs into the shade of a tree for about a week, then relocates them for another week or so to her north-facing front steps, where they receive even less light. Next, she brings the herbs indoors on chilly nights and returns them to the steps during the day until the first frost, when the plants come inside for the season. Many herbal gardening guides also recommend this regimen.

Before making the final move indoors, check your herbs for pests. If you see any, consider giving the plants a spritz of diluted Ivory Liquid. Be forewarned, however, that the herbs' flavor may not be as good as before. Another option is simply trimming off the affected growth or rinsing with water.

As with annuals, once your perennials are indoors, you must be sure they receive plenty of water, nutrients and light. Herbs naturally grow more slowly indoors than outdoors, and some plants may inexplicably grow poorly. A couple of winters ago, for example, Strauch's rosemary grew well indoors, but the next winter it didn't, despite receiving the exact same treatment both years. You too will probably find that indoor herbal gardening involves some serendipity and a bit of trial and error, but by consulting with a local nursery and a gardening book or two, you should be able to grow herbs to season your favorite dishes all winter long.

BEST HERBS FOR INDOORS

Basil (Ocimum basilicum). This fragrant annual grows readily from seed, germinating in six to 10 days. Prefers dry, medium-rich soil. Cut back blossoms and upper leaves to encourage more growth.

Chervil (Anthriscus cerefolium). Annual with a flavor a bit like tarragon. Not a long-lived plant; to ensure a continuous supply, plant new seeds every month or so. Likes moderately rich soil.
Chives (Allium schoenoprasum). A perennial that is hardy far into northern climes, chives should go through a period of freezing and dormancy outdoors before being brought inside. Prefers somewhat moist, medium-rich soil.

Mint (Mentha species). Peppermint and spearmint are both annuals that make good container plants; they remain productive in pots for up to six months. Water when soil begins to dry.

Oregano (Origanum vulgare). A perennial that prefers soil a bit on the dry side. Cut back often to contain spreading.

Rosemary (Rosmarinus officinalis). A tender perennial that prefers well-drained soil but humid conditions; for this reason, it can be tricky to grow indoors. Because it is unlikely to survive the winter, however, it's worth trying to maintain.

Sweet marjoram (Origanum majorana). A tender perennial that prefers dry, rich soil. Tends to bush out; cut back to control spreading.

Thyme (Thymus vulgaris). A hardy perennial that tolerates just about any soil. In fact, be careful not to fertilize too much or flavor will become overly pungent.

CREATIVE HEALTHFUL HOLIDAY GIFT IDEAS
by Maria Liberty

Holiday time is a great time for planning for the year ahead. What better way to relax and enjoy a little self-indulgence than by putting together some creative gifts, such as perfume or developing fragrances for the home.

Aromatherapy is the use of pure, essential oils, extracted from flowers, trees, herbs and spices specially blended to heal both mind and body, according to the internationally recognized authority on the subject, Robert B. Tisserand of England. Here are some ideas for easy-to-make, aromatherapy-related gifts:

* As a facial moisturizer that will nourish and beutify the skin, add five drops of lavender oil, five drops of rose geranium oil, two drops of patchouli or sandalwood oil and three drops of lemon, frankincense or chamomile oil to a base of two fluid ounces of sweet almond, apricot or jojoba oil. Include a few drops of natural vitamin E or wheat germ oil to keep the mixture fresh. Choose an elegant bottle to place this in and you have a beautiful and practical gift.

* To design your own perfume, add 20 drops of essential oils (see the list below) to one-fourth ounce of jojoba oil. Choose a perfume bottle and add a holiday ribbon.

Here is a guide to some selected essential oils:

* Bergamot: has a citrusy, floral scent; uplifting for anxiety and depression; blends well with lavender and geranium. Used frequently as a perfume, facial and massage oil.

* Jasmine: rich, floral scent; strong antidepressant -- imparts a feeling of self-consciousness. Used as a perfume for potpourri, massage oil and the bath.

* Lavender: cooling, relaxing scent; restorative when mentally or physically exhausted; also effective as an aid against insomnia. Used a perfume, for inhalation and in a facial steam.

* Lemon grass: sweet, grassy, lemony scent; uplifting -- used for the bath and as a
perfume.
* Lime: more refreshing than lemon; used in men's after-sahve or as a massage oil and perfume.
* Orange: encourages cheerfulness; a sunny fragrance. Used as a perfume and bath oil, or also as an air freshener.
* Patchouli: stimulating, musky scent. Used as a potpourri and a perfume.
* Rose: tonic effect on dry, sensitive or aging skin. Used as a perfume and bath oil as well as a facial oil.

Making herbal soaps yourself is easier than you may think. You can use store-bought, all-natural soaps and/or powders for your base. Aromatic herbs from your garden -- or from your health food store -- can be incorporated into the base for wonderful scents. The following herbal soap recipes call for essential oils to both intensify the scent and increase longevity.

* Chamomile-sage facial scrub. This facial scrub will remove dead skin cells and stimulate circulation. This mixture can be put in a pretty jar or you can make up little scrub bags and put them in a closed jar. Grate three bars of all-natural facial soap into a bowl. Add one and one-half cups of dried chamomile flowers (which have an apple-pineapple scent and are known to relax and soften the skin); one-half cup of dried sage leaves (which are a natural cleanser); and a cup of oatmeal flakes. Toss all ingredients together until very well blended. To make up scrub bags, place one tablespoon of this mixture in the center of a 4-inch square of doubled cheesecloth, then twist and tie with a string or ribbon and place in a jar.

* Lavender soap balls. Lavender flowers are antiseptic and relaxing. Victorian women loved the lingering scent; it's a classic that will never go out of style. Make a "tea" by pouring one-third cup of boiling water over one tablespoon of dried lavender buds. Steep for 15 minutes. Grate two large bars of an all-natural soap (approximately three and one-fourth cups). Reheat the lavender "tea" and add four drops of lavender oil. Pour this mixture over the grated soap. Knead the soap mixture together and form it into balls. Place a soap balls on a piece of waxed paper and allow to air dry for two to five days.

Here are some other ideas for gifts that can be found at your health food store. For those "party eyes," that are familiar after too much partying or not enough sleep, put in your gift assortment a tube of chamomile under-eye therapy, which reportedly removes puffiness and dark circles.

Put together a hair-care package for that special someone. Include a cruelty-free shampoo, conditioner and a small bottle of jojoba oil to keep dry hair glossy and moisturized. Wrap this in recycled wrapping paper.

Recycle an old-fashioned cookie tin. Fill with old popcorn for packaging. Choose from a variety of small soaps that pamper face and body. Select from soaps containing such ingredients as oatmeal, patchouli oil, glycerin, olive oil and honey. Add a natural loofah or sea sponge as an extra treat.

Most women will appreciate an all-natural, cruelty-free assortment of cosmetics. Choose a foundation or makeup base (be sure it doesn't contain mineral oil), a talcum-free facial powder, blush, eye shadow and eyeliner, along with a mascara and lipstick. For an added touch, include an assortment of natural bristle cosmetic brushes or combs.
For a stress-free holiday season, give your friends and family an emergency stress relief formula that can be used at home or while traveling. It can even be spritzed on a pet to keep them calm.

Bath and shower gels make another nice gift pack. One line of aromatherapy body therapies includes black forest pine bath oil, tangerine shower gel, ginger shower gel, cinnamon shower gel, rose mist freshener and a foot lotion that includes peppermint and cypress.

Don't forget a dental-care package. Include a natural, cruelty-free toothpaste or powder, natural bristle toothbrush and an alcohol-free mouthwash and dental floss. Reuse old comic books or comics from the Sunday newspaper as a gift wrap.

For men or women, a foot-pampering kit is a nice gift. Be sure to include a natural pumice stone, natural bar of soap containing olive oil, a small bottle fo oil for moisturizing, such as vitamin E or kukui nut, and a creamy moisturizer containing aloe vera or jojoba to put on after the oil.

Don't forget a deodorant package. Since many people are allergic to the various commercial products available, select products using all-natural ingredients from your health food store. An Israeli formulation has been shown to protect underarms from four to 15 days. This aluminum-free product is based on a formula using arnica and calendula. The same company has a foot deodorant that reportedly keeps feet, shoes and sneakers odor-free for days. Wrap this gift in pages from a 1995 calendar.

For the the book lovers on your gift list, here are several ideas.

* How to Make the World a Better Place, A Guide to Doing Good, by Jeffrey Hollender, William Morrow and Co., New York. This book offers ideas on how to help and give to others. Hollender shares with you over 120 specific actions anyone can do in just minutes a day. It includes clear and concise instructions, complete with phone numbers and addresses and lots of inspiration.

* If your gift recipient is intrigued by herbs, Herbal Treasures by Phyllis V. Shaudys, Storey Communications, Inc., Pownal, Vt., is a great book filled with inspiring, month-by-month projects for gardening, cooking, skin care preparations and crafts using herbs.

* How to Treat Yourself with Chinese Herbs, by Dr. Hong Yen Hsu, from Keats Publishing, Inc., New Canaan, Conn., is an easy-to-read introductory book to Chinese herbs and how they can be used to build a lifetime of good health and happiness. What's the main thing on our minds at holiday time? Food! So what makes a better gift than a food basket?

For the weight-conscious, put together a fat-free food basket. For the snack lover, how about a basket filled with an assortment of snack pouches made up of dried fruits and nuts, carob-covered rice cakes and wholewheat fig bars.

Appliances also make excellent holiday gift ideas. Your health food store will have some or all of the following: juicers, blenders, yogurt makers, wheat grass juicers, drinking water purification products, and many others.

For any gift basket, why not include citrus-scented air fresheners for home of office. The non-aerosol, chemical-free freshners, which use essential oils, are said to eliminate odors, pollen, smoke and dust.

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MAINTAINING EQUILIBRIUM

by Andrew Weil

To be healthy means to be in a relative condition of balance. Picture a child's knockdown toy with a weighted bottom. Hit it from any direction, and it bounces back. Hold it down, if you will. As soon as you release it, it finds its centered, upright position. Health embodies that kind of bounce and resilience. Potentially unbalancing forces assault us continually, from within and without. We move through a sea of microorganisms, many of them capable of causing disease. We eat, drink, and breathe toxins, both natural and artificial. We suffer emotional and physical injuries and the declines of age. But if we are healthy, we can absorb these insults and come back to center quickly.

Scientists talk about two kinds of equilibrium: static and dynamic. A chemical reaction reaches a state of dynamic equilibrium when the concentrations of beginning and end products remain equal, even though compounds are constantly breaking apart and reforming. The appearance of stability rests on the reality of constant change. Clearly, the equilibrium of health is dynamic and not static. We may appear to be unchanging from day to day, but a lot is going on to maintain that appearance.

In fact, a state of unchanging, absolute, perfect health is unattainable, titles of popular books notwithstanding. Anyone who promises you perfect health, if you will just do this or that, is selling something. What you can work toward are more frequent, longer-lasting states of relative health, with enough bounce to rebound from whatever comes along to disturb your equilibrium. Health is always being threatened by forces of disorder, always being lost in order to be regained. You can easily learn to notice all the little breakdowns and regroupings that are normal parts of the dynamic equilibrium of health.

Whenever health is lost temporarily, corrective forces immediately come into play to restore equilibrium. This process is perfectly natural. It is useful to remind yourself that healing is a natural process taking place within, even though outside intervention may help to stimulate it.

People often ask me, "What kind of medicine do you practice?" I just practice medicine, based on common sense and an appreciation of the human potential for healing. If I have to qualify what I do, I say that I practice natural and preventive medicine. A main difference between what I do and what conventional M.D.'s do is that I operate on the belief that people can get better, because I know that nature is always trying to pull us back to a balanced state of relative health.

I could write at length about why so many doctors seem pessimistic about healing and convey their pessimism to patients. The fact is that patients are often "hexed" by doctors--told in one way or another not to expect to get better. Often these hexes are inadvertent, the result of thoughtless remarks that reveal doctors' lack of faith in the
healing power of nature.
A man in his mid-50s came to see me recently from British Columbia. He had ignored worsening urinary symptoms for several years, then finally had gone to a urologist a few months before. The problem turned out to be prostate cancer that had spread to the bones of the pelvis by the time of diagnosis. The only treatment offered was hormonal therapy to slow down the tumor's growth. The man was terrified. Although he was desperately doing daily visualizations of his cancer shrinking, he continued to smoke cigarettes addictively. When I asked why he had not made an effort to stop, he told me that he had asked the urologist at the time of the diagnosis if he should quit smoking. The urologist had answered, "At this point, why bother?"

Those words had the effect of a hex from a malevolent shaman and were the real source of the patient's fear. I would guess the urologist though he was doing the man a favor, sparing him further trouble. But what the patient heard was: "You Are Going To Die Soon," and those words were burned into his mind, where they continued to act as an obstacle to healing. I do not know whether I was able to neutralize them.

You would think that doctors-in-training would focus on health and healing and come away optimistic. After all, people get better all the time. Yet medical education concentrates mostly on disease, on illness rather than wellness. The word "healing" is seldom mentioned.

Because of my long-time interest in alternative methods of treatment, I receive countless testimonials to the healing powers of various therapies, practitioners, substances, and practices. I have also interviewed many people who have experienced dramatic recoveries from conditions that doctors were pessimistic about. Many physicians dismiss such accounts as "anecdotal." Testimonials are not highly regarded in the world of conventional medical research. I find them always interesting and worth listening to, but my interpretation of them is somewhat different. I do not think testimonials prove the worth of particular products or practitioners; what they testify to is the human capacity for getting better, evidence of which is all around us.

I cannot imagine being in treatment with a doctor who did not think I could get better. I cannot imagine being a practitioner who did not try to fortify the belief of patients in their natural capacity for healing.

My philosophy of treatment is to use whatever works as long as it does not cause harm. I have no allegiance to any one system of treatment and use elements from many that I have studies. I do not hesitate to recommended allopathic drugs and surgery if they are indicated but prefer always to use herbs and other gentler interventions whenever possible. I recommended changes in many areas: diet, exercise, stress management, and breathing, for example, along with body work and mind work to remove obstacles to healing. I always try to convey to patients my sincere belief in the possibility of healing and the restoration of healthy balance through natural processes.

Some of the people who come to me are well and want preventive lifestyle counseling. I strongly encourage such visits. Others come with common ailments that have not responded to conventional treatment: hay fever, arthritis, sinus conditions, irritable bowels, depression, anxiety, insomnia, and so forth. Others come with overwhelming illnesses like cancer. Natural medicine has something to offer all of them.

It is a pleasure to be writing for a magazine with the name Natural Health. In this column I will share ideas and information with you, the same kinds of information I give
to my patients: my own discoveries as a practitioner and the latest research findings on factors in our control that influence health. I will try to answer common questions that patients ask me and will summarize case histories to illustrate points. Also, I invite your questions and suggestions for topics you would like to see discussed here. I look forward to our dialogue.

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**INTIMACY: THE ART OF WORKING OUT YOUR RELATIONSHIPS**

by Lori H. Gordon

Most of what goes wrong in relationships can be traced to hurt feelings, miscommunication, and disillusionment - leading partners to erect defenses against one another.

Confusion. Hurt. Silence. Missed opportunity. It is one of the ironies of modern life that many couples today are living together as complete strangers. Or worse, in great unhappiness. The data on divorce lead us to conclude that intimate relationships have been falling apart for the last 20 years or so. The truth is that couples have never learned reliably how to sustain pleasure in intimate relationships. The difference is it never mattered so much before.

Here at the close of the 20th century we have the luxury of living in splendid isolation. Unlike in more "primitive" cultures, most Americans no longer live as part of a large family or community where we develop a sense of comfort and safety, a network of people to confide in, to feel at home with. This, I have come to believe, is what has drawn many people into cults - the need to feel part of a bonded community, where there is a sense of being at home emotionally as well as physically. Our culture provides for meeting all other needs, especially the need for autonomy, but not for intimacy. Within this framework, couples today must provide for each other more of the emotional needs that a larger community used to furnish.

Compounding the wide-scale deprivation of intimacy we actually experience, our cultural talent for commercialization has separated out sex from intimacy. In fact, intimacy involves both emotional and physical closeness and openness. But we wind up confusing the two and end up feeling betrayed or used when, as often happens, we fail to satisfy our need for closeness in sex.

Shifts in our general views about what makes life worth living have also contributed to a new demand for intimacy. For many generations the answer lay in a productive life of work and service in which the reward of happiness would be ours, in Heaven. That belief has broken down. People want happiness here and now. And they want it most in their intimate relationships.

Here, it's clear, we are unlikely to find it easily. Couples today are struggling with something new - to build relationships based on genuine feelings of equality. As a result, we are without role models for the very relationships we need. And rare were the parents who modeled intimacy for us; most were too busy struggling with survival requirements. Yet the quality of our closest relationships is often what gives life its primary meaning.
Intimacy, I have come to believe, is not just a psychological fad, a rallying cry of contemporary couples. It is based on a deep biological need. Shortly after I began my career as a family therapist I was working in a residential treatment center where troubled teenage boys were sent by the courts. Through my work I began to discover what had been missing for these kids: They needed support and affection, the opportunity to express the range and intensity of their emotions. It was remarkable to discover their depth of need, their depth of pain over the lack of empathy from significant people in their lives.

It is only in the last 20 years that we recognize that infants need to be held and touched. We know that they cannot grow - they literally fad to thrive - unless they experience physical and emotional closeness with another human being. What we often don't realize is that that need for connection never goes away. it goes on throughout life. And in its absence, symptoms develop - from the angry acting out of the adolescent boys I saw, to depression, addiction, and illness. In fact, researchers are just at the very beginning of understanding the relationship of widespread depression among women to problems in their marriages.

When brought the boys together with their families through processes I had not learned about in graduate school, it transformed the therapy. There was change. For the adolescent boys, their problems were typically rooted in the often-troubled relationships between their parents. They lacked the nurturing environment they needed for healthy growth. What I realized was that to help the children I first had to help their parents. So I began to shift my focus to adults.

From my work in closely observing the interactions of hundreds of couples, I have come to recognize that most of what goes wrong in a relationship stems from hurt feelings. The disappointment couples experience is based on misunderstanding and misperception. We choose a partner hoping for a source of affection, love, and support, and, more than ever, a best friend. Finding such a partner is a wonderful and ecstatic experience - the stage of illusion in relationships, it has been called.

To use this conceit, there then sets in the state of disillusion. We somehow don't get all that we had hoped for. He didn't do it just right. She didn't welcome you home; she was too busy with something else; maybe she didn't even look up. But we don't have the skills to work out the disappointments that occur. The disappointments big and little then determine the future course of the relationship.

If first there is illusion, and then disillusion, what follows is confusion. There is a great deal of unhappiness as each partner struggles to get the relationship to be what each of them needs or wants it to be. One partner will be telling the other what to do. One may be placating - in the expectation that he or she will eventually be rewarded by the other. Each partner uses his or her own familiar person communication style.

Over the disappointment, the partners erect defenses against each other. They become guarded with each other. They stop confiding in each other. They wall off parts of themselves and withdraw emotionally from the relationship, often into other activities - or other relationships. They can't talk without blaming, so they stop listening. They may be afraid that the relationship will never change but may not even know what they are afraid of. There is so much chaos that there is usually despair and depression. One partner may actually leave. Both may decide to stay with it but can't function.

They live together in an emotional divorce.
Over the years of working with couples, I have developed an effective way to help them arrive at a relationship they can both be happy with. I may not offer them therapy. I find that what couples need is part education in a set of skills and part exploration of experience that aims to resolve the difficulties couples trip over in their private lives.

Experience has demonstrated to me that the causes of behavior and human experience are complex and include elements that are biological, psychological, social, contextual, and even spiritual. No single theory explains the intricate dynamics of two individuals interacting over time to meet all their needs as individuals and as a couple. So without respect to theoretical coherence I have drawn from almost every perspective in the realm of psychology - from psycho-dynamics to family systems, communication theory and social learning theory, from behavior therapy to object relations. Over the past 25 years I have gradually built a program of training in the processes of intimacy now known as Practical Application of Intimate Relationship Skills (PAIRS). It is taught to small groups of couples in a four-month-long course in various parts of the United States and now in 13 countries.

There are no specific theories to explain why the course works. In time that will come, as researchers pinpoint exactly which cognitive, behavioral, and experiential elements (and when and for whom) are most responsible for which types of change. Nevertheless I, my associates, and increasing numbers of graduate students have gathered, and are gathering, evidence that it powerfully, positively influences marital interaction and satisfaction.

Studies of men and women before and after taking the course show that it reduces anger and anxiety, two of the most actively subversive forces in relationships. Judging from the hundreds of couples who have taken the PAIRS course, partners in distressed relationships tend to have more anxiety and anger than the does the general population. Once they have taken the course there is a marked reduction in this state of anger and anxiety. What is most notable is that there is also a reduction in the personality trait of anger, which is ordinarily considered resistant to change. Learning the skills of intimacy - of emotional and physical closeness - has a truly powerful effect on people.

We also see change in measurements of marital happiness, such as the Dyadic Adjustment Scale. Tests administered before the course show that we are seeing a range of couples from the least to the most distressed. And we are getting significant levels of change among every category of couple. It is no secret that most attempts at therapy produce little or no change among the most distressed couples. Perhaps it's because what we are doing is not in the form of therapy at all, although its effects are therapeutic. In addition to improvement in many dimensions of the relationship, achieving intimacy bolsters the self-worth of both partners.

Love is a feeling. Marriage, on the other hand, is a contract - an invisible contract. Both partners bring to it expectations about what they want and don't want, what they're willing to give and not willing to give. Most often, those are out of awareness. Most marriage partners don't even know they expected something until they realize that they're not getting it.

The past is very much present in all relationships. All expectations in relationships are conditioned by our previous experience. It may simply be the nature of learning, but things that happen in the present are assimilated by means of what has
happened in the past. This is especially true of our emotions: every time we have an experience in the present we also are experiencing it in the past. Emotional memory exists outside of time. It is obvious that two partners are conditioned by two different pasts. But inside the relationship it is less obvious. And that leads to all kinds of misunderstanding, disagreement, disappointment, and anger that things are not going exactly as expected.

The upshot is statements like "I can't understand women:" "who knows what a woman wants," and "you can never please a man." All of the classic complaints reflect hidden expectations that have never surfaced to the point where they could be discussed, examined kept, or discarded.

To add insult to injury, when one partner is upset, the other often compounds it unintentionally. When, for example, a woman is unhappy, men often feel they are expected to charge out and fix something. But what she really wants is for her partner to put his arms around her and hold her, to soothe her, to say simply, "I'm sorry you feel bad." It is a simple and basic longing. But instead of moving toward her, he moves away. And if when you are upset you don't get what you want from the person you are closest to, then you are not going to feel loved. Men, too, I hasten to say, have the same basic need. But they erect defenses against it for fear it will return them to a state of helplessness such as they experienced as children.

At the heart of intimacy, then, is empathy, understanding, and compassion; these are the humanizing feelings. It is bad enough that they are in short supply among distressed couples. Yet I have observed that certain careers pose substantial roadblocks to intimacy because the training involves education not in humanization but in dehumanization. At the top of the list is law. Built primarily on the adversarial process, it actively discourages understanding and compassion in favor of destroying an opponent. Careers in the military and in engineering also are dismissive of feelings and emotions. Men and women who bring what they learn from such work into a love relationship may find that it can't survive.

An understanding of intimacy has its own logic. But it runs counter to conventional wisdom and most brands of psychology. They hold that to understand the nature of, and to improve, relationships, the proper place to start is the self. The thinking is that you need to understand yourself before you can confide in a partner. But I have found just the opposite to be true.

An exploration of the self is indeed absolutely essential to attaining or rebuilding a sense of intimacy. Most of the disappointments that drive our actions and reactions in relationships are constructed with expectations that are not only hidden from our partners but also ourselves. From our families of origin and past relationship experiences, we acquire systems of belief that direct our behavior outside of our own awareness. It is not possible to change a relationship without bringing this belief system into our awareness.

But a man or a woman exploring their personal history experiences some powerful feelings that, in the absence of a partner to talk to, may make one feel worse rather than better. So the very first step a couple must take to rebuild intimacy is to learn to express their own thoughts and feelings and carefully listen to each other. A partner who knows how to listen to you can then be on hand when you open up your past.

Exploration of the self is an activity often relegated to psychotherapy; in that case a psychotherapist knows how to listen with empathy. But that is not necessarily the only
way and at best is a luxury affordable only by a few. It is not only possible but desirable for couples of all economic strata to choose to confide in each other and build a relationship with a life partner rather than with a paid confidant. Both partners have an ongoing need to open up the past as well as share the present. But there are skills that have to be learned so that such interaction can be safe. Both partners need to learn how to listen without judging or giving unwanted advice. Disappointment in a partner's ability to hear is what often sends people to a psychotherapist in the first place.

All of us bring to our intimate relationships certain expectations that we have of no one else. On the positive side they usually involve undivided attention - words and gestures of love and caring, loyalty, constancy, sex, companionship, agreement, encouragement, friendship, fidelity, honesty, trust, respect, and acceptance. We are all too alert to the possibility that we will instead find their exact opposites.

If we are not aware of our own expectations (and how they are affected by our history), there is no hope of expressing them to a partner so that he or she has a shot at meeting them. More often than not, we engage instead in mind reading.

Mind reading is often related to a past disappointing relationship experience. We tend to expect what we previously had the opportunity to learn; we make assumptions based on our history. And when in personal history there are people or situations that were the source of heartache, resentment, or anxiety, then any action by a partner in the present that is similar in some way often serves as a reminder - and triggers an intense emotional reaction. I call this "emotional allergy." As with other forms of prior sensitization, the result tends to be an explosive reaction - withdrawal, counterattack - and is typically incomprehensible to a current partner.

If I had to summarize how to change the hidden expectations that work to distort a relationship, I would boil it all down to a few basic rules:

* If you expect a partner to understand what you need, then you have to tell him or her. That of course means you have to figure out for yourself what you really need.

* You cannot expect your partner to be sensitive and understand exactly how you feel about something unless you're able to communicate to him or her how you feel in the first place.

* If you don't understand or like what your partner is doing, ask about it and why he or she is doing it. And vice versa. Explore. Talk. Don't assume.

Expressing your feelings about a given situation and asking for your partner's honesty in return is the most significant way to discover truth in your relationship. Instead, most communication between intimates is nonverbal and leans heavily on mind reading. The only thing you have to go on is your own internal information, which could easily be skewed by any number of factors. This is also why genuine responses are so important. Telling your partner what you think he or she wants to hear, instead of what is really going on, complicates and postpones a useful solution to the problem.

Confiding is much more than being able to reveal yourself to another. It is knowing with absolute certainty that what you think and feel is being heard and understood by your partner. Instead, we tend to be passive listeners, picking up only those messages that have a direct bearing on ourselves, rather than listening for how things are for our partner.

Listening with empathy is a learned skill. It has two crucial ingredients: undivided attention and feeling what your partner feels. Never assume that you know something
unless it is clearly stated by your partner. And you need to understand fully what your
partner's thoughts and feelings mean to him or her. Instead of focusing on the effects of
your partner's words on you, pay attention instead to your partner's emotions, facial
expression, and levels of tension. The single biggest barrier to such empathic listening is
our self-interest and self-protective mechanisms. We anticipate and fill in the blanks. One
of the simple truths of relationships is that often enough, all we need to do to resolve a
problem is to listen to our partner - not just passively listen but truly hear what is in the
mind and in the heart.

What more often happens is that, when we experience threats to our self-esteem
or feel stressed, we resort to styles of communication that usually lead to more of a
problem than the problem itself. The styles of communication that we resort to during
stress then often prevent real contact from happening. If your partner tends to be a
blamer, you will distance yourself. You develop a rational style of relating, but no
feelings are ever dealt with. Not only is no love experienced, but at the emotional level
nothing can get resolved.

Most people tend to react to stress with one or more of four communication
styles:

* Placating. The placater is ingratiating, eager to please, apologetic, and a "yes"
  man or woman. The placater says things like "whatever you want" or "never mind about
  me, it's okay." It's a case of peace at any price. The price, for the placater is
  worthlessness. Because the placater has difficulty expressing anger and holds so many
  feelings inside, he or she tends toward depression and, as studies show, may be prone to
  illness. Placaters need to know it is okay to express anger.

* Blaming. The blamer is a fault-finder who criticizes relentlessly and speaks in
generalizations: "You never do anything right." "You're just like your mother/father." Inside,
the blamer feels unworthy or unlovable, angry at the anticipation he or she will
not be getting what is wanted. Given a problem, the best defense is a good offense. The
blamer is unable to deal with or express pain or fear. Blamers need to be able to speak on
their own behalf without indicting others in the process.

* Computing. The computer is super reasonable, calm and collected, never admits
mistakes, and expects people to conform and perform. The computer says things like,
"Upset? I'm not upset. Why do you say I'm upset?" Afraid of emotion, he or she prefers
facts and statistics. "I don't reveal my emotions and I'm not interested in anyone else's." Computers need someone to ask how they feel about specific things.

* Distracting. The distractor resorts to irrelevancies under stress, avoids direct eye
contact and direct answers. Quick to change the subject, he or she will say, "What
problem? Let's have Sam and Bridget over." Confronting the problem might lead to a
fight, which could be dangerous. Distractors need to know that they are safe, not helpless,
that problems can be solved and conflicts resolved.

Each style is a unique response to pain, anger, or fear, which keeps us from
understanding each other. Knowing that, the next time you find yourself resorting to
blame, you can conclude there is something painful or scary bothering you and try to
figure out what it is. If it's your partner who is blaming, you can conclude he or she is
possibly not intending to be aggressive or mean but probably afraid of some
development. What's needed is to find a way to make it safe to talk about the worry; find
out what is bothering him or her.
How, then, can you say what is bothering you, or express what you really need, in a way that your partner can hear it, so that your message can be understood? This is a basic step in building the relationship you want. For this, the Daily Temperature Reading is particularly helpful.

After partners have been heard and understood, they may need to work on forgiveness. Of course, some things are unforgivable, and each partner has to decide if that line has been crossed and the relationship is worth continuing. If it is, there has to be a recognition that you can't change the past. No relationship can recover from past disappointments and mature unless both partners can find a way to let go of grudges. This is one of the most important relationship skills couples can develop.

In a relationship, letting go of grudges is something you do for yourself, not just to make your partner feel better. It is done by making simple statements of facts, not statements of blame. "You took me to your office party and you got so busy with everyone else you didn't introduce me to anyone to talk to me all night. You acted like I didn't matter and that your boss was the most important man in your life."

In the beginning, the course works best in the safety of a group, which prevents the isolation of couples and keeps partners from getting defensive and negative. But once they've practiced this, and it's a simple act of confiding, couples continue it on their own far more easily.

This is not just an exercise of the emotions. There is a cognitive restructuring taking place during these exercises. What is really going on is that one partner is, probably for the first time, learning the meaning of another's experience. That by itself enhances their closeness. All it requires is listening with empathy, and the experience becomes a source of pleasure for both of them. At the same time, there is conceptual understanding of what each is doing that deprives the relationship of pleasure and what they need to do to make it better.

Because the past continually asserts itself in present experience, both partners in a relationship are obligated to explore themselves, their beliefs, needs, and hopes, and even uniqueness of personality through their family's emotional history. Most people operate in the present, using messages and beliefs silently transmitted to them in their family of origin. Or they may be living out invisible loyalties, making decisions based not on the needs of their partner or present relationship, or even their own needs, but on some indebtedness that was incurred sometime in the past.

Particularly at issue are messages we acquire about ourselves, about life and love, trust, confiding, and closeness. Those things we take as truths about love, life, and trust are beliefs we had the chance to learn from specific people and situations in the past. It is on this information that we make the private decision to ourselves: "Nobody cares." "It doesn't matter what I think or say, you're not interested in me." If, for example, you grew up in a family where your mother or father drank or was depressed, or was otherwise emotionally unavailable, you may have drawn the conclusion that no one was really interested in you.

It is vital to know the lineage of our beliefs because we transfer onto our partners what we were dealt in the past. One of the decisions often made unwittingly is, "I don't trust that anybody is really going to be any better to me." It can become a way of saying, "I'm going to get even for the way I was treated." You wind up punishing your partner for what someone else actually did.
When you displace the blame for past hurts onto your present partner, you are activating a dynamic that psychiatrist Ivan Boszormenyi-Nagy, M.D., describes as "the revolving ledger." At certain periods in your life, important people, or even life itself, through events that affected you, ran up a series of debits or credits in terms of what you needed. Time passed. You walked through life's revolving door. And now you hand me the bill. And you hold two hidden expectations. "Prove to me you are not the person who hurt me." In other words, "make up to me for the past." "Pay me back." And, "if you don't, if you do one thing that reminds me of that, I will punish you." The emotional transfer is accomplished.

Freud described this as transference and identified it as a crucial part of the therapeutic relationship. In fact, it is part of our everyday transactions in relationships. It is crucial to understand that this emotional transfer often does not take place early in a relationship. It sets in after a couple has been married for some time when you are disappointed and discover what you expected or hoped to happen isn't happening.

That is the point when we transfer the hidden expectations, especially the negative ones, from our history, from any or all of our previous close relationships, whether to parents, siblings, former spouses, lovers, or friends. It is one of the core emotional transactions of marriage. And making it explicit is one of the psychological tasks of achieving intimacy.

The problem is, the person to whom you hand the bill is unaware of the account books in your head. The result is endless misunderstanding and disturbance. In fact, the attitudes you hold tend to be outside of your own awareness. I believe that they can be found through personal exploration.

Otherwise, you find yourself thinking of your partner as the enemy, someone to hurt, someone to get even with, to punish. And because you don't recognize the ledger as the motivating power behind your behavior, you rationalize. You seek reasons to treat your partner as the enemy. You are really just evening up the balance on someone else's account.

Roger called his wife Jenny at work. She was in the middle of a staff meeting and so she was particularly abrupt with him. When she got home, she found a note from him. He was gone. From somewhere in his past experience he was so sensitized to demonstrations of lack of interest in him that her behavior constituted absolute proof. One misstep - one hint that she was anything like whoever ran up the debit - was all she was allowed. This is a common pattern in relationships. And the "proof" of disinterest could be anything. Perhaps she didn't look at him. Perhaps she was tired. Perhaps she was sick. One reason men are often intolerant of a wife who gets sick is that she isn't there for them. It is a painful reminder of other accounts from the past.

Not only do couples maintain revolving ledgers, but they also carry over feelings of indebtedness and entitlement from one generation to the next. Invisible loyalties thus accrue in a family over the generations, whether or not we end up acknowledging them. An artistic man buries his creative longing because his family legacy calls for being a success in business. For each of us, behavior is greatly affected by the family ledger of entitlement and indebtedness.

Every couple needs to trace the source of behaviors and attitudes, many of which turn out to have been handed down through their families of origin. Much unhappiness in relationships can be traced to the fact that one partner learned as a family rule never to
express anger, or even perhaps happiness. Many people grow up learning to subjugate
their own needs and feelings to those of others. Still the feelings influence present
relationships, and until they can be brought into awareness and spoken, it is very difficult
to improve current relationships.

Once a couple has done this and discovers where their beliefs come from, they
can review them together and decide which legacies they want to keep, which they'd
rather discard. They each work out their personal history so they do not punish the one
who's here now.

At this point I find that couples do well if I introduce an experience in bonding
that is usually very emotionally powerful.
For men, these experiences are revelatory. Men, because they are often cut off from the
emotional part of themselves, are especially often forced to piggyback their need for
intimacy on sex. They have no less need for intimacy than women, but it usually gets
suppressed and denied. Or they attempt to satisfy their need for closeness through contact
sports and roughhousing. They don't know how to work things out in man-woman
intimate relationships. But when they learn, they almost always feel an enormous sense
of wholeness and relief.

In growing up men have learned that the only thing they are supposed to need to
be close to a woman is sex. They discover that bonding is a valid need in its own right,
and needing physical closeness doesn't mean they are going to regress into helplessness
and never function again. It doesn't weaken you, it strengthens you.

But this is not learnable merely by cognitive statement. Having the experience
illuminates the point and changes the thinking. The exercises are important because they
integrate the emotional acceptance, the behavioral change, and the cognitive
understanding that occur.

It is no news that sexual problems in a relationship are frequently the by-product
of personal and relational conflicts and anxieties. For too many couples, sex has become
a substitute for intimacy and a defense against closeness. Most poor sex stems from poor
communication, from misunderstandings of what one's mate actually want - not from
unwillingness or inability to give it.

In the realm of sex as in other domains of the relationship, you cannot expect your
partner to guess what pleases you. You are obligated to figure out for yourself what
stimulates, delights, and satisfies you - and acknowledge it. It is not enough to give and
receive, you also have to be able to speak up or reach out on your own behalf and take.
Ideally, sexual love will be a flow of this give and take, but it has to go both ways to keep
desire alive.

Before sex can be rewarding for both partners, they have to first restore the ability
to confide and reestablish emotional openness, to establish a sense of camaraderie. Then
physical closeness has meaning, and the meaning serves only to heighten the pleasure of
the physical experience even more.

Of course, intercourse is not the only avenue to physical pleasure. There is a
whole range of physical closeness couples can learn to offer each other. Being together.
Hugging. Holding each other. Caressing each other's face. Massaging your partner's
body. in fact, taking pleasure in each other is a habit that some couples actually have to
acquire. But taking pleasure in your partner is the very thing your partner needs most
from you.
The Daily Temperature Reading

Confiding - the ability to reveal yourself fully, honestly, and directly - is the lifeblood of intimacy. To live together with satisfaction, couples need dear, regular communication. The great intuitive family therapist Virginia Satir developed a technique for partners and families to maintain an easy flow about the big and little things going on in their lives. I have adapted it. Called the Daily Temperature Reading, it is very simple (and works for many other kinds of relationships as well).

Do it daily, perhaps as you sit down to breakfast. At first it will seem artificial - hokey, even. In time you'll evolve your own style. Couples routinely report it is invaluable for staying close - even if they let it slide for a day or two when they get busy. It teaches partners how to listen non-defensively and to talk as a way to give information rather than to stir a reaction. Here are the basics:
Sit close, perhaps even knee-to-knee, facing your partner, holding each other's hands. This simple touching creates an atmosphere of acceptance for both.

1. Appreciation. Take turns expressing appreciation for something your partner has done - and thanking each other.
2. New information. In the absence of information, assumptions - often false ones - rush in. Tell your partner something ("I'm not looking forward to the monthly planning meeting this morning") to keep contact alive and let your partner in on your mood, your experiences - your life. And then listen to your partner.
3. Puzzles. Take turns asking each other something you don't understand and your partner can explain: "Why were you so down last night?" Or voice a question about yourself: "I don't know why I got so angry while we were figuring out expenses." You might not find answers, but you will be giving your partner some insight about yourself. Besides, your partner may have insights about your experiences.
4. Complaint with request for change. Without placing blame or being judgmental, cite a specific behavior that bothers you and state the behavior you are asking for instead. "If you're going to be late for dinner tonight, please call me. That way the kids and I can make our own plans and won't be waiting for you."
5. Hopes. Sharing hopes and dreams is integral to a relationship. Hopes can range from the mundane ("I hope you don't have to work this weekend") to the grandiose ("I'd really love to spend a month in Europe with you"). But the more the two of you bring dreams into immediate awareness, the more likely you'll find a way to realize them.

Bonding Exercise

Most people put a lid on the hurts or fears of the past: "It doesn't bother me anymore"; "It isn't that important. But I find that it is essential to lift that lid - in the context of the current relationship - to close the revolving ledger.

* Choose a time when you are feeling somewhat edgy.
* Put on some soft music in the background.
* Lie down with your partner. Lie on your sides cradled into each other, both facing the same direction.

While your partner is holding you, quietly reveal something he or she does that triggers a full-blown intense emotional reaction in you. It might be that she doesn't listen to you. Or he interrupts you constantly. Or doesn't call when he's away. Or rejects whatever you suggest. "When you do this, I am very upset." As you are speaking, your partner is holding you and listening.
Now tell your partner what experience out of your history your reaction connects to. Perhaps his not calling infuriates you because it arouses the fear you felt when a parent left or died. Or your first husband walked out.

Now comes the remarkable part Tell your partner what you would have needed to happen in your history that would have helped. What actions would you have preferred to have happen? What words would you have needed to hear?

Now let your partner tell you what you needed to hear, while you take it in. Your partner is free to say it in his or her own way: "I'm sorry that happened to you?"; "I wish I had been there."

And now discuss the price you are paying in your current relationship for having this emotional reaction to events of the past. Perhaps it is that you don't talk to your partner, you withdraw, withhold, get even.

What you talk about next is what you can then do to help yourself. "How can I signal you neutrally to let you know when you trigger this response in me."

At this point you are talking about what will help you in the future. You are jointly and consciously outlining useful behaviors, constructing a relationship in which actions and experiences have the same meaning and same effect for both of you. This is essential for happiness to occur in a relationship.

Playing Dead

Rarely in long-term relationships do we talk about what we appreciate in our partner. Yet it is not possible to sustain a pleasurable relationship without that. I have found that most couples need to rediscover what it is they value in each other.

I have developed an exercise that can quickly restore a sense of priorities, of what is important in life and in relationship. Don't be misled by its simplicity. I ask a couple to talk about what they never talk about together - death and loss. This usually turns out to be an experience with a dramatic - literally and figuratively - emotional impact.

Choose a quiet time and a quiet place when there are no immediate pressures on you or your partner. Plan ahead to set aside the time. Allow about an hour.

Lie down on the floor, eyes closed, arms closed or at your side, as if you were dead. Take a few deep breaths and allow yourself to relax, but remain still.

Your partner now gets to imagine that you are gone, and talk to you as if you were. your partner must speak about what he or she will miss about you, any regrets, etc. Give him or her time to get into the experience. All you do is lie still and listen. Then switch places, while you speak about what you will miss.

Most people are profoundly moved by the emotional discoveries they make about themselves, their partner, and their relationship. They realize they have something they don't want to throw away.

But in the days to come, don't stop there. Use what you have learned to construct a more rewarding relationship. Sit down in a spirit of goodwill, voice your appreciations, make a specific request for behavioral change, and jointly negotiate the steps that will preserve the emotional closeness.

For more info about PAIRS, call 800/477-2477.
LET US NOW PRAISE ORDINARY PLEASURES: KEYS TO HAPPINESS
by Hara Estroff Marano

Nothing formal, mind you. Just your standard office survey, which is to say I asked whoever happened to be standing around whenever I remembered: What makes you happy? The results don't even aspire to statistical validity - think of it as a quality thing not a quantity thing.

Exercising, baking, browsing in a bookstore, said one. Figuring out the solution to something that has been frustrating, offered another, almost apologetically. Bubble bath, ventured a third. Really cliche things, confided another - laughing, being with good friends. These, it is obvious, are extremely ordinary pleasures. About as mundane as you can get. Which places them right there, smack on the cutting edge.

If you've been paying close attention, you might have noticed something vaguely familiar about this issue of Psychology Today. For the third year in a row, right about this time, we have examined, from one perspective or another, the subject of happiness.

Indeed, a year ago, we introduced Peter Kramer, M.D., and the captivating stories he was about to put forth in his remarkable best-seller, Listening to Prozac, about people who arrived at better living through chemistry. We also focused on other ways to capture the inner peace that over the past few years seems to have been drained from our lives, suddenly shifted into some zany souped-up gear.

Life, liberty, and the pursuit of happiness - it's that time a year, alright. But that's only part of the logic. It's the very speed of our lives that supplies our main motive for looking at happiness (and in other issues, the assorted other goals and values and beliefs we attempt to hitch our lives to). Because in a world where virtually the only constant is change, you can pretty much bet on this - that none of yesterday's assumptions are safe today. If we are living, breathing, intelligent creatures and we heed the feedback we get from the world, over time we can't help but shift our goals, our strategies, our beliefs, maybe even traits that make up our personalities.

So it's altogether appropriate - necessary, actually - that from time to time we sit down and intentionally examine the rules we live by. And because we Americans are singularly, maybe even obsessively, devoted to the pursuit of happiness, we have taken it upon ourselves here at Psych Today to maintain a Happiness watch.

Here's where the cutting edge comes in. We have detected a subtle shift. North America's leading researchers on happiness report that the elusive quarry is so cloaked in ordinariness it might easily be mistaken nowadays. Ordinary pleasures are the workhorses of happiness. They keep us going day to day. When it comes to happiness, our experts agree, there's no Big Bang. You can't stage manage it by orchestrating great occasions. It's more like grass on city streets. It crops up between the cracks; you have to take care not to trample it.

What it is extraordinary about this emerging view of happiness is that it has just received a king of validation from a very unexpected quarter. Literally as we were going to press, psychologist Arthur A. Stone, Ph.D., of the State University of New York at Stony Brook released findings revealing that the same mundane events that make us happy also keep our immune system humming. A pat on the back from the boss, a good conversation with friends - these little things boost the production of antibody, which is the body's first line of defense against illness.
Petty occurrences of everyday life have a detectable physiological effect. Of course. Our moods are related to our physiology. The body has a head.

Stone found that upsetting events - criticism from the boss - have a negative effect on immune function. But what was most striking was that pleasurable little events have a larger effect - their influence is longer-lasting.

The part it's wise to dwell on is that little things are not always little. Or as that Fourth-of-July guy, Carl Sandburg, might have said, happiness comes in on little cat feet.

WHAT MAKES MARRIAGE WORK?

by John Gottman

If you are worried about the future of your marriage or relationship, you have plenty of company. There's no denying that this is a frightening time for couples. More than half of all first marriages end in divorce; 60 percent of second marriages fail. What makes the numbers even more disturbing is that no one seems to understand why our marriages have become so fragile.

In pursuit of the truth about what tears a marriage apart or binds it together, I have found that much of the conventional wisdom--even among martial therapists--is either misguided or dead wrong. For example, some martial patterns that even professionals often take as a sign of a problem--such as having intense fights or avoiding conflict altogether--I have found can signify highly successful adjustments that will keep a couple together. Fighting, when it airs grievances and complaints, can be one of the healthiest things a couple can do for their relationship.

If there's one lesson I've learned in my years of research into martial relationships-having interviewed and studied more than 200 couples over 20 years--it is that a lasting marriage results from a couple's ability to resolve the conflicts that are inevitable in any relationship. Many couples tend to equate a low level of conflict with happiness and believe the claim "we never fight" is a sign of martial health. But I believe we grow in our relationships by reconciling our differences. That's how we become more loving people and truly experience the fruits of marriage.

Although there are other dimensions that are telling about a union, the intensity of argument seems to bring out a marriage's true colors. To classify a marriage, in my lab at the University of Washington in Seattle, I look at the frequency of fights, the facial expressions and physiological responses (such as pulse rate and amount of sweating) of both partners during their confrontations, as well as what they say to each other and what in tone of voice they interact verbally.

But there's much more to a successful relationship than knowing how to fight well. Not all stable couples resolve conflicts in the same way, nor do they mean the same thing by "resolving" their conflict. In fact, I have found that there are three different styles of problem solving into which healthy marriages tend to settle:

* Validating. Couples compromise often and calmly work out their problems to mutual satisfaction as they arise.

* Volatile. Conflict erupts often, resulting in passionate disputes.

* Conflict-avoiding. Couples agree to disagree, rarely confronting their differences head-on.
Previously, many psychologists might have considered conflict-avoiding and volatile marriages to be destructive. But my research suggests that all three styles are equally stable and bode equally well for the marriage's future.

"HEALTHY" MARRIAGES STYLES

One of the first things to go in a marriage is politeness. As laughter and validation disappear, criticism and pain well up. Your attempts to get communication back on track seem useless, and partners become lost in hostile and negative thoughts and feelings. Yet here's the surprise: There are couples whose fights are as deafening as thunder yet who have long-lasting, happy relationships. The following three newly married couples accurately illustrate the three distinct styles of marriage.

Bert and Betty, both 30, both came from families that weren't communicative, and they were determined to make communication a priority in their relationship. Although they squabbled occasionally, they usually addressed their differences before their anger boiled over. Rather than engaging in shouting matches, they dealt with their disagreements by having "conferences" in which each aired his or her perspective. Usually, they were able to arrive at a compromise.

Max, 40, and Anita, 25, admitted that they quarreled far more than the average couple. They also tended to interrupt each other and defend their own point of view rather than listen to what their partner was expressing. Eventually, however, they would reach some sort of accord. Despite their frequent tension, however, they seemed to take much delight in each other.

Joe, 29, and Sheila, 27, said they thought alike about almost everything and felt "an instant comfort" from the start. Although they spent a good deal of time apart, they still enjoyed each other's company and fought very rarely. When tension did arise, both considered solo jogging more helpful in soothing the waters than taking things out or arguing.

Not surprisingly, Bert and Betty were still happily married four years after I'd first interviewed them. However, so were Max and Anita, as well as Joe and Sheila. Marriages like Bert and Betty's, though, which emphasize communication and compromise, have long been held up as the ideal. Even when discussing a hot topic, they display a lot of ease and calm, and have a keen ability to listen to and understand each other's emotions.

That's why I call such couples "validators": In the midst of disagreement they still let their partners know that they consider his or her emotions valid, even if they don't agree with them. This expression of mutual respect tends to limit the number of arguments couples need to have.

Anita and Max take a different approach to squabbling than do Bert and Betty, yet their marriage remained just as solid over time. How can people who seem to thrive on skirmishes live happily together? The truth is that not every couple who fights this frequently has a stable marriage. But we call those who do "volatile." Such couples fight on a grand scale and have an even grander time making up.

More than the other types, volatile couples see themselves as equals. They are independent sorts who believe that marriage should emphasize and strengthen their individuality. Indeed, they are very open with each other about their feelings--both positive and negative. These marriages tend to be passionate and exciting, as if the
marital punch has been spiked with danger.

Moving from a volatile to an avoidant style of marriage, like Joe and Sheila's, is like leaving the tumult of a hurricane for the placid waters of a summer lake. Not much seems to happen in this type of marriage. A more accurate name for them is "conflict minimizers," because they make light of their differences rather than resolving them.

This type of successful coupling flies in the face of conventional wisdom that links martial stability to skillful "talking things out." It may well be that these different types of couples could glean a lot from each other's approach—for example, the volatile couple learning to ignore some conflicts and the avoidant one learning how to compromise. But the prognosis for these three types of marriage is quite positive—they are each healthy adaptations to living intimately with another human being.

THE ECOLOGY OF MARRIAGE

The balance between negativity and positivity appears to be the key dynamic in what amounts to the emotional ecology of every marriage. There seems to be some kind of thermostat operating in healthy marriages that regulates this balance. For example, when partners get contemptuous, they correct it with lots of positivity—not necessarily right away, but sometime soon.

What really separates contended couples from those in deep marital misery is a healthy balance between their positive and negative feelings and actions toward each other.

Volatile couples, for example, stick together by balancing their frequent arguments with a lot of love and passion. But by balance I do not mean a 50-50 equilibrium. As part of my research I carefully charted the amount of time couples spent fighting versus interacting positively—touching, smiling, paying compliments, laughing, etc. Across the board I found there was a very specific ratio that exists between the amount of positivity and negativity in a stable marriage, whether it is marked by validation, volatility, or conflict avoidance.

That magic ratio is 5 to 1. As long as there is five times as much positive feeling and interaction between husband and wife as there is negative, the marriage was likely to be stable over time. In contrast, those couples who were heading for divorce were doing far too little on the positive side to compensate for the growing negativity between them.

WARNING SIGNS: THE FOUR HORSEMEN

If you are in the middle of a troubled marriage, it can seem that your predicament is nearly impossible to sort out. But in fact unhappy marriages do resemble each other in one overriding way: they followed the same, specific, downward spiral before coming to a sad end.

Being able to predict what emotions and reactions lead a couple into trouble is crucial to improving a marriage's chances. By pinpointing how marriages destabilize, I believe couples will be able to find their way back to the happiness they felt when their marital adventure began.

The first cascade a couple hits as they tumble down the martial rapids is comprised of the "Four Horsesmen"—four disastrous ways of interacting that sabotage your attempts to communicate with your partner. As these behaviors become more and more entrenched, husband and wife focus increasingly on the escalating sense of negativity and tension in their marriage. Eventually they become deaf to each other's
efforts at peacemaking. As new each horsemen arrives, he paves the way for the next, each insidiously overriding a marriage that started out full of promise.

THE FIRST HORSEMEN: CRITICISM

When Eric and Pamela married fresh out of college, it soon became clear that they had different notions of what frugality meant. Pamela found herself complaining about Eric's spending habits, yet as time passed she found that her comments did not lead to any change on her husband's part. Rather, something potentially damaging to their marriage soon began occurring: instead of complaining about his actions, she began to criticize him.

On the surface, there may not seem to be much difference between complaining and criticizing. But criticizing involves attacking someone's personality or character rather than a specific behavior, usually with blame. When Pamela said things like "You always think about yourself," she assulted Eric, not just his actions, and blamed him for being selfish. Since few couples can completely avoid criticizing each other now and then, the first horesman often takes long-term residence even in relatively healthy marriages. One reason is that criticizing is just a short hop beyond complaining, which is actually one of the healthiest activities that can occur in a marrage. Expressing anger and disagreement makes the marriage stronger in the long run than supressing the complaint.

The trouble begins when you feel that your complaints go unheeded and your spouse repeats the offending habits. Over time, it becomes more and more likely that your complaints will pick up steam. With each successive complaint you're likely to throw in your inventory of prior, unresolved grievances. Eventually you begin blaming your partner and being critical of his personality rather than of a specific deed. One common type of criticism is to bring up a long list of complaints. I call this "kitchen sinking": you throw in every negative thing you can think of. Another form is to accuse your partner of betraying you, of being untrustworthy: "I trusted you to balance the checkbook and you let me down! Your recklessness amazes me." In contrast, complaints don't necessarily finger the spouse as a culprit; they are more a direct expression of one's own dissatisfaction with a particular situation. Criticisms also tend to be generalizations. A telltale sign that you've slipped from complaining to criticizing is if global phrases like "you never" or "you always" start punctuating your exchanges:

Complaint: "We don't go out as much as I'd like to."
Criticism: "You never take me anywhere."

Being critical can begin innocently enough and is often the expression of pentup, unresolved anger. It may be one of those natural self-destruct mechanisms inherent in all relationships. Problems occur when criticism becomes so pervasive that it corrodes the marriage. When that happens it heralds the arrival of the next horseman that can drag you toward martial difficulty.

THE SECOND HORSEMAN: CONTEMPT

By their first anniversary, Eric and Pamela still hadn't resolved their financial differencies. Unfortunately, their fights were becoming more frequent and personal. Pamela was feeling disgusted with Eric. In the heat of one particularly nasty argument, she found herself shrieking: "Why are you so irresponsible?" Fed up and insulted, Eric retorted, "Oh, shut up. You're just a cheapskate. I don't know how I ended up with you anyway." The second horseman--contempt--had entered the scene.
What separates contempt from criticism is the intention to insult and psychologically abuse your partner. With your words and body language, you're lobbing insults right into the heart of your partner's sense of self. Fueling these contemptuous actions are negative thoughts about the partner--he or she is stupid, incompetent, a fool. In direct or subtle fashion, that message gets across along with criticism.

When this happened, they ceased being able to remember why they had fallen in love in the first place. As a consequence, they rarely complimented each other anymore or expressed mutual admiration or attraction. The focal point of their relationship became abusiveness.

What Pamela and Eric experienced is hardly uncommon. When contempt begins to overwhelm your relationship, you to forget your partner's positive qualities, at least while you're feeling upset. You can't remember a single positive quality or act. This immediate delay of admiration is an important reason lby contempt ought to be banned from marital interactions.

Recognizing when you or your spouse is expressing contempt is fairly easy. Among the most common signs are:

* Insults and name-calling
* Hostile humor
* Mockery
* Body language--including sneering, rolling your eyes, curling your upper lip.

It is easy to feel overly critical at times, and it is human to state criticism in a contemptuous way now and then, even in the best relationships. Yet if abusiveness seems to be a problem in your relationship, the best way to neutralize it is to stop seeing arguments with your spouse as a way to retaliate or exhibit your superior moral stance. Rather, your relationship will improve if you approach your spouse with precise complaints rather than attacking your partner's personality or character.

THE THIRD HORSEMAN: DEFENSIVENESS

Once contempt entered their home, Eric and Pamela's marriage went from bad to worse. When either of them acted contemptuously, the other responded defensively, which just made matters worse. Now they both felt victimized by the other--and neither was willing to take responsibility for setting things right. In effect, they both constantly pleaded innocent.

The fact that defensiveness is as understandable reaction to feeling besieged is one reason it is so destructive--the "victim" doesn't see anything wrong with being defensive. But defensive phrases, and the attitude they express, tend to escalate a conflict rather than resolve anything. If you are being defensive, you are adding to your marital troubles. Familiarize yourself with the signs of defensiveness so you can recognize them for what they truly are:

* Denying Responsibility. No matter what your partner charges, you insist in no uncertain terms that you are not to blame.
* Making Excuses. You claim that external circumstances beyond your control forced you to act in a certain way.
* Disagreeing with Negative Mind-Reading. Sometimes your spouse will make assumptions about your private feelings, behavior, or motives (in phrases such as "You think it's a waste of time" for "I know how you hate it"). When this "mind-reading" is delivered in a negative manner, it may trigger defensiveness in you.
*Cross-Complaining. You meet your partner's complaint (or criticism) with an immediate complaint of your own, totally ignoring what your partner has said.

* Repeating Yourself. Rather than attempting to understand the spouse's point of view, couples who specialize in this technique simply repeat their own position to each other again and again. Both think they are right and that trying to understand the other's perspective is a waste of time.

The first step toward breaking out of defensiveness is to no longer see your partner's words as an attack but as information that is being strongly expressed. Try to understand and empathize with your partner. This is admittedly hard to do when you feel under siege, but it is possible and its effect are miraculous. If you are genuinely open and receptive when your partner is expecting a defensive response, he or she is less likely to criticize you or react contemptuously when disagreements arise.

THE FOURTH HORSEMAN: STONEWALLING

Exhausted and overwhelmed by Pamela's attacks, Eric defensively, to her accusations. Their marriage went from being marred by poor communication to being virtually destroyed by none. Once Eric stopped listening to Pamela, their relationship became extraordinarily difficult to repair. Instead of arguing about specifics issues, every confrontation degenerated into Pamela screaming at Eric that he was shutting her out: "You never say anything. You just sit there. It's like talking to a brick wall.

Stonewalling often happens while a couple is in the process of talking things out. The stonewaller just removes himself by turning into a stone wall. Usually someone who is listening reacts to what the speaker is saying, looks at the speaker, and says things like "Uh huh" or "Hmmm" to indicate he is tracking. But the stonewaller abandons these messages, replacing them with stony silence.

Stonewallers do not seem to realize that it is a very powerful act. It conveys disapproval, icy distance, and smugness. It is very upsetting to speak to a stonewalling listener. This is especially true when a man stonewalls a woman. Most men don't get physiologically aroused when their wives stonewall them, but wives' heart rates go up dramatically when their husbands stonewall them. The fourth horseman need not mark the end of a relationship. But if your interactions have deteriorated to this extent you are at great risk of catapulting even farther down the marital cascade--becoming so overwhelmed by the negativity in your relationship that you end up divorced, separated, or living lonely parallel lives in the same home. Once the fourth horseman becomes a regular resident, it takes a good deal of hard work and soul-searching to save the marriage.

The four horsemen are not the end of the line. It is only after they turn a relationship sour that the ultimate danger arises: Partners seize on powerful thoughts and beliefs about their spouse that cement their negativity. Only if these inner thoughts go unchallenged are you likely to topple down the final marital cascade, one that leads to distance and isolation. However, if you learn to recognize what is happening to your once-happy marriage, you can still develop the tools you need to regain control of it.

"DO WE HAVE TO?" YES! BECAUSE SOMETIMES MOTHER REALLY DOES KNOW BEST

by Elizabeth Berg
"Do We Have To?"

Parents these days seem overly solicitous. Witness my conversation with my nine-year-old daughter, Jenny, just this morning:

Me: You know, it's really cold this morning. Only three degrees! And with the wind chill--

Jenny: Mommm! I know!

Me: Well, I'm telling you this because I think you should wear a hat or at least put your hood up.

Jenny: No.

Me: Well, it really is cold, and when the wind blows on your ears--

Jenny: No!

Me: Listen, you can lose a whole lot of heat through your head. Wearing a hat will make you a good, oh, 30 percent warmer.

Jenny: I don't want to wear a hat! I hate hats.

Me: Well, could I maybe just pull your hood up a little? It doesn't have to be tight or anything.

Jenny: No! (I pull her hood up anyway).

Jenny: Mommmm!!!

Me: I don't care!! It's freezing out!! You wear that hood up, and don't you dare take it down!!!

Jenny: Fine.

As she walks down the sidewalk, I see that she is wearing not her brand-new, fur-lined boots but, rather, last summer's sneakers, complete with holes in the toes. I'd say the victory is split here.

I know that Jenny hates to wear anything on her head. Too confining. And anything that ties below her chin "chokes" her. Boots are nerdy. And she has other rules for living: Foods on her plate cannot touch. She can use only the upstairs bathroom, even if I have just stepped in there (actually, especially if I have just stepped in there), although we have two other perfectly fine bathrooms. Certain clothes are too itchy (though I never understand this one--cotton nightgowns are itchy? After they've been washed three times with double doses of fabric softener?).

Well, this is what kids are like. I know what. They have certain eccentricities, and in their own way, they're as crazy as adults (though considerably more charming in their neuroses). What I want to know is, why do we listen so hard? Why didn't I just put Jenny's hood up this morning after her first "No" and be done with it, saving both of us time and grief? Why do I see parents everywhere going through the same thing--arguing sweetly (or not so sweetly) with unassailable logib before a stony-faced humanette who won't go along with the program no matter what they say? It's sometimes better just to ignore kids and to go ahead and do what you think is best. Forget the explanations, the cajoling, the justifications, the dark stories of what might happen if they don't do what you say, the inspiring predictions of what will happen if they do.

Before my children could speak, they sometimes argued with me anyway. They made it clear with body language that they were not at all interested in doing what I wanted them to do. I usually bore all of this with good humor and went right ahead and did what I wanted to. Here's one example of this lack of cooperation that you see all the
time: A mother is putting her baby's snowsuit on. The baby hates it. He screams, stiffens his legs, and tosses his head from side to side. The mother perseveres, often smiling and chatting away in a low voice. When the snowsuit is in place, the mother picks up the baby, shows him a toy, and the baby is fine, snowsuit forgotten. Right? So what changes? Why, then a child begins talking, do we feel compelled to win him over to our side? I suppose because we want to be excellent parents, fair and compassionate, willing to hear our children out at all times. We're unwilling to be the inflexible and insensitive parents of old.

Sometimes, however, trying to reason with children backfires: We end up getting angry and frustrated, and so does the child. In addition, I believe there is some truth to the age-old maxim that children want clearcut rules and explanations; when they are not sure who's in charge, it makes them anxious.

This message was brought home when I bought tickets to the play Anne of Green Gables. I thought my daughters might enjoy seeing it. However, the response I got when I told them about it suggested otherwise. My fourteen-year-old, Julie, asked, "Do I have to come? I don't like to go places with the family! It's embarrassing, Mom!" Jennifer offered the more succinct and usual response: "Eeeuuuuuw!" So much for my swell idea. I guess it isn't much fun to spend time out with the family when you're fourteen, I thought. It's so uncool. And when you're nine, watching a play isn't first on your list of things you want to do. But I had already bought the tickets, and so I simply told them that they had to go and left it at that. (Well, all right--I sulked as I made dinner, but that's all.)

My daughters complained on the way to the play. They complained as we sat in our seats and waited for it to begin. But then they fell quiet. In the middle of the first act, I stole glances at them and saw that they were--could it actually be? --enjoying the play. At intermission, they thoroughly examined the glamorous photos of the actors and actresses displayed in the lobby. Julie casually asked how one got to be in such plays. When we got home, Jenny found the book and took it to bed with her.

My children will soon be on vacation from school. I have plans for them. I know they will say they don't want to do any of them. This time I will smile, listen, and perhaps compromise some. But mostly I will see my daughters as still being in snowsuits. My children are larger and more complex, it is true, but they still need guidance; they're still unsure of what they want; and they still need to understand, if only by being "forced" into things, that sometimes parents are right--no explanation required.

Elizabeth Berg's volume of collected essays, and a book about family celebrations, will both be published next year by Grolier Press. She is the new First-Person Parent columnist for Parents Magazine.

MAKE-OVER MAGIC: YOUR FAVORITE RECIPES MADE LIGHTER
by Kristi Fuller

"Please, make my recipe healthier!" wrote Jennifer Spencer of Michigan, as did hundreds of readers in similar letters. So, we took a sampling of recipes to our Test Kitchen and slashed calories, fat, cholesterol, and sodium in each--without sacrificing flavor. Each chosen reader fixed the new dish. Their reaction: "We loved it!"
Cathie Elias-West of Mission Viejo, California, enjoys her improved Mexican dinner with these easy changes:

* Bake the tortilla bowls instead of frying them. Baked tortillas are crispy and low in fat.
* Lean on lettuce. Toss some extra lettuce into the salad. It's filling, but 1 cup has only 8 calories.
* Make meat the sidekick. Most of us eat more protein than we need. Cutting back on meat and replacing it with vegetables lowers the amount of fat, calories, and cholesterol.
* Lighten the guacamole. Combine healthful tomatillos (also called Mexican green tomatoes) with just half of an avocado. Linda Colucci of Connecticut now turns her Italian feast into a healthfest this way:
  * Sprinkle lightly with Parmesan cheese. Just a little goes a long way.
  * Use evaporated skim milk in the sauce. It's a flavorful substitute for cream in recipes and has fewer calories and almost no fat.
  * Trade bacons. Ounce for ounce, turkey bacon has half the fat of pork bacon.
  * Oust the fat. Linda's original recipe had 4 tablespoons of butter; now there are none.
* Add peas, please. Lean peas and red sweet pepper flavor the carbonara sauce and give it color.
* Cook the egg. Concerned about eating raw eggs? You cook the egg for this healthful carbonara sauce.

Lori Kelton of Germantown, New York, loved her Greek recipe but not the fat. It tipped the scales at a whopping 50 grams of fat per serving (440 fat calories), while the new recipe weighs in at only 5 grams (45 fat calories).

* Spritz with nonstick coating. Instead of slathering margarine or butter between the layers of phyllo, use nonstick spray coating (try the butter or olive oil variety, if you like).
* Snip the amount of cheese. We halved the amount of feta cheese Lori used in her recipe. But you won't miss it here.
* Layer with fewer sheets of phyllo. We went from 20 sheets of phyllo dough to just three. This saved about 100 calories per serving. Jenny Spencer fondly dubbed her favorite recipe "Heart-Attack Enchiladas" because of its 32 grams of fat. She'll have to think of a new name now.
* Toast the nuts. This simple step brings out the nutty flavor so you can get by with fewer. Toast them in the oven or microwave.
* Trim the sodium. Canned soups often are high in sodium. If you must watch your sodium intake, use a reduced-sodium soup in recipes in place of regular soup.
* Search for lighter dairy products. Light cream cheese and reduced-fat cheese or sour cream deliver a bowlful of calorie savings with big taste. "Cholesterol Casserole," a favorite of Elizabeth Ming Cooper of Redmond, Washington, is now heart healthier with 32 milligrams of cholesterol.
* Try turkey sausage. Turkey sausage has half the cholesterol of regular pork sausage.

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* Use an egg substitute. One egg has 213 milligrams of cholesterol and 5.6 grams of fat while 1/4 cup of egg substitute (equivalent to 1 egg) has 1 milligram of cholesterol.
and 0 grams fat.

* Shred on reduced-fat cheese. Ounce for ounce, save 4 grams of fat compared to regular cheddar. Using the sharp natural variety adds more flavor than the mild.

Esther R. Bowring of Virginia used to fret about the amount of fat in her family's favorite stew. But no more. Here's what to do:

* Drain off fat. Brown the meat to add flavor and drain off any fat. Use nonstick spray coating instead of oil in the pan.
* Flavor with herbs. Toss in herbs, such as thyme and bay leaves, to boost flavor.
* Load up on veggies. Vital vegetables add few calories and no fat. Add them freely to meat dishes, such as stew. We replaced some of the beef with eggplant, which has a meaty texture.
* Adjust the sour cream. Cut the amount and switch to reduced-fat sour cream. Or, substitute plain nonfat yogurt for sour cream in most recipes.

Beryl Manley Wauson, of Centennial, Wyoming, nicknamed her recipe "Snow on the Mountain" for the avalanche of fresh coconut sprinkled atop. To make the fat melt away:

* Flavor with buttermilk. Use low-calorie, low-fat buttermilk in the sauce.
* Choose condiments wisely. Both coconut and nuts, traditional toppings for curry dishes, pack a lot of calories. Top each serving with lighter condiments such as bananas, raisins, and pineapple. Or, use just a sprinkling of coconut or nuts, if you like.
* Thicken with cornstarch. Eliminate the fat needed for a flour roux by mixing cornstarch with water instead. We shaved off almost 1 tablespoon of fat per serving this way.

Desperate for dessert? Follow the tips we used to slim down Marie Ann Donovan's spiced cake.

* Substitute egg whites for whole eggs to cut cholesterol. The rule of thumb for replacing egg whites with whole eggs: Use 2 whites for every egg yolk. Replace only about half of the yolks in a baked product because the yolks act as a tenderizer.
* Try juice for some of the oil. You won't be able to replace all of the oil, but we replaced more than half of it with juice.
* Toss in only a nibble of nuts. Finely chop nuts so they'll go farther.

FALL APPLE CAKE

1 1/4 cups sugar 1/2 cup cooking oil 2 egg whites
1 egg
2 tsp. vanilla
1 cup apple juice
2 cups all-purpose flour
3/4 cup whole wheat flour
2 tsp. baking powder
2 tsp. ground cinnamon
1 tsp. ground nutmeg
1/2 tsp. baking soda
3 cups peeled, cored, and sliced cooking apples (such as Golden Delicious or McIntosh)
1/2 cup finely chopped walnuts, toasted
Powdered sugar (optional)
Vanilla yogurt (optional)
* In a large mixer bowl beat sugar and oil on medium speed of an electric mixer till combined; add eggs and vanilla. Beat on medium speed for 1 minute or till creamy. Stir in juice.
* In a medium mixing bowl stir together the all-purpose flour, whole wheat flour, baking powder, cinnamon, nutmeg, and baking soda. Stir flour mixture into egg mixture. Gently stir in the apples and the walnuts. Pour the batter into a greased and floured 10-inch tube pan. * Bake in a 350 [degrees] oven for 60 to 65 minutes or till wooden pick inserted comes out clean. Cool in pan for 10 minutes. Remove from pan; cool on a wire rack for 30 minutes. Serve warm. If desired, sprinkle the cake with powdered sugar; top each slice with a dollop of vanilla yogurt and additional nutmeg. Makes 12 servings.

BASIL-POTATO SOUP

Nancy Rice of White Bear Lake, Minnesota, challenged us to make her potato soup more healthful. Here's how:
* Try the tang of buttermilk. To mimic the flavor and creaminess of the 1-1/2 cups of sour cream in Nancy's recipe, we used buttermilk instead. Just a small dollop of sour cream atop the soup satisfies.
* Use Canadian-style bacon. Ounce for ounce, it has 116 fewer calories than regular bacon.

1 large onion, finely chopped
4 fresh shiitake or button mushrooms, sliced (about 1/2 cup)
2 tsp. olive oil or cooking oil
3 large potatoes, peeled and thinly sliced (about 4-1/2 cups)
1 14-1/2-oz. can beef broth
1 14-1/2-oz. can reduced-sodium chicken broth
1/2 cup buttermilk
1 Tbsp. cornstarch
2 slices (1-1/2 oz.) Canadian-style bacon, chopped (about 1/3 cup)
1 Tbsp. snipped fresh basil or 1 tsp. dried basil, crushed
1/4 cup reduced-calorie dairy sour cream or plain low-fat yogurt Fresh basil leaves (optional)
* Cook onion and mushrooms in hot oil over medium-high heat till onion is tender and light brown.
* Add potatoes, beef broth, and chicken broth. Bring to boiling; reduce heat. Cover and simmer about 30 minutes or till potatoes are tender.
* In a small bowl stir together buttermilk and cornstarch; stir into broth mixture. Stir in bacon and basil. Cook and stir till thickened and bubbly. Cook and stir for 2 minutes more. Top each serving with sour cream or yogurt. If desired, garnish with basil. Makes 6 side-dish servings.

Microwave directions: In a 2-quart microwave-safe casserole combine onion, mushrooms, and oil. Micro-cook, covered, on 100% power (high) for 2 to 4 minutes or
till onion is tender. Add potatoes and chicken and beef broth. Cook, covered, on high for 15 to 18 minutes (low-wattage ovens: 20 to 25 minutes) or till potatoes are tender, stirring once.

Stir together buttermilk and cornstarch; stir into casserole. Stir in bacon and basil. Cook, uncovered, on high about 5 minutes (low-wattage ovens: 7 minutes) or till mixture is slightly thickened and bubbly, stirring after every minute. Cook for 2 minutes more, stirring once. Serve as directed.

**CREAMY POTLUCK POTATOES**

Brenda Hudson of Springfield, Oregon, felt guilty when she made her special potato dish. She won't feel guilty anymore with these easy changes:

* Shake in a butter-flavored mix. For buttery taste, sprinkle in dry butter-flavored mix--it adds just 24 calories.
* Clip the cream cheese. We used light cream cheese and cut the amount Brenda used by half. You won't even miss the other half.
* Lighten the dairy products. Again, use dairy products that are low in fat and calories. Reduced-calorie sour cream and reduced-fat cheese let you enjoy the richness without the guilt.

5 large (2-1/2 lb.) potatoes, peeled and chopped (7-1/2 cups)  
1 10-3/4-oz. can reduced-sodium condensed cream of chicken soup  
1/2 cup reduced-calorie dairy sour cream  
1/2 of an 8-oz. package light cream cheese (Neufchatel), softened  
1/2 of a 1/2-oz. pkg. butter-flavored mix (about 1 Tbsp.)  
3/4 cup shredded reduced-fat sharp cheddar cheese (3 oz.)  
1/4 cup sliced green onion  
1/4 cup skim milk  
1 Tbsp. dried parsley flakes  
1/4 tsp. garlic salt  
1/4 tsp. pepper

* Cook potatoes in boiling water for 10 to 12 minutes or till tender. Drain. Rinse with cold water. Drain again.

* In a large mixing bowl stir together the soup, sour cream, cream cheese, and the dry butter-flavored mix. Add 1/4 cup of the shredded cheese, 3 tablespoons of the green onion, the skim milk, parsley, garlic salt, and pepper; stir mixture to combine. Stir in the cooked potatoes. Transfer the mixture to a 2-quart shallow casserole or 12x7-1/2x2-inch baking dish.

* Bake, uncovered, in a 350 [degrees] oven for 30 to 35 minutes or till heated through. Sprinkle with remaining cheese. Bake 5 minutes more or till cheese melts. Sprinkle with remaining green onion. Makes 10 servings.

**CARROT-RAISIN MUFFINS**

Over the years, Mary Dunneback of Chicago has baked her muffins for Boy Scouts, car trips, and luncheons at work. But, the amount of fat in them made her cringe. To trim 115 calories per muffin, try this:

* Replace oil or fat with corn syrup. Fat-free corn syrup gives the tender texture and moistness you expect.

1-1/2 cups all-purpose flour  
1/2 cup whole wheat flour
1/2 cup sugar
2 tsp. baking powder
1/2 tsp. ground cinnamon
1/4 tsp. ground ginger
2 beaten eggs
1 8-oz. can crushed pineapple (juice pack)
1/4 cup finely shredded carrot
1/4 cup raisins
2 Tbsp. light corn syrup
1 tsp. vanilla
Nonstick spray coating
1/4 cup finely chopped walnuts

* In a large mixing bowl stir together flours, sugar, baking powder, cinnamon, and ginger. Make a well in the center; set aside. In a small mixing bowl stir together eggs, undrained pineapple, carrot, raisins, corn syrup, and vanilla; add all at once to flour mixture. Stir just till moistened.


TACO SALAD

The tomatillo (tohm-ah-TEE-oh) looks like a small green tomato, but has a thin, parchment-like covering (that is removed before cooking). The flavor is a combination of lemon, apple, and herbs. We’ve used it here in the lightened guacamole. Look for tomatillos in Mexican markets or the produce section of your supermarket.--- 1 recipe Tortilla Cups 1 recipe Tomatillo Guacamole 1/2 lb. lean ground beef 3 cloves garlic, minced 1 15-oz. can dark red kidney beans, drained 3/4 cup frozen whole kernel corn 1 8-oz. jar taco sauce 1 Tbsp. chili powder 1 small head lettuce, torn into pieces (about 8 cups) 2 medium tomatoes, chopped 1 large green pepper, chopped 3/4 cup shredded reduced-fat sharp cheddar cheese (3 oz.) 4 green onions, thinly sliced Salsa (optional)

* Prepare Tortilla Cups; set aside. Prepare Tomatillo Guacamole; chill. In a medium skillet cook beef and garlic till beef is brown. Drain off fat. Stir in kidney beans, corn, taco sauce, and chili powder. Bring to boiling; reduce heat. Cover; simmer for 10 minutes.

* Meanwhile, in a large bowl combine lettuce, tomatoes, green pepper, cheese, and green onions. Add beef mixture; toss to mix. To serve, divide lettuce mixture among Tortilla Cups. Top each with Tomatillo Guacamole and salsa, if desired. Makes 6 servings.

Tortilla Cups: Lightly brush six 9-or 10-inch flour tortillas with a small amount of water or spray nonstick coating onto one side of each tortilla. Spray nonstick coating into 6 small oven-safe bowls or 16-ounce individual casseroles. Press tortillas, coated side up, into casseroles. Place a ball of foil in each tortilla cup to help hold its shape. Bake in a 350 [degrees] oven for 15 to 20 minutes or till light brown. Remove foil. Cool; remove Tortilla Cups from bowls or casseroles. If desired, cups can be made ahead and stored in an airtight container for up to five days.

Tomatillo Guacamole: Rinse, drain, and finely chop 4 canned tomatillos (about 1/3 cup). (Or, simmer 2 husked tomatillos, about 3-1/2 ounces, in boiling water for 10
minutes. Drain and chop.) In a small mixing bowl combine tomatillos; 1/2 of a small seeded, peeled, and chopped avocado (about 1/2 cup); 2 tablespoons chopped canned green chili peppers; and 1/8 teaspoon garlic salt. Cover and chill up to 24 hours. Makes about 3/4 cup.

**SPAGHETTI ALLA CARBONARA**

You'll love the creamy, smoky flavor! 8 oz. linguine or spaghetti Nonstick spray coating 2 slices turkey bacon, sliced crosswise into strips 1 beaten egg 1 cup evaporated skim milk 1/2 cup frozen peas 1/4 cup chopped red sweet pepper 1/2 tsp. crushed red pepper 1/2 cup freshly shredded or grated Parmesan cheese (about 2 oz.) Black pepper

* Cook linguine or spaghetti according to package directions.

* For sauce, in same saucepan combine egg, evaporated skim milk, peas, sweet pepper, and crushed red pepper. Cook and stir over medium heat just till the mixture coats a metal spoon (about 6 minutes). Do not boil. Stir in bacon and half of the Parmesan cheese. Heat through.

* Immediately pour over hot, cooked pasta; toss to coat. Transfer to a warm serving platter. Sprinkle with black pepper and remaining Parmesan cheese. Serve immediately. Makes 4 main-dish servings.

**GREEK SPANAKOPITA**

Span-uh-KOH-pee-tuh is phyllo pastry stuffed with spinach, feta cheese, eggs, and seasonings-- 2 lb. fresh spinach leaves or two 10-oz. pkg. frozen chopped spinach, thawed 1-1/4 cups chopped onion 2 cups low-fat cottage cheese, well drained 1 cup crumbled feta cheese (4 oz.) 1 8-oz. carton frozen egg product, thawed (1 cup) 1/3 cup quick-cooking rice 2 Tbsp. snipped fresh basil or 2 tsp. dried basil, crushed 1/4 tsp. salt 1/8 tsp. ground nutmeg 1/8 tsp. pepper Nonstick spray coating 3 sheets frozen phyllo dough (18 x 14-inch rectangles), thawed 2 tsp. margarine or butter, melted

* Wash, stem, and chop spinach, if using fresh. In a large saucepan cook fresh spinach, covered, in a small amount of boiling water 3 to 5 minutes. (Do not cook frozen spinach.) Drain fresh-cooked or frozen-thawed spinach well in a colander, pressing with the back of a spoon to force out excess liquid; set aside.

* In a small skillet cook onion in small amount of boiling water, covered, till crisp-tender; drain. In a large mixing bowl combine the spinach, onion, drained cottage cheese, feta, egg product, uncooked rice, basil, salt, nutmeg, and pepper.

* Spray a 13x9x2-inch baking dish with nonstick coating. Spread the spinach mixture in the dish. Spray one sheet of phyllo with nonstick coating; fold in half crosswise. Place atop spinach mixture. Spray the top of the sheet again lightly with nonstick coating. Repeat with remaining sheets of phyllo dough. Brush the top layer with melted margarine or butter.

* Bake in a 375 [degrees] oven for 40 to 45 minutes or till golden. Let stand for 5 to 10 minutes before cutting into triangles or squares. Makes 8 main-dish or 16 to 20 appetizer servings.

**TURKEY ENCHILADAS**

Toasted pecans add rich flavor to the filling. To toast them, place the pecans in a small skillet and cook over medium heat, stirring often, for 5 to 7 minutes or till golden--
1/2 cup chopped onion Nonstick spray coating 1/2 of an 8-oz. pkg. light cream cheese (Neufchatel), softened 1 Tbsp. water 3/4 tsp. ground cumin Salt (optional) 4 cups chopped cooked turkey or chicken 1/4 cup chopped pecans, toasted 12 6-inch flour tortillas 1 10-3/4-oz. can reduced-sodium condensed cream of chicken soup 1 8-oz. carton reduced-calorie dairy sour cream 1 cup skim milk 1 or 2 Tbsp. pickled jalapeno pepper strips, finely chopped 1/2 cup shredded reduced-fat sharp cheddar cheese (2 oz.) Snipped cilantro or parsley (optional) Chopped tomato and green sweet pepper (optional)

* In a small skillet cook onion, covered, in a small amount of water over medium heat till tender; drain.

* For enchiladas, spray a 13x9x2-inch baking dish with nonstick coating. In a small mixing bowl stir together cream cheese, water, cumin, and salt to taste, if desired. Stir in cooked onion, turkey or chicken, and toasted pecans.

* Meanwhile, wrap tortillas in foil. Heat in a 350 [degrees] oven for 10 to 15 minutes or till softened. (Or, wrap tortillas in microwave-safe paper towels and micro-cook on 100% power [high] for 30 to 60 seconds or till softened.)

* Spoon about 1/4 cup turkey mixture onto each tortilla; roll up. Place, seam side down, in the baking dish. For sauce, in a medium mixing bowl combine soup, sour cream, milk, and chili peppers; pour over enchiladas.

* Bake, covered, in a 350 [degrees] oven about 40 minutes or till heated through. Sprinkle enchiladas with cheddar cheese. Bake, uncovered, for 4 to 5 minutes more or till cheese is melted. Top with snipped cilantro or parsley, tomatoes, and green pepper, if desired. Makes 12.

BREAKFAST CASSEROLE

6 slices whole wheat bread Nonstick spray coating 1/2 lb. ground turkey sausage 1 medium red or green sweet pepper, chopped (about 3/4 cup) 1/2 cup chopped fresh mushrooms 4 oz. shredded reduced-fat sharp cheddar cheese (1 cup) 1 10-3/4-oz. can reduced-sodium condensed cream of mushroom soup 1 8-oz. carton frozen egg product (1 cup), thawed 1 cup evaporated skim milk 3/4 tsp. dry mustard 1/8 tsp. pepper

* Cut bread into cubes; place in a large, shallow pan. Bake in a 350 [degrees] oven for 8 to 10 minutes or till toasted, stirring once. Spray a 12x7-1/2x2-inch baking dish with nonstick coating. Place half of the bread cubes in the baking dish; set aside.

* Meanwhile, in a large skillet cook sausage, sweet pepper, and mushrooms over medium-high heat till sausage is brown. Drain off fat. Pat vegetable mixture with a paper towel to remove excess fat. Spoon mixture atop bread cubes in dish. Sprinkle with half of the shredded cheese. Top with remaining bread.

* In a medium mixing bowl combine soup, egg product, evaporated milk, mustard, and pepper. Pour over bread, pressing down cubes with back of spoon, to moisten. Cover; chill for at least 2 hours or for up to 24 hours.

* To serve, bake in a 350 [degrees] oven for 30 minutes or till a knife inserted near the center comes out clean. Sprinkle with remaining cheese. Bake 2 to 3 minutes more. Let stand for 5 to 10 minutes before serving. Serves 6 to 8.

BEEF STEW WITH SOUR CREAM BISCUITS

In order to counter the amount of sodium in the bouillon, we used low-sodium tomato paste-- 3/4 lb. boneless beef top round steak, cut into 1/2-inch cubes 1 Tbsp. all-purpose flour Nonstick spray coating 1 cup chopped onion 3 medium potatoes, cubed 1 14-1/2-oz. can Italian-style stewed tomatoes 1/2 of a 6-oz. can low-sodium tomato paste
*(1/3 cup) 2-1/2 cups water 2 tsp. instant beef bouillon granules 1 Tbsp. sugar 1 tsp. dried thyme, crushed 1 tsp. Worcestershire sauce 1 bay leaf 1 cup cubed eggplant, peeled, if desired 1 recipe Sour Cream Biscuits (see recipe, page 136) 1/3 cup reduced-fat dairy sour cream 1 Tbsp. all-purpose flour 2 tsp. milk 1 tsp. sesame seed (optional) Fresh thyme (optional)*

* In a plastic bag combine meat and the 1 tablespoon flour; shake to coat meat. Spray a 4-1/2-quart Dutch oven with nonstick coating. Add meat and onion; cook till meat is brown and onion is tender. Drain off any fat. Add potatoes, undrained tomatoes, tomato paste, water, bouillon, sugar, thyme, Worcestershire sauce, and bay leaf.
* Bake, covered, in a 350 [degrees] oven for 1 hour. Add eggplant. Cover and bake for 30 minutes more.

* Meanwhile, prepare Sour Cream Biscuits. Remove stew from oven; increase oven temperature to 425 [degrees]. Discard bay leaf. Combine sour cream and remaining 1 tablespoon flour; stir into stew. Brush biscuits with milk. Sprinkle with sesame seed, if desired. Arrange cutout biscuits atop meat mixture. Bake, uncovered, for 20 to 25 minutes or till biscuits are golden. If desired, garnish each serving with fresh thyme. Serves 6.

Sour Cream Biscuits: In a large mixing bowl stir together 1-1/4 cups all-purpose flour and 1-1/2 teaspoons baking powder. Cut in 1/4 cup margarine or butter till mixture resembles coarse crumbs. Stir in 1/3 cup reduced-fat dairy sour cream and 1/4 cup skim milk. On a lightly floured surface knead dough 8 to 10 times. Roll or pat to 1/2-inch thickness. With a 2-inch biscuit cutter, cut dough into circles. Makes 12 biscuits.

SHRIMP CURRY
2 lb. fresh or frozen large shrimp in shells 1/2 cup chopped onion 1 Tbsp. margarine or butter 1 Tbsp. curry powder 4 medium carrots, bias-sliced 1/4 inch thick 1/2 cup water 1 tsp. instant chicken bouillon granules 1 12-oz. can evaporated skim milk 3/4 cup buttermilk 3 Tbsp. cornstarch 2 Tbsp. lemon juice 1/2 cup chopped green pepper Hot cooked brown rice Assorted condiments, such as 2 bananas, sliced; 1/2 cup drained pineapple chunks, coarsely chopped; 1/4 cup golden raisins; 1/2 cup chutney and/or 1/4 cup unsweetened coconut (chopped if pieces are large) or coarsely chopped peanuts
* Thaw shrimp, if frozen. Peel and devein. Cut down the back of each shrimp, cutting completely in half.
* Meanwhile, in a large saucepan or Dutch oven cook onion in margarine or butter till tender. Stir in curry powder; cook and stir for 1 minute over medium-low heat. Stir in carrots, water, and bouillon granules. Bring to boiling. Cook, uncovered, about 10 minutes or till carrots are just tender.
* In a small mixing bowl stir together the evaporated milk, buttermilk, and cornstarch; add to saucepan. Stir in lemon juice, 1/4 teaspoon salt, and 1/8 teaspoon pepper. Cook and stir till thickened and bubbly. Add shrimp and green pepper; return to boiling. Cook and stir 2 minutes more or till shrimp turn pink. Serve shrimp mixture over rice. Serve with desired condiments. Makes 8 servings.

FROM PARTNERS TO PARENTS

by Nancy Rubin
One night, John Kemper arrived home from work to find his wife, Priscilla, tearful and exhausted. Their infant son, Adam, was still not sleeping through the night, and because Priscilla was nursing, John was unable to give their baby his late-night feedings.

"Why not let me give Adam a bottle every other night?" John asked his wife gently. Although Priscilla had refused John's earlier offers, she accepted this one. Within a few days, Priscilla felt more energetic and John began to look tired. But the dark rings under John's eyes were easily compensated for by his pride in caring for Adam.

"It's our first opportunity to have man-to-man talks," John joked with Priscilla when she expressed concern about his lack of sleep.

That same night, Jenna and Chuck Ryder were finishing the dinner dishes when they heard their two and-a-half-year-old son, Bryan, crying in the living room. Jenna and Chuck exchanged a glance, and without missing a beat, Chuck tossed the dish towel on the counter and walked into the living room. Bryan was upset at being left out of a game his two older siblings were playing. Before long, Chuck returned to the kitchen carrying Bryan, dressed in his pajamas, so he could kiss Mom good night. While Jenna finished the dishes, Chuck read Bryan a bedtime story and then called the other children to bed. "It's taken ten years of practice, but my husband and I are a much better team today at 34 than we were at 24," says Jenna.

The Kempers and Ryders are only a few years apart in age, but they are at dramatically different stages as parents. The Kempers are just beginning to struggle with the concept of shared responsibility for their infant son. In contrast, the Ryders quickly and quietly manage their children by dividing the daily responsibilities.

Most of us are familiar with the various stages of childhood, but we may not realize that adults go through a parallel developmental process as parents. These stages reflect the natural progression we experience as we raise children to adulthood.

Each of these stages requires parents to develop different skills and sensitivities, to change and develop in response to the demands of their children's development. But in addition to our individual growth as mothers or fathers, having children forces us to change as couples.

"Children are a catalyst," says Candyce Smith Russell, Ph.D., professor of human development and family studies at Kansas State University, in Manhattan. Successfully meeting the challenges of each stage of parenthood can enrich a couple's relationship and bring them closer together. But there are risks, too, as well as the possibility that the couple may be pulled apart. As with child development, the stages are part of a continuum, each building on the previous one.

Stage 1: Imagining the infant.

It starts with pregnancy. When a couple learn they're expecting a baby, they daydream that their "perfect" child will have all their best personal features. They also idealize themselves as future parents, comparing themselves with their own parents and vowing to copy or reject certain aspects of their upbringing.

During this stage, too, a couple often have idealized expectations about the kind of mother or father the other spouse will be. As Ellen Galinsky writes in The Six Stages of Parenthood (Addison-Wesley), "The changes that the pregnancy brings in the couple's relationship ... are seen [by prospective parents] as an early indication of the changes to
come. Little episodes or encounters are judges as clues."

According to David Olson, Ph.D., professor of family social science at the University of Minnesota, in St. Paul, "The challenge of this stage is to get the husband connected with the infant, to get him involved in the birth process. Anything the two of you can do to cement the relationship in the beginning--like attending prenatal classes--will enhance the bonding of husband and wife. If a woman feels her husband was supportive in pregnancy and child-birth, they're off to a good start."

Stage 2: Nurturing.

The reality of the baby's arrival is usually far different from the idealized visions of pregnancy. The needs of the infant come first, and the parents' needs must be temporarily put aside. "The major task of this stage is to form an attachment to the baby," notes Galinsky. This includes finding the mother or father within oneself, an identity that did not exist before.

The changes during this stage are dramatic and can tax even the strongest relationship, since men and women experience new parenthood so differently. Donna and Larry Feldman, whose first child is now fifteen, tried to remember what they found most difficult about adjusting to parenthood. "The baby had trouble nursing," recalled Donna. "For some reason, she couldn't latch onto my breast, and she would scream and we'd both end up in tears."

"Not having sex for six months," said Larry emphatically. "That was the most difficult thing." Neither had any recollection of what the other considered "the worst part."

Adding a third person--a totally dependent one, at that--to an established twosome causes a major shift in couple dynamics and responsibilities. For some, this stage can bring hurtful surprises.

According to Helen Cleminshaw, Ph.D., professor of child and family development and director of the Center of Family Studies at the University of Akron, in Ohio, "Women typically want to communicate their stress to their husbands, while men may retreat from such discussions." Some men even begin to withdraw emotionally--putting more energy into their work, going out after work with friends, or acting helpless when it comes to caring for the baby.

Ten years ago, when Jenna Ryder asked Chuck to take their baby to the store with him so she could rest, he refused. "He said he wasn't sure he knew how to get her in the car seat, that it would be too hard to carry her around in the store--things that I had to do almost every day!"

We had a big fight," says Jenna. When Jenna cooled off, she realized that Chuck probably felt as scared and incompetent as she'd felt the first time she was alone with the baby. As she shared her feelings of insecurity and Chuck talked about his--their first frank conversation in weeks--they realized how much they had been keeping inside.

Experts believe that couples need to set aside time during this period--perhaps twenty minutes a night--just to discuss their feelings about their new roles so that each spouse knows what the other is experiencing. Such talks can even lead to more self-understanding.

Stage 3: Setting limits.

As children move from infancy to toddler and preschool age, the parents' role expands and changes too. Parents must learn to supervise and control their toddler while
allowing her to explore her environment and develop a sense of mastery.

Later, as the child becomes a preschooler, parents continue to socialize her--teaching her interpersonal skills and ethical values--and to exercise discipline. "Having a preschooler can be one of the most stressful periods for a marriage because the child takes so much time and energy," says Louise Guerney, Ph.D., professor of human development at The Pennsylvania State University, in University Park. Yet this stage can also increase couple cohesion. "For parents who are learning to work cooperatively, this can be a strengthening time for the marriage," she says. Parents are required to talk about such issues as discipline, setting limits, expectations, and standards for behavior--working out conflicts, making compromises, and learning more about each other in the process.

Lack of communication at this stage, however, can result in problems later in the marriage. Right from the beginning, for example, Mark Bello relegated the care of his three children almost entirely to his wife, Sarah. When problems arose, instead of talking with her and arriving at a mutually satisfying approach, he accused her of spoiling the kids. "At times I felt as if I had four children instead of three," says Sarah. Eventually, the couple drifted so far apart that they divorced.

"This is the stage at which parents need to work out a consistent style of handling their children," notes David Olson. "And they need to praise each other for the things they're doing well." For instance, when the Ryders' son Bryan knocked over the milk, Jenna -- rather than get angry -- gave him a sponge and showed him how to clean it up. Chuck let his wife know he was impressed with how she handled the situation. "You need to look for success in each other as well as in the child," says Olson.

This kind of cooperation relieves mothers of the full burden of caring for the children and deepens the parental experience for both partners. Fathers who are closely involved with their kids not only exert a profound influence on them but also have much more to share with their wives.

"It may seem obvious, but when both partners pitch in, parenthood is more likely to be a bond for the couple rather than a wall between them," Olson observes.

Stage 4: Mediating.

Eventually, as kids move into middle childhood and become heavily involved in school, sports, community activities, and friendships, parents who have developed a cooperative approach become even more adept at teamwork. During this stage, they must act as mediators between the school or neighborhood and their children, serving as parent volunteers in the classroom, as carpool drivers, and as social secretaries for the kids' play dates.

Parents usually rescue the demands of his stage by splitting some of the work and by taking care of the kids separately. "It's a very busy household," says Judy LaGrange, who has three children, ages six, eight, and eleven. "Someone always needs to be picked up from sports practice while someone else has a band rehearsal and the third, a dental appointment. But my husband and I have a deal. We trade off responsibilities on weekends and evenings. If I sit through one school meeting, he sits through the next. If I do the grocery shopping, he picks up the dry cleaning. The problem is, we only see each other at bedtime."

While middle childhood can be a "golden" time for parental cooperation, this stage can drain large amounts of time and energy from the couple's own relationship, which, without their awareness, may become absorbed into "the family." Although the
family identity is healthy and important to kids' stability, one real danger of this period experts say, is that the couple's romantic or private life gets pushed into a corner. Sometimes there simply isn't enough time or money to enjoy a night out on the town, enough hours in the day to sit and talk, or enough energy to make love.

"One reason there is a high divorce rate among parents with youngsters in middle childhood is that parents tend to be so busy with their children that they take the marriage for granted," says Olson. To avoid this trap, parents should make their relationship top priority. "Couples should make sure they get an evening alone at least once a week--so they can rebuild their intimacy as friends and lovers--rather than sacrifice all their time to taking care of the kids," he says.

Stage 5: Stepping back.

Gradually, as children enter adolescence and begin to pull away from their parents, they spend more time away from home, with friends. When they are home, they push for independence, even though they are not yet ready to assume adult responsibilities. At this stage, the parents must not only redefine their previous role by allowing kids more freedom but must also begin to see their children as individuals with ideas of their own.

For Don and Helen Franklin, parents of sixteen-year-old Stephanie, this means compromising on how neat she keeps her room and whether she attends every family function. As the Franklin see it, the biggest adjustment was learning to "step back." "We're there to help her if she needs it, but we are coming to understand that Stephanie's a separate person," says Don. "She has to work out many things on her own."

The delicate balance that parents of a teenager must maintain, between imposing their authority and letting their child experiment with independence, inevitably sparks tensions. "Adolescents demand less direct supervision from parents and at the same time more say in decisions about their well-being. This puts increased pressure on a couple," notes Olson. Although most adolescents do not get into serious trouble, Olson stresses, the daily hassles of teen behavior--such as not coming home on time, leaving things around the house, and failing to do chores--are still aggravating.

Not surprisingly, parents identify the teen years as the time when their level of satisfaction with family life is at its lowest. Because raising adolescents is hard and the rewards not as obvious as in middle childhood, the strong couple relationship you've built can provide you with much needed mutual affection, support, and communication.

"Parents need to do more to support each other and the marriage," asserts Olson. "And seeing a strong relationship between their parents is a good model for teenagers--they can learn how a good marriage works."

Stage 6: Launching.

When grown children leave home for college, jobs, or marriage, their parents must form new relationships with their as independent young adults. This can be a rough transition period for many people--especially for women, who may be struggling to find a role apart from motherhood.

Parents who use the opportunity to pursue personal interests and to renew their relationship as a couple usually find this last stage easier to manage. "Once the children are gone couples have the opportunity to relearn what it was they once found exciting in each other," observes Ellen Galinsky. In fact, the experiences and shared memories of the child-rearing years add a new dimension to married love; and, according to Olson,
many couples come full circle and reexperience the joy they shared with each other during the newlywed period.

At every stage of parenthood, Olson reiterates, "it's essential to talk to each other, to praise each other's successes, to let the other person know what you're going through. Don't put all your energy into the kids and leave nothing for the marriage. Most of all, kids need their parents to have a strong marriage." If you've got that, you and your children can weather any stage.

Nancy Rubin, a contributing editor of Parents Magazine, has been through almost all the stages of parenthood with her husband and two teenage daughters.

HOW TO NURTURE A POWERFUL, PASSIONATE AND ENDURING RELATIONSHIP

by Harold H. Bloomfield and Robert K. Cooper

Psychologists agree on two central truths about love: First, loving relationships are built, not found. And second, they have little - if anything - to do with luck and, contrary to popular wisdom, have absolutely nothing to do with being "made for each other." Experts also agree that lasting love - and the deep, often exhilarating shared experiences of intimacy and romance - may be kindled and sustained in innumerable small and varied ways.

And here are some of them - simple steps that may take only five minutes (or five seconds!) that if done consistently and with care can make all the difference in the world. Take five minutes at day's end to get in sync with your lover. There's just no denying it: Intimate relations are tied to a kaleidoscope of biological forces. Researchers have discovered a key relationship between sexual energy and the natural, ongoing influence of two biological cycles - the 24-hour circadian rhythm and the 60- to 90-minute ultradian rhythms. Successful, sexually satisfied couples tend to have overall activity patterns, appetite, need for diversion and sexual rhythms "all occurring in synchrony." In contrast, unsynchronized sexual-energy cycles produce some of the most frustrating sexual problems: When one of you is sexually aroused and sexually energetic, the other one isn't. Or when one of you is in the mood for comforting, nonsexual cuddling, the other desires exciting, active sex.

Years ago, at the end of the day in almost any town or village in Europe, America or Asia, you could see couples sitting together in rocking chairs or on a porch swing, gazing at the sunset, talking to each other, reflecting on the day. Without realizing it, says psychobiologist Ernest Lawrence Rossi, Ph.D., they were synchronizing their circadian and ultradian rhythms and increasing their sexual energy. The shared quiet time and rocking rhythm helped to lower their stress levels and reduced the odds that tensions or frustrations would be imposed from one mate to another.

Today, more and more couples rush home, hurry to prepare dinner, flip through the newspaper, eat quickly and then either collapse for the evening in front of the television or plunge into another round of scheduled activities - nightly errands, exercise sessions, parental duties, catching up on paperwork, preparing reports or paying bills. What's missing is a transition period - 15 or 20 minutes will do - to unplug from the commotion and sit together quietly, without the television on in the background, to tune
into each other's energy rhythms and recover together from the day's pace. Here are some of the ways to increase sexual synchrony:

* Kissing and greeting each other whenever leaving and arriving, thereby using the sensory power of touch to help align your energy cycles.
* Slowing down the pace when seated for the main meal and enjoying each other's dining companionship.
* Going for a shared early-morning or evening stroll.
* Spending time together fixing meals, doing dishes or puttering around the lawn or garden.
* Sitting together quietly, listening to music you both enjoy, sipping a cup of tea or a glass of wine.
* Stretching out on the sofa and holding each other - fully clothed, with nothing unsnapped, unhooked or unzipped - in a "spoon" position, with one person wrapping arms around the other from behind. The warmth and comfort of this sensual embrace strengthens the closeness between you and helps release stress.
* Sharing a warm bath or gentle, rhythmic massage for 15 to 20 minutes prior to sexual intimacy.

In each of these simple actions, powerful verbal and nonverbal cues are helping to synchronize your energy rhythms and renew and increase intimate bonds after time apart.

Enjoy five-second 'humor breaks.' Every love relationship has its own unique reservoir of humor. Private jokes, shared laughter, ticklish spots on the body, comic faces, favorite funny experiences together. Make it a point to find more moments to ignite this humor each day, to remember some of the comical situations you witnessed or created during the day. Usually there are lots of humorous little events and situations. Share these with each other! A study by Avner Ziv and Orit Gadish, professors of psychology at Tel Aviv University in Israel, suggests that 70 percent of a married couple's satisfaction may depend in some way on humor - on making each other laugh and feel happy despite life's ups and downs.

Use generous listening. One of the reasons that love wanes is neglect, and one of the principal kinds of neglect is the inability to listen well. In many cases, the number-one way a man may succeed in fulfilling a woman's primary love needs is through communication. "By learning to listen to a woman's feelings," explains John Gray, Ph.D., author of Men Are From Mars, Women Are From Venus (HarperCollins, 1992), "a man can effectively shower a woman with caring, understanding, respect, devotion, validation and reassurance."

One of the simplest, most effective ways to enhance your listening abilities and warm up your dialogues may be to ensure that you and your partner eat something before having important conversations. Low blood sugar causes epinephrine (adrenaline) release in your bloodstream and, according to some authorities, may make your temper short, your frustrations higher and reasoned thinking very difficult. After eating a healthy meal or snack, you'll often be better able to head off arguments and listen more attentively and lovingly.

Share a five-minute snuggle at least once a day. Of all the ways in which people need each other, holding is the most primary, the least evident and the hardest to describe, says Ruthellen Josselson, Ph.D., professor of psychology at Towson State University in Maryland, and author of The Space Between Us: Exploring the Dimensions of Human
Relationships (Jossey-Bass, 1992). "From the first moments of our life to the last, we need to be held - or we fall." There are physical and emotional aspects of holding, Dr. Josselson explains. "Holding not only provides care and meaning; it also provides hope." So make it a point to loosen up a bit and spend time just holding your partner - in a caring but nonsexual way.

Relate eye-to-eye. One of the most important ways we affirm our connection to loved ones is eye-to-eye. No matter how old you become, you never cease to need unconditional, simple valuing in another's eyes - and in our own eyes. "These looks," says Dr. Josselson, "are far beyond words: Eyes speak more profoundly than language the tenor of relatedness. The express, surely and absolutely, how much and in what way we matter to the other."

End 'unconscious exits.' A related way that man of us lose romance and kill intimacy is by making detours in and out of the time we spend together. Beyond eye-to-eye validation, reduce the bothersome "exits" that drive apart, such as staying up late, night after night, watching television while our partners are in bed; making long business calls in the evening and on weekends; not paying attention when your partner talks ("tuning out"); or making plans without consulting loved ones first. Consider bringing this out into the open by writing a simple agreement: "Beginning now, I agree to give our relationship more energy and attention. In particular, I agree to..." and then make a brief list of simple changes you could make that your partner would value. Strengthen your love with five-second validations. For many of us, some of the best relationship advice is "Worry a bit less about what you think is important - money problems, career track, the annual vacation - and pay more attention to the little things." Begin with the power of validation. "Letting your spouse know in so many little ways that you understand him or her is one of the most powerful tools for healing your relationship," Gottman, Ph.D., professor of psychology at the University of Washington in Seattle. "Validation is simply putting yourself in your partner's shoes and imagining his or her emotional state. It's then a simple matter to let your mate know that you understand those feelings and consider them valid, even if you don't share them. Validation is amazingly effective. It's as if you opened a door to welcome your partner."

Validations - some requiring as little as five seconds - can lead to genuine empathy and understanding. Few things make a person feel more valued and loved. You can increase empathy in ways like acknowledging responsibility ("Yes, I know this upsets you." "It feels like I really made you angry. Did I?") and apologizing ("I'm sorry. I was wrong"). Grow closer by expressing five seconds to five minutes of appreciation. Once you're making progress with validation, take a look at the power of appreciation. How many times has your day been brightened by one small, unexpected gesture of appreciation or caring? Unfortunately, many men think they make "points" with their partners when they do big things like buying a car, replacing the refrigerator, setting up a new stereo or taking the family on a vacation. At the same time, many men assume that little things - opening doors, sharing loving glances, giving hugs or kisses, saying "I love you," sitting close together when watching a movie or television, checking with each other first before making plans, holding hands, saying "You look great," buying flowers or writing thank-you notes - count very little when compared with the "big things." But there is evidence that when many women keep score, no matter how big or small a gift of love or caring is, it scores a point.
"You will survive major calamity, disaster and death," says psychiatrist William Nagler, M.D. "You will not survive leaving the top off the toothpaste tube on a daily basis. The toilet seat left up, often enough, can kill you. That pile of clothes on the floor can be fatal. The little things are everything in terms of tension reduction. The casual details of everyday life are what allow long-term relationships to survive."

To help bring this concern to the fore, spend a few minutes doing sentence completions, such as: "I feel valued and loved when you..." and "I used to feel valued and loved when you..." and "To feel more valued and loved I would like you to..." When you finish, exchange lists - and circle the items that are conflict-free for you and that you would be willing to start doing more of. You can add ideas as they arise and express appreciation to each other for each new caring behavior that results. Don’t keep score - do your caring behaviors as gifts, not obligations, and do them no matter how you feel about your partner or how many caring acts he or she has done for you that day.

Here’s another love-building exercise: Arrange for five minutes in private to tell your partner many of the specific reasons you appreciate him or her. What meaning and inspiration can you and your spouse find in the detailed history of your relationship? Make a list ahead of time so you can "bathe" your loved one in appreciation. Some suggestions: What attracted you to your lover in the first place? What specific qualities about him or her do you admire the most? What were some of the highlights - and moments of laughter and fun - when you first began dating? How did your partner help the two of you overcome any differences or obstacles along the way? Once you’ve made a list of specific experiences and qualities that you appreciate in your loved one, share the results. One rule: The partner who is listening must not make judgments or negate any of the appreciative comments ("I'm not really that considerate...." "I never looked that sexy; besides, now I've got to lose 10 pounds....") Then find another time to trade roles. This simple exercise helps you stop taking each other for granted and can effectively reawaken an awareness of the qualities in your partner and yourself - that form the shared, sometimes hidden, foundation of your love.

Use ‘I love you’ as a heartfelt phrase-not a verbal club. In most cases, to say "I love you" is not to report or express a feeling of intimacy or passion. "It is an aggressive, creative, socially definitive act," says Robert C. Solomon, Ph.D., professor of psychology and philosophy at the University of Texas at Austin. Dr. Solomon notes in his book About Love: Reinventing Romance for Our Times (Littlefield Adams, 1994), that the expression "I love you" is essentially a plea, sometimes a demand, for a response in kind. Its uses and meanings are nearly as varied, or elusive, as lasting love itself. These three words can be an instrument - more powerful than the loudest noise - to interrupt a boring silence or painful conversation. Saying "I love you" can serve as a threat ("Don't push me on this; you might lose me"), a warning ("It's only because I love you that I'm willing to..."), an apology ("I could not possibly have meant what I just said to you"), a verbal signal ("Pay attention to me!"), a disguised invitation for sex ("I love you" whispered while nodding at the bedroom door), an excuse ("It's only because I love you...") or an attack ("How can you do this to me?").

How you use the expression "I love you" can, by itself, be a significant force in defining and expressing the love in your relationship. The best advice? Initiate the reciprocal romantic exchange - "I love you," "I love you, too" - only when you can mean it heart-to-heart. Find other ways - and alternative expressions - to draw closer to each other and
clearly assert your needs.

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PRENUPTIAL AGREEMENTS MAKE HAPPIER MARRIAGES.
by Meredith Gould Ruch

By expressing my husband's and my shared beliefs, our "contract" has helped us to resolve problems as they arise.
We'd been married just six months, but the atmosphere in our home was already dark with dispute, disappointment, and the fallout of prior marriages. We were such a decent, loving couple, I couldn't believe the cloud cover we'd managed to generate.
My husband turned to me one morning after our zillionth inane argument and announced it was time to get into therapy. I said flatly, "No way." He responded with one word that overruled me: "Contract."
Before we got married, my husband and I had agreed that we would get outside help for our relationship if either of us felt we needed it. This was just one condition of a written agreement that we had the foresight to create in advance of exchanging vows. Our marital agreement represents a consensus we had already reached. The purpose was to provide a vehicle to resolve any future confrontation. I had no choice the morning my husband called for therapy. I joined him in the search for a therapist who, by the way, soon got us back on track.
Every partner brings to marriage a set of values--and strong views--about appropriate roles and behaviors. Ideally, these attitudes move from background to foreground during courtship as we explore with our prospective partner how we feel about such things as sex, money, work, children, in-laws, and chores. Oftentimes, though, the marriage "contract" is not explicit, and conflicts inevitably arise: "You never told me you hated cooking." "Who decided I'd do all the yardwork?" "When did we decide to watch television during dinner?"
My husband and I decided to address these kinds of questions at the outset of our marriage (the second for each of us). We knew we didn't want a contract that read like a list of hostage demands. Nor were we interested in a legally-binding agreement that coldly divided our financial assets in advance. We wanted to blend romance with pragmatism, without being too nit-picky or legalistic. We wanted tangible evidence of our shared beliefs.
One night we holed up at home, fortified with plenty of popcorn and chocolate, and we worked out a set of "conditions" and "preferences." What we created was a statement of guiding principles for living our lives together. In addition to a few standard clauses about sexual exclusivity and joint decision-making, we drafted others that express who we are and who we hope to become. Any couple planning marriage can create an agreement that addresses whatever they decide is important to their marriage. Here are the conditions of our agreement that so far have played a role in building a successful marriage.
The well-being of our relationship will always come first. If there's one fundamental condition, this is it. Each time we put our relationship first, we enhance the "us" we've created through marriage. Choices get simple when we practice this. Over time we've gotten better at letting go of anything that conflicts with the welfare of our marriage. For example:

* My first husband ended our marriage in part because I chose post-graduate work over him. This time, I decided to at least postpone taking a demanding course of study, because it would have taken a lot of time from the first year of my marriage.

* Preserving the well-being of our marriage sometimes calls for us to do things separately. Once, instead of joining me on a trip and being miserable, my husband stayed home and puttered around the house. The time apart gave our marriage the fresh air it needed.

* We blended bank accounts, because building trust was more important to us than having financial autonomy.

* Having separate hair dryers absolutely supports the well-being of our relationship.

We've used this principle to sort through such issues as whom to invite for a weekend, where to stay when visiting relatives, and even how to divide desert. I believe we have a built-in protection against putting our individual welfare above the health of our partnership.

We are willing to try anything with each other at least once. My husband insisted we include this provision. I've claimed that I never agreed to it, which irks him to no end. A homebody at heart, my husband is adventuresome in a Walter Mitty-esque way, which is to say, in his head. Nevertheless, I worried about being forced into activities I couldn't veto. I had tried plenty of adventures in the 1970s that I wasn't about to try ever again, even--or perhaps especially--with my husband. My fear faded once I realized we made this condition primarily to experiment with food, rather than try anything kinky or illegal.

To my surprise and his initial horror, I'm the one who may invoke this agreement first. We have an opportunity to live in a spiritual, co-housing community for a year, and I think I want to do it. My husband thinks he does, too, but having never tried it before, he's understandably nervous. I haven't quite said "contract" yet, but I just might.

Now I understand why he wanted this included--it promotes adventure in a safely contained way and opens up possibilities we might not otherwise consider.

We will go to sleep with as much completion as possible.

Lots of couples have a "never go to sleep angry" rule. We realized how absurd this was after arguing all night, then collapsing into bed with nothing resolved. We also realized that rushing to end a dispute by bedtime--as if we'd turn into pumpkins otherwise--usually creates a false sense of resolution.

Our contract recognizes that some issues will take a few days to play out. There's something to the adage, "Let's sleep on it." I'm a night person, so this agreement also lets my husband say "enough for now" without being accused of a capital crime.

We will kiss each other good morning and good night.

We tossed this one in without realizing how rewarding it might be. The great thing about this agreement is that it unhooks caring from mood, and connects it instead to commitment.
My husband and I kiss each other at the endpoints of each day, not as a reward for exemplary marital behavior, but because we believe we benefit from consistently expressed affection. Oh, sure, those kisses are awfully perfunctory at times, but they're there, reminding us that we are, too.

We will always give each other another chance.

If my husband and I have learned anything in our lives, it's that we all make mistakes. Instead of assigning blame or punishment, we believe forgiveness is much more healing. I cannot remember ever specifically citing this condition, but I'm convinced its presence in our contract has done a lot-to create the safety and security we both crave. Imagine living with the constant promise of another chance. This clause, by the way, does not eliminate how each of us feels about the other forgetting a birthday or not balancing the checkbook. But it does eliminate blame and groveling.

Now into our second year of marriage, we've had an opportunity to put most of these provisions into play. What started out as an evening's project has evolved into a living document that seems to grow right along with us, and I'm convinced our marriage is more durable and flexible as a result.

**TALKING WITH YOUR DOCTOR: COMMON PROBLEMS,**

**UNCOMMON SOLUTIONS: COMMUNICATING EFFECTIVELY WITH YOUR DOCTOR**

by Larry Moore

This article concerns the many problems that regularly occur in talking with doctors, and what you can do about them.

Common Communication Problems

We have all either heard about, or experienced, these problems:

* We are interested in our well being, but often we simply do not know what to ask. Most of us, from factory workers to top business executives, are unaccustomed to talking with a doctor. Additional stress factors are that usually we don't have any clothes on (as contrasted with the doctor dressed in an authoritarian "uniform") and that we may alread be worried about our health and our future.

* Doctors use so may technical terms, and go over them so rapidly, that we do not fully understand what is being explained.

* We return home from the doctor's office and are unable to explain to our spouse what the doctor said. The spouse proceeds to ask some very logical questions, to which we have no answers. We only wish that we had thought of those questions while we were seeing the doctor.

* Doctors are cold, abrupt, and give us signals that they really prefer that we not ask questions.

* Doctors appear so buy and important that we are hesitant to ask questions that
are important to us.

Uncommon Solutions
You Can Use

Many of the following suggestions are uncommon, in that, while they are simple, they are used by only a small percentage of patients:

* Prepare a list of questions before visiting your doctor.
  Discuss your list of questions with a loved one or a close friend. Since they see your illness from a different perspective, they may be able to offer additional questions or improve the ones you already have.

* Don't ask "leading" questions.
  Be careful how you ask a question if you really want honest answers. "Leading" questions can cause the doctor to give the answer you want to hear, even if it isn't true. For example, "I'm going to be okay, aren't I?" implies that you really do not want to hear any bad news. If you want the doctor's honest opinion, try asking an "open-ended" question such as, "Doctor, what is my prognosis?" An open-ended question asks for facts or opinions without indicating the answer you hope to hear.

  Asking a surgeon, "Have you performed very many of these operations?" may automatically lead him to respond that he has, which really doesn't give you much information. An open-ended question, such as "How many of these operations have you performed in the past twelve months?" asks for information which you can then evaluate.

* Take notes during the visit.
  Sometimes we feel awkward in taking notes. But usually it is just a matter of getting accustomed to it. If you were buying a house or a car, often you would take notes. Visiting the doctor can be far more important.

* Take a loved one or close friend with you.
  Having someone else along with you can reduce the stress associated with seeing the doctor, and help you to understand what is said. Sometimes a patient's recollection isn't what was actually said, but what he wanted to hear. The person who accompanies you should have three main qualities: the ability to give emotional support, the capacity to listen and remember accurately, and the skill to think objectively.

* Visualize what's being explained to you.
  Ask your doctor to show you an illustration in one of his medical books that will help you understand where your problem is. Ask for a copy of the illustration. Ask how tests and operations will be performed.

* Ask for explanations in terms familiar to you.
  It is only after you understand what is being said that you will be an effective partner in your treatment and recovery.

* Rephrase your questions and/or the doctor's answer.
  If you do not understand the doctor's answer, ask the question in a different way, or ask him to explain the answer in a different way.

* Verbalize what you heard.
  Repeat to the doctor what you thought he said. That gives him an opportunity to clear up any misunderstanding.

* Take a miniature tape recorder with you.
  Ask your doctor in advance if he would mind if you record the conversation. Explain that it would help you better to understand and to follow his advice. It can allow
you to be more relaxed when seeing the doctor, since it will free you from note taking. It will not, though, free you from the responsibility of paying close attention and asking questions when necessary.

In one study, hospital discharge interviews between forty-eight patients and their doctors were tape recorded. When the patients were later surveyed to determine if the recordings had been helpful, the responses were highly favorable: 91% thought the recordings helped them understand the doctor's discussion, 75% found it helpful to have their loved ones listen to the tape, and 86% believed the taped interviews improved their health care.

* Ask how you can learn more. Your doctor may be able to refer you to printed material, a video, or other resources to help you understand the procedure or treatment being explained.
* If you don't follow any of the above suggestions, you can at least remember this:

We all have times when we're just not "up to" following these suggestions. Or, we may think they are unnecessary for a "routine" doctor's visit. Then, we get caught off guard, hearing more from the doctor than we had anticipated. Like a news media reporter, always remember that you have the opinion to ask:

  - Why?
  - Why Not?
  - What?
  - How?
  - When?

* Be open with your doctor.

If you are having difficulty communicating with him, ask how you can work with him to solve the problem. If this is stressful to do, you might discuss the problem with his nurse, asking her to be an intermediary in solving the situation for everyone's benefit.

* As a last resort, consider changing doctors.

If significant communications problems can not be resolved, consider whether you want to continue such a relationship on a long-term basis. Above all, do not feel guilty or hesitant about changing doctors if you really want to do so. He'll get over it.

INTIMACY: WHO HAS IT, AND WHY?

Intimacy comes in three flavors: physical, emotional, and sexual. And some couples mix them up. You may be asking for more intimacy and you mean you want to talk more. That's emotional intimacy. He may be saying he wants more intimacy and he means he wants more sex.

Dr. Ellyn Bader, psychologist and cofounder with her husband of The Couples Institute in Menlo Park, California thinks that midlife women have the best potential for intimacy. "Mid-life changes create psychological stress that can become the impetus for very positive change. It can also go the other way," she admits, "when people aren't able to address the problems successfully.

"Usually in the couples I see in therapy," she says, "it's the woman who is asking for more intimacy. However, by the time they get here, the woman, who thinks she is
expressing her feelings, is actually criticizing and attacking her partner. She's been hurt and disappointed because her partner hasn't interacted like a woman. She says, 'I hate you and you're terrible and you did this and this and this to me.' She believes she is being intimate. If that same woman could say to her partner: 'I'm very lonely. I'm missing the kind of interactions that feel good to me. I feel isolated and sometimes I wonder if I can be heard in this relationship.' If she can talk about herself and not her partner, the interaction will be more intimate.

"Emotional intimacy comes about in two ways. One member of the couple is open enough to share their feelings, their dreams, their desires, their hopes, their fears. They make that an ongoing part of their interaction. The other side of that is that intimacy is built and developed when a partner can ask questions and take the interaction deeper rather than taking comments personally and becoming reactive.

"Recently, I had a couple in my office," Dr. Bader explains, "and the man said, 'I want to move back to the East Coast.' The woman was hysterical in 30 seconds. She doesn't say to him, 'Tell me more about why you want to move back to the East Coast. What does that mean to you? What do you think you will get out of it? What is it that is missing here for you?' These kinds of questions would promote and develop more intimacy between them.

"There's a key interaction that goes on in most couples over and over again. And that is that there is a moment of opportunity for intimacy, but a partner takes a comment personally and it gets turned into a fight or a power struggle and the moment for intimacy is lost.

"In a regular couple's home on a regular evening, one partner puts something out for which there would be potential for deeper intimacy, and the partner responds in a way that doesn't promote or enhance it, and, in fact, might squelch it. And then you have that happening 10 or 15 times in a week. With many couples you can walk into their living room and watch that happen."

One idea that Bader stresses is that intimacy in a couple's relationship is not contingent upon the commitment of both partners to intimate communications. "To be open with your partner in an ongoing way is not dependent on what your partner does. This means that you will tell them about your feelings, your hopes, your dreams, your fantasies and you won't make that contingent upon what your partner does. Very few people who come into therapy are that mature. They make their communication contingent on what their partner does. This puts a very low feeling on how far intimacy in the relationship can go.

"For example, I had a woman who thought that all her husband ever wanted was sex. 'All he ever wants is sex. That's all he's ever after.' I had her ask him a series of questions about what sex meant to him. By the end of the discussion, she was blown away by the things he said that she had never known. He described how he thought about her during the day and really appreciated the things she did for him. To him having sex with her was a way to show her his appreciation. These were things she had never imagined. She thought he was just trying to get his rocks off."

Sexuality Is Another Area That Might Benefit from a Mid-life Review According to Barbara Golden, MSW, a 52-year-old therapist in private practice in New Haven, Connecticut, mid-life women often come into her office because they have a change in their sexual experience, which may involve desire, ability to respond to stimulation, or
orgasm, all possible side effects, it seems, of lower estrogen. (We might wish we had a better idea of the percentage of women who have these problems, but that information is hard to come by because of faulty study designs or lack of studies. Most professional sex therapists will send you back to Kinsey, circa 1956, for statistics. We've certainly learned much since then, but as Golden said, "We should be spending some money on government studies to find out what people do.")

When working with a woman with changed sexual experience, Golden takes a thorough sexual history, attempting to learn what has changed--when was the woman satisfied. She tries to sort out how it is different now, and what she is noticing. "I try to find out what her function was like before and what was going on that got her off-track. Then the question is: how do you help her get back on-track?"

Golden, using herself as an example, said that her lower estrogen definitely affected her sexual response despite having read that that wasn't necessarily going to be the case. "I had a major change in my ability to respond to sexual stimulation. I experienced vaginal atrophy very quickly so that intercourse was painful. I couldn't start HRT because of another physical problem that took a year-and-a-half to resolve. During that time, I couldn't have intercourse without lubricants, which made intercourse less painful, but not pleasurable. I need estrogen to respond now with an orgasm. With HRT, I got my sexual response back, and my desire returned. My hot flashes went away and I began sleeping at night. This made a big difference."

"Sometimes HRT is part of the solution and sometimes I help a woman look at her mid-life issues." Golden says that many women begin to lose sexual interest if they are involved in too much caretaking.

"The more they caretake, the less sexy they feel," she says. "Sometimes at this stage of life, women really need to have their consciousness raised about how they are going to take care of themselves sexually.

"Some women think sexual desire drops out of the sky. One day you wake up and you're horny and you don't know how it happened. They don't think about what they used to do that made them aware of desire. They might have read sexy books, thought sexy thoughts, or experienced themselves in a centrally sexy way. A woman may need to reorient herself and look at the conditions she needs to feel sexual and desirous, a feeling that comes from within. She may not be paying attention to it. She's too busy grocery shopping, trying to manage a family, and going to work.

"I have also found that women often need some kind of primary encouragement to represent and assert themselves. Some women have been sexually very fortunate. One woman I'm working with was easily orgasmic, and now she has to go uphill a little bit. This means that she is going to have to do more on her own behalf. She's gotten lazy. She has to learn to ask for specific stimulation. She needs to think more and to be more verbal. Ok, what would feel better for me now. She needs to respect herself and treat herself as though she has a right to continue to be sexual even though it might be more difficult. She can use her imagination, not for fixing everyone else in the universe, but for doing some of that in her own behalf. I try to help women not to jump off the train because they have run out of a little juice."

Golden has found in her practice that lesbian women seem to be able to maintain their sexual response and she believes this would be an interesting area for research. Maybe they are more accepting of menopausal changes or they have more oral or manual
stimulation.

When Golden was a cotherapist with Dr. Philip Sarrel, a leading sex therapist and researcher at Yale University Medical School, they found it was often a man who came into therapy, with erectile dysfunction. He would have noticed that his partner was lubricating less, and even though she might have been experiencing desire, he interpreted her loss of lubrication as a change in her feeling for him. "If the woman were treated with estrogen, his erection would come back if the situation had not gone on too long," they observed.

Golden is an advocate of checking estrogen levels if vaginal atrophy continues, or testosterone levels if loss of desire is a problem. "Some of the women I see on testosterone like feeling stronger. Some have acne, but they are willing to tolerate that to have their libido intensified. I've had that feedback from women. But it is important to monitor for side effects of lowered voice and hair growth."

**RECIPE MAKEOVERS**

by Elizabeth Alston

**STICKY HONEY-NUT BUNS**

You won't miss the fat in this recipe! For added flavor and looks, we added a cinnamon sugar swirl to the dough. If you use black steel muffin pans, the buns will have a deeper golden color.

**DOUGH**

1 envelope active dry yeast 
1/4 cup granulated sugar 
1 3/4 cups warm skim milk (105 [degrees] F to 115 [degrees] F) 
5 cups all-purpose flour 
1/4 cup calorie-reduced margarine (in a tub), melted 
Whites from 2 large eggs 
1/4 cup plus 2 teaspoons calorie-reduced margarine (in a tub) 
3/4 cup plus 2 tablespoons honey 
1/2 cup plus 4 teaspoons chopped walnuts 
1/4 cup plus 2 teaspoons ground cinnamon

1. Dough: Stir yeast and 1/2 teaspoon of the sugar into skim milk. Let stand 10 minutes or until foamy. (Foam assures you the yeast is active. If no foaming occurs, yeast is dead.)

2. Meanwhile mix remaining sugar and the flour in a large bowl.

3. Make a well in center of flour mixture. Pour in yeast mixture, margarine and egg whites. Stir with a wooden spoon until flour is incorporated and a soft dough forms (dough will pull away from sides of bowl).

4. Turn dough out onto a lightly floured surface. Knead about 5 minutes, until smooth and elastic, sprinkling surface with more flour if sticky.

5. Wipe bowl clean. Spray with vegetable cooking spray. Place dough in bowl and turn to oil all sides. Cover bowl with plastic wrap and let dough rise in a warm draft-free place about 1 hour until doubled.

6. Grease twelve 2 1/2-inch muffin cups and two 6-ounce custard cups.

7. Place 1 teaspoon margarine in bottom of each cup. Next add 1 tablespoon honey and 2 teaspoons walnuts to each cup.

8. Punch down dough and knead in bowl several times. Turn out onto lightly floured surface and roll into a 21/12-inch rectangle. Sprinkle with the cinnamon sugar. With a long side facing you, roll dough tightly lengthwise, jelly-roll style. Cut crosswise
into 14 pieces.
9. Arrange cut side down in prepared muffin cups. Let rise in warm place 50
minutes or until doubled.
10. Meanwhile heat oven to 350 [degrees] F. Place muffin pan and custard cups
on a cookie sheet to catch potential drips. Bake 35 to 40 minutes until golden brown.
11. Invert muffin tin and custard cups on a cookie sheet. Slowly lift up pan and
cups, allowing any excess honey to drip onto buns. Cool 15 minutes. Serve warm.
* Makes 14. Per bun: 334 cal, 7 g pro, 61 g car, 7 g fat, 1 mg chol, 88 mg sod.

**SUBTLE ABUSE: HOW COUPLES GET INTO TROUBLE**  
by Julius Rosen

Verbal interchange is the reason many couples get into trouble. We attribute our
relationship problems to the way we were raised, how parental influences affected our
thinking--and in the process, we ignore the way we speak to each other.

You are standing in the kitchen of your apartment, and although the walls are
thick, oh, those kitchen vents! Yes, through one vent you can hear the upstairs neighbors.
They are venting their feelings:
"Your mother is illiterate...."
"I only slapped you once...."
"We made love once in the last ten years...."
"So big deal, I pulled a few hairs from your head...."
"Drinking again...?"
"Where did you hide the charge card...?"

You recognize the verbal abuse. It comes as an attack, not disguised in the least.
Then another vent alerts you to the softer whispers of the downstairs neighbors.
This couple is subtle, bright, sophisticated, introspective, analytical, and highly
intellectual:
"Are you sure you made that reservation...?"
"It's more important that we first go on vacation...."
"Don't go out without your umbrella...."
"You look upset...."
"You'll feel better when you get a haircut."

Back away from that vent, you discover something odd: both couples are
being abusive. While the upstairs couple is obviously abusive, the downstairs couple is
subtly abusive. This type of abuse is evaluative, judgmental, and harder to detect. Still, it
is an infliction. One person's need is pasted onto the other person, without any
permission granted.

Observations from Your Neighbor Family Therapist

Let's decode the dialogue. The upstairs comment "I only slapped you once" is
obvious, invasive, and intrusive. The downstairs remark "You'll feel better when you get
a haircut" is less obvious, but equally invasive and intrusive. it is, in effect, a command--
disguised under the "You'll feel better" proclamation --to get a haircut.

How does the speaker know that her partner will feel better? All she knows is
that she will feel better. Without giving him any choice in the matter, she has affixed her
judgment onto her partner. This license to inflict causes madness in a relationship.

Subtle abuse of this sort can lead to depression, chemical abuse, divorce, infidelity, gambling, drinking, suicide, smoking, overeating, even unhappiness. That's right, verbal provocations can cause a person to act nuts.

Imagine yourself as the recipient of this verbal attack. You are walking out your front door, and you hear, "You'll feel better when you get a haircut." You were not thinking about your hair. You were thinking about your high school prom and feeling great. You were 17 at the time, and you remember that pretty dress you were wearing. It took a week to get your outfit together--the earrings, necklace, stockings, shoes, and all. You even forgave your parents for their comment on your newly cropped curls: "Son, are you dressed appropriately?" Walking out the door with these warm memories, you wonder, where did "You'll feel better when you get a haircut" come from? You were feeling great. Now, you are furious at your partner for making such a statement. You might even attack your partner with a counter subtle-abusive statement, by saying, "Well, it's about time you noticed me."

Could you react differently? After hearing such a rigid, condescending, authoritarian statement about "your needs," what should you do? Rebel? Get a wig? Submit to a haircut? Drink? Find a lover who appreciates your hair? Perhaps you decide to be "original" and hide your feelings. So you close the door quietly and say nothing. Wow, a prize for inventive solutions? No, hiding your feelings will create sadness and only provoke more subtle abuse.

Verbal interchange is the reason many couples get into trouble. We attribute our relationship problems to the way we were raised, how parental influences affected our thinking--and in the process, we ignore the way we speak to each other. As a couples therapist, I frequently hear the socially correct explanation "My marriage failed because I was able to express my feelings, but my partner could not." During couples therapy, however, I hear endless varieties of subtle abuse. The question is: when are those "feelings" truly feelings, and when are they inflictions of abuse?

"I feel you are hiding from me" is not a declaration of feelings. It is an evaluative statement--an accusation of hiding--that belittles the partner and incites rebellion. It implies that the partner owes something to the message sender. ("You have been hiding, and you owe it to me to stop.") If the partner determines that the interest due is too high, the partnership may slip into emotional bankruptcy. The recipient will hide even more, while the sender continues dispatching faulty messages under the guise of expressing feelings. An alternative to the hiding statement might be "I love to hear about you," which is not an attack.

Rarely have I heard an individual say, "Yes, I am verbally abusive." Yet, so often people will say, "I'm just expressing my feelings." This is one way we have of granting ourselves the license to abuse.

The sad truth is that under the pretense of expressing feelings, abusers can get away with verbal brutality. If you sustain a verbal assault and decide to rebel, for example, the dispatcher of the abuse may say, casually, "What is wrong with you?" or "Why are you getting so excited?" or "Maybe you should seek some help." Yes, you become the patient, because the abuser has decided that you have a problem of overreacting to a statement of "feelings."

If you sustain a verbal assault and decide not to rebel, you're still in for trouble.
The abusive message sender may say, "I think you're trying to avoid me." You answer, innocently, "What do you mean?" Unfortunately, this question invites only more abuse. You are told, "You have not called me for three months." Although you are now in a position to explain why you did not call, whatever you say will probably stir up further investigation and attack. If you say, for example, "I was busy," the verbal abuser may reply, "So, what are you now, a big shot?" or "That's no excuse" or "You are always busy" or "I'm also busy."

Even if you say, "Well, I had a heart attack, and I developed amnesia," the abuse will continue. You may be told, "So you didn't remember to call me from the intensive care unit?"

Although you may not have an immediate repeat heart attack, you will surely get palpitations. Welcome to the world of subtle abuse!

**When Words Push Us Apart**

Words can bring us together or push us apart. When a relationship collapses, we point to differences -- in values, personalities, behaviors, ideas, issues, goals, and so forth. However, the collapse may instead be caused by the way we speak, the way we use words. We know we are being abusive when we lose our temper or scream or hit. We do not understand that we are also being abusive in our use of words. We fail to see our words as hurtful because we have given ourselves license to practice subtle abuse.

Subtle abuse is by its nature difficult to recognize. On the surface, it appears as a gentle verbal transmission, while underneath is a manipulative evaluation that causes rage in the recipient. Not even the recipient will know its source, especially if it is a delayed rage. The fury may not surface for days, weeks, or decades; and when it does, the recipient may feel as if the assault just happened.

Say you are upset about something seemingly insignificant: your partner has just told you that your pajamas need pressing. Though the suggestion seems trivial, your anger is not. Hours pass before you realize that it is rooted in a long-ago scolding about pajamas. The original reprimand had nothing to do with your partner, and was not an open attack. It was a logical, intellectual question, such as "Do you feel safe with non-pressed pajamas?" or "Do the wrinkles in your pajamas reflect the way you feel about yourself?" Consider yourself fortunate for being granted such enlightenment.

Without it, you may decide to divorce your partner in hopes that a new marriage will be easier. If so, do not be fooled. The pajama inquisition will still be with you the second time around. By your third or fourth marriage, you may become so disgusted that to avoid the problem, you'll sleep in the nude. Will this set things straight? No, because you'll probably be asked, "Do you sleep in the nude to avoid wearing pajamas?"

What is a defective verbal transmission system? One thing's for sure: it's nothing like a defective auto transmission, which can often be fixed with a wrench. When the problem is verbal, then the effect is wrenching, and injurious to human relationships. Another distinction is that the verbal defect is practically inaudible. Your best friend will probably not notice it. In fact, your therapist may also miss it.

Rarely does it surface in an individual interview. When the same individuals arrive with their partners, though, it becomes apparent within minutes. The first thing I notice is a dual transmission track. Words travel along a surface track expressing one thing. "You'll feel better when you get a haircut," for instance, suggests an improvement in self-esteem through the clipping of a few strands of hair. At the same time, judgments
and expectations move silently along an underground track expressing something else—in this case, "Whether you like it or not, I'm going to make you feel better about yourself by expecting you to get a haircut."

Next, I notice that while the message sender is being attentive, focusing benevolently on the explicit tract of improving the recipient, he or she is tuned in to the expectational track. Intimidated by the order to change ("Feel better, and clip your hair"), the recipient snaps back, "Don't tell me what to do," or "Don't tell me how to feel," or "Cut your own hair!"

Now you see why I sometimes have trouble decoding verbal transmissions on a one-to-one basis. If the sender says, "Well, I was as loving as can be. I simply told my partner that it would be nice to get a haircut," all I as a therapist get is the good intent. If my response is "I can see that you were trying to protect your partner," I might well be colluding with an attack and approving of the abuse. To truly help the abuser, I need to first identify the faulty transmission, then shift gears from the language of inflicting to the language of sharing.

The ultimate goal is to avoid using dual-track transmissions and commands. Do not tell your partner that she or he will feel better with a haircut. Instead, try a nonabusive statement, such as "The next time you go for a haircut, I would love to join you." This conveys a wish to share in an experience, rather than a desire to order it.

What is the difference between sharing and inflicting? Partners who wish to share feelings and ideas have many opportunities to generate love, affection, passion, nurturance, and kindness. Partners who inflict their judgments and ideas have many opportunities to generate anger, despair, depression, deprivation, intimidation, and hurt. Even an opinion or judgment can be shared, rather than commanded.

The first step is to give your partner a chance to express his or her opinion. If you listen well and let your partner know it, then you will make an ally. If you cut your partner off, or cut your partner up, then you will make an enemy.

It is abusive to say the following: "That's ridiculous," "You must be kidding," "Where did you learn that?" "If only you did it this way," "You must know the consequences," "I have a better way," "That's stupid," "An idiot would know what to do," and "Did your mother tell you to say that?" If you send these types of messages, know that they will be interpreted as abusive, even though you have not meant to be hostile.

It is better to share, to encourage, to say, "I may have a different point of view, and I do want to hear your ideas."

What causes anxiety in your neighborhood family therapist? In my work with couples, I have often pondered, what type of partnership is most skilled at subtle abuse? For a while, I ranked lawyers married to lawyers as outstanding in the field. These couples are great. Every sentence they utter is part of a cross-examination. They pound away at their partners, analyzing each statement, then go in for the kill. Married lawyers were soon replaced by married therapists—a class act.

When I first interview therapist couples, I now say: "What have I done in my life that you have chosen me? I am not a bad person. I enjoy life without stress; yet, I know that the aggravation you have shared with each other will soon be inflicted on me. Please be kind to me. If I make a therapeutic error, please expose my incompetence in a gentle way."

I share my anxiety only to illuminate their power struggles. Therapists can use
such abusive forms of intellectualism, logic, and insight with each other that I often twitch in their presence. Typical tension arousers include the following: "When did you first feel that way?" "Did your father say the same thing?" "I know that your father was emotionally devoid of any feelings and you decided to mimic him at an early age, but when you mistake me for your father and deny any negative feelings that you have toward me because... (twitch)."

Therapists are certainly the worst offenders. The reason is they bring their office skills home with them --and at home, effective therapeutic tools become weapons of verbal violence. Insight, for one, can become a deadly force. My advice to therapist couples: first generate warmth and affection, then let surface a small dose of insight.

Do you engage in subtle abuse? The answer is yes. We all engage in subtle abuse. Verbal violence has become so commonplace that we consider it normal. Think of all the times you have told others what is good for them. Think of all the times you have evaluated others, and formed a judgment without even knowing their circumstances. If someone treated you in these ways, you would not be happy. If you continually treat your partner in these ways, your relationship could be in trouble.

Yes, we all engage in subtle abuse, and it's time to confess. Simply admitting to the violation is a step toward cleansing your use of language. And a giant step toward rehabilitation.

Am I abusing you by telling you how to talk in a relationship? Ha, not me. I feel that I am sharing, and not inflicting. On no account would I order you to be effective in a relationship.

By the way, when you finish reading this article, give it to your partner and insist on a follow-up discussion over tea. Oops, caught me!