Insights and Innovations in Community Mental Health

The Erich Lindemann Memorial Lectures

organized and edited by
The Erich Lindemann Memorial Lecture Committee

hosted by William James College

William James College

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Foreward

The Erich Lindemann Memorial Lecture is a forum in which to address issues of community mental health, public health, and social policy. It is also a place to give a hearing to those working in these fields, and to encourage students and workers to pursue this perspective, even in times that do not emphasize the social and humane perspective. It's important that social and community psychiatry continue to be presented and encouraged to an audience increasingly unfamiliar with its origins and with Dr. Lindemann as a person. The lecturers and discussants have presented a wide range of clinical, policy, and historical topics that continue to have much to teach.

Here we make available lectures that were presented since 1988. They are still live issues that have not been solved or become less important. This teaches us the historical lesson that societal needs and problems are an existential part of the ongoing life of people, communities, and society. We adapt ways of coping with them that are more effective and more appropriate to changed circumstances—values, technology, and populations. The inisghts and suggested approaches are still appropriate and inspiring.

Another value of the Lectures is the process of addressing problems that they exemplify: A group agrees on the importance of an issue, seeks out those with experience, enthusiasm, and creativity, and brings them together to share their approaches and open themselves to cross-fertilization. This results in new ideas, approaches, and collaborations. It might be argued that this apparoach, characteristic of social psychiatry and community mental health, is more important for societal benefit than are specific new techniques.

We hope that readers will become interested, excited, and broadly educated.
For a listing of all the Erich Lindemann Memorial Lectures, please visit www.williamjames.edu/lindemann.

The Erich Lindemann Memorial Lecture Committee presents

THE FOURTH ANNUAL
ERICH LINDEMANN MEMORIAL LECTURE

A Comprehensive View of Service to Families and to Their Elders

Speaker

Stanley H. Cath, MD, Director, Family Advisory Service and Treatment Center

April 30, 1981

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When Erich first published his work on grief and loss, in 1944 after the Cocoanut Grove fire, it changed the lives of many people: not only the survivors of the fire, but the survivors of other kinds of disasters. For the first time people who suffered tragedies had a better listening ear on the part of the professionals. The key to success in psychotherapy isn't always what you do, it's how well you listen.

When people suffer the losses, the depletions, the depressions, the despair which may accompany aging they often display a characteristic sequence first delineated by Lindemann as the grief reaction. He pointed out specific bodily concerns, a preoccupation with the image of the deceased, guilt feelings, irrational outbursts of hostility or irritability and loss of the usual patterns by which they were previously known.

In more traditional grief reactions, such as widowhood, you don't see quite the same picture, but more crying, more depression, loss of appetite, difficulty in sleeping and concentration, and poor memory. Only one-fifth of depressed widows feel guilty; and these will have a higher incidence of psychosomatic illness, suicide and death in the first year. Now that finding in itself points the way to preventive mental health if we are aware that in that first year after bereavement such people are prone to accidents. When they are depressed, you listen differently to the suicide potential; to the possibility that they may be thinking of joining the departed person. That's true, for some strange reason, more of men than of women. Higher rates of psychosomatic illness, suicide and accidents are found in men than in women - especially, again for some strange reason, if the death took place in a hospital. These observations are not to be taken as accurate, dire forecasts, but as clues, so that when you are working with a patient you think about these things.

Bowlby, Kuebler-Ross and Lindemann each have described slightly different stages for the sequence of grief. However you look at it, just remember these things: there is shock, a feeling of unreality, disbelief; followed by mourning and grief; and finally there is a resolution. I want to differentiate mourning and grief: mourning is the psychological process that is set in motion by the loss. It refers to all the processes that people use to restitute, to make up for, the loss. Grief is the affective, subjective state that accompanies mourning.

Up to now I have been talking about the reality loss, the tragedy that takes place when someone dies. But the loss may not be absolute, it may be partial, as in aging. You may lose part of yourself, your ideal self, your beauty, your skill, your profession. Most

people are many selves, many-sided; and in the process of living long begin to lose various components of their self/object world, especially the dyads or coupleships we form over a lifetime.

How long would you say that grief should last, what is the average? Six months is about a minimum, but I've seen it last as long as five years, ten years. Grief after a divorce sometimes lasts a lifetime of bitterness and hurt. One is dealing, then, with a tremendous variation when one talks about grief, bereavement and mourning, because it depends not only on what is lost, but also on how one interprets that loss. Grief and mourning can be aborted, fixated, sometimes even a pseudo-repair can take place, like an imperfect patch that is ready to blow. An illustration is a woman who lost her husband to a coronary and then tried to patch up that loss by getting remarried quickly, or going through a promiscuous sexual phase–not unusual in many males or females who lost their spouse and later have to start the grieving process all over again.

And so, many times we see delayed grief reactions; and as people age, the accumulation of grief becomes enormous. The amount of grief in a human being–well, I can't tell you how many people come in and cry through most of an hour. In some measure they feel they shouldn't be crying at all. When one is old, however, the patches get more difficult to put on. Others may weep through their organs, psychosomatically, unable to tolerate more direct, more appropriate, affect.

For some there is the activity outlet - going to work everyday. I know a woman who lost her husband two weeks ago and is back to work already. She says work is a blessing to her. I don't disagree with her. There are some people for whom work is really a balm, for whom activity can be healing. Other people, who are older, can't use that outlet. They may be retired, they may have arthritis, every movement may be painful.

Social restraints also limit the active seeking for sexual gratification. Many older people think it is terrible that they should have such feelings. There are limited emotional resources available, even in friends and family; and there are fewer available objects to choose from as a replacement. Again in this group, the risk of fatal accident or disease is extremely high.

Lindemann's contribution, like that of Freud, Abraham, and others, was to appreciate that grieving and mourning were not only good, but prolonged and important parts of growing up and growing old, and that people needed time to work these things through. It is interesting to know that in recent years computers have confirmed the work of men like Erikson: a study of 900 people showed that those who react calmly to the death of an intimate are more likely to develop psychosomatic symptoms, severe depression, restlessness, and die earlier, than those who express their grief openly.

Aging, then, contains a unique form of mourning and grief, not only for the lost object, but for the lost aspects of self and self-aspirations; for dreams that one cannot

realize. Aging is also a family affair. How does one go about providing comprehensive services to people who have undergone losses in all basic anchorages: losses in body self, in home and family, in the social anchorages, the economic anchorages, and in the purpose which gives life meaning? Most of us cling to life, we cling to other people, we cling to our job, our profession, we cling to our purposes with good reason, because without them we lose part of our identity. Under the most favorable conditions, we human beings have yet to attain the almost impossible ideal of self-object constancy, knowing we are who we are and achieving decent relationships with others based on fairness and social justice. We have not even devised a good method by which we rule ourselves. Democracy is imperfect, in an evolutionary process, I hope, because if you just live around Boston, you can see that it doesn't quite work. We encroach on each other, without meaning to, for space, for the riches of the earth. We have to learn that while we want our place in the sun, we have to share that place; we have to give love and be loved; we have to ask each other's pardon for

being what we can't help being.

As we age, all of this accumulates. I call these inventories. Every few years, every few months, every few weeks, each of us will take an inventory: where we are in this life; where we are going; what we have done. Have we loved more than hated; built more than we destroyed; are our relationships rewarding or frightening, is the feedback of the system coming in a way that sustains or takes away our dignity?

I think that what I am also trying to imply are some of the things that Shakespeare said in his own way in King Lear. You remember the story: he had three daughters. Cordelia was asked, as the other two daughters were, "How much do you love me?" And her response was, to me, the only loving, good response, the only realistic one. She said, "According to our bond, Your Majesty." The others said, "I'll love you to the end of time." Of course they had all sorts of reasons to protest their love. But Cordelia was honest, and she said, "I love you according to our bond."

When you work with old people and their families and try to structure a matrix, a supportive network, around them, you have to take into account what was the bond between the adults and the children; and you have to remember another Shakespeare quote, because to consider the rightness of Lear's claim on his daughter or Cordelia's position with regard to her father, you must remember that Shakespeare also said, "Lilies that fester smell far worse than weeds." In other words, it isn't who you are or how rich you are, or anything else; if you are a festering lily you're not going to be approached and loved. It would be better to be a weed and not fester; and in some people's minds, their parents fester.

Now I expect that of adolescents. It's hard to get families to appreciate that in their children's minds they smell badly, they look badly, and have to be destroyed, turned

away from, in order to achieve independence. But one doesn't expect that in 40 and 50-year-old people with whom I'm dealing constantly, who look at their parents and somehow cannot approach them. My task becomes how to strengthen the bonds between generations; to get the children to forgive their parents for being human, even if at times they thought they smelled like festering lilies.

We must also remember that the generation gap is relatively real. Quoting again, "Call out to the old, Resign! Resign! Civilization decays if the young do not command it in their prime." The problem becomes: When should a person give up his or her command? After the 50s and 60s which are called the "command generation," people move into their 70s and 80s, and some are not willing to give up their command. Again, Shakespeare said, "Love is proud with the prime in the springtime," as if to say that this is the peak of life. Supposedly your body says your peak of sexuality is 17 to 19 for males, the late 20s to 30s for females. I don't really believe that. All of us will peak at different ages in different ways. Because a person has gray hair, or can't run a mile under five minutes doesn't mean that therefore they should be put on the shelf and taken out of the mainstream of life.

Whenever possible, I try to bring the family together in an encounter aimed at bringing out the best in both generations. I hope to change misperceptions, to help them work on a level that is compatible for them, using their reserves in a way they have not done before. Even people who appear to be confused a certain number of hours a day may be lucid for other parts of the day. In cases of dementia we can frequently see a change when the matrix is supporting, when the children can be involved. So how to embrace the constructive worthwhileness, the rightness and beauty, if you will, of a human being without abandoning consideration for the family becomes a challenge - the one we are addressing at the Family Advisory and Treatment Center. There we try not to just work with an older person, but always to involve the family in the treatment planning.

It is not always possible. There are some children who cannot be approached because they will have nothing to do with this obnoxious creature. Now I grant you, I'm deluded, because I look at this nice old lady and this nice old man, and I can't see thirty years back when they were beating this kid. You knowhow hard it is to look at an old person as a child abuser. Or, they told this kid he couldn't go to school, he had to go to work - one of those terrible crimes that parents commit. The children will tell you how bad it was, and you look at this older person and just can't see it. The question, then, is how to bring the aged person and the family together in a realistic working alliance–not too self-sacrificing and just altruistic enough.

Have we lost perspective to some degree because we prolonged life so well? Eighty-two is the average life expectancy for those who reach 65, with a difference between men

and women of six to thirteen years. The average woman should look forward to 13 years of widowhood. Do you plan for that? Of course not, but it is true. Those are the years that are least planned for in terms of what may happen. So the question is, what if we prolong life to age 100. In the foreseeable future, possibly by 2050, people will be living to that age. Can we live to that age in our society under the present circumstances, where people retire at 65? In no way. By 2020 there would only be six workers to support every three retirees. At any rate, it is obvious that the "nature" in human nature will have to change if we are going to support each other. I really think there is going to be a reversal of the concept that one must grow up, become independent of one's family, move away and have only limited relations with them. If that doesn't happen, then the federal government and state and other agencies will have to move in vast numbers to accommodate the growing masses of older persons with no homes, families or supports. There is only one way I know of in which to do this, namely, to engage the older people themselves in the process. I call this the ortho-geriatric concept - preventive geriatrics. This is the only way in which we are going to be able to work with the number of people who have become progressively disabled, namely, to engage the younger, more intact elders in the processes of elder care.

As we make people live longer, it is possible that they can die withoutany disease you can pick up at post mortems. There is a depleting, wearing-out process in which all of us wait for the mean time of failure of the weakest link in our system, which may be the heart, the lungs, the kidney. But essentially we will die because we reach the end of the genetic line, if we reduce all diseases. Aging is not a disease; aging is a process of nature. Disease comes into it to shorten that span. If Leonard Heyflick, the cell biologist, is right, our span should be about 100 years and we should die almost without disease. Isn't that what's happening in many hospitals today? We keep people alive when, in truth, there is no one disease except that everything in them, all their tissues, have lost their vitality and reserve.

By the age of 75 to 85, one must change one's approach to treatment, because by that time people do begin to approach a natural death. A survey of 120 persons over 100 years of age on Social Security in 1978 found none were doing any more than existing in anticipating death. The Russians could not find any birth certificates to back up the stories of healthy, yogurt-eating centenarians living and thriving in the mountainous regions of their country. But the incidence of people who grow old without disease and the incidence of chronic disease, are both rising. Instead of having the survival of the fittest, we now have the survival of the unfit.

That is what modern medicine has done. We now have many old people who basically just survive, who are not able to care for themselves or adapt to a social role. That's the dilemma of the aged, as we see it.

Let me come back to the family issue. I would like to quote Emily Dickinson. Here is what she said in the play, "The Belle of Amherst": “Hold your parents tenderly, for when they are gone, the world will seem a strange and lonely place." Then she added, "But we were not intimate as parents and children. While she was our mother she seemed to be our child; and when she was our child we had affection for her."

But she died, and
Her little figure at the gate
The angels must have spied,
Since I could never find her
Upon the mortal side.

And then she went on. "Why do we cling to this body? What are we so afraid of...unless it's the dark." And finally,

Hope' is the thing with feathers -
That perches in the soul -
And sings the tune without the words -
And never stops - at all -

Now that expresses sad and lovely thoughts about the problem most of us have or will have. You may not find your mother on the worldly side, she may never be the ideal, perfect person you'd have liked her to have been; but you almost hope that someone at the gate will spy her, take her in, love her. You know that although you may not have found her, there was something good about her.

Emily went on with a very important statement, which I pondered: "I want to eat evanescence slowly." She wants to live her life to its fullest. Many times with older people I don't hesitate to say to them, "You have a choice: you can live until you die, or die now, before you're dead." They often don't like me for saying that to them, but they are forced to think about it. We owe a debt to life, our life. Inevitably, such a choice is traumatic but surmountable.

Aging is a family matter. The children may be going through a mid-life crisis in their mid-thirties or early forties at the same time that they confront the aging, dying and death phases of the parents. A parent can be relatively intact, yet suddenly experience that strange combination I now call depression, depletion and dementia. Those are the three witches, the three scourges of old age. I used to try to make a differential diagnosis to distinguish between them, but now I see this as a combined, multiple effect in many of the elderly I see.

If you were to ask how common is Alzheimer's disease, or organic brain syndrome, or dementia, you'd get various statistics. They would tell you that about 1.4 million people in this country live in institutions, and that in the community five to ten percent of the people suffer from various degrees of dementia or organic brain syndrome. In my opinion, those are half figures. When I look at families all around me, I hardly see one without somebody in it who suffers from one of these diseases. So, if I take my figure, I would say that approximately 20% of the population have varying degrees of intermittent memory loss and periods of disorientation. Most manage to compensate for their deficits, as I will describe later when I present a typical profile of a family with this particular set of circumstances.

What often happens is then a wish to distance that aged person. Children, especially, want to keep away from their parents and to deny the process that goes on. Jack Weinberg wrote a wonderful paper with the title, "What Do I Say to My Mother When I Have Nothing To Say To Her?" It might be rephrased, What do I say to my mother when I see that she's losing some of her skills, her sharpness, her memory? How do I relate to her when I don't think she records every thing I say or do? What do I do when she doesn't recognize me? These are the dilemmas I see all the time. How do I handle the shock of knowing that personhood can be lost before a person dies? Just as it is born from almost nothing, it seems to go into nothing - you can face the shell of a person. Sometimes it's only for a few hours a day; at other times, it's around the clock.

Communication falters between families at times like this. If there is ever a time when a third person is needed to come into the situation, this is it. Our Family Advisory Board then becomes a third party, an emphatic participant observer. The daughter who comes forward to take care of an older parent may be the least-loved child, still hoping to shine in the sun, still hoping to get some of the warmth from the relationship that she never got before, at the expense of her own life or her husband and family. Such a person does not have to act on the impulse to give up her family and career in order to come and live with her parent. I would say to her, "We can keep in touch with you, let you know what's happening, and if something like that is necessary, we'll let you know. Right now, maybe we can handle it with the social worker and the other things we've structured around your mother."

What we try to do with the older person and with the family is to reduce the real fear and the neurotic anxiety that surround the situation. Each family has a life history of its own; it has a dynamic maturational path which it tries to follow. In keeping with its astonishing variation in structure and function, the focus will shift from person to person, all according to the nature of the bond. I wrote a paper to trace the reactions of a whole family when the parent had to be institutionalized in this case, one of the four children was breaking out with hives, another was seeing a psychiatrist, a third was

having trouble with a child who resented the attention the grandparent was receiving; and a fourth had marital problems.

Insomnia is one of the worst enemies of an aging person. We try to relieve it in the least toxic way that we can. One of the purposes of sleep seems to be not just to dream, but to restore neurotransmitter functioning. Neurotransmitters have to do with how memory is stored and accessed, how information is processed, going from one nerve cell to another in that miraculous three pounds of jelly you have on the top of your spine. We are just beginning to discover twenty-six known neurotransmitters, of which there may be dozens more that we don't know anything about. All the tranquilizers, all the neuroleptics we are using today are essentially drugs to poke the neurotransmitter system along and make it work a little more smoothly. They have little or nothing to do with the etiology of the disease we are treating. The anti-depressants aren't truly anti-depressants; the anti-psychotics are not truly anti-psychotics–they have nothing to do with the basic pathology. They are all designed for the relief of the symptoms of the disorder. It used to be thought it was too dangerous to try to treat depression or the symptoms of depression in old people. It is not. We try to preserve any purpose they have; to increase their motor and physical health, taking care of all the basic anchorages I mentioned.

Families, like individuals, have their own level of competency as well as incompetency, and a wide range of susceptibility to illness which is very threatening to young people. If your father or mother develops cancer, is operated on and survives, and you take care of them year after year; if your grandparents had a similar history, what are you thinking about yourself? What does that do to your perspective of aging? Are you going to be gerontophobic? I hope so–it would seem absurd if you weren't. Yet you're going to resent your family tree; you're going to see them as having cursed you. A young woman in her late twenties or early thirties was plummeted into a deep depression by the discovery of a lump in her breast. She expressed resentment and anger over the deaths of her mother and grandmother, both due to breast cancer. I could go on illustrating for you what the family image can mean as you get older, when you see your life span and what might happen to you.

The purpose of the family, ideally, is the maturation and stabilization of the parental personalities and the production of autonomous children. An optimal family works in the following way: power is shared; each person has his or her own competencies; leadership is shared; there are no competing coalitions; there is intimacy with shared deep feelings and each person's feelings are sensed by the other; there are high affect bonds; high levels of sexual gratification between the parents; increasing understanding between the generations; differences are respected. Do you know any such families? Neither do I. But that's the ideal.

In our studies of patients who develop serious organic dementias, we are beginning to be able to trace a prototypical path. There is, in my opinion, a difference in immunity that is involved in longevity. I am going to suggest that not only is the mean time to failure crucial, but also how intact is the immunological system. Cancer, Alzheimer's disease and others like schizophrenia are now thought to be viral or autoimmunological diseases, in which the body fails to produce those elements which protect it from the hostile influence of certain viruses. There is no evidence of senile dementia being simply an hereditary disease–there are too many people who get it without a positive family background. The clearest thought we can have is that decrements in immunity in some cases permit the body's defensive cells to mark and attack its own tissues because of wrong signals.

One family picture is quite typical. As women live longer than men, they will often have something of the following history: they will have nursed a parent or two through the aging process and as their husbands become ill, they then become the nurses and caretakers of their spouse. So you have a relatively intact older wife observing the onset of a degenerative syndrome in one system or another or in the brain of her husband. What usually happens is that this is too threatening. A shock-like state occurs, "I can't believe it." Some of the most striking examples of denial I have ever seen have taken place in women observing their husband's decline. One woman moved with her 65-year-old, newly-retired husband to New Hampshire, where he built a beautiful, expensive ham radio station and then just sat in the living room. For six months the wife paid no attention to this change in the man's behavior until a daughter visited and arranged a referral. This man then became my patient, and we followed him for seven long years of progressive, declining dementia.

Dementia may take a number of different courses. There may be a rapid plunge into senility, so rapid that it takes your breath away, such as happens with Pick's disease in the late 40s or early 50s. This may be followed by a plateau, where the person adapts and may be perceived as cured. The wives, especially, want me to think this is a cure, because "he doesn't do what he used to do, but he isn't bothering anybody." We often see at this plateau what we call la belle indifference : the person is senile but doesn't seem to care. "I just don't remember." "Oh well, I used to know that but I don't know it anymore." Who is president? "Oh, it's on the tip of my tongue." There are others whose observing ego gets so upset when they can't answer a question that they avoid any kind of interrogation whatsoever. So there are different patterns of this type of decline, including those who just slowly, slowly go downhill as in Alzheimer's disease.

Some people who are demented lose their sense of continuity. They can no longer use judgment based upon informed insight. When a person has lost the ability to process information, to remember what is current and what is past, then the family has

to conceal their errors or their colleagues do; and they do it for multiple reasons. President Wilson was kept in office for several years after his stroke. His wife and Colonel House ran the country. So it may be politically expedient for many families or employees or colleagues to keep someone at work, in the harness, even when they know they are non compos mentis, and really shouldn't be there. This denial process is part manipulation and part the wish to maintain that things have not changed.

It is clear that early-onset dementia is frequently denied. One of the things we have to do in work with families is to help them to come to grips with this. How can a person think her husband can go off to play bridge with her when he can't think of four different suits? Can you imagine what an intact woman feels if she, at 70, is able to play bridge and her husband at 68 becomes a bungling bridge player? She doesn't want to believe that it is because he can't process information, so the fights go on, and the arguments and the nagging. We do marital therapy with people like this. We do it over a period of time and sometimes have to bring the children in to pick up the pieces as the gradual awareness of what is happening to the spouse takes place. It's a tremendous narcissistic wound; to watch people shrink over time is no pleasure.

There's a story about a little man who was on his way home one night and couldn't make it. He stopped at an inn and was told, "No, we don't have any rooms." The man said he'd sleep anywhere. The innkeeper said, "There's an extrabed in the room with the general, but I can't let you have that because he's a general." The man persuaded him to let him sleep there. The innkeeper said, "OK, but in the morning what you've got to do is get up early before daylight, and get dressed and out of there so the general won't know I let you sleep there." The traveler paid him well. In the morning he got up in the dark, put on his clothes and walked down the road. As the sun came up he looked down, and lo and behold! he had the general's uniform on. He said, "Oh my God! They waked the wrong man."

It's so much easier to deny what you can see and what you know than to accept the concept that everyone owes to life aging, dying and death. One of our jobs is to get families to see that there are times when people do not die simply; they die in this painful, complicated and prolonged way in which they lose parts of themselves first.

The internalized storehouse of expectations and disappointments that the woman has, all the feelings she has about having been this woman who took care of so many people, now begin to accumulate. She will often undergo a serious depression as she realizes that her destiny now may be just to nurse this man for so many more years. If she's not depressed, what is very likely to happen is that she will have her own psychophysiological disturbances. She will be sleepless, or her stomach or her bowels will be upset, and she will go to her doctor and he will treat the symptoms rather than the underlying depression and the problem. Can you imagine, then, why it's appropriate

that some therapeutic support be available to these people? As founder and Chairman of the Geriatric Committee of the Massachusetts Medical Society, I try to communicate to my medical colleagues the responsibility to understand the complexities of life such patients experience and to place their symptoms of disease and distress in the total setting.

What seems like a guilt-laden adhesiveness is considered by most as marital fidelity in late life. In my forty years of practice I have yet to see a woman in her 50s, or 60s or 70s desert her dementing husband. I've never known one to be unfaithful to him. It is as if sex doesn't exist for these women. If you go to a geriatric hospital, as I do as consultant to the V.A., you will find these women wheeling their husbands in wheel chairs like babies in carriages. As they pass each other they talk just as mothers would talk about their children: "He had a bowel movement today"; "he was clean today"; "he drank well today"; "I fed him." Unbelievable to me, the need to infantalize these men. The nurses and staff also tend to infantalize these patients. In some cases we work with them and help them realize what they are doing and how this selective nurture impacts the rest of their colleagues and patients.

These observations of "caretaking" wives are not a criticism. I would say it is a lifestyle built into the female population of being a caretaker, of devoting and sacrificing their lives to others. Frequently one of our therapeutic tasks is to break into this pattern, if we can. I can't tell you how difficult this is. We say to women, "You don't have to visit every weekend at the hospital if he doesn't recognize you. He doesn't remember you were there. Why are you doing it?" You find people doing this because it fills the void in their life. To correct the situation requires what Erich Lindemann called "grief work": if I admit this loss of my partner is real, then I must start restructuring my life, invest again and get hurt again and face the frailties of people again. And so if we disturb attachments to the living dead, we find we deal with unresolved grief and mourning.

You may find a wife saying to her senile husband, "You're dirty, why don't you keep your room clean? Why don't you take a bath - you know you smell?" As you listen to this conversation you feel the sadistic anger, disappointment and hurt. But it's all done in the spirit of "I'm trying to help him." It's important to take this kind of pressure off these demented persons who respond so poorly to it–it only provokes them with more frustration. So one is trying to intercede in an argument and in a relationship that is obviously going nowhere. If the wife were to give up on this man it would be equivalent for her to abandon a sick child. She has to be helped to find some other way to channel this need–perhaps to work in a place where she can take care of people with whom she is less personally involved. Thus the ghosts of one's past become the ghosts of the senior person: altruistic care becomes confused with a kind of abandonment anxiety retained

in memory from childhood. It may be only through therapy that the wife will reduce that confusion and separate his needs from hers.

An enormous range of guilt may affect the children of an aging parent and spread throughout the family, sometimes down to the grandchildren who don't understand why their parents are irritable or upset or preoccupied.

One senile old man had an emotionally unstable wife. He would wake up during the night, knock on his wife's bedroom door and ask, "Where is she?" The wife whose ego boundaries were not too secure, would respond, "I'm your wife. I'm here." Then he would ask, "Why don't you come sleep with me?" She would say, "I can't sleep with you. I've never slept with you all these years. Now go back to bed." Then in a panic, unable to wait until morning, she would telephone her children screaming, "You know what your father is doing to me? He woke me up again. I can't sleep, I can't take it. I'll kill myself! This is the end of the road." Such nocturnal incidents went on for several years. The spouses of the adult children were infuriated, demanding, "You tell your mother to stop waking us up every night!" Eventually we were able to hospitalize the husband, stabilize him with medication so that he slept through the night, and mother calmed down, allowing the children to sleep. In the community, families like this deserve informed intervention.

To conclude: with long life, we may realize how much we have encroached on others without meaning to - for space, for possession, for air, for the riches of family resources. We may have learned that to find our place in the sun we needed to share these resources with others in our families and in our larger society. We need both to give love and be given love; to be protected and to protect the vulnerable among us. To do this requires that we make sacrifices; forgive and be forgiven, asking each other's pardon for being what we couldn't help being as children, as parents and as adult children parenting parents. And we have an ongoing, lifelong obligation to protect the most vulnerable in the family - the very young and the very old. But our needs for narcissistic continuity demand that our elders not change. We are not prepared. For while we are potentially gerontocrats, in practice we are gerontophobic.

Each of us might like to live to a ripe old, healthy and wise phase of life, having earned and held the respect of people around us. Through history there are many, such as Thomas Jefferson, Freud, Picasso, Pablo Casals, Einstein, etc., who have continued to be loved, respected, creative and productive to the end of their years. They lost little of skilled judgment or shrewdness until almost just before they died; they did not deplete in essential areas even if, as with Freud, they struggled with horrible diseases and needed much care. But the truth seems to be that such individuals are the exception that proves the rule. Most of us have reason to fear aging and the demands which loss of personhood

places upon the survivors. We will meet it with considerable anxiety derived from the uniqueness of our experience.

Few gerontocrats are able to express their appreciation of their own vulnerabilities and tolerance for human depletion as well as Sigmund Freud, who, very near the end of his life, wrote:

To someone else, my diagnosis would be senile depression. I see a cloud of disaster in my world - even my small world. I have certainly taken a huge step out of the circle of life. To live with one's health and preserve it like a national treasure is hard to bear. As for myself, I no longer want to live ardently enough. The crust of indifference is slowly creeping up around me–a fact I state without complaint. It is a natural development - a way of beginning to be inorganic. The detachment of old age, I think it's called. It must be connected with a decisive crisis–that's the old crisis in slow motion. The changes taking place are perhaps not too conspicuous. Everything is as interesting as it was before. Neither are the qualities very different, but some kind of resonance is lacking. Unmusical as I am, I imagine the difference to be something like using the pedal or not. There is a tendency to experience everything sub specie aeternitatis. I still have important work to do; and I must hurry, I must hurry. I must fight against the inexorable chronos. I must do this before the resonance becomes even more muted.

I have referred to Cordelia, who defined family obligations "according to our bond." Cultural values are determined by the deep emotional bonds generated within a family. With the years, these bonds may become clogged by unresolved grief. We are indebted to all like Dr. Lindemann who have helped us to understand the human need to mourn and to transcend the death of loved ones.

References

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