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Where Ego Was, Id Shall Be - A Call for A Psychodynamic Approach to Behavioral and Psychological Symptoms of Dementia

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Abstract

Patients presenting with behavioral and psychological symptoms of dementia (BPSD) are commonly met with a social and medical-organic approach, while little attention is paid to psychological understanding and treatment.

With reference to Freud's famous maxim, "where Id was, there Ego shall be", dementia involves weakening of the ego and regression to behavior based on pure instinctual and innermost desires and fears. This article suggests a mental paradigm of understanding BPSD through examining the behavioral and psychological symptoms of a person with dementia in the context of the person's history and personality. Such approach may serve as a guide to non-pharmacological interventions and assist both patients and their caregivers. Two clinical cases of BPSD will illustrate the technique and value of enhancing medical knowledge with psychological understanding.

Keywords: Dementia; Behavioral and Psychological Symptoms of Dementia; Psychology

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Introduction

Behavioral and psychological symptoms of dementia (BPSD) is a term coined by the International Psychogeriatric association in a 1996 consensus conference, to describe "Symptoms of disturbed perception, thought content, mood or behavior that frequently occur in patients with dementia" (Finkel 1996) [1]. The purpose of the conference (and similar ones following) was to review the data and to form a consensus regarding the definition, description and causes of the clinical symptoms, and delineation of future research directions. Although one of the declared goals of the consensus forum was "understanding of the underlying … psychological substrates", relatively little has been written since regarding dynamic psychological conceptualization and treatment of BPSD. Several specially designed (or adapted) therapies for dementia patients such as reality orientation therapy, validation therapy and reminiscence therapy have been developed (Verkaik 2005) [2]. However, those are not based on psychodynamic understanding, and most physicians are not acquainted or trained of these practices. Other non-invasive approaches are largely behavioral or psycho-educational, such as to identify the setting for an intrusive symptom and change it, or advocate alternative behaviors through positive reinforcement. These are easier to apply and mostly proven effective yet lack psychodynamic depth. Most psychiatry residencies include substantial psychological training, yet somehow, when facing a demented elderly in distress, physicians forgo psychological approach and refer mechanically to their medicine cabinet.

Dementia research has not always been exclusively medical. In a series of captivating articles in the psycho-analytic / political journal "Free associations", social psychologist Thomas Kitwood reviews and challenges the current notion of dementia as a "purely organic" disease, and advocates a combined psychological approach (Kitwood 1987, 1987, 1990) [3-5]. He illustrates a shift of focus from psychological and social theories in the mid 20th century (e.g. dementia as a result of poor social skills, pre-morbid obsessive personality or psychosomatic illness) to the organic aspects in the 70's, following breakthrough advances in the biological understanding of Alzheimer's. From there onward, psychology seems to be limited to care of the caretakers and facilitation of environment, yet excluded as a causative and potentially therapeutic agent. The poor efficacy of anti-psychotics and anti-depressants for BPSD, and the loose association between the neuropathological findings and the clinical picture of dementia (Boyle 2013) [6] raise a question mark regarding sole organic causes, and should at least point us to seek alternative directions.

In theory, physiological models of a clinical process do not eliminate a parallel attempt to psychological conceptualization, both for causation and treatment. For all neuro-psychiatric disorders, including schizophrenia, depression and personality disorders, medical and psychological knowledge co-exist and complement each other. For instance, an approach to depressed individuals amid COVID19 pandemic, includes not only their serotonin levels, but the effect of recent losses (loved ones, employment status) and pre-morbid resilience.

Hence, the scientific progress in understanding dementia cannot account for the blunt exclusion of psychological stance on the subject.

Of all neuropsychiatric clinical syndromes, why was dementia medicalized? Medicalization appears most strongly where there is a difficulty to cope with the emotional aspects of the afflicted condition. In this case, BPSD forces us to face the terror of old age, senility and ultimately - death. Examples of medicalization / dehumanization of the demented elderly are readily found in our culture, such as Shem's comic-tragic (and horribly realistic) "House of God", where they are described as GOMERS (initials of Get Out of My Emergency Room"), or differentiated by "O and Q signs" (marking an open mouth without or with a protruding tongue) (Shem 1978) [7]. Even empathic consideration of lucid aging is often inflicted with ageism, defined as "prejudicial attitudes towards older people, old age and the aging process" (Butler 1969) [8]. Even Freud deemed patients above 40 as unfit for analysis. As of our approach to death, suffice to quote the Tibetian Rinpoche's shocked reaction, when first encountering Western attitude: "I learned that people today are taught to deny death and taught that it means nothing but annihilation and loss. That means that most of the western world lives either in denial of death or in terror of it" (Rinpoche 1992) [9].

Dementia combines lethal enemies from within and without: loss of mental and cognitive abilities, with loss of social, professional, personal and economical standing. But just in his most dependent and weak state, with the utmost need for care and attention, the demented is faced largely with a cold scientific approach and a handful of drug prescriptions. I would now like to propose a different approach.

Following a general mental conceptualization of the dementia process, two cases will be presented, demonstrating the technique and value of the psychological thinking.

Dementia is characterized by loss of memory, language, emotional regulation and impulse control, and as such, in psy-

chological terms, it is a disease of self disintegration. In accordance with the medical model of infectious disease, the clinical picture and outcome are determined by the characteristics of the host, the pathogen and the way in which they inter-relate. The host – his personality, past and milieu; the pathogen – the dementia type (acute vascular vs. slow degenerative, frontal vs. temporal, cortical vs. sub-cortical, etc); and their meeting point. The picture will transform as the disease advances, conquering more brain territories and dwindling the remaining mental resources. Environmental support (or lack of) will be crucial in determining the outcome.

With reference to Freud's famous maxim, "where Id was, there Ego shall be", dementia involves weakening of the ego and regression to behavior based on pure instinctual and innermost desires and fears. A brilliant and unique article in Psychoanalytic Psychotherapy describes three psychological stages of the dementia process (Evans 2008) [10]. Initially, the ego still exists and aware of the loss, responding in anxiety and depression (or occasionally denial). With time, the reality principal weakens and the pleasure principal domains, with diminishing anxiety and occasional emergence of disinhibition. As the outer world fades, the inner one takes over, reality testing is feeble, leading to paranoia and jealousy. In the third and final stage, verbal communication is scarce, and the person returns to early communication manner such as projective identification, at times resulting in horrific agony to both ailed and his caretaker. Combining Evans' depiction with BPSD research, the clustering of BPSD syndromes may be viewed as a chronological continuum of coping mechanisms with self disintegration. First appears the affective pattern, ensued by the psychotic and/or frontal patterns, and eventually ends in motor aberrancy and apathy. The above narrative coincides with the observation that affective and psychotic pictures rarely co-exist (Levy 1996) [11].

The dementia process is too variable and complex to be viewed simplistically as a reversal of previous theories of developmental stages; however, association to several psychological models seems inevitable. In Melanie Klein's terms, there is a shift from the depressive position, in which one is faced with the grief and guilt of realistic experience of the intricate reality (the affective syndrome), to the earlier schizoid-paranoid position, marked by the inability to unify good and evil in the same object, leading to splitting and projecting evil outwards (e.g., paranoia and envy, the psychotic / frontal syndrome) (Klein 1957) [12]. A further decline would lead to the final dementia state of Ogden's autistic-contiguous position (Ogden 1989) [13], which is a sensory-dominated, pre-symbolic mode of experience and communication (apathy / motor aberrant symptoms).

Case presentations

Case 1

Mrs. B is an 83-year-old widow and a mother of five. Born in a small village in Lybia, she has never attended school. At the age of 15 she was wedded and immigrated with her husband to Israel. She was a diligent housewife until her husband's demise, 8 years ago. In the years since, she had suffered significant cognitive and functional decline, and is now fully dependent on home care. I was summoned by her daughters to a house-call, to "help manage her hygiene". She was sitting on an old sofa in the front yard of her tiny home, staring at an unseen point in the horizon. Throughout my visit, she incessantly ripped the sofa's upholstery, which was already completely torn, in tiny repetitive movements. She seemed calm yet passive. The daughters confirmed this to be her usual state, but described that when it is time to shower, she becomes both verbally and physically aggressive, seems terrified and resists undressing with all her might. On exam she was cooperative, her affect somewhat perplexed and her thought content dull. Her cognitive abilities were consistent with intermediate dementia. She acknowledged refusing to shower, explaining simply "I'm not married anymore". There was no evidence of psychosis or major affective disorder. Her family physician suggested a psychiatric consult regarding a suitable tranquilizer to be given before the shower.

The case describes a woman with advanced dementia, who refuses to shower. In the absence of clear affective or psychotic elements, the first conspicuous symptom is her hand wringing, consistent with aberrant motor behavior. The excess and typical repetitive movements comprising this behavior (such as pacing, wandering and fidgeting), can be best understood dynamically when exploring theoreticians of early infantile anxieties. Winnicott postulated that in infancy, the mental experience is inseparable from the physical one, a notion well articulated in the term "psyche-soma" he coined (Winnicott 1949) [14]. With proper Holding by the environment, this mind-body unit may materialize to an integrative Self. Esther Bick, a later psychoanalytic doctrinaire, thus termed the environment "secondary skin", essential to hold the fragmented self until timely integration (Bick 1968) [15]. When environment fails, the infant frantically seeks alternative holding methods against un-integration. Sensorial concentration on an external object such as sound, light or fabric, may serve as a temporary and partial replacement to the actual human object. Jane Symington further enriched the examples of self holding methods with descriptions of repetitive movements (e.g. rocking) and clenching (like a hypertonic state or constipa-

tion) (Symingtom 1985) [16]. I view aberrant motor behaviors of the demented as self holding methods in face of internal disintegration and a lack of sufficient holding environment. These are especially prominent in the later stages, when cognitive abilities can no longer (or never could) compensate for the losses within and without. Mrs. B's hand wringing is highly reminiscent of Bick's and Symington's descriptions of sensorial focus, while her ferocious attempt to remain clothed sets an almost concrete illustration of secondary skin. Once the meaning of undressing – taking off the secondary skin which holds her - is clarified, her profound panic makes perfect sense. Instead of anxiolytics, the daughters came up with a measured bathing method of removing only one piece of cloth at a time. This way, secondary skin remained intact and the anxiety decreased significantly.

Case 2

Mrs. W was born to a Polish-Jewish family in the 1930s. Following her mother demise in the course of her birth, she was sent with her older sister to an orphanage in Russia, where they survived the war. Father and both brothers were perished in a concentration camp. Several years after the war, she married and moved to Israel. Her daughters describe her as a cold, distrustful and "difficult" person, traits that seem to have intensified with the appearance and progression of Alzheimer's disease in the past 5 years. Three months prior to my exam, she had fractured her hip bone, imposing significant physical disability. She "reacted badly", was seen by a psychiatrist, who diagnosed adjustment disorder and prescribed anti-depressants. The family stopped treatment within a couple of weeks, due to aggressive behavior. A month prior to my exam, Mrs. W began accusing her long-time devoted caregiver of theft. She became verbally assaultive, including curses, threats and shouts, and forbade her to enter several rooms in the house. On exam, she seemed guarded and easily irritated. She remembered the distant past well, but was confused as to recent events, yet denied all memory impairment "I only forget unimportant things". Though careful not to disclose her full thought content, paranoid delusions toward the caretaker were obvious.

Delusions in the course of dementia are often of persecutory or jealous nature, and described as "dull" (as opposed to florid delusions of schizophrenia). Nonetheless, even the content of "dull" delusions is not coincidental, but represents an anxiety distinctive to the person and his current state. As mentioned above, Melanie Klein described two positions one may assume to deal with aggression. In the Schizo-Paranoid Position, one splits the frustrating imperfect (internal) object to "all good – all bad", and projects all aggression toward the latter, consequently saving the good object. In the more developed Depressive Position, the object is perceived as a whole, for its imperfection and separateness, and aggression is owned, leading to blame and anxiety. In the case illustrated above, one can readily see how the depressive position (mourning over a new physical constraint) is converted to the schizo-paranoid position, in a woman with previous paranoid personality traits. As dependence on the caregiver grows, frustration and aggression deepen, turning the caretaker to "all bad". The individual difficulties are projected outwards almost concretely: I cannot remember where I placed my belongings = my belongings were stolen; I cannot walk independently = you may not enter the room. As reality testing loosens, the reality principal (I am dependent) surrenders to the pleasure principal (I want independence). Rather than facing the dismal reality, manic defenses emerge, foremost denial of all disability and need ("I only forget unimportant things"). Thus, the victim is converted to the aggressor, a "Victimator" [Durban 2002] [17,18].

How would such psychological understanding advance treatment in this case? Winnicott theorized the object must survive the attack, in order to allow the subject to unite the splits and obtain reality testing (Winnicott 1969) [19]. Explaining the mental state to the family and caregiver, reduced their anger and anxiety, making them more tolerant and responsive to her needs. A non-confrontational approach was advised, alongside verbal recognition of her physical difficulties. Psychiatric drugs might have ameliorated the situation, but the family was apprehensive after the previous failed trial. In a follow-up conversation they reported improvement in her aggression and general demeanor.

In summary, I advocated and illustrated a psychological approach to understanding and treating BPSD, complementing the prevailing behavioral and medical paradigm held almost exclusively nowadays. Further psychological conceptualization and treatment options, including psychotherapeutic practices, are required.

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