

‘Blessed are the Pacemakers’

‘BLESSED ARE THE PACEMAKERS’ DEMENTIA, PSYCHOSIS, AND THE PSYCHOANALYTIC DISCOURSE

Cormac Gallagher¹

Dementia has been described as the major mental health epidemic of the 21st century. Yet far from being the living death it was seen as up to the 1980s, revolutionary new research, lead by Tom Kitwood, has shown that, while people suffering from the illness have undergone severe cognitive impairment, they retain a deeply subjective, visceral intelligence that allows carers to communicate with them to a degree formerly thought impossible. Psychiatrists and psychoanalysts who work with psychotic patients have much to learn from this re-discovery of the subjectivity of dementing patients and the need to counteract the ‘malignant social psychology’ that affects both groups. In return they have much to contribute to an enrichment of ‘reminiscence therapy’ now seen as a key technique in the treatment of dementia.

Keywords: Dementia; psychosis; Kitwood; reminiscence therapy; malignant social psychology; Lacanian psychoanalysis.

Introduction

This paper was intended to be a discussion on psychosis in Lacan’s *L’tourdit* as reread by Christian Fierens. But it was blown off course by a chance encounter with what, for me at least, were new ideas and research which brought back a memory that took me in an unexpected but I hope fruitful direction.

More than 30 years ago in the late 70s or early 80s, immediately after a conference like this, Oliver FitzGerald one of the princely physicians who in those days presided over most matters in this hospital buttonholed me and said challengingly: ‘This talk about anorexia’ – or whatever the subject of the conference was – ‘is all very well, but what are you psychiatrists doing about dementia?’

¹ Cormac Gallagher is a practising psychoanalyst in Dublin, having studied and trained in Paris. He introduced Lacanian psychoanalysis to Ireland in the 1970s and established The School of Psychotherapy at St Vincent’s University Hospital. Founder of the Irish School for Lacanian Psychoanalysis, he is known throughout the world for his translations of Lacan’s seminars www.lacanianireland.com

Now I was at that time a clinical psychologist in the Department of Psychiatry and, to the best of my memory, I had seen a total of three patients with dementia. One a town clerk from north Leinster, the other a prize-winning architect, and the third, a member of the landed gentry who had managed to drink himself into something like dementia. All three in their early to mid-50s. So, as far as I was concerned, dementia was a very marginal condition and pretty well irrelevant to the practice of psychotherapy or indeed psychiatry.

So for the 30 plus years since, I paid no attention to the condition and indeed with my focus on Freud and Lacan there was very little stimulus to think about it. Freud does use ‘dementia’ in a context that we will mention in a moment. But in Lacan’s thousands of pages of seminars and writings, as far as I recollect, I don’t think dementia is ever referred to. And in Henry Krutzen’s classic index it is not mentioned as one of the themes to be found in the seminars.²

Edinburgh awakening

What roused me from my Lacanian slumber, and reminded me of Oliver FitzGerald’s challenge, was a completely chance attendance at the *5th International Conference on Aging and Spirituality* held at the University of Edinburgh in July 2013.³ The conference, attended by a worldwide audience of several hundred people, many doctors, clergy, psychologists, a few psychiatrists, a lot of NHS people, was organised around the theme of the creativity and resilience of older people and, in particular, focused on the spiritual gifts possessed by people with dementia. It made me realise that not only was dementia an accelerating phenomenon in our aging population, but that the new approaches to the understanding and treatment of the illness had a lot to teach psychiatry and psychoanalysis about how our approach to serious psychiatric illness might be up-dated and renewed in ways not envisaged by DSM-5.

Contrariwise, it seemed to me that the speakers presenting the new approach would have greatly benefited from a knowledge of Lacanian psychoanalysis, with its emphasis on the signifier and the formations of the unconscious, to enrich their understanding and treatment of dementia. Limiting themselves to a rather naive Rogerian ‘person-to-person’ psychology did not seem to do

² Krutzen, H. *Jacques Lacan Seminaire 1952-1980, Index Referentiel*, 2nd edition, Paris, Anthropos 2003.

³ I want to thank Jean Kilcullen for the invitation to attend and for once again pushing me out of my comfort zone.

justice either to the sincerity of their commitment to dementing patients nor to the spiritual wisdom that is being recognised in them.

Now I apologise to those among you who already have a thorough knowledge and experience of dementia and its treatments, but for the moment I am going to assume that a good number of you, even experienced therapists and psychoanalysts, are as ignorant about the condition as I was a few months ago.

A 21st century epidemic

Edinburgh taught me two main lessons. First was that, far from being a minor and peripheral problem, dementia is perhaps the major mental health epidemic of the 21st century and in this, it certainly rivals psychosis and all the human suffering that arises from the mental illnesses we diagnose as schizophrenia, bipolar disorder and depression. Henry O’Connell, a psychiatrist heavily involved in the Alzheimer’s Society of Ireland (ASI) reckons that at present there are approximately 45,000 sufferers in Ireland and that in 20 years time there may be upwards of 100,000. This compares with the 75,000 to 100,000 people that DETECT reckon can be diagnosed as suffering from a psychotic illness.

Not only are the statistics on dementia extremely disturbing but now, for the first time in my experience, it features in the news media on an almost daily basis. One unnerving aspect of these reports is that dementia seems to strike at random and that, as we and our loved ones grow older, we are more and more likely to have close or even first-hand experience of it. A former Prime Minister of Ireland is said to be in an advanced stage of dementia. Tony Booth, father-in-law of Tony Blair, recently allowed his wife to come out with a full page article in the Irish Times on his growing dementia problems and the Times also published two full pages in recent weeks on the advances in the treatment of dementia in Ireland and on the efforts being made, principally by the Alzheimer’s Society of Ireland, to provide services for those suffering from the condition, and also to provide dementia friendly communities both to care for those suffering and respite for the carers.⁴

⁴ Booth, S. *Married to Alzheimer’s*, The Irish Times, Saturday November 23 and Tuesday December 17, 2013. Sheridan, C. *Tailoring localities to support the vulnerable*, The Irish Times, Tuesday November 26, 2013. O’Neill, D. *Global initiative on dementia: a major turning point*, The Irish Times, Tuesday December 17, 2013

The word dementia has been removed from DSM-5 and replaced by the category of ‘major cognitive neurological disorder’. We will see in a little while how this definition is challenged by the new enriched view of dementia.

Dementia is an ancient word for madness. When the poet writes that ‘those whom the gods would destroy, they first make mad’ the word used for mad is dementia. The first psychiatric use that I can find in modern times is in the mid-19th century and for Emil Kraepelin (1826-1926), now restored as the founder of modern scientific psychiatry over against the unreliable speculations of Sigmund Freud and psychoanalysis, it was a key word indicating the link between brain disease and psychosis. So in the early 1900s we had ‘dementia praecox’ which later became schizophrenia, and I had overlooked that Freud described President Schreber’s illness as a ‘dementia paranoides’.

The high point for this project of grounding mental illness in brain disorder was the discovery in the first decade of the 20th century by Aloysius Alzheimer (1864-1915) of the link between a set of behavioural peculiarities - short term memory loss, amnesia, wandering, etc - in a 51 year old woman, Auguste Dieter, with a breakdown in the structures of her brain.

The image often given of the brain is that of a sponge, and, in what has become known as Alzheimer’s disease, this sponge shrinks in size and gaps and holes appear in it. In addition, the millions of neurotransmitters and receptors that make up the functioning of the brain are damaged and this results in permanent damage to brain functions. Alzheimer’s discovery was perhaps the greatest success of the theory of brain dysfunction as the origin of psychosis and stimulated the now renewed search for a neuropathological basis for all serious mental disorders.

The new enriched view of dementia

However, the focus of the conference on *Aging and Spirituality* was not on the links between dementia and mental illness but rather on the revolution that has taken place in the last 15 to 20 years in the understanding and treatment of dementia itself. And this was the second lesson I learned at Edinburgh.

Malcolm Goldsmith, a recently deceased Methodist minister, is celebrated as the patron saint of this movement but Goldsmith himself, in his account of the changes that have taken place, credits Tom Kitwood of Bradford University as the main figure in this revolution and with being responsible for the most

important, innovative and creative developments in a field that had long been neglected.⁵

It is in Kitwood’s work, he argues, that there lies the foundation of a whole understanding, and approach to the treatment, of dementia. Tom Kitwood, a social psychologist, ended his career as Aloysius Alzheimer Professor of Psychogerontology in Bradford University and is well known in Irish dementia circles. And pretty well everyone concerned with dementia has adopted what is called his person-centred approach.⁶

Kitwood’s starting point is the view of dementia that was unquestioned among health professionals and carers alike up to quite recent times:

Around 1980 the prevailing view of the conditions known as primary degenerative dementia was that they presented a hopeless picture. Care for those who were affected were seen mainly as a matter of giving attention to basic physical needs while the process of degeneration in nerve tissue took its inexorable course. Generally it was believed that very little could be done in a truly therapeutic way through direct human intervention.⁷

It was this view that he sought to challenge by what was then a revolutionary approach to the condition and he chose to summarize his theory in what, at first sight, is a rather bizarre equation:

$$\mathbf{D = B + P + NI + H + MSP}$$

This formula condenses an approach to dementia which, when teased out, sounds familiar enough to psychoanalysts but is at odds with a contemporary psychiatry dominated by psychopharmacology and DSM-5. The elements of this equation can be briefly understood as follows:

D = Dementia

⁵ Goldsmith, M. *In a strange land...people with dementia and the local church*, Nottingham, 4m publications, 2004

⁶ Unfortunately, my own information on Professor Thomas Kitwood (1937-1998) derives almost entirely from the internet. Those curious to look further will find some bibliographical references in his obituary.

⁷ Goldsmith, M. op. cit. p. 20

B = Biography

In other words the person’s own personal history which is principally to be explored by a technique known as Reminiscence Therapy.

P = Personality

The pre-morbid personality traits of the sufferer.

NI = Neurological impairment.

Which is apparently the only category considered by DSM-5 where dementia is defined as a major cognitive neurological disorder

H = Health

MSP = Malignant social psychology

By this Kitwood means that dementia is at least as much a socially and culturally constructed category as a medically defined entity.

It is worthwhile considering some of these elements in more detail, in particular because they reveal ways in which an unquestionably neurological condition can be approached by techniques which relate closely to psychotherapy.

Personal Biography

My impression at Edinburgh, and in what I have read since, is that Kitwood’s approach to this autobiographical review could greatly benefit from the insights of psychoanalysis. The main tool that he employs is ‘Reminiscence Therapy’ which certainly involves verbal communication with the patient when this is possible but for the most part focuses on such things as old newspaper clippings, personal belongings provided by carers and other such tangible reminders of the patient’s past. But while this method of Reminiscence Therapy is more or less widely used in Irish nursing homes, Malcolm Goldsmith seems to envisage a far more explicitly verbal method:

When there are problems communicating with people with dementia, invariably the problems reside with the person who does not have the disability. There is now a vast amount of literature to suggest that given time and skill, patience and commitment it is possible to communicate with people with dementia for much longer that was thought possible only a few years ago. Perhaps the most significant feature of this new conviction about communication is that it occurs when the person without the disability believes that communication is possible.⁸

⁸ Goldsmith, M. op.cit. p. 83.

These remarks bear a startling parallel with Lacan’s remarks in *Intervention on Transference* that resistance is always on the side of the analyst rather than, as is usually assumed, on the side of the analyser. Goldsmith’s chapter on communication and dementia deserves to be read not simply by dementia carers but also by the psychiatrists, psychologists and psychoanalysts who deal with people who have a psychotic illness. And he emphasises how important it is for the practitioner to actually believe that communication is possible and to be prepared to respect the time and pace of the person they are communicating with.

What is more, the approach must be personalised, depending on how the person is feeling, how tired they are, what time of day it is, whether there are distracting noises.⁹ He further emphasises how important it is to know the cultural, social and personal background of the person, their name and how they prefer to be addressed, whether they have any further problems apart from dementia or, in our case, psychosis.

*This is hard work and it needs all the resources that you have at your disposal. Make sure that you have enough time. You cannot rush in and out of these visits. You need to know that you have some leeway at the end of what you might normally be expecting to be the end of a visit.*¹⁰

Together with this we need to develop what is described as a ‘poetic awareness’. To realise that words may be symbolic metaphors for a reality that may not at first be obvious. Kitwood puts it in this way:

*We need to slow down our thought processes, to become inwardly quiet and to have a kind of poetic awareness. That is, to look for the significance of metaphor and allusion rather than pursuing meaning with a kind of relentless tunnel vision.*¹¹

All of this has distinct echoes of the way in which psychoanalysts are taught to listen. This slowing down of our thought processes echoes the free-floating attention that Freud describes as essential in the listening role of the analyst. But whereas the psychoanalyst has to explain to his patient the need for free association, the dementing person seems to have fallen back, quite naturally,

⁹ Ibid. p. 85.

¹⁰ Ibid. p. 87.

¹¹ Ibid. p. 91.

into it. So, in his speech, there are linking principles, but as often as not it may be simply the sound of a word that suggests the next link in the chain of meaning. This is startlingly reminiscent of the notions of metaphor and metonymy by which Lacan has brought up to date Freud’s principles of condensation and displacement in the formations of the unconscious. Curiously, Lacan’s notions of metaphor and metonymy were borrowed from Roman Jacobsen’s study of the language styles of neurologically impaired patients whom he classified as suffering from two distinct types of aphasia: metaphorical and metonymical.

If people with a major cognitive neurological deficit can be addressed as human subjects, why not those with psychosis whose neurological deficits, after over a century of investigation, still remain largely in the realm of speculation? The answer surely lies in the overwhelming power of the psychopharmacological industry and the influence exerted on mental health professionals since the 1960s by a series of diagnostic statistical manuals.

Gary Greenberg describes how many American psychiatrists have argued that the DSM is logically defensible mainly because it diagnosed illnesses such as depression without regard to a person’s life circumstances and pushed clinicians to pay attention only to diagnostic checklists and not to the patient in front of them.¹²

He tells of his efforts to introduce psychiatrists to the idea of listening to the patient’s history and of the response from Professor Bob Spitzer, whom he describes as the king of American psychiatry:

Smart and compassionate doctors spill buckets of ink over the question of whether or not they should consider what we are going through or they tell us what we are suffering from and what we should do about it, and when the proposal to do so moves Bob Spitzer to say to me ‘If we did that then the whole system falls apart’, then you know that you are knee deep in a setting of psychosocial adversity.¹³

Malignant social psychology

¹² Greenberg, G. *The book of woe: the DSM and the unmaking of psychiatry*. London, Bride Publications, 2013. pp 166-167.

¹³ Ibid.

The final point in Kitwood’s formula for dementia he abbreviates as **MSP**, meaning malignant social psychology. Kitwood points out that the losses a person experiences because of their neurological condition are then followed by a change in people’s relationships to them. Once a person has been diagnosed with some form of dementia, people seem to think that they are somehow different and begin to treat them in a different way, sometimes rather subtly and at time quite blatantly:

‘People with dementia are subjected to a debilitating onslaught from both within and from the outside world’.¹⁴ Like those diagnosed with psychosis, they are disempowered, intimidated, labelled, banished and frequently mocked. For example, a recent well-publicised court case dealt with a carer in a nursing home taping a patient’s mouth shut so that he could get on with his work.

And the chemical straight-jackets used to control psychotic behaviour are too well-known to need elaboration.

The Alzheimer Society of Ireland

Kitwood’s work has had a world-wide impact and has done a lot to remove the stigma of dementia and the MSP that accompanied it. In contrast to the apartheid that still afflicts those diagnosed with psychosis, Alzheimer sufferers can count on the support of a number of government and voluntary agencies to provide services and supports in the community and to advocate their rights.

On the voluntary side The Alzheimer Society of Ireland, founded in 1982 by a number of people caring for sufferers from the disease, is a service-provider operating over 125 dementia-specific services including Day Care, Home Care and Respite Services, Social Clubs, Support Groups and Family Carer Training. The Society comprises over 2,500 members, 300 volunteers and over 900 full and part-time staff. It also has a Helpline and information service which is staffed by a panel of 25 trained helpline volunteers. There is also a Medical and Scientific Advisory Panel which contains a number of prominent members of different disciplines, including Tom Kitwood’s successor at Bradford, but sadly no psychotherapist or psychoanalyst.

¹⁴ Ibid. p. 77.

Is it legitimate to ask why the family and friends of those with serious mental illness have not been able to set up a similar group to provide support for their loved ones?

The psychoanalytic discourse: meaning, sense and ab-sense

Finally, let me say a few words to justify the last element in the title of this paper.

The role of psychoanalysis has often been seen as bringing meaning to what Lacan has called the formations of the unconscious – dreams, parapraxes, symptoms and childhood memories. But Freud himself, especially in his study of the witticism, was at pains to distinguish between the meaning of the joke and its sense. We laugh, or smile, without knowing the *meaning* of the joke or witticism.

Seamus Heaney’s ‘Blessed are the pacemakers’, a witticism made when he was fitted with a pacemaker a few years before his death, is a case in point. It is a meaning-less remark and indeed it might not even raise a smile among those who have never heard of the Sermon on the Mount with its ‘Blessed are the peacemakers, they shall be called the children of God’. But Christian theologians themselves would be hard put to it to *explain* why it is a witticism – there is simply some way in which the *sense* of the *bon mot* is grasped in a way that defies rational, conscious cognition.

Lacan, in *L’tourdit*, takes things even further and it was left to Christian Fierens to fully tease out its implications for the psychoanalytic – as opposed to the master, academic, hysterical – discourse. Here is a brief indication of how he spells out how Lacan goes beyond Freud’s distinction between meaning and sense:

How discover or rediscover sense?

Precisely starting from the moment when meaning loosens or may loosen. It is this loosening of meaning that the practice of free association proposes. Sense is produced at the moment when meaning fails. At the following stage, it is at the moment when sense in its turn has failed that there will be produced ab-sense and transference (this will be sex). Sense properly speaking only arises when the saids no longer have a meaning.¹⁵

¹⁵ Fierens, C. *The psychoanalytic discourse, a second reading of Lacan’s étourdit*, 2012, trans. C. Gallagher, www.lacaninireland.com. p. 125.

Conclusion

This paper, as I have already said, is not based on my very meagre and distant experience of working with dementing patients, but rather on the testimony of those who have promoted their new and enriched understanding of dementia. This testimony cannot but resonate with our experience as psychotherapists and psychoanalysts.

We have much to learn from the way in which the long-held view of dementia as a living death has been turned round in the last 20 to 25 years, both in terms of the treatment of individual patients and the reversal of the malignant social psychology that surrounded them. Would that the equally nihilistic approach to psychosis, so prevalent among mental health professionals, undergo a similar revolution.

But psychoanalysis has also its contribution to make to the further enrichment of the understanding and treatment of dementia. In particular its contribution to reminiscence therapy seems to have been completely under-exploited. And Lacan’s enigmatic highlighting of the place of an ab-sense beyond meaning and sense offers a theoretical framework that gives psychoanalysts a legitimate role in society’s attempts to come to terms with the major mental health epidemic of our 21st century.

e-mail: cormacgallagher@eircom.net