The Four Phases Explained

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Introduction:

This paper was written to assist Validation Teachers in how to present Feil's theory of phases of resolution in training programs, presentations and workshops. It flowed from criticism of Feil's Four Phases because they are sometimes used as labels and labeling is something that does not fit in Validation theory. We have tried to address this issue. We find that it is a matter of HOW we teach it, not a change in the theory of the Four Phases of the Resolution Stage of Life.

Additionally, this paper incorporates the 2019 changes in titles or names of the four phases. These changes were made by the Education Committee to reinforce the fact that we should not label people, and these descriptions are more humanistic.

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What are the Four Phases?

Naomi Feil developed the Four Phases of Resolution as a way to identify the differences between client's state of being .

She was responding as well to a scientific community that did not take her work seriously and felt that the more specifically she could define the characteristics of each phase, the more her work would appear to be concrete and based in practice.

The characteristics for each phase are specific and come from her personal practice of many years. Feil identified physical, psychological and social characteristics which flowed from her observation that these factors influence older adults' level of orientation. From her first book, published in 1982, she wrote:

> *A slow, progressive unfolding of feelings marks the retreat inward from occasional confusion – Malorientation – to Severe Disorientation. Adult controls fade. Repressed sexual feelings spill. Speech, social controls, awareness of clock time, reason and logic slowly blur. Memory becomes selective. People forget present time. They choose to remember the past to resolve living.... Disoriented old-old can move back and forth from Malorientation to Severe Disorientation, depending on their feelings of worth. They tend to stay in one stage[1] most of the time.*

She goes on further to describe the *General Signs of Withdrawal Inward*:

> "Withdrawal" in this context refers to a psychological disconnection with reality. An individual becomes less aware of the environment and more focused on his or her thoughts and feelings. As a person loses connection with the environment, he or she might not be aware of people and not be motivated to speak to others unless spoken to. This process can continue until the person becomes totally non-verbal. Movement also is affected by withdrawal, becoming less and less as the individual's focus is increasingly on an internal reality.

- *Less communication with words that have a dictionary meaning*
- *Unique word combinations. Listener is not supplied with missing words*
- *Communication with symbols and rhythms instead of words*
- *No use of "as-if" metaphoric, logical comparisons (nurse becomes mom)*
- *Tenses change. Past time becomes present time*
- *Loss of recent memory, hearing, vision and motion*
- *Less conforming to social rules. Person becomes sloppy, few controls*

Feil calls this focus on inner thoughts and feelings, the wisdom to resolve the past.

[1] Feil used the term 'Stages of Disorientation' for many years. Later, it was changed to 'Phases of Resolution' to differentiate between the STAGE of Resolution and the Phases of Resolution

The revised titles and descriptions of the Four Phases

Phase 1: communicating well, mostly oriented
Denying, confabulating, energetically and fearfully clinging to what they have not yet lost.

Phase 2: communicating, mostly living in their personal reality
Verbally expressing needs and feelings with few filters

Phase 3: still communicating, mostly internalizing needs and feelings
Expressing needs and feels through movements and sounds

Phase 4: barely perceptible communication, withdrawn
Internalizing their needs and feelings

Why do we have the Four Phases?

Identifying which phase a client is in gives a Validation Practitioner (V/P) an idea of which Validation techniques to use, how close to get to make respectful contact and what sort of response to expect from the other person. It helps set up the V/P's expectations.

Using primarily verbal techniques with a person who no longer communicates with words will not be effective. Using touch, singing or other non-verbal techniques with a person who is mostly oriented could trigger an angry response or further withdrawal. In order to create a trusting relationship with a client, the V/P must observe, listen and feel the different characteristics, and make an evaluation. This evaluation leads to a specific approach: directly in front of the other person or a bit on the side, very close or a normal social distance, intense eye contact or normal eye contact. Once the contact has been made, the V/P must choose among many different techniques and set goals for the Validation session. We adjust ourselves to match the capabilities of the client, in the moment, understanding that these capabilities change over time.

All people's cognitive and physical capabilities change in the course of a day, a week, a year. People in the Resolution Stage of life also experience different levels of cognitive and physical capacities. Often in the morning, people have more clarity of thinking and memory while in the evening, memory is reduced and people are less orientated. A bad night's sleep can lead to less orientation, as can an infection, dehydration or emotional triggers that bring up memories of the past. Older adults struggle to find integrity and that struggle takes a lot of work and affects how they relate to the external reality. All people's cognitive capabilities often deteriorate when there is emotional tension: for example, children get bad grades in school when they frequently hear their parents fighting at home. Their mind is busy facing the fear and has less learning capability.

Emotional needs for security, recognition, feelings of worth and usefulness can affect orientation. These emotional needs can arise from past experiences. When the past feels more important than the present, the individual can become time confused. Feil sees this as the wisdom of older adults to self-heal.

Understanding that clients shift from phase to phase is important for every V/P to know. A person can be oriented and then mostly living in a personal reality, have characteristics of being mostly oriented and then withdraw into a personal reality, be verbally expressing needs and feelings with few filters and then later be perfectly oriented – and every other possibility. It's useful for teachers to have examples of this and reinforce this idea.

Being able to adjust our approach and choice of techniques, to adapt to each shift is one of the qualities of being a Certified Validation Worker.

What do we do with this information?

Validation Practitioners must constantly observe and calibrate in order to adjust to the shifts in phase. During a Validation session, clients often shift phases, becoming more oriented, communicating more both verbally and non-verbally, as their needs and emotions are validated. All older adults have an individual pattern that is typical for them. Some are more stable and remain mostly in one phase. Others shift a little bit over longer periods of time. And yet others make more frequent jumps from phase to phase within 24 hours. Learning what is normal for each client can help a V/P prepare.

If a person is verbal, using open questions to explore the client's present state of being would be good practice. If the person is non-verbal and openly expressing a need or emotion, the V/P might choose the non-verbal technique of mirroring to establish a strong relationship and a practice grounded in empathy to accompany the client in expressing the need or emotion.

Each Validation session with a client has to be treated as new. While the life history remains in the back of a V/P's mind, the individual could be in a different mind-set, a different phase of orientation and need a different sort of approach.

We must embody the first Validation principle: All very old people are unique and worthwhile, focusing on the word, 'unique'. Each moment is unique, each individual is unique in that moment and V/Ps must keep an open mind, an open heart and an array of Validation skills ready to be used at each moment.

First we set up a structure in our minds, we make the phases and their characteristics clear. We do that to be more competent, more grounded. **Then** we work on our flexibility and open-mindedness: people can't be put in strict boxes because, as people, they have many different nuances. For example, we can find characteristics from two phases at the same time, frequent shifts and much more. Feil's phases are the rails that guide us, flexibility and openness are the action.

Sliding Scale

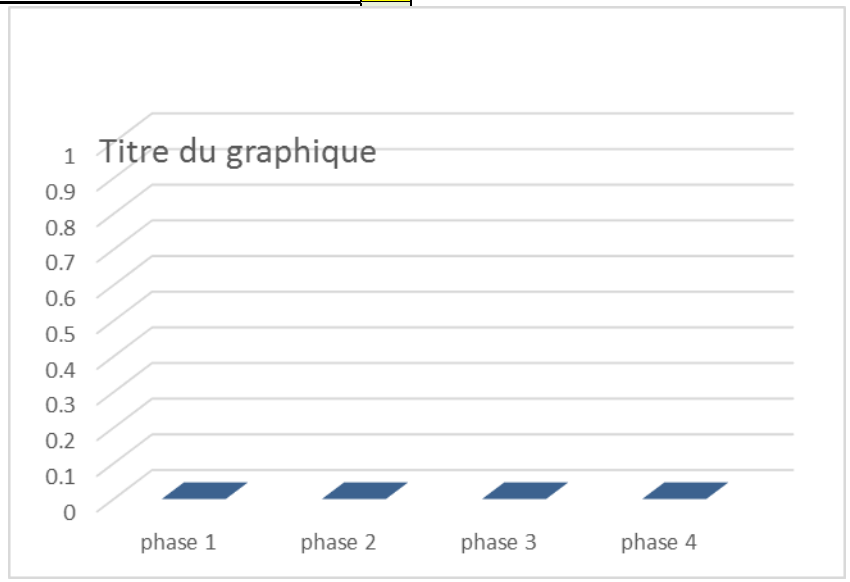
We have developed a sliding scale that can help you and your course participants discover how clients' express characteristics of different phases. This scale is most useful as an excel spreadsheet . The Word document that follows can be used to notate characteristics during a Validation session. Later you can fill in the excel spreadsheet which will automatically calculate the foremost phase of resolution.

This scale can help determine the individual's phase of resolution – **in the moment.**

Place a "1"in the yellow columns when you see a characteristic. Don't worry if there are characteristics in different phases. At the end, you can total the number of points in each column and see how the behavior of the individual can reflect more than one phase of resolution in a highly individual way.

Phase I. Physical Characteristics		**Phase II. Physical Characteristics**		**Phase III. Physical Characteristics**		**Phase IV. Physical Characteristics**	
Eyes are clear and focused. Does not hold eye contact for long		Muscles are loose, graceful movements		Sings but cannot talk in sentences		Eyes are mostly closed, not focused or blank	
Often rigid stance		Eyes are clear, but often unfocused, gazing into the distance		Makes humming, clucking, moaning sounds		Muscles loose	
Movement in space (even in a wheelchair) is definite, sustained, precise		Movement in space is slow, indirect, and often questioning: which way?		Muscles are loose, moves gracefully, but is unaware of movements		Sits slumped in a chair or lies in bed in a fetal position	
Face and body muscles are tight		Speech is slow, voice monotonous and low		Constant movement keeps her/him alive, gives pleasure, controls anxiety, relieves boredom and confirms existence		Has lost awareness of her/his body	
Coat, walking stick or handbag are within easy reach		Hand gestures match the feelings, often questioning		Is incontinent		Movements are barely perceptible	
Reads, writes, figures. Uses dictionary words		Shoulders tend to slump forward, neck down. She/he often shuffles when walking		Eyes are often closed or not focused		**Phase IV. Psychological Characteristics**	
Hears, sees, talks and moves fairly well. Listens		**Phase II. Psychological Characteristics**		Paces		Does not recognize close relatives	
Phase I. Psychological Characteristics		Reality is blurred because of increased deterioration of rational thinking, eyesight and hearing		**Phase III. Psychological Characteristics**		Rarely expresses feelings of any kind	
Holds onto present reality		Capable of expressing emotions, but does not remember facts		Need of speech is lost through disuse		Does not initiate any activity	

Denies confusion or confabulates (make up stories to fill in memory gaps)		A lifetime of experience has given her/him crystallized wisdom; she/he returns to an intuitive knowing		Repetitive sounds stimulate, reassure and help resolve feelings		There is no way of knowing if she/he is resolving	
Usually well orientated in time and space		Remembers sensory feelings from childhood		Has a short attention span. Cannot focus on more than one person or object at a time			
Resists change		Forgets recent events, but has excellent recall for past events that hold strong feelings		Does not respond unless stimulated through a combination of close contact, nurturing touch, voice tone, and eye contact			
Denies feelings (such as loneliness, rage, fear, sexual longings.)		The energy focus is to resolve past unfinished conflicts, to trigger feelings of usefulness and pleasure		Has the wisdom to try to resolve unfinished conflicts through movement			
Blames others when losses become great		Uses unique word forms from early memories, is poetic and creative					
Can not achieve insight into the reasons behind behavior		Tells time by personal feelings, not by the clock. Time is measured by liftime experiences. e.g. A person is hungry for love. Love = food. They demand food right after lunch					
Gets angry at others who cannot or will not use self-control		There is an increasing use of symbols to represent people and events remembered from the past. She/he thinks in (eidetic) images, rather than words					
Resents touch and intimacy. Does not want her/his vulnerability exposed		Responds to nurturing touch and eye contact with decreased stress					



	Likes to sing, loses often ability to commence a song	
	Often retains the ability to read, but loses the ability to write	
	has a short attention span	
	Loses adult controls, often demanding immediate satisfaction of instincts such as sex, love and food	
	Beginning identity loss	

Total	
phase 1	
phase 2	
phase 3	
phase 4	

External and internal factors that influence the shift

External Factors:

1. the environment:

    Being surrounded by people who are known or unknown (strangers or family/friends) creates ease or possibly fear.

    Being in a familiar or unfamiliar place creates ease or possibly fear or anger. Note that anger is often expressed when a person is afraid.

    A change in environment (hospitalization, a change in room or roommate) can create disorientation.

    Odors that are unpleasant can create withdrawal

2. People in the environment (staff, caregivers, family)

    Using a respectful approach or infantilizing, using confrontation or diversion

    Using physical or chemical restraints; these include psychotropic medications, sedatives, confining chairs, bed rails, or any other form of stopping movement

3. Time of day

    The color of sunlight or less light can trigger memories and needs that lead to more disoriented behavior; the approach of sunset can create anguish, agitation, the need to go home, memories of children coming home, etc.

    People often have less concentration in the afternoons or if given sedatives, are groggy in the mornings

    A change in caregiver shift in the afternoons can trigger memories and needs that lead to more disoriented behaviors. When there is more chaos, energy or simply more people running around, some people react by withdrawing inward or becoming more active themselves.

4. Stress in the environment

    Conflicts, rushing, agitation in the staff, caregivers or those present in the environment can create withdrawal (an atmosphere of dis-ease)

    Loud sounds, chaotic sounds, tv or radio played all day or music that is not appropriate can create withdrawal. This includes residents who are yelling all day long.

Other resident's behaviors that create an unsafe feeling can cause withdrawal

Internal factors

1. Cognitive factors such as a stroke or other type of brain damage that makes it difficult to decode reality.

2. Psychological factors such as anxiety can affect memory and orientation.

3. Sensory losses can make it difficult to recognize the environment; this can lead to isolation and anxiety. When sensory information takes a long time to reach the brain, it can feel scary.

4. Fatigue in the morning due to sedatives, bad sleep or nightmares, or in the evening, can affect the phase.

5. Inability to deal with stress in the environment or internally (not enough coping mechanisms).

6. Emotional triggers that bring up memories from the past can cause withdrawal.

7. Pressing needs (in the present or from the past) that are not fulfilled or unheard can create withdrawal.

8. Health problems such as an infection, dehydration or over-medication can cause withdrawal.

Stories from Real Life

1. Orientation to denying, confabulating, energetically and fearfully clinging to what they have not yet lost

Mrs. C, 84 years old had been a hard worker all her life. As a refugee from Europe in 1946 at the age of 3, she was thrust into a scary new world. Her very strict parents put emphasis on learning and being the best. Competition, perfection, striving, working – these words best describe her youth and young adulthood. Marriage and children followed but the role of the 1950s type of mother did not really fit her. She was a free spirit, a painter at heart, someone who wanted to pursue a life of art and bohemian style stuffed into a mold that did not fit her real self. She worked to become the best mother she could be to her children and although the marriage did not last, her second marriage to an artist did. Their spirits were the same and she was freed a bit from the strangling role of 'wife and mother' and allowed to follow her artistic spirit – at least when she wasn't mothering or taking care of her husband.

Mrs. C now lives at home with caregivers who come in two times a day to help with household tasks, cooking and driving her to her many activities. She takes art class, goes to lectures, attends concerts and keeps an incredibly full schedule, enjoying it all fully. There are increasing moments of forgetfulness. She double books appointments. When she realizes this, she blames this on not being able to find her calendar or on the assistant who tries to keep her schedule. She gets confused as to where she is going but then corrects herself and denies having been confused. Her eyesight is getting worse but she still wears the glasses she bought 10 years ago, saying that it's fine and her eyes have stayed the same.

At her classes she is perfectly normal; her friends think she is charming and she can spend a full day at an art museum discussing the differences between Picasso and Miro. And then there are moments when she is fully in Phase One. These moments are usually triggered by any mention of her forgetfulness or decline due to aging. The moments are worse in the late afternoons and evenings when she is more tired and lacks concentration. Her moments of being not well oriented are scary to those around her, the caregivers and her assistant. She mutters under her breath about how stupid they are, pacing the floor, not making eye contact with anyone, slamming cups, saucers and anything she touches. Sometimes she lashes out verbally,

blaming the caregivers for being lazy, blaming the assistant for mixing up her appointments. She denies ever getting angry or behaving in these ways. She denies her losses; she denies her own behavior.
And then she's back to normal, oriented behavior.

2. Orientation to mostly living in a personal reality

Mrs. F had been a happy child with many friends. After she finished high school she got married and had three children. The focus in her household was maintaining a huge social life. There were many parties at her home that she was proud of hosting. Her large circle of friends were always welcome. There was always a pot of coffee and cookies ready for spontaneous guests. This was her life.
At age 83, her forgetfulness was making it hard for her to stay at home. When she left the gas on the stove and there was a fire, that was the signal for her children to talk her into moving into the nursing home where she now continues to live. She has made friends among the residents and is always in the day room chatting with anyone who comes along. She recognizes the people who are disoriented and tends to mother them. She knows where she is, who the other people are, the day and the date. She is oriented but forgetful.
But, when someone mentions her old apartment, she begins to hyperventilate. She switches into a totally other person. Frantically, she calls out, "I have my apartment, don't I?" "Where is my apartment?" She stops making eye contact and goes into her own world. She doesn't know where she is or recognize the people around her. She is expressing her needs and feelings with few filters.
Once this moment is over, and it only lasts around 15 minutes, she is exhausted but back to her normal, oriented self.

3. Orientation (with some cognitive losses) to expressing needs and feelings through movements and sounds

Mrs. Yvonne X was born in 1932 into a wealthy family. She had an older brother who took over the family business, which is now bequeathed to her brother's children.
Mrs. X has always been the "little" one in the family, the person that everyone took care of.

Smart, full of life, and perhaps with the desire to exist for herself, it was at the age of 16 that she decided to go to German-speaking Switzerland to learn German. She met her husband there and they returned to French-speaking Switzerland for his work.
The couple had two children, a son and a daughter. The son died at the age of 40, was single and had no children. Mrs. X's husband died 13 years ago of cancer. It was not long after that she went to live with her daughter, who was also single.

Her daughter found a job after a long period of unemployment. Moving only from her bed to her chair with the help of her daughter due to polyarthrosis problems, Mrs. X could not stay alone with her daughter and no longer wanted to, realizing her daughter's need to take care of herself at the end of a work day. It was then, four years ago, that she was admitted to the home.

During the first few years, Mrs. X actively participated in the activities offered, taking particular pleasure in all aspects of cooking. She maintained courteous relations with other residents. She regularly forgot scheduled appointments (events, meetings with other residents). When others asked for her, she apologized by saying, "Oh, I forgot again, fortunately I have guardian angels to remind me!“

At the end of 2018, the flu and its complications made her bedridden. Her daughter and the team thought they were losing her. After antibiotic treatment, Mrs. X finally regained her strength and began to recharge her batteries with help. However, now she no longer uses utensils, but eats with her hands, and is still able to drink alone with a straw.
In bed or in her geriatric chair, she puts all her energy into repetitive movements. She swings and rubs her clothes, saying yes, yes, yes, yes.

4. Mostly oriented to orientation

Mr. B is 94 years old and lives with his wife who is deteriorated to the point that she needs assistance with walking, bathing and dressing. They now live in an assisted living apartment with home help every day. Mr. B blames everyone around him for doing a lousy job. Caregivers don’t care for his wife well. He goes on the internet everyday and tries to conduct business. He answers the same email 5 times because he can’t remember that he already

answered it. He can't concentrate long enough to read more than a few lines. He can't organize his thoughts and his short-term memory is gone.
His old company still appreciates his input in online meetings and he feels he can participate in these meetings. While Mr. B needs help to get online, he enjoys feeling useful and appreciated for his 50 years of experience.
He dresses in a suit for these meetings and has an assistant help him get online. Once he sees the others, he switches automatically into 'business mode' and is totally oriented, making very useful comments and participating fully and professionally.
After these meetings, Mr. B returns to his blaming behavior. It's clear that the need to feel useful drives him from Phase One to orientation and back.

5. Mostly oriented to living in their personal reality

Mrs. R, now 91 years old, was abandoned at birth and was placed by Public Assistance with a family in Montpellier where she lived all her life. She says she was happy in this family.

At age 20 she married Mr. R, an adjuster at Renault, and had 3 children with him, of whom she is very proud because they did graduate studies. She worked and was very proud to have had a career as a civil servant. She has been a widow for 10 years. She continued to live in their apartment by herself. About a year later, daily life became difficult due to cognitive disorders; she was apparently diagnosed with a Alzheimer disease.

Her children were concerned, and after a family meeting, Mrs. R decided to leave Montpellier to be closer to her daughter in Marseille. She chose and entered a 20-bed retirement home, which is located close to her daughter, who comes to see her regularly.

Soon after her move, she began denying her losses. She accused her children of placing her there: "I could very well stay at home. Each of my children could have cared for me in rotation." She complained of losing her circle of friends, neighbors, and co-workers. Her daughter, asked one of her friends, a validation worker, to care for her. Because Mrs. R was fond of remaining in contact with Montpellier, her daughter bought her a subscription to a Montpellier newspaper. She liked to read this paper and discuss it with her validation worker. She had been the member of a Scrabble club in Montpellier, so her daughter signed her up in a nearby Scrabble club. When it

became difficult for her to play, she accused the other players of being too competitive. So she refused to continue with the club but continued to play Scrabble with her validation worker.

At this time Mrs. R rejected disoriented people. In the summer of 2017, there was a heat wave and Mrs. R, after an episode of severe dehydration, was hospitalized on an emergency basis. She was in a state of extreme distress and was completely disoriented. She became very violent and was placed in a closed psychogeriatric service in a very bad condition. She walked in a near-nakedness, with a newspaper under her arm, a tooth brush in her hand and screaming "I'm from Montpellier, that's who I am." At that time she became partially incontinent and totally lost the ability to play Scrabble and to have a sensible conversation.

In her condition, she couldn't return to the small previous facility and her daughter was forced to find urgently a more suitable facility. In this new facility, when she went to have lunch in the dining room, it felt like the canteen where she used to join her colleagues. After the meal she wanted to get out, go home, saying It's only up the street.

After a bad fall she was given sedatives and strapped into her seat in front of a television watching endless violent scenes related to a local crisis. She shouted "Save yourselves Frenchmen, all the French are being taken captive." She was upset and very distressed. She became totally incontinent, because she is not always taken to the toilet when she asked.

Fortunately, she was able to enter a protected unit with fewer residents, less people and without continuous television. Initially, she was rather in her own world, indifferent to the other patients in the unit. Now, she's recovering little by little and is quieter: her medications were reduced, she takes only a sleeping pill at night. Having more staff attention, she is again mostly continent. In Validation sessions, Mrs R is sometimes confused and in her world. At those moments she is in Phase Two and speaks of herself in the 3rd person: “she loses her memory?” “Does she have a daughter?”It must be hard for her daughter.”

More and more often, when a trusting relationship is established, when there is time and within the safety of her room, there are short periods of time when

Mrs. R is more oriented and puts order in her life. During those moments she says, "my life started badly, but I have had a good life". She asks for the names of her children, grand children and great-grandchildren. This makes her proud. She concludes that she has done a good job, she did what she had to do, she lived well and said: "God may take me. I'm at the end of my life and that's just fine! "
These moments of were also noticed by her daughter, allowing her to rediscover the woman her mother used to be.

6. Mostly oriented to mostly internalizing needs and feelings

Mr. Jean R. is the son of a man who lost his father. Jean studied law and became a judge. More focused on work than affection, he led a brilliant career, working long hours in the office and then at home, while his wife raised their four children.

At the end of his career, Jean tried to secure his legacy in the judiciary. But the successor he installed in his place turned out to hold far different values and commitment. The reports he gets in his retirement from former colleagues give him the impression that what he had built during his professional life was being destroyed.

A great reader, prodigiously fast, with a remarkable memory, Jean, approaching 90 years of age, began to forget. He would read a page aloud and reread it without realizing that he has just read it. Very sensitive, he denied all these mistakes, claiming that he had read something else. At the dining table, on a holiday, he said that he didn't want coffee, then got impatient not to see his coffee arrive. It was pointed out to him that he initially refused it. He replied strongly that he has always had a coffee at the end of meals and that this is not about to change. His wife, understanding the pain he is experiencing by losing his memory, avoids confronting him about his forgetfulness.

Jean had vascular incident which forced him to be placed in a facility. Now, his reactions are feared by the staff of the establishment, and even by his family. He gets angry, and expresses his anger verbally and physically when he is touched, forced, or even just invited to eat, or to be washed in the mornings. During family visits, he closes himself off and can get angry if the family is silent for too long or if his relatives try to talk to him when he cannot answer.

The family shorten their visits. Only his wife seems to be able to stay with him, patient when he gets carried away.

7. Mostly living in their own personal reality to orientation

Mrs. Suzanne G is over 90 years old. She is living in the nursing home in her native village where she chose to enter five years earlier. The eldest of four children, she and her husband ran a small food business. She was very popular with customers, known for her sweetness, kindness and smile. When the business closed due to competition from the giant supermarkets, Suzanne and her husband found work in a bank. She worked at the customer reception desk where her discreet sweetness continued to be highly appreciated. After Suzanne suffered through a badly handled miscarriage, the couple were never able to have children. Suzanne took great care of her nephews, and then the next generation of her relatives. Her husband died two years before his retirement. Once she retired herself, she sold her house and returned to her home village to be closer to her family.

As she approached her 90th birthday, she decided to move to the nursing home. Used to living alone since the death of her husband, she found many points of contact, meeting people from her youth, getting attached to the staff, and always surrounded by her family. Passionate about travel, fond of music, she reads magazines and watches documentaries on television. Sometimes, she mixes up different times of her life. She tells her niece about her own sister thinking that her sister, her niece's mother, is her own mother. Then, she is like a child who just realized that her mother has died, while her mother died as an elderly woman in a long-term care facility. At that moment, she is sad as if her mother just died.

These episodes are of short duration. At other visits, she is fully present, asking for news of all the members of the family, her sister, her sister-in-law, her 2 nephews and 9 nieces, her little nephews whose names she knows, remembering each other's work, each other's worries, following the path of each in her mind and heart.

8. Living in their personal reality to mostly internalizing needs and feelings

Mrs. Claire F is the youngest of 4 children. Her parents were a loving, affectionate, and very religious couple. Her father was a small independent craftsman, and her mother kept the accounts of this small business of honest,

modest and simple people. The couple was affected by the death of a son at the age of 18, who died of sepsis.

Claire F had 4 children. She led a happy life with her husband who was devoted to his family, hardworking, serious and faithful. A stay-at-home mother, she devoted herself to her children and husband, running the household with a beautiful and joyful energy and an innate sense of economy. Her 70-year-old brother died of cancer and her older sister died peacefully at the age of over 90.

At over 90 years of age, after the death of her husband, she left the family home, which she found unsatisfactory and far too big for her, to enter a protected living establishment. Surrounded by her children and grandchildren, she always welcomed them with her bright smile. Now her memory confuses times and generations. She addresses her son as if he were her brother and tells him about her son. She sometimes worries at the end of the day about having to go home to cook for her husband. When she participates in activities, she then worries about her husband waiting for her, anxious not to linger.
Enjoying good health, Claire F lives many more years in this establishment. She sleeps for many hours. Naturally shy, and uncomfortable in speaking, Claire speaks less and less. But when the caregivers give her care, or when her family comes to see her, she naturally and actively seeks contact, placing her hand on their arm, in a back and forth movement of her thumb, which makes it like a caress. She opens her eyes, and her face lights up in the other's eyes.

9. Internalizing needs and feelings to barely perceptible communication

Mrs. M was born in 1918 into a military family (very authoritarian officer father), mother from a noble family with no money (seamstress). She was the second child of 3. She was active in scouting as a girl.
She studied law and met her husband there. Her husband, who was a young officer in the Resistance, was taken prisoner by the Gestapo and sentenced to death, was able to escape. This was a very difficult time for her.
The eldest son was born in 1944 and she was the mother of 5 children. She had two miscarriages, which was traumatic for her.
She had a good relationship with her husband, who was a soldier. She and her husband were always independent and autonomous from each other.

Mrs. M had a very strong character and was very willful. Her motto: you always have to be active and busy. She led her family with a stick. Despite her large family, Mrs. M did not only want to be a stay-at-home mother and did everything possible to work as a teacher. She taught Latin, history and geography. Mrs. M was always very coquettish and wore high heels. She loved being with friends, entertaining friends, playing bridge. She was never inactive. When her husband, a retired officer, went to Africa to train future officers, Mrs. M, who was retiring, created a real estate agency and worked there until the age of 73.

She was a widow at 67 years of age, got used to living alone and continued her activities, even through her grief. She cared a lot for her daughter's two daughters, who lived with her during the week after their parents' divorce and for several years until adolescence, when they lived full time with their mother. This separation with these little girls, whom she loved to take care of, was very painful for Mrs. M. She did not take it well.

Memory problems gradually appeared and signs of disorientation: she could no longer find her car and was driving more and more dangerously. She was 78 years old at the time. She mistook her landlord for a butcher. She was in complete denial and was making up explanations to cover her mistakes. Suddenly, she became angry and thought that people were laughing at her or saying bad things about her behind her back.

She had a stroke and her children had to trick her into confiscating her car. She wanted to continue driving. After a second stroke, they had to set up a home helper during the day and at night. She didn't accept this well and blamed a lot of things on her home helper: stealing her laundry, drinking wine in secret and also blamed many people about everything that went wrong. Sometimes, often at the end of the day, she said she had met her great aunt (with whom she spent her childhood holidays) and had spent an "absolutely delicious" time with her. She regularly talked to empty chairs when her daughter ate with her, as if she was talking to her little girls: "I already told you not to put your elbows on the table."

She lived like that for several years at home, withdrawing more and more in her own world. Following an episode of severe dehydration, linked to a heat wave, and a hospitalization, Mrs. M had to be placed in a retirement home. She was aphasic for one month, after which she was able to say a few words and express sounds, but there were no more complete sentences. She no longer walked independently, due to ankylosis and some paralysis of the ankles, but still liked to walk with the physiotherapist on her toes. Sitting in her armchair, she constantly passed her left leg over her right leg. She would unbutton and re-button her sweater all the time, or smooth her scarf with care. She screamed as she passed her hand over her cheek.

When her ankles were paralyzed and she couldn't move, as her daughter says, she "had been a fighter, a warrior, gave up the fight." There was no more screaming, no more sounds, no more eye contact and she died after a few months.

Her daughter, who confided this story to us, said: “Mom died on Easter Day, which fell that year on my father's birthday. She had always said that Peter, her husband, would be her ferryman for the afterlife!“ (The word Easter means "passage")