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The Biomedical Deconstruction of Senility and the Persistent Stigmatization of Old Age in the United States

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This oft-quoted characterization of the seventh and final stage of a person’s life has usually been taken as a commonplace of old age: this period has always been stigmatized. In particular, the mental losses associated with age, “second childishness and mere oblivion,” have been among the most deeply stigmatized conditions. In its frightening totality—effacing the memories and abilities that are widely seen as the very essence of personhood—senile dementia seems to taint the entire experience of aging. In its relentless inevitability, deeply associated with aging and the mere passage of time, it makes a mockery of the achievement of longevity.

But if senility has always been stigmatized, it has not always been stigmatized in the same way. In this chapter, I will discuss some of the complexities of the stigmatization of senility in the United States since World War II. In doing so, I intend to challenge the view that the causes of stigma are ignorance and mystification and that the remedy, therefore, is scientific progress and education. Stigma is the product not simply of ignorance but of deeply felt anxieties about the coherence and stability of the self. To be sure, scientific progress and education remain important for a variety of reasons, but they will not address the sorts of anxieties that produce stigma.

After World War II a diverse array of professionals in the emerging field of
gerontology sought to remove the stigma surrounding senility and old age through scientific understanding and education. By the late 1970s, they sought to destigmatize aging by recasting senility as Alzheimer’s disease, a problem in the brain, not of the mental or moral fortitude of the person suffering from it. Since then, researchers can claim much in terms of scientific progress and public education concerning Alzheimer’s. Yet I will argue that Alzheimer’s remains at least as stigmatizing as “senility” was before it, and that this stigma continues to overshadow the entire experience of aging.

**Representing Senility in the Modern United States**

Since the late nineteenth century, representations of senility have been part of a broader narrative on the fate of old age in modern society—about whether the aging body and mind could possibly keep up with the frenetic pace of change in an industrial and postindustrial age. The image of the senile, especially of the senile man, has been one of the most prevalent stereotypes for managing anxiety about the coherence, stability, and moral agency of the self under the conflicting demands of liberal capitalism.

There is perhaps no better example of the stereotype of the senile than that found in the writing of George Miller Beard, the New York neurologist who, in the 1870s and 1880s, popularized the diagnosis of neurasthenia, an ailment that many historians have seen as emblematic of late-nineteenth-century American anxiety about the pace of modern industrial society. Historians of aging have seen him as one of the principle architects of the scientific legitimization of the denigration of old age (Achenbaum 1978, 46–47; Graebner 1980, 30; Cole 1992, 161–190).

In Beard’s *Legal Responsibility in Old Age*, first published in 1874, we can see the modern stereotype of the senile in its most characteristic and vitriolic forms. Beard asserted that the brain and the mental and moral faculties that depended on it were subject to deterioration and in fact normally would decline more rapidly than the rest of the body. “Men die as trees die,” he argued, “slowly, and frequently at the top first. As the moral and reasoning faculties are the highest, most complex and most delicate development of human nature, they are the first to show signs of cerebral disease; when they begin to decay in advanced life we are generally safe in predicting that, if neglected, other faculties will sooner or later be impaired. When conscience is gone the constitution may soon follow (Beard 1979, 11).

For Beard, senile mental deterioration could only be regarded as a calamity, signifying the start of the gradual, vegetative process of death—the slow, top-down withering away of a life. The dissolution of the intellectual and moral faculties was not a simple process, however. “Very few men decline in all the moral faculties,” Beard observed. “One becomes peevish, another avaricious, another
misanthropic, another mean and tyrannical, another exacting and querulous, another sensual, another cold and cruelly conservative, another vain and ambitious, and others simply lose their moral enthusiasm, or their moral courage, or their capacity of resisting temptation and enduring disappointment” (11). Beard thus represented the senile in a number of characteristic guises—as miser, tyrant, fool, and dirty old man.

Whatever the particular form, Beard represented the senile as hopelessly out of step with the times. Failing to fulfill the complex intellectual and moral tasks required of individuals in modern society, the senile were ultimately an obstruction to progress. Beard thought that the biologist Louis Agassiz, who died shortly before Legal Responsibilities was published, was a perfect example. “The intemperate manner of his opposition to the theory of evolution,” Beard argued, “by which he was so rapidly winning favor among the thoughtless and ignorant, and so rapidly losing favor among the conscientious and scholarly, may find its partial, if not complete explanation in the exhausted condition of his brain” (11n).

In pointing to Agassiz’s unwarranted influence on the “thoughtless and ignorant,” Beard represented the senile as dangerous. Society could no longer afford to indulge a reflexive reverence for the aged. Most people, Beard feared, revered the aged blindly and disproportionately and were credulously persuaded by the opinions of the aged on the merits of past accomplishments or, what was worse, on the merits of age alone (19–20). In the case of Agassiz, the “conscientious and scholarly” would revere Agassiz for “the original work that he did before his fortieth year” (emphasis in the original). But they would not be influenced by his late opinions, which were clearly the product of the mental deterioration of aging, a sign of what was “well known” to Agassiz’s friends—that he actually “began to die” long before his death in 1873 (11n). Beard’s representations of the senile as dangerous extended also to practical affairs of public and private life, where the senile were perhaps even more disruptive. “Corruption in political and business life, and breaches of trust, are very common among the old, as every morning newspaper bears witness,” Beard asserted; and “offenses that depend on the sexual passion are not infrequent among the aged; for it is a fact of interest that in the decline of life we sometimes return to the vices of youth” (30).

Overall, the impressive variety of moral and intellectual failures used by physicians such as Beard to illustrate male senility can be read as a catalog of nineteenth-century middle-class anxieties about a masculine self imperiled by progress. The dominant gender ideology in the Victorian era figured men as aggressively competitive and bold. The moral failings and calamities that Beard ascribed to senile men threatened to undo a man at every stage of his life in this highly individualistic and competitive society. Projecting these failings onto a figure—the aged man—visibly marked as decadent and diseased helped restore
a sense of moral stability. Whatever particular guise that figure might take, he was always and above all the very picture of the ruined man. But if the doddering old man, afflicted with cerebral degeneration of one sort or another, might unravel under the conflicting pressures of the modern world, the young man, in his intellectual and moral prime, would surely flourish.

The stereotypical representation of the senile man as presented by Beard remained dominant in medical and popular texts through the 1940s. It can be clearly seen, for example, in William Osler’s (1979) infamous joke that men, having forfeited their productivity and creativity as they aged, ought to be euthanized at the age of sixty-five. Ignatz Leo Nascher, in Geriatrics, published in 1914, devoted a chapter in the textbook to “sexual perversion,” examples of which were always figured male. These, he argued, were not indications of “depravity or inverted sexuality,” as they were in the young. Rather, the condition was simply a reflection of the “weakened mentality [and] diminished control over the emotions” that afflicted old men (Nascher 1979, 504–506). Many gerontologists have argued that it has persisted as a salient representation of aging down to today (Shenk and Achenbaum 1994; Nelson 2002).

The Gerontologic Persuasion in the Postwar United States

Following World War II, the popular and professional literatures on aging were reshaped by the creation of gerontology as a field of research and practice by a diverse array of biomedical and social scientists, policy makers, activists, and entrepreneurs interested in tapping the “gray market.” These various groups, allied only loosely and at times in conflict with one another on various matters of policy or analysis, nonetheless shared an optimistic attitude toward aging and a commitment to improving the lives of the elderly—what I term the gerontologic persuasion (Calhoun 1978; see also Achenbaum 1995; Katz 1996).

To those imbued with the gerontologic persuasion, negative attitudes toward the elderly no longer seemed tenable. Consigning the fastest-growing segment of the population to “corner rocking chairs, to lifeless rooming houses, and even to mental hospitals” was increasingly seen as a major threat to the future prosperity of the nation (Tibbitts and Sheldon 1952, 2). The gerontologic persuasion of the post–World War II United States set out quite literally to reverse the negative assumptions about old age that had dominated discourse about old age since the late nineteenth century. Where the old, and particularly old men, had been seen as unable to adjust to modern society because they were decrepit and senile, gerontologists and other advocates for the elderly began to argue that the elderly were in fact made decrepit and senile primarily because modern society no longer made a place for them. The relentless adoption of new technological and bureaucratic means of production, it was argued, deprived
older men of their traditional place in society as essential repositories of valuable wisdom and experience. The problems of aging were thus seen as an unintended—and unnecessary—effect of modernization.

This idea was formalized by Yale anthropologist Leo W. Simmons, in his widely influential 1945 book, *The Role of the Aged in Primitive Society*. Synthesizing and statistically analyzing ethnographic literature on seventy-one preindustrial cultures from around the world, Simmons argued that different types of cultures produced different attitudes toward and roles for the aged. Although ostensibly concerned in this work only with “primitive” cultures, his implicit comparison of the exotic opportunities for fulfillment open to the elderly in these cultures with the dead end of modern old age constituted a powerful critique of the treatment of the aged in modern society. In a later article, Simmons made the comparison explicit. “In anthropological perspective,” he wrote, “it is literally true that societies achieved a very good old age for a few long before there could be any substantial age at all for the many. But modern civilization has reversed the process and the problems” (1952, 43). He went on to argue that while senility was a virtually universal phenomena, it was an ascribed status whose timing was culturally contingent. Senility was not an objectively measurable state of physical weakness, mental infirmity, or both, but an ascribed status of uselessness and burden, a status that “may be attained under various degrees of physical and mental debility in different societies.” Although all societies evidently made some distinction between old age and senility, the senile phase of old age “has had little significance for the simple societies which were never able to sustain more than a few really old people anyway, and those under conditions in which the very helpless could not long survive.” This was not true for modern society, where this “helpless and hopeless period of life [was taking] on paramount importance” because economic and medical progress was successfully removing the physical barriers to old age. “While modern civilization has greatly progressed in the promise of longer life for larger proportions of the population,” Simmons argued, “it has disrupted many of the time-tested adaptations of the aged, and perhaps even regressed in its solution of the problem of successful aging.”

Yet Simmons remained optimistic. The ultimate lesson for modern society was that “the basic qualities of successful aging rest . . . upon the capacity of individuals to fit well into the social framework of their own times, to win their rights to prolonged participation and recognition, and to know when they are through.” In short, society had only to cease dwelling on the problems of old age and focus instead on its opportunities; society could not solve the problems of old age for the elderly, but could allow the elderly to create meaningful roles for themselves. “It is possible that these potentialities wait to be rediscovered, developed, and refitted into our own times,” Simmons concluded. “This may, indeed, be an old frontier that calls for new pioneering” (44. 50–51).
This account of the problems of aging as the pathological by-products of modern society was explicitly or implicitly present in most discourses on aging through the 1960s. For example, sociologists and educators writing about retirement argued that the challenges it posed to the elderly and society were unprecedented; the need to cease remunerative labor at the arbitrary age of sixty-five was a product of the vagaries of industrial society’s labor market, and society was challenged to find new meanings for old age that had traditionally been supplied by work (for example, see Donahue and Tibbits 1950; Kaplan 1953; Friedman and Havighurst 1954; Havighurst 1960). Similarly, problems associated with the family and social network of the elderly were typically attributed to modernization; the report of the first White House Conference on Aging, held in 1961, suggested that issues within family life and friendships were the result of the rural-urban population shift and of improvements in transportation and communication that increased mobility and undermined traditional patterns of caring for the elderly within families and neighborhoods (U.S. Department of Health, Education, and Welfare 1961, 223–224). But the idea that modern society created the problems of aging was perhaps most prominent in psychiatric discourse, where it was employed as an explanation for mental deterioration in old age. For example, in David Rothschild’s account of the social origins of senile dementia, he argued that “in our present social set-up, with its loosening of family ties, unsettled living conditions and fast economic pace, there are many hazards for individuals who are growing old” (1947, 125).

Other psychiatrists took this approach further, arguing that brain pathology itself was a symptom of social pathology. Maurice Linden and Douglas Courtney argued that “senility as an isolable state is largely a cultural artifact and . . . senile organic deterioration may be consequent on attitudinal alterations” (1953, 912). The authors acknowledged, however, that this hypothesis was difficult to prove. David C. Wilson, writing in 1955, was less circumspect, arguing that the link between social pathology and brain deterioration was simply a matter of waiting for “laboratory proof” to support what was adequately demonstrated by clinical experience—that the “pathology of senility is found not only in the tissues of the body but also in the concepts of the individual and in the attitude of society.” Wilson cited the usual hallmarks of pathological social relations in old age: the breakup of the family, mandatory retirement, and isolation. “Factors that narrow the individual’s life also influence the occurrence of senility,” he asserted. “Lonesomeness, lack of responsibility, and a feeling of not being wanted all increase the restricted view of life which in turn leads to restricted blood flow” (905). The pathology of modern society, it seemed, could be discerned within the constricted blood vessels of the aging brain.

Whatever the merits of this model of the social production of “senility” as an account of the pathogenesis of dementia, those who embraced it were generally
successful in winning a series of significant policy changes that helped to transform the experience of aging in America after the 1960s. The material circumstances of old age were markedly improved, with people over age sixty-five moving from the poorest age group to one of the best off; significant legal protections had been won against age discrimination in the labor market, negative stereotypes were challenged, and the elderly themselves organized for political action on their own behalf in large and influential advocacy groups such as the American Association of Retired Persons (AARP) (Calhoun 1978; Laslett 1991; Haber and Gratton 1994).

The Biomedical Deconstruction of Senility

With these developments, the expansive concept of senility that had been the basis of psychodynamic psychiatry and gerontology in the 1940s and 1950s was no longer seen in the gerontologic movement as an effective way to approach the problem of aging. To a more aggressive and politicized group of gerontologists and aging advocates in the 1970s, ageism had become a keyword in their efforts. The term was coined by Robert Butler in 1968 to describe the “process of systematic stereotyping of and discrimination against people because they are old, just as racism and sexism accomplish this with skin color and gender” (1975, 12). One of the worst aspects of ageism was the belief that the process of aging entailed inevitable physical and mental decline. Virtually all the physical and mental deterioration commonly attributed to old age was more properly understood, Butler and other gerontologists argued, as the product of disease processes that were distinct from aging. The term senility was thus particularly obnoxious, in Butler’s view, and ought to be abolished. It was not a medical diagnosis at all, but a “wastebasket term” applied to any person over sixty with a problem. Worse, it rationalized the neglect of those problems by assuming that they were inevitable and irreversible. “Senility is a popularized layman’s term used by doctors and the public alike to categorize the behavior of the old,” Butler argued. “Some of what is called senile is the result of brain damage. But anxiety and depression are also frequently lumped within the same category of senility, even though they are treatable and often reversible.” Because both doctors and the public found it so “convenient to dismiss all these manifestations by lumping them together under an improper and inaccurate diagnostic label, the elderly often did not receive the benefits of decent diagnosis and treatment” (9–10). Butler did not discount the reality of irreversible brain damage, as had an earlier generation of psychiatrists. Rather, he argued that the ageist refusal to systematically distinguish the various physical and mental disease processes from one another and from the process of aging itself exacerbated the tragedy of mental illness in old age.

From his position as first director of the National Institute on Aging (NIA),
established in 1974, Butler focused on making funding for research into Alzheimer’s disease a priority. In so doing, he played a key role in breaking down the broad concept of senility that was aggressively pursued in biomedicine in the late 1970s and the 1980s. In part, deconstructing senility involved developing effective diagnostic procedures to systematically distinguish between irreversible dementias produced by conditions such as Alzheimer’s disease, and reversible dementias caused by treatable conditions (National Institute on Aging Consensus Task Force 1980). More important, it entailed recasting irreversible progressive dementia in old age as a number of disease entities distinct from aging—the most prominent being Alzheimer’s disease. This was accomplished by clinical neurologists, neuropathologists, and biochemists who entered the field in the late 1960s and 1970s. In the view of this new generation of researchers, Alzheimer’s disease was clearly to be regarded as a brain disease, and research returned to the conundrums involving the correlation between pathology and dementia, and the distinctions that could be made at a pathological and clinical level between disease and aging and between presenile and senile dementia. Far stronger correlations between pathology and dementia were made by the British group of Blessed, Tomlinson, and Roth. American researchers led by Robert Terry and Robert Katzman dropped the distinction between Alzheimer’s disease and senile dementia, arguing that at both the clinical and the pathological level, they were identical. More important, this new generation of researchers argued that this entity was not part of aging, but was a disease whose mechanisms could be unraveled through basic research leading eventually to effective treatments and ultimately prevention—hence their insistence on the term Alzheimer’s disease rather than the more general senile dementia or senility (Katzman and Bick 2000). There was nothing especially new in these arguments; they had all been made, albeit more tentatively, decades earlier. Nor did research of this period end debate around these issues. But in the context of the 1980s, these claims did allow researchers, aging advocates, and policy makers like Butler to make a convincing case that public resources should be allocated for research into Alzheimer’s disease. This case was very persuasive in the federal arena, with the result that by the end of the 1980s, the NIA budget for Alzheimer’s disease research had increased by more than 800 percent (Fox 1989).

The Persistence of Stigma

But if this biomedical deconstruction of senility has been a clear success in winning public support for research into Alzheimer’s disease, it has been at best ambiguous in lessening the stigma of old age. Alzheimer’s disease advocates often claimed that the new conceptualization of the disease, based on advances in neuroscience, and the ambitious public awareness campaigns that had
accompanied it had lessened the stigma of late-life dementia. But there is much evidence to suggest that stigma has in fact been heightened.

Educational material aimed at the general public and Alzheimer’s victims and their families in particular frequently contained assurances that there was nothing stigmatizing about Alzheimer’s. “There is no reason to be ashamed or embarrassed because a family member has a dementing illness,” the authors of *The 36-Hour Day*, the most popular guidebook for families of Alzheimer’s victims, assured readers. “Many brilliant and famous people have suffered from dementing illnesses. Although dementias associated with the final stage of syphilis were common in the past, this is very rare today.” Similarly, they thought that if the public understood that the unsettling behavior of the demented was a symptom of a disease, stigma would be lessened. “It is important for those around him to remember that many of the person's behaviors are beyond his control: for example, he may not be able to keep his anger in check or to stop pacing the floor. The changes that occur are not the result of an unpleasant personality grown old; they are the result of damage to the brain and are usually beyond the control of the patient” (Mace and Rabins 1981, 7–9).

But such formulations fundamentally misconstrue the nature of stigma. Stigma is more than the degree to which the suffering of victims can be attributed to something being “wrong with them,” or to which they “brought the suffering on themselves.” Stigma is the amount of anxiety surrounding the boundary between the normal and the pathological. Put another way, stigma is directly related to the social stakes of a particular set of behaviors or symptoms that are judged to deviate from some notion of normal. (These behaviors and symptoms may or may not be brought together under the rubric of a disease category.) The behaviors and symptoms commonly brought together in the category of having a cold are not deeply stigmatized, even though those who cough, sniffle, and sneeze clearly have something “wrong” with them, and are often “blamed” for their failure to rest properly, take vitamin C, suck zinc lozenges, or drink echinacea tea. There is simply too little at stake in whether one does or does not have a cold for it to be highly stigmatized.

In the United States at least, the stakes involved in behaviors and symptoms variously called senility or Alzheimer’s disease became enormous in the twentieth century, calling into question the very personhood of those who exhibit them. Alzheimer’s attacks the cognitive skills necessary to maintain both an inner sense of selfhood and, perhaps more important, to present a stable and coherent self to others. “This illness strikes at the very core of our being, depriving the individual of the qualities that endeared them to all around them,” writes one physician in the foreword to a caregiver’s account of the disease. “There is little physical pain, disfigurement, or mutilation. . . . Instead, the disease insidiously robs the victims of their unique thought processes, their insights, their judgment, their ability to learn new information. Without these
capabilities, the adult human regresses to an earlier, dependent life” (Ellis 1991, vii). As a result of these losses, dementing persons have been deeply stigmatized—not for having the disease per se, but for their resulting inability to carry off their role as respectable middle-class individuals. Nor could attributing these failures to changes in the brain that are beyond the control of the victim lessen the stigma, for loss of self-control, awareness, and personal responsibility are themselves perhaps the most horrifying things imaginable to middle-class Americans. Consider the promotional copy on the back cover of a sensational “supermarket” paperback on Alzheimer’s disease titled The Living Death: “They steal. They shoplift. They’re violent. They ‘expose’ themselves in public. They’re verbally abusive. They lie. And they don’t know any better. Meet some of the 4 million Americans who have Alzheimer’s disease in the pages of The Living Death” (Lushin 1990). The Alzheimer’s disease victim, it seemed, was guilty of the most loathsome violations of propriety. In his or her total loss of self-control, the sufferer, as portrayed in the stereotype, was the epitome of the failed individual, just as the figure of the senile man had been in the nineteenth century.

Representations of the Alzheimer’s disease victim were a means of maintaining the distinction between decent, middle-class citizens and the sort of failures invoked on the back of this paperback. Thus, if the exemplary Alzheimer’s disease victim was, before the disease struck, a solid, respected, middle-class citizen—as represented by Alzheimer’s advocates—he or she became someone or something quite different as the disease progressed. The stereotypical Alzheimer’s sufferer was in fact at the outer limit of stigmatization—often represented as a stranger, a ghost, a shadow, a nonperson. This distinction between the stable, respectable self before the disease and the confused, discredited self that was lost to the disease was at the core of representations of the Alzheimer’s victim, which were frequently instantiated by the Alzheimer’s Disease and Related Disorders Association (ADRDA). For example, in 1984, the association began using a graphic that consisted of a series of close-up photos of an attractive, intelligent-looking woman in her mid-fifties. Each photo was identical, except that, moving from left to right, they faded from sharp black and white to gray, with the last image virtually blank—suggesting visually the gradual effacement of the self. In its newsletter, in a brief caption explaining the graphic, the association noted that “the image of the [Alzheimer’s] victim ‘getting further away’ is reflected throughout ADRDA’s posters, magazines and newspaper advertisements, as well as in the theme song, ‘It’s a Long Goodbye’” (ADRDA 1985).

The persistence of stigma clinging to Alzheimer’s and aging was perhaps most perfectly articulated in Beyond the Thin Line, a little-known novel by Robert Gard, published in 1992. Gard had written some forty books before this novel, most of them dealing with life, history, and culture in Wisconsin. According to the report on the book’s dust jacket, at age eighty-two Gard was an excellent
example of what gerontologists describe as successful aging. “Never even thinking of retiring,” he maintained “a heavy schedule of writing, teaching and lecturing.” Gard characterized the book as “a fictional synthesis of one of the great human dramas and tragedies of our time—Alzheimer’s disease,” one based on his experience of watching a longtime friend become demented (Gard 1992, ix–x). In a long passage describing the subtle early indications of dementia in his friend, Gard vividly describes his own fears of dissolution. Observing the residents of a nursing home to which his friend has been confined, Gard senses that they have all “passed some invisible line. They can never come back and their families know this and perhaps have witnessed it happening over years, but they could not prevent, nor could they identify exactly when their loved one crossed the line of no return” (21). But where was this line? How and when did one cross over it? “The line is a mystery. Little by little it becomes knowable to friends and family, but hardly ever to the stricken persons. Often they are unaware of the presence of such a line. My friend Harry didn’t know, but his friends became slowly aware, very slowly, and in some disbelief. They didn’t understand” (22). Gard describes a number of incidents that occurred during Harry’s descent into dementia, a recounting that culminates with his discovery that Harry was on a locked ward of the Veteran’s Hospital, where he had been admitted for diagnosis because he was apt to wander away and become lost. “I could only feel shocked, and conferring with other close friends of Harry I learned that it was all true. Little by little Harry had been slipping toward the line” (23).

For Gard, finding this line was crucial, for it defined the boundary between the normal and the pathological, between a coherent, stable self and the incoherent, chaotic dependency of dementia. Yet the line was almost impossible to detect, except when it had been irrevocably crossed. It could only be discerned through the closest scrutiny of the behavior not only of others but of oneself as well.

I found myself beginning to watch for the line in several older friends and even in myself. I began taking careful heed of where I put things, of noting what my daily habits were and if I ever varied from them unknowingly. Sometimes I thought I could discern small lapses—at home I would head for another room to get a certain object and entirely forget what it was I went to fetch. I learned that these small signs were almost universal in older people, however, and that the larger lapses, the confusion, the wandering away were more serious. Of these I was not guilty, and I noted that in my public addresses, of which I gave a fair number, my train of thought was never broken or inextricably lost. I could talk for two hours without notes and never lose track of where I was. I was told that this was encouraging, and that I was certainly not yet approaching the line. But the line
became an antagonist. In my imagination it grew almost into a living thing, a reality, and I fancied I saw it often drawn for this person or that. When one considers the line it becomes easy to think in negative terms, and to become fanciful about many aspects of life. Often I heard friends say, “The thing I dread most is becoming senile,” and I wondered whether they too were aware of the line. (21–23)

Although Gard felt reassured that he was not “guilty”—that he was not approaching the line beyond which his status as a responsible, respectable person would be open to serious question—that reassurance could never be more than provisional and temporary. Despite being a prolific author, despite maintaining a fully active and productive life into his eighties, Gard continued to carefully scrutinize his behavior and that of those around him, trying desperately to detect the line of no return. Why was this so important to Gard? Even if its signs were detected early, nothing could be done to prevent Alzheimer’s disease. In paying such careful attention to the signs of approaching dementia in himself and others, Gard was trying to reassure himself that his selfhood was secure and stable.

Despite the best intentions of professionals in medicine and gerontology to destigmatize old age by recasting senility as Alzheimer’s disease, the latter a more clinically precise term and a disease entity that is slowly yielding its secrets to the explorations of biomedical science, their discourse has merely reinforced the boundary line that separates the senile from the rest of us. That line emerged, at least in its modern form, in representations of the senile that appeared toward the end of the nineteenth century. But it is a line that palpably remains with us, structuring knowledge, policy, and the experience of every aging individual—a line that has been drawn and redrawn in the hope that somehow it need never be crossed.

NOTES

1 The distinction between Alzheimer’s disease and senile dementia had been problematic from the moment it had been made. By the 1940s, as research pointing to the clinical and pathological similarities of the two conditions piled up, researchers were hard pressed to maintain the distinction, though for a long time the logic of age categories remained compelling. This can be seen in a 1941 article by William McMenemy and Eugene Pollack, in which they argued that the distinction between senile and Alzheimer’s presenile dementia should be made not on the basis of pathology, but on whether “the mental illness commenced at an age when the patient still retained normal vitality, the decline in which is usually evident somewhere between the ages of 60 and 70” (683). A decade earlier, William Malamud and Konstantin Lowenburg (1929) had argued that their own findings and the preponderance of evidence in the literature suggested that Alzheimer’s disease was not limited to the presenium, but that nonetheless the distinction should be maintained on pragmatic grounds. Since little was actually known about senility, saying that Alzheimer’s disease was a form of
senile dementia would not add anything to the understanding of Alzheimer’s but would blur the meaning of senility by linking it to conditions occurring in earlier ages. In 1936, Rothschild and Jacob Kasanin argued that practical considerations dictated the opposite: because the pathological pictures were so similar, advances in understanding Alzheimer’s would have the practical benefit of shedding light on the larger problem of senile dementia. “It is evident,” they concluded, “that in a broad discussion of Alzheimer’s disease one must include also the problems of senility in its normal and pathologic aspects” (293). The distinction between Alzheimer’s disease and senile dementia persisted in official nosology until the mid-1970s, but in 1940 it had little meaning. Most researchers of this period acknowledged that Alzheimer’s disease and senile dementia were for all practical purposes the same entity, but found no compelling reason to abandon the traditional distinction.

2. British psychologist Tom Kitwood has claimed that the best contemporary correlations leave as much as an 80 percent variance between pathology and the degree of dementia. Kitwood is one of the few contemporary researchers working with a psychodynamic model of senile dementia, one that is very similar to Rothschild’s. See Kitwood (1987, 1989, 1997).

3. Of course, this is not to suggest that people who, in one way or another, are outside the broad notion of “middle class” do not suffer from Alzheimer’s disease. Indeed, one would expect—political representations notwithstanding—that factors such as poverty would compound the suffering of Alzheimer’s disease. But this broad notion of middle class dominated the Alzheimer’s disease movement (as it dominated most other areas of American culture). The experiences of other people have not been represented in the Alzheimer’s disease policy discourse, and it would require another sort of study to bring that experience to light.

REFERENCES


