

Some Observations on the Social Consequences of Forgetfulness and Alzheimer's Disease: A Call for Attitudinal Expansion

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The stigma associated with Alzheimer's disease has arisen from at least three sources in American society: (1) the lack of understanding and fear that persons experiencing forgetfulness and their family members may have when encountering symptoms of Alzheimer's disease; (2) emphasizing the negative consequences of the disease to gain political support for policy change; and (3) scientific reductionism wherein the person is reduced to sets of pathological behavioral and biological signs and symptoms. This article is a plea for a change in the way the condition commonly known as Alzheimer's disease is both publicly and professionally understood in our society.

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A PLEA FOR CHANGE

This article is a plea for a change in the way the condition known as Alzheimer's disease is both publicly and professionally understood in our

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society. Reflecting on issues of aging and memory, we will highlight the way in which the human process of forgetting as we age has been pathologized into a symptom of dread disease (Lyman, 1989; Shabahangi & Szymkiewicz, 2008; Whitehouse and George, 2008). The fear and anxiety that this forgetting has engendered in our society has been linguistically encapsulated in its designation as a disease, although age associated cognitive changes such as forgetfulness are an essential aspect of growing older (Foster, Cornwell, Kisley, & Davis, 2008).

Biomedical interpretations of life events exert a powerful influence on the meaning of our experiences. Conceptions of the relationship between health and old age permeate social, cultural, and political images of elderly people. In American society, these images tend to reflect a medicalized view of elderly people. Aging tends to be characterized as a process of biological decline to which an increasing variety and quantity of medical resources are dedicated.

Alzheimer's disease is one of the most feared diseases associated with aging. The reconstitution of senility as Alzheimer's disease transformed the meaning of cognitive impairment associated with age from an inevitable process to a medical condition that might be delayed or avoided altogether (Fox, 1989). The acceptance of this definitional transformation has been crucial not only medically, but also politically, because it marshaled resources for the support of research into aging-related diseases by researchers and medical professionals.

The fear and anxiety associated with Alzheimer's disease is mainly caused by the loss of the ability to function in the social world in normatively acceptable ways. This, combined with the objectification of the disease as a biological problem to be studied, dissected, and hopefully solved, has contributed to the creation of what one observer has called a "malignant social psychology" (Kitwood, 1997a). This refers to a situation wherein the actions and words of those who are most concerned with the welfare of the person with dementia, may actually be detrimental to them. The unintentional deprivation of the social self of the person with dementia can occur in many ways, including disempowerment, infantilizing, labeling, stigmatization, invalidation, and banishment, as well as negative stereotyping, to name but a few (Kitwood, 1997a; Scholl and Sabat, 2008). All of these can result in a form of excess disability resulting from an unnecessary constriction of the lives and social roles of people with Alzheimer's disease.

SOURCES OF THE SOCIAL DISENFRANCHISEMENT OF FORGETFUL PEOPLE

This phenomenon does not arise from the nefarious intentions of caregivers, but rather from the "social disenfranchisement," if you will, of people who

have been diagnosed with Alzheimer's disease (Beard & Fox, 2008). That is, traditionally proscribed privileges are limited or eliminated when individuals are deemed unable to function in socially appropriate ways caused by cognitive impairments. This social disenfranchisement has arisen from three sources: (1) in social contexts from the difficulties people with forgetfulness and their families have accepting and understanding these cognitive changes; (2) in political contexts by the demonization of Alzheimer's disease as a consequence of advocacy efforts aimed at increasing funding for biomedical research; and (3) in scientific contexts by the diseases' objectification wherein the biological and behavioral features of people are reduced to their component parts in an effort to unlock Alzheimer's complex mysteries. These social forces emphasize the interdependence of social relationships that not only bestow the status of "personhood" on others, but even define others' humanity in a web of social relationships.

In social contexts, the difficulties both people who are forgetful and their family members have accepting and understanding the cognitive changes wrought by the progression of the disease are part and parcel of the transition from previously normal experiences to what are deemed abnormal changes that interfere with a person's ability to function in accustomed ways. For example, in interactions between family members and people diagnosed with Alzheimer's disease there is often a strong negative reaction when someone with forgetfulness cannot remember his or her or our names. Names are emotionally linked with identity. They differentiate us from others. Forgetting personal names is often a shock to those in contact with forgetful people.

It has been argued that Alzheimer's disease and its symptoms have come to represent an obliteration of selfhood (Kontos, 2004), resulting in the person so afflicted being stigmatized as a member of a socially undesirable group. In spite of autobiographies illustrating the experiences of people living with the disease (Davis 1989; DeBaggio, 2003; McGowin, 1994; Rose, 1996), such experiences have historically been marginalized or communicated using a third-person narrative style (Braudy Harris, 2002; Mills, 1997; Usita, Hyman & Herman, 1998; Vittoria, 1998). Dominant assumptions that it was impossible to meaningfully determine the experiences of people living with Alzheimer's disease arise from the stigma resulting from their inability to navigate the social world in a normatively acceptable manner. Such stigmatizing (Goffman, 1963) emerges as a result of the focus being on the disease and its manifestations, rather than the experiential aspects of living with Alzheimer's disease.

It is clearly difficult to ponder what may be involved in the latter, but recent narratives on this topic include Gloria Sternin's (2002) and Christine Bryden's (2005) accounts of living with the disease that provide insight into this issue. Recent social movements such as the Dementia and Advocacy and Support Network International (www.dasinternational.org) have also

arisen to counter the stigma of living with Alzheimer's disease. These efforts have begun to challenge the notion that people with Alzheimer's disease become a hollow shell, devoid of humanity. They may also herald the development of a public face of Alzheimer's disease that may counter the social trends that have historically silenced the voices of forgetful people.

In political contexts, the demonization of the disease as a consequence of what one observer has called the "health politics of anguish" (R. Butler, personal communication, May 23, 1986), has increased the public's awareness of Alzheimer's disease largely by characterizations of the negative consequences of the disease on caregivers. Such characterizations as "the never ending funeral," a "slow death of the mind," and "the mind robber," have demonized Alzheimer's as a part of efforts to focus public attention and political support to address the impact of this social and health concern (Cutler, 1986; Froelich, 1986; Thomas, 1983). This approach has been used by the Alzheimer's Association as part of political strategies to raise public and Congressional awareness of the disease.

These efforts have historically emerged from: (1) scientific research causing a shift in the biomedical conceptualization of Alzheimer's disease that resulted in its characterization as a major social and health problem; (2) the activities of a handful of neuroscientists interested in promoting the disease; (3) the intersection of the interests of these neuroscientists with the interests of representatives of the National Institute on Aging (NIA); (4) the interaction between scientists, NIA representatives, and caregivers of people with Alzheimer's disease in the creation of the Alzheimer's Association that formed the basis of a social movement devoted to providing support to caregivers and to advocating for increased funding for research into the disease; and (5) the interaction of members of the Alzheimer's Association and representatives of the NIA with patrons, the media, and representatives of Congress to increase awareness of the disease and, from this, an increase in the level of federal funding available for research (Fox, 1989, 2000).

These advocacy efforts have largely been successful in increasing funding for biomedical research with the hope of finding effective treatments, and even a cure, for this dread disease. These efforts have largely been by proxy. By this we mean by people who do not have the disease, but who are either affected by those who do, or who have either a personal or professional interest in it. Caregivers and researchers have historically been at the forefront of shaping these policy and research responses to Alzheimer's disease (Beard, 2004b; Fox, 1989, 2000; Fox, Kelly, & Tobin, 1999).

In scientific contexts, social disenfranchisement emerges from the objectification of people arising from the process of scientific investigation wherein the biological and behavioral features of the disease are reduced to their component parts in an effort to unlock its extremely complex mysteries (Beard & Fox, 2008). Jonathan Franzen poignantly describes the problem with scientific reductionism in relation to his father's diagnosis:

I can see my reluctance to apply the term Alzheimer's to my father as a way of protecting the specificity of Earl Franzen from the generality of a nameable condition. Conditions have symptoms; symptoms point to the organic basis of everything we are. They point to the brain as meat. And, where I ought to recognize that, yes, the brain is meat, I seem instead to maintain a blind spot across which I then interpolate stories that emphasize the more soul-like aspects of the self. (Franzen, 2002)

The reduction of the "soul-like" aspects of a forgetful person to quantifiable biological and behavioral features that are symptomatic of an underlying disease pathology has led to medically diagnosed people finding themselves in an interpretive dilemma. Caught between a sort of biological determinism and a desire to retain a sense of personal and social efficacy, people struggle to avoid a dramatic rupture in biography (Beard & Fox, 2008). The resolution of this struggle is complicated by biological and psychological models of pathology that generally disregard the social interactions and sociocultural contexts within which forgetfulness is manifest (Ehernberger Hamilton, 1994). Cheston and Bender note in this regard:

The assumption that people with dementia are almost non-people means that it is hard to arouse practitioner interest in exploring their subjective world We have very little understanding of what it is like to have dementia largely because this has not seemed to be an important question to answer. In the standard paradigm, the internal world of dementia sufferers is almost irrelevant. (Cheston & Bender, 1999, p. 82)

Understanding the experience of AD is complex, in that each individual is equipped with a repertoire of resources that are acquired through differentiated experiences, and these resources define one's personality and coping styles. An individual with a more abundant "kitbag" of resources can cope with the feelings of loss, frustration, and confusion of dementia more successfully than one who has had less extensive experiences and therefore a less abounding kitbag (Kitwood, 1997b).

Unfortunately, what has, until very recently, been largely left out of the discourse on AD is the experience of the individual who has forgotten. But thinking about this in a broader context of potential meanings may help us to expand our horizons of the role of medicine and science in influencing our conceptions of health, and even our notions of the variety of experiences that define our humanity as social beings living in the community of others. What we may accept as taken-for-granted may need to be challenged so that as a society we are individually and collectively opened to understanding difference and the diversity of experience as something to be embraced rather than stigmatized.

CHALLENGES TO STEREOTYPICAL NOTIONS OF PEOPLE WITH ALZHEIMER'S DISEASE

Counters to the stigmatizing terms representing Alzheimer's disease in popular and professional discourse have arisen from the perspectives of religious belief (Ballenger, 2006), bioethicists (Post, 1995) social constructionists (Beard, 2004a; Bender & Cheston, 1997; Sabat & Harre', 1992), behavioral scientists (Kitwood, 1997a; Kitwood & Bredin, 1992), support group facilitators (Yale & Snyder, 2002), physicians (Whitehouse & George, 2008), and humanistic/existential psychologists (Shabahangi & Szymkiewicz, 2008). These perspectives have challenged the notion that a person with dementia becomes a hollow shell. They have begun to create a cultural space that emphasizes the dignity of all humans, even those severely impaired by dementia. The preservation of human dignity in the face of dementia is critical, because characterizations of Alzheimer's disease that serve political or scientific ends do not wholly represent the phenomenology of the disease. As Franzen noted about his father:

Consider, too, what I believe are the last words he ever spoke to me, three months before he died. For a couple of days, I'd been visiting the nursing home for a dutiful ninety minutes and listening to his mutterings about my mother and to his affable speculations about certain tiny objects that he persisted in seeing on the sleeves of his sweater and the knees of his pants. He was no different when I dropped by on my last morning, no different when I wheeled him back to his room and told him I was heading out of town. But then he raised his face toward mine and—again, out of nowhere, his voice was clear and strong—he said, “Thank you for coming. I appreciate your taking the time to see me.” Set phrases of courtesy? A window on his fundamental self? I seem to have little choice about which version to believe. (Franzen, 2002)

Another important trend that has the potential to counter the dehumanizing tendencies of the demonization of Alzheimer's disease is, ironically, fueled by researchers who have begun to expand the “clinical gaze” of Alzheimer's disease in their efforts to identify its “preclinical” indicators and predictors. This has largely occurred under the assumption that for treatments to be effective in staving off the disease, they must be introduced earlier in its course than has heretofore occurred. The rise of diagnostic categories such as *mild cognitive impairment* is the most salient indicator of this effort (Peterson, 2004).

A consequence of this trend is people who are diagnosed with memory problems but who retain a substantial degree of their cognitive and functional abilities. We are moving into a period where people afflicted with the disease are beginning to be incorporated into the advocacy efforts that are

part and parcel of the “Alzheimer’s culture” in the United States. While this may not signal the end of advocacy by proxy, it may signal the beginning of a new public face for Alzheimer’s disease that has not previously been readily evident—the face of the person so diagnosed, her or himself.

This might heighten the potential for a reorganization of the social typing of people with Alzheimer’s to be more inclusive of the notion of personhood. It might also temper the demonization of the disease so we don’t lose sight of our social responsibility to care for people with dementia in ways that recognize and preserve their dignity as human beings. Such efforts are already underway as models of person-centered, relationship-centered, or family-centered care begin to emerge. The expansion of the clinical gaze has implications for caregiving, if for no other reason than we will have more and more people labeled with the diagnosis for longer periods of their life than ever before. This raises the important question of what does the forgetful person bring to our lives? This question is often put aside in the attempt to understand the disease at the expense of the person who has the disease.

Toward Reconceptualizing the Meaning of Alzheimer’s Disease

Diagnosis itself is always from a particular theoretical framework. For example, the psychoanalytic model attempts to locate the origins of psychiatric disease in specific stages of development, thereby reifying the disease as an objective entity. The DSM-V classifies according to bullet lists of symptoms; diagnosis is supposed to inform treatment. However if we approach forgetfulness from a nondiagnostic, open, radically present perspective we can begin to see Alzheimer’s not as a symptom of disease, but rather as a natural process which needs to be understood *in its unfolding*. We must not lose sight of alternative ways of typifying forgetfulness and Alzheimer’s that deemphasize notions of pathology and demonization, and instead see forgetfulness as a phenomenon that has purpose and meaning. Disease is the way in which the body, with its unconscious processes, is attempting to express itself. In fearing and resisting this, we do not allow the body to fully reveal itself to us.

What we suggest is needed to balance these trends is an attitudinal expansion concerning forgetfulness and Alzheimer’s disease (Whitehouse & George, 2008). Since the revolution in physics brought about through the discovery of the *Quantum Universe*, it has become more and more obvious that the reductive, atomistic model is suspect as *the* way to understand the processes that govern the structuring of life at all levels, including the biological, cognitive, and social. If we begin to feel our way into a new vision of the human body and its interconnectedness with the entirety of the multivalent matrix within which it has developed, we can begin to see that reducing the natural processes into clearly defined categories of “health” or

“disease” is problematic—even irresponsible. This quantum jump in the way in which we approach the person suffering from Alzheimer’s disease will, we assert, lead to interpreting these phenomena in different ways, thus providing a greater cultural space for the role of caring in an expanded context of understanding the meanings of forgetfulness (cf., Mindell, 2000).

Forgetfulness and Alzheimer’s Disease as Our Teacher

This attitudinal expansion encompasses a number of reconceptualizations. First, rather than simply a disease, the embodied phenomenon of Alzheimer’s has purpose and meaning. The label of Alzheimer’s disease is an expression of social control and oppression, while at the same time can be a signifier of empowerment for individuals trying to cope with forgetfulness. As Beard and Fox (2008) suggest in relation to a diagnosis of Alzheimer’s disease, the label creates an “identity irony” that can simultaneously rob people of their uniqueness while at the same time solidify group identity among people sharing common circumstances. Second, rather than people simply in need of our care, people with forgetfulness can teach us about life and living. Third, rather than a burden, people with forgetfulness offer us an opportunity to deepen ourselves—to go deeper into our souls.

This expansion of attitude demands more than a slight adjustment in how we perceive the world; it requires a fundamental change in the way we look at ourselves and the world we inhabit. What is required is, foremost, a curiosity, an openness to all that *is*. An attitude of “not-knowing” allows that which manifests itself in front of or within us to present itself in the way it *is*, not in the way we already know it. This attitude demands a willingness to live in the question, to appreciate the mystery that envelops us (Shabahangi & Szymkiewicz, 2008).

Our belief that we can control and direct our lives is only one possible truth. It is this belief, lying at the heart of the scientific paradigm that is the foundation of the hope of medical science to find effective treatments for Alzheimer’s. While belief in this truth is robust in American society, it would be foolish to only focus social attitudes and efforts in this one direction. This is because the fruits of such an approach are elusive and difficult to obtain, and no clear timetable can be set for harvesting the fruits of this belief. In the meantime as the population ages, the phenomenon of forgetfulness will become ever more pervasive.

Another possibility is the belief that places our fate in the hands of some other force, whether it is called God, Nature, the Tao, Quantum Wave, or some other concept or idea. From this point of view, events and relationships occur with meaning—that is, we ascribe meaning to them. As such, what happens to us, events we often categorize as good or bad are part of our life-path—our destiny. The basic assumption that life has meaning implies that somehow everything—people, planet, universe—makes sense

and has purpose. In other words, the universe is meaningful and not random. In a random universe we need to differentiate between good and bad; in a meaningful universe we live in a world that is beyond good and bad. In a meaningful universe we are at least as much controlled as controllers; in a random universe we must rely on our own smarts and feel that we need to follow our own desires and wants. If the universe is meaningful, then suffering, too, must have meaning.

From this point of view we suffer because we don't understand the reason for our pain. If we were to understand why we feel pain, it would lessen our suffering because we would know that our suffering is needed to grow and move deeper into our soul. Without suffering we do not become aware, do not deepen our understanding of who we are. This realization, denied by the proponents of the reductionist-materialist model, is central to all of the world's great religions. The core issue is our attitude towards the difficulties and hardships we encounter in life: do we see them as unnecessary, as unneeded, or do we see them as exactly that pain we need to become more complete and deeper as human beings?

Biomedicine seeks symptom removal or disease cure as primary goals. While this is a valid and important approach, we can, alongside this, also seek for a deeper meaning of the symptom and/or condition. In the context of Alzheimer's, we try to understand forgetfulness as having a larger meaning or wisdom. This is why in everyday life we suggest moving away from using the label "dementia," for it stigmatizes and demeans the person with symptoms of forgetting. Although we are aware that Alzheimer's disease has a host of diverse expressions, we emphasize forgetting as a central theme and call this phenomenon simply Forgetfulness. For "de-mentia" literally means no-mind, and since we have yet to define mind, calling something no-mind makes little, if no, sense.

A person who experiences Forgetfulness forgets what you and I have no difficulty remembering: our name, address, age, profession, and the like. Remembering such facts is certainly convenient. What's more, a keen memory is often rewarded with appreciation, accolades, even money. Forgetting, in contrast, is seen as a weakness. Why? What is so undesirable about forgetting? Perhaps it is we who are forgetting that the values we tacitly accept as "givens" are part of the paradigm we are born into, part of the narrative we tell ourselves about what is of value in life. In our adherence to the "twenty-four-seven" work ethic do we blindly adhere to beliefs which reinforce the desires of those who benefit materially from measured outcomes and a robust bottom line? According to the "gain/loss" model of reality, conditions such as forgetfulness must be placed solidly in the loss column. In other words, in line with our dominant striving for gain, our society's conception of dementia represents a metaphor for loss. This definition reveals a disturbing truth about the medical interpretation of dementia: we cannot gain anything from it. Dementia is tantamount to the disintegration of the self.

Expanding Our Conceptions of Identity

The question of what is undesirable about forgetting can also be answered in part by one of the above-noted social trends we have identified that contribute to the demonization of Alzheimer's disease—difficulties forgetful people and family members have in understanding and accepting the changes in their own and their loved one's identity wrought by forgetfulness. But what is this phenomenon called identity? It's who we are, we say. And we know how rich and complex we are. When asked to identify ourselves, we often say, I am a man/woman, this young or old, live here or there, have this job, like this or that food, am with this or that person. Yet we also know that these describe only a small part of who we are. When we are in an intimate relationship, we speak less of these demographic facts and focus more on what is not as obvious: our dreams, desires, ambitions, vulnerabilities, and hopes.

These less obvious characteristics also form part of who we are—the most important part, many would say. Thus, we see at least two aspects of how we define our individuality: a public, objective way and a private, subjective way. As Simmel notes: "Although this individuality cannot, on principle, be identified by any name, it surrounds our perceptible reality as if traced in ideal lines. It is supplemented by the other's view of us, which results in something that we are never purely and wholly. It is impossible for us to see anything but juxtaposed fragments, which nevertheless are all that really exist" (Simmel, 1971, p. 11).

This is not the place to enter into the rich topic of exploring the nature of human identity. Rather, we simply want to point out how malleable this concept of identity is and how it may only partially be related to our ability to remember. We suggest here that certain parts of our identity might even benefit from forgetting. Forgetting may allow for other, deeper parts of our identity to come to the foreground, parts our remembering keeps forgetting. Thus the stories behind identity, behind remembering and forgetting, are not fixed but fluid; they depend much on our vantage point, our priorities, and our lives.

Appreciating Multiple Meanings of Forgetfulness

As alluded to here, dementia is a narrative, paradigm-bound construct imposed from without on forgetful people. Comparative research on the cultural influence of values and perceptions in understanding dementia yields a variety of folk models of dementia and forgetfulness caused by worry and stress, normal aging, being crazy, having bad blood, to give but a few reasons (Dilworth-Anderson & Gibson, 1999, 2002; Gallagher-Thompson et al., 2003; Hinton, Franz, Teo, & Levkoff, 2005; Kane & Houston-Vega, 2004). The values and beliefs derived from our sociocultural experiences

provide a foundation for our construction of meanings that are assigned to people who are forgetful. These factors create frameworks where meaning is found in experiencing forgetfulness, whether it is viewed as a normal part of aging or as evidence of a disease. "Folk models may help those with dementia and their families find meaning in the illness and the suffering it brings, an area in which biomedicine provides only limited and reductionistic answers" (Hinton et al., 2005, p. 1408). Both folk and medical models of forgetfulness provide a story to explain the phenomenon which ". . . is not simply told, but relates to its circumstances. Issues such as what stories are for, what they do for people, and preferred ways of conveying experience are always at stake" (Gubrium, 2003, p. 24).

We think it is the time to strive to counter the fear that forgetfulness engenders in many people. We become fearful that we could lose the minds of our parents, relatives, and partners while their bodies are still with us. Moreover, we are jolted by the same fears every time we can't find our keys or remember the name of a friend. We seem to take it for granted that a meaningful life is possible only when one is blessed with excellent memory and cognitive abilities, a byproduct of our "hypercognitive" society (Post, 2000). From this point of view, life makes little sense for the ever increasing numbers of people around the world afflicted with Forgetfulness.

CONCLUSION

We think it is time to shift this attitude from a narrow, fearful one, to a more expansive, inclusive one. We invite the exploration of new ways of understanding the people for whom we care and how we might prepare for our own Forgetfulness. The search for the deeper meanings of forgetfulness can begin with the asking of two basic existential questions: (1) How do we understand what happens to those with symptoms of Forgetfulness? and (2) How do we understand what happens to those who care for them? As Sabat notes:

What is required to make . . . improvements involve a journey far beyond the goal of palliative care, a journey in which caregivers of all types seek out and support the sundry aspects of Alzheimer's sufferers' remaining abilities – indeed, their very humanity. . . . This rather "simple" recognition changes the social dynamics because in order to support and sustain the humanity of the afflicted, caregivers must delve more deeply into and develop further their own humanity. (Sabat, 2001, p. 340)

A nurse employed at the Intensive Care Unit of a large European hospital told us this story: During the usual morning rounds, a group of doctors,

nurses, and students stood around the bed of a young boy in a coma. The doctor looked at the boy's chart and announced, "Well, nothing will come out of this one!" A moment later, the nurse saw a tear fall from the boy's eye. Others saw it too and they all stood in shocked silence. Later, the doctor said, "From now on nobody talks about the patients as if they were not present, no matter how unconscious they seem. We may discuss our opinions elsewhere. Perhaps that tear was just an automatic reflex, but the truth is—we don't know. Let's take it as a lesson in humility: what happens between body and soul is a complete mystery" (Shabahangi & Szymkiewicz, 2008, p. 16).

However, understanding the needs of individuals living with forgetfulness poses a unique challenge to caregiving and to research. How are these needs communicated? Kitwood (1997b) proposes six ways of understanding the experience of dementia: (1) deciphering meaning from handwritten personal accounts of persons with dementia; (2) interviewing the individual living with dementia; (3) engaging in conversation with and taking observations of people with dementia; (4) consulting with people who have illnesses with symptoms similar to that of dementia, such as meningitis and depression; (5) writing poetry and using poetic expressions; and (6) role playing and simulation.

Persons caring for individuals with forgetfulness should provide sensitive care and allow the other to express his or her needs in his or her unique, individualized ways. By asking forgetful people to share their perspective of their care during illness, we may be able to better understand what they need (Phinney, 1998). It is important to understand the needs of the forgetful person so as to allow them to maintain their autonomy and human qualities through their forgetfulness.

With elderly people, we are confronted with this mysterious connection between body and soul again and again. We so often experience deep moments of closeness with people who are supposedly not "here" anymore, who have problems with the simplest tasks of daily living. We believe it is time for an attitudinal expansion in our society in which we start to perceive contact with forgetful elderly people as an enriching journey for both sides. We can draw from both modern science and spiritual traditions, all the better to understand this journey of forgetfulness and to make it more meaningful.

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