Zimmermann, Martina. "Culture shapes politics shapes science." *The Diseased Brain and the Failing Mind: Dementia in Science, Medicine and Literature of the Long Twentieth Century*. London: Bloomsbury Academic, 2020. 55–66. *Bloomsbury Collections*. Web. 26 Apr. 2023. <<http://dx.doi.org/10.5040/9781350121836.ch-003>>.

Downloaded from Bloomsbury Collections, www.bloomsburycollections.com, 26 April 2023, 03:13 UTC.

Copyright © Martina Zimmermann 2020. Released under a CC BY-NC-ND licence (<https://creativecommons.org/licenses/by-nc-nd/3.0/>). You may share this work for non-commercial purposes only, provided you give attribution to the copyright holder and the publisher, and provide a link to the Creative Commons licence.

Culture shapes politics shapes science

Researching old age: From medical science to old-age psychiatry

Old age in America is often a tragedy. Few of us like to consider it because it reminds us of our own mortality. It demands our energy and resources, it frightens us with illness and deformity, it is an affront to a culture with a passion for youth and productive capacity. We are so preoccupied with defending ourselves from the reality of death that we ignore the fact that human beings are alive until they are actually dead. At best, the living old are treated as if they were already half dead.

Robert N. Butler, *Why Survive?*¹

Robert N. Butler (1927–2010) was an American old-age psychiatrist whose work on the social needs of the elderly profoundly influenced healthcare politics in the 1960s and 1970s.² In 1974, this development culminated in the Research on Aging Act, Butler becoming the first director of the newly emerging National Institute on Aging (NIA). The NIA has shaped scientific and medical research on ageing and old-age diseases both nationally and internationally, and its actions have strengthened a medico-scientific dementia discourse and formed a parallel sociopolitical and healthcare dementia discourse, during the 1980s. In his Pulitzer Prize-winning *Why Survive? Being Old in America* (1975), Butler engaged with popular beliefs about ageing and old-age diseases, among them dementia and memory loss.

Butler's observation that the elderly were being treated as half-dead reminds us of early-twentieth-century cultural images of the dementia patient as living dead, such as Galsworthy's Timothy Forsyte and Hoult's Claire Temple. It suggests that popular concepts of ageing and dementia had become linked by the mid-1970s. This chapter tells the story of how this amalgamation happened.

I will trace the continued evolution of a cultural dementia discourse that centres on loss and decline, charting it against the background of ageing as a growing challenge to healthcare between the mid-1940s and the mid-1970s. During this period, age-related medical research – geriatrics and old-age psychiatry – began to become a distinct field. I will illustrate three mechanisms that supported how popular concepts of ageing and dementia became linked. First, gerontology as the science of ageing employed terminology that strongly relied on early-twentieth-century medico-scientific concepts in the images of decline, degeneration and loss it adopted. Second, old-age psychiatry relied on materialist descriptions in how it blended concepts of ageing as illness with those of senility or dementia as old-age illness and so perpetuated notions of loss and decline. Third, on a cultural level these discourse developments contributed to dementia becoming a prevalent attribute for older people.

Until the 1870s, the elderly were considered incurable, because old age and the decline of the body meant the same thing.³ In the discourse of ageing, degeneration referred to tissue alteration and cell loss. Therefore, as late as 1904, a general theory of old age – considered to begin between 50 and 60 years of age – might be expressed in the following way: ‘a general atrophy of the organism’ explained by the loss of cells in kidney, liver and brain and cells showing ‘signs of degeneration in the form of deposits of fat’. The immunologist Elie Metchnikoff (1845–1916), who used this terminology, believed that one’s immune system attacked the body’s own tissue weakened by age and described old age as a ‘chronic disease which is manifested by a degeneration, or an enfeebling of [nervous cells]’.⁴ Similar expressions were employed by Alois Alzheimer and his colleagues in relation to dementia. Around 1900, both dementia and ageing were considered pathological: conditions of degeneration and enfeeblement.

In the early twentieth century major advancements in the medico-scientific understanding of old age came from the United States. They evolved around the idea that debilities typical in later life were caused by decline in old age.⁵ The Austrian-born American Ignatz Nascher (1863–1944), who in 1909 coined the term ‘geriatrics’, defined disease in old age as a pathological process that occurred in a normally degenerating body.⁶ This degeneration became normal, because, as in Georges Canguilhem’s maxim, ‘statistical frequency expresses not only vital but also social normativity’; with an increasing lifespan in an ever-increasing number of individuals, biological processes related to ageing had to become normal.⁷ This means that ageing remained linked to a process of degeneration, but began to be seen as only one period in life, wherein diseases were more likely, statistically and biologically. One of these illnesses was senile dementia.

In the United States in the 1940s attention to health and illness in old age intensified further. By 1941, leading figures of gerontology and geriatrics were convinced that research regarding the elderly should cover three distinct areas: 'the biology of senescence, geriatric medicine, and the sociology of an aging population'.⁸ The related change of perspective – to consider the sick elderly as patients – spread across the United States and eventually Europe.⁹ In Britain, the geriatrician Marjorie Warren (1897–1960) was the first figure publicly to lament the neglect of the elderly in hospitals.¹⁰ Her writing perpetuated the conceptual link between illness in old age, and ageing and dementia as conditions of degeneration. In particular, Warren considered 'senile conditions of all types, including all the degenerative conditions, from simple uncomplicated senescence to the terminal stages of senile dementia'.¹¹ That said, her efforts, together with those of other geriatricians, laid the groundwork for what in 1947 became the British Geriatrics Society. A year later, the National Health Service came into being, enabling the growth in Britain of geriatric medicine and research related to old people's welfare and service provision as well as medical conditions.¹² This research was keenly interested in what was normal as compared to pathological in older people, and I will show how the ways in which this research relied on organic understandings of dementia further strengthened notions of ageing as loss.

As one of the first socio-medical studies conducted around the middle of the century, Joseph H. Sheldon's *The Social Medicine of Old Age: Report of an Inquiry in Wolverhampton* (1948) addressed this issue.¹³ Sheldon (1893–1972) surveyed the health status of older people living in their own home. Based on his observations, he defined elderly people as 'normal' when they led 'for the most part an active life, with full retention of their faculties and without undue emotional disturbance' (117). He further distinguished individuals with 'slightly impaired' faculties (118), who showed 'a tendency to apathy ... depression of spirits; a slight failure of memory' (122). 'Cases with severe mental deterioration', in turn, showed themselves 'forgetful, childish, difficult to live with' or even 'demented, very difficult to live with' (123). Importantly, Sheldon concluded that 'the feeling of being still necessary to the world and of having something to do is essential to the mental health of old people' (117).

Building on Sheldon's insights, Kenneth Hazell aimed to outline 'medical and social problems and the link between the two' in *Social and Medical Problems of the Elderly* (1960).¹⁴ Such research was mainly driven by two factors: fears about the ageing of the population, and the awareness of old-age poverty in the context of post-war prosperity and the welfare state.¹⁵

Considerations of 'productive capacity', in fact, played a major role in how the elderly were viewed negatively during the 1960s and 1970s. In one of his books on the societal challenges of ageing, Trevor H. Howell, for example, stated that 'old people consume more of our national wealth than they produce ... in fact from the economic point of view most old people are parasites'.¹⁶ When considering Butler's definition of ageism as manifesting itself in 'discriminatory practices in housing, employment and services of all kinds', the growing geriatric healthcare initiatives by themselves risked contributing to this kind of stereotyping of the elderly.¹⁷ In Barbara Pym's tragic-comic *Quartet in Autumn* (1977) the healthcare worker Janice thinks in such marginalizing terms about Marcia Ivory. She wonders 'what kind of job could somebody like Marcia do? ... keeping a house in order needed a certain attitude of mind', and later muses that 'sometimes you almost felt it wouldn't be a bad idea to shove [all these retired people] off all together somewhere'.¹⁸

Hazell's 1973 edition of *Social and Medical Problems of the Elderly* is the first major medical work that I have discovered to make substantial reference to dementia in clinical practice (as compared to medico-scientific research activities at the beginning of the century). Dementia as one form of 'organic mental syndrome' was described in terms which Alois Alzheimer had used in relation to Auguste D's behaviour:

The patient is likely to show gross loss of memory, intellectual weakness, lack of concentration, grasp and attention, and to be hopelessly disorientated as to time and place ... Emotionally, he may be quite out of control, weeping one moment and laughing at another, or flying into petty tempers. Or the patient may show emotional loss with gross apathy and indifference to his surroundings, undue drowsiness and perhaps incontinence. (1973; 145)

Alzheimer's disease, as a condition of socio-medical concern, emerged only in the early 1970s, as a newly introduced chapter on 'Mental disorders in the elderly' in the 1973 edition of Hazell's book suggests. This slow change might be related to the fact that there was no agreement on who should be responsible for cases of dementia: welfare services, psychiatry or medical geriatrics.¹⁹ Medical scientists focused on the specimen, that is, molecules, mechanisms and methodologies related to Alzheimer's disease diagnosis. Old-age psychiatrists, in turn, paid attention to behavioural aspects. However, the science-based emphasis on the condition's organic nature was imported into, and perpetuated by, old-age psychiatry during the 1960s. An analysis of the studies presented at

the first international conference featuring Alzheimer's disease in Lausanne in 1967 reveals that the patient was considered a carrier of behavioural symptoms of loss that could be related to cerebral losses.

Work discussed at this conference focused on evidence for mental events grounded in brain tissue studies. It reveals a reciprocating relationship between geronto-psychiatric approaches and medico-scientific research. This relationship reinforced concepts of decline and dissolution. Researchers charted patients' 'progressive demential dissolution' and presented evidence of '[spectacular] similarities between the behaviour of the demented and of children.'²⁰ These similarities included, among other aspects, 'disintegration of body awareness,' 'loss of recognition' and impoverished vocabulary.²¹ As noted previously, the idea of mental illness as aligned with childhood was initially expressed during the 1850s and developed further by social Darwinists. By the mid-to-late 1960s, it had become scientifically entrenched: expressed as a 'hierarchy in disintegration which proceeds in an inverse order to that of infantile evolution,' where disintegration moved 'from voluntary action towards automatism'.²²

The images drawn by old-age psychiatrists at this conference consolidated the medico-scientifically cultivated narrative of loss and expanded this concept of loss to the entire individual (as McMenemey's work had anticipated). By the end of the conference, however, delegates had to acknowledge that they were unable clearly to delimit normal from pathological ageing processes; nor could they offer 'precise and common definitions for the various degrees of senile decline'.²³ Both gerontologists and geriatricians in Europe and America considered these two issues to be of central importance. Their attempts to delineate the boundaries between normal ageing and disease in older age, together with growing efforts to improve the situation of older people, ultimately drove the creation of the NIA in 1974.²⁴

Coinciding with the NIA's creation, neuroscientists like Robert Katzman (1925–2008) advocated the elimination of age of onset as the criterion separating senile dementia from Alzheimer's disease, writing that

the argument that Alzheimer disease is a major killer rests on the assumption that Alzheimer disease and senile dementia are a single process and should, therefore, be considered a single disease. Both Alzheimer disease and senile dementia are progressive dementias with similar changes in mental and neurological status that are indistinguishable by careful clinical analyses ... We believe that it is time to drop the arbitrary age distinction [younger or older than 65] and adopt the single designation, Alzheimer disease.²⁵

In other words, Alzheimer's disease should become the term used for all cases of dementia – both senile and presenile. The move prepared by Katzman galvanized public awareness of, and led to increased funding for, Alzheimer's disease. This process went hand in hand with scientists increasingly seeking contact with the popular press.²⁶ Katzman's 'killer' metaphor would remain prominent, eventually serving as a central figure of speech in a growing scientific and cultural dementia marketplace. By 1985, the NIA had established ten federally funded Alzheimer's disease research centres to coordinate clinical, behavioural and laboratory research. This fast rise in biomedical research suggests that Alzheimer's disease advocates could convincingly pitch finding a cure as a necessary and good thing. However, they articulated less successfully the need for caregiver relief.²⁷ As I will discuss later, this strategy drove the neuroscientific, non-psychiatric description of the patient, while the caregiver's struggle for support increasingly marginalized the patient.

By the late 1960s, cultural representations linked ageing and dementia in their images of decline and loss. I will read Paul Bailey's novel *At The Jerusalem* (1967) against contemporary socio-medical work to show how research-driven attention to the elderly as needing care turned them into an entity requiring clinical management, without any recognition of their individuality. Bailey's narrative is both product and reflection of this development.²⁸ But *At The Jerusalem* does more. It is a fictional counter-narrative to the patient being objectified by the 1960s' geronto-psychiatric discourse that equated ageing with senile dementia. It is a riposte to what Sally A. Gadow called the 'failure of gerontology to attend to the subjectivity of aging'.²⁹ I would even describe it as the beginning of a counter-discourse which patients would develop in the 1990s: a counter-discourse to the objectification conditioned by the NIA's healthcare campaigns of the 1980s.

At The Jerusalem: Dementia defines the elderly in 1960s new realist fiction

Loneliness is the cause of much misery and also the root cause of much ill health and disease in the elderly. It leads to depression, a disinterest in what is going on around and, coupled with a poor memory, presents many of the features of mild dementia.

Kenneth Hazell, *Social and Medical Problems of the Elderly*³⁰

In 1973, Kenneth Hazell described the socio-medical causes of dementia in terms that summarize much of what Bailey's Faith Gadny endures in a home for

the elderly.³¹ Paul Bailey returns to earlier images of the forgetful senior, destined to die in a confined space, and broaches the burden of elderly caregiving. But he sharpens these images in the light of an increasingly ageing population, especially since, by the 1950s, the majority in the United Kingdom would live well into their sixties.³² In fact, Bailey had not thought of either Alzheimer's disease or dementia when imparting memory loss to Faith Gadny: he 'simply wanted to make Faith look old'.³³ Bailey narrates dementia as dispossession on a societal scale: as the loss of independence and dignity, freedom and will. Dementia as the loss of one's mind, and the loss of a life worth living, is presented as the result of the devaluation of the elderly in institutionalized contexts.

In a flashback, the narrative's second part shows the reader the reason for Faith's predicament: her perceived loneliness in her stepson Henry and his wife Thelma's house before she is sent to live at The Jerusalem. Set outside the time and space of the chronological sequence of events in the narrative, we can take this section as Faith's reminiscing about the past. This reminiscence is triggered by her being 'sentence[d] to solitary confinement' within the home, which in turn is covered in the narrative's final part.³⁴ In reliance on Robert N. Butler's definition, I would describe Faith's life review as

a naturally-occurring universal mental process characterized by the progressive return to consciousness of past experiences, and particularly, the resurgence of unresolved conflicts; simultaneously, and normally, these revived experiences and conflicts are surveyed and reintegrated. It is assumed that this process is prompted by the realization of approaching dissolution and death, and by the inability to maintain one's sense of personal invulnerability.³⁵

Faith's unresolved conflicts lie at the root of her having been sent to a home for the elderly in the first place. They are intimately related to the time in Henry and Thelma's house, where she moves after her husband's and her daughter Celia's deaths.

Since the mid-1940s, it has been commonly accepted among geriatricians and social researchers that enabling older people to live in their own home for as long as possible would help them stay fit and active, because they retained their independence for longer.³⁶ The resulting need for more support in the community for the elderly became clear in the 1950s, and socio-medical concerns about the elderly at home rose in the 1960s. With or without assistance from their families, elderly people, like Faith, had to adapt to new forms of dependence. Given that 'in seventy years she had never sunk so low [that] she had to accept charity' (98), Faith fears being seen as a burden. She refuses to disengage from social life

'out of a desire to remain useful', consequently 'dust[ing] and polish[ing]' (100), and offering to mind her grandchildren Edna and Michael.³⁷

In this context, Faith's wish to pass on some of her books to her grandchildren powerfully symbolizes her increasing feelings and fears of uselessness and dispossession, not least as these books end up 'in a dustbin' (152). The thrown-away books therefore embody Faith's increasing loneliness and become an image of her losses, both material and intellectual. Helen Small notes that 'old age and decline are not simply biological facts ... but highly responsive to a person's perception of their ability to go on possessing certain goods crucial to their sense of themselves as themselves – including favourable historical, political, and intellectual environments'.³⁸ Just as Timothy's dummy books had anticipated the image of the dementia patient as an empty shell, Faith's thrown-away books could be read as her mental deterioration and emptying, also because she wonders herself: 'If I tried to read would I reach the end of a line? Would my brain desert me halfway?' (152). As an image of lived experiences, acquired knowledge and wisdom, discarded books ultimately stand in for Faith's losing herself: she considers herself treated by Henry and Thelma 'like trash, waste' (41).

Faith's feelings of low self-esteem follow her sense of loneliness – her perception that she was just 'a guest in [Thelma's] house' (119) – battling to get 'through the day, talking, eating, dressing, trying to sleep' (137). These indicators of depression are accompanied by the first signs of memory loss.³⁹ Eventually, Faith's decline becomes physical. She wets the bed. In this state, she is sent to The Jerusalem, feeling that 'she had dragged her body about [Thelma's] house. The only suitable description. You could hardly say it was living' (140). She feels, is led to feel, like the living dead.

Read against what we come to understand as Faith's past, the narrative's opening broaches what social medics like Hazell were concerned about. Faith will decline into senile dementia in The Jerusalem:

Then there was a dazzle of green and white, white and green. Then the colours separated, became clear: the white was above, the green below. Tile, she saw, followed tile ... there were graves ... Beyond the graves, women were seated on benches, enjoying the sun. One woman's skirt was drawn up above her knees ... The sun shone on the graves, the women, the pair of knees. Like the tiled walls, they became confused before her. She had to blink to make certain that a gravestone wasn't grinning. (9)

Faith enters 'a home for the elderly and dying' (14). Its maze-like corridors and tiring staircases match Hazell's description of old-type institutions that were

originally workhouses and, as such, not suitable for very old and frail individuals (1965; 243).⁴⁰ It contributes to Faith's unsuccessful restoration in her 'new life' (10).

Faith has the impression that 'the painted brick walls would have suited a prison more' (19). These descriptions also included what researcher Erving Goffman described as the loss of autonomy and self-control, ideas of 'permanent dispossession' and 'civil death', and the fear of falling into a category beyond the 'normal'.⁴¹ Faith loses autonomy and independence, is constantly being taken by the hand, only to 'ma[k]e her hand slide free' (18) for it to be 'gripped' again (19). She feels treated 'as if I was a thing' (26); and interactions with caregivers remain superficial and non-empathetic. Especially the matron's smile 'was more like a tic' (59), as she, again and again, 'smiled, shut the smile off quickly' (e.g. 11, 12, 13, 57, 167). Faith is fully aware of the impact on her state of her surroundings, 'the dinners, the graves, the tiles, the doctor ... the humiliation' (36), and will hold their impact at bay as best she can. Setting herself apart from the women, whose ridden-up skirts reveal their lack of self-awareness, Faith keeps an eye on her appearance (48).⁴² She refuses to comply 'with the official role expectation of the "happy" and adjusted inmate' and destroys the few photographs that remind her of her past, rather than sharing them during the 'photo session' (55) held by others.⁴³ Such behaviour contributes to her not being considered normal any more, rather 'a child' (82), 'simple' (83), 'mad' and 'dotty' (92). Eventually, she is isolated from the home's community.

With reference to Hazell's initial observation, Faith is unquestionably located within a social network – first in the form of a family and then the community of women in the home. But these networks do not work for her. She sees herself in 'a world of enemies. Henry. Thelma. Edna.' (139) and feels repelled by some of the elderly, whom she refers to as 'creature[s]' (66) and characterizes as 'crazy' (68). This feeling of loneliness leads her to disengage and withdraw from the women's chatter. She becomes isolated first emotionally, then physically. Faith's relocation to a single room in the home's attic matches concern about the power relations that were played out in the life of elderly. Kathleen Woodward argues that 'the aged have been forgotten and hidden from sight in nursing homes and hospitals by the narcissistic younger social body, by those in power'.⁴⁴ Faith's sense of self is threatened by her social isolation. Her initial feelings of loneliness lead to what Hazell termed disinterest and feelings of depression. Her physical isolation from the home's network, then, reduces her sense of self-worth, which derives from relations with others. Consequently, once Faith lodges in isolation, the narrative slows down to observe her memory loss, mental absence and

physical neglect. Physical isolation leads to dementia, that is, the exacerbation of what were initially loneliness-related symptoms.

As previously observed in the context of Timothy Forsythe's final appearance, the small room's sparse fixtures anticipate (together with Bailey's staccato style) Faith's dissolution: 'A small window, she saw. A bed. A table. A chair. A bowl of chrysanthemums.' (91). When living at Thelma's, she had simply sat 'for long stretches, staring' (118), appearing to be 'living with the dead' (116). Now, she feels 'helpless; too weary to look' (156) but is aware of being 'old ... [with] her poor body' (169). Eventually, during a party she is allowed to attend, Faith feels drawn into a 'black hole' (181) and begins to scream and 'use her hands' (181). The inmates call her 'mad', 'an animal' (181), and demand she be sent away 'to a bin' (182). Faith's dementia, by now manifest, eventually leads to her further, final, isolation. She is sent away in an ambulance. Reading this scene against Butler's remarks on 'hospital tactics in handling the elderly', we must assume that she is taken to a 'hospital for the mentally ill' and might 'conveniently die in the ambulance'.⁴⁵

Bailey claimed that 'the ending of the novel is both tragedy and victory' – a statement I would like to consider in relation to R. D. Laing's assertion that 'madness need not be all breakdown. It may also be break-through. It is potentially liberation and renewal as well as enslavement and existential death'.⁴⁶ Laing endeavoured to change the treatment of psychiatric illnesses between the 1960s and 1980s. He proposed that a patient's behaviour and experience be considered within his or her specific social context.⁴⁷ In Faith's case, her reaction helps her to escape the social norms and rules she experiences as oppressive and limiting: nursing home-imposed structures that don't match individual patients' needs. Her behaviour liberates Faith from the objectifying patient images Bailey explores in the women's chatter. At the same time, this ending brings out the losses incurred by the patient, once such objectification has influenced healthcare considerations. It brings out what a contemporary reviewer described as 'society's ways of dumping its human garbage'.⁴⁸

Bailey's new realism is powerful in bringing home this message. The women's and nurses' conversations are reported in excruciating detail, almost cruel detachment. Imparting no feelings, the invisible narrator treats Faith with exactly the same lack of empathy she experiences within the institution. In addition, the textual arrangement suggests that neither matron nor nurses ever become aware of her past and reasons for her situation and behaviour. The reader, by comparison, is given access to Faith's past as conditioning her behaviour. This means, we take in much more fully the deleterious effects institutionalization has

on Faith's mind. We could consider this constellation to represent the period's continued disregard for the patient's narrative and personal illness experience, a view that is amplified when noting the exhortation of a contemporary physician, namely: 'Listen to the patient's story – he is telling you the diagnosis.'⁴⁹

This brings me to a further dimension to the dispossession pictured by Bailey, appreciated all the more when considering Helen Small's thoughts on the historical figure Cephalus in Plato's *Republic*. Cephalus's authority 'rests on his age and his place in society', explains Small; it rests on 'his ability to speak from the perspective of a long and prosperous life.'⁵⁰ Compared to this view of age, dispossession in dementia is further aggravated: a dementia patient's decreasing ability and – in Faith's situation – limited opportunities to speak further lessen her authority. It is left to the reader to identify the necessary actions that would prevent individuals like Faith Gadny from ending their life in an institution – mindless, dispossessed, demented. That said, as early as 1967, Villa and Ciompi suggested a 'dynamic approach leading to real human communication ... also with intellectually deteriorated patients.'⁵¹ But the fate of fictional characters like Bailey's Faith and, a few years later, Taylor's Mrs Palfrey (1971) and Pym's Marcia Ivory (1977) suggests that such measures were rarely implemented. In conjunction with Thelma's claims, their fate also anticipates patient loneliness and isolation in the face of caregiver-centred approaches in the 1980s, which I illustrate in Chapter 4.

Kingsley Amis used comparable narrative tactics in *Ending Up* (1974), a short study of shared living for older people, preoccupied 'with mortality and the disintegration of the body, if not the personality, with age.'⁵² George, for example, 'had nowhere else to go, except into a hospital ward' (11), and, for Adela, the cottage is 'far from a bad place to end up' (6). But Marigold, convinced that her memory loss 'is senility' (43) and that she is 'losing [her] poor little mind' (48), feels differently. Most telling in the context of Faith's fate, she senses 'aversion from the prospect of becoming hopelessly senile in the company of people who knew her' (60). Such feelings are perhaps not unexpected, considering that Shorty plays tricks on her memory and Bernard cherishes hopes 'of suggesting to Marigold that her insides had started to decompose!' (79). Reading the death of Amis's five characters in Tuppenny-hapenny Cottage against Faith Gadny's death by institutionalization further highlights how culturally dominant socio-medical and healthcare concerns for the elderly had become.

I have not only placed Bailey's narrative in the context of Hazell's studies, but read it alongside Butler's pioneering work. The similarities between the insights of a British and an American writer bring home that, by the mid-1970s,

ageing, and dementia as a condition in old age, had reached a comparable level of preoccupation on both sides of the Atlantic. In fact, Bailey had written *At The Jerusalem* after having read John Updike's first novel, *The Poorhouse Fair* (1958).⁵³ Like Bailey's creation, Updike's fictional home offers lodging to those whom 'the world ... had in the end discarded' and the poorhouse fair featuring in his fiction wants to give the elderly purpose.⁵⁴ By the early 1970s, socio-medical concerns regarding the elderly (whose core condition was dementia) had reached cultural awareness on an international scale. Their significance would be reflected in how the NIA, at its inception, sought to address two issues: large-scale funding for medico-scientific research on dementia and the support of long-term care for the ill.

In the next chapter, I pay closer attention to how the image of the elderly person as demented featured in the NIA-instigated social movement that transformed Alzheimer's disease from a rarely applied clinical diagnosis to a major medical condition in the Western world.⁵⁵ I ask how the power relations established between the young (and healthy) and the elderly (and demented) played out in the conceptualization of the patient in the healthcare context at a time when Alzheimer's disease began to replace senility in the public conception of ageing during the early 1980s.