

Summary of Presentation on
Karen A. Lyman: Bringing the Social Back In:
A Critique of the Biomedicalization of Dementia

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“Bringing the Social Back In: A Critique of the Biomedicalization of Dementia” by Karen A. Lyman, is an essay that challenges the notions of how a dementing illness was a normal part of aging. It states that only recently has it been in our time that attention has been given to the illness of senility. We first learn that Alzheimer’s disease is the most common of the dementing illness, and that there is no cure for Alzheimer’s disease as of yet. Due to the population growth of the old, Alzheimer’s disease is now considered an epidemic. This view, furthered by the prospect of staggering health care costs legitimized research and interest in the topic. However the current, defining approach towards studying and dealing with Alzheimer is based on the biomedical model. According to the author it overlooks the social factors of the issue such as the treatment's impact on the patients, the caregivers and the support system and their relationships to each other.

The first portion of the paper is titled “The Medicalization of Senility.” In this section we are informed that “medicalization of deviance” refers to explaining and treating personal and social troubles as medical problems. When medical authorities look at the difficulties related to the caring of the increasing numbers of impaired older people, they define it as a medical problem. They determine if the disease is getting worse or better by the difficulty in the caregiving relationship. The concept of dementia evolved significantly since its conception. Originally, dementia was believed to be a type of madness. This condition might have been the cause of labeling some older women as witches. As time moved on and more studies were done on the notion of “madness.” It was found that third stage syphilis produced neurological breakdown, which led to renewed interest in the classification of mental illness. At this time, “dementia praecox”

also known as early senility was classified, but this did not include the elderly, since it was still thought that senility of old age was still normal. As you can see, there was still this underlying notion that senility was expected because of old age.

Interest in Alzheimer's came in the 1980's, around the same time children's hyperactivity was discovered and redefined in medical terms. Previously both were seen as normal behavior, but now both are seen as a disease. Today we are able to diagnose dementia of the Alzheimer's type by the decline of intellectual functioning as defined by the family or caregivers. By viewing dementia as a biomedical condition, it helps bring order to the care that we give the infected. Once someone is labeled as having Alzheimer's disease, which eases the stress of care by predictability and control, it can have significant effects of how others treat the person. Even normal behavior by the person can be seen as signs of the disease, leading to "learned helplessness" through the vehicle of self-fulfilling prophecy.

The next section of the paper is titled "The Biomedical Model of Dementia." The three main aspects of the model are pathology versus normalcy, disease stage attributions, and medical control. The biomedical model doesn't provide any help to grasp the social factors affecting the definition and progression of the disease, therefore by itself it is limited, and too narrow. The pathology versus normalcy section challenges the common sense notion of normalcy. For example, behavior that may happen throughout a lifetime, that would not be considered abnormal, is labeled as such for people with this Alzheimer's disease. An example that they show of this is wandering. The conceptualization of the action "wandering" has different meanings for different people, all depending if you are talking about a person with Alzheimer's disease, or a young man

walking the hallways of a maternity ward. One is seen as a behavioral problem while the other is seen as normal. It is crucial to understand the “moral career” concept in this context. Once people are labeled demented, it limits their social opportunities, very little is expected of them, and again this leads to learned helplessness. Disease stage attributions is the second feature of the biomedical model. It states that there a staged decline is expected with a person diagnosed with this disease. Most of the person's actions are associated with the condition, and due to this it sets the stage for limited opportunities for the person and even social death. It is even believed that no new learning can take place in the later stages of dementia. It is important to point out that there are no dividing lines between the “stages”, nor there are definite treatment for people in certain stages. The stage technique is used for structure and order, to ease the job of the caregivers and service providers. Medical control is the last feature of the biomedical model and it explains that treatment is in accordance to medical authority. Generally dependence is encouraged and acts of independence by the person are ignored in long term care facilities. Control is justified for the good of the patient.

The next section is called “Caregiver Strain: The Impact of the Biomedical Model.” Here we are informed that it saves health care significant expenses when demented people are able to stay in the community longer throughout their life. But the family taking care of a person that has been diagnosed with dementia can experience strain and stress. Therefore, both families and paid caregivers adopt the biomedical model to try to predict the next “stages” of the disease. This can help face some of the uncertainty of the disease, and understand that there might be a regression to childlike state of dependency. One problem with the biomedical model is overgeneralization.

When a person has been diagnosed with dementia, family member see “impairment everywhere”, which can be false descriptions of what the person is actually going through. An interesting note listed here is that people inflicted with this disease are sometimes known as “hidden victims” because we see their troublesome behavior as causing stress to other people’s lives, not dealing with stress themselves. Also, we see their behaviors as burdensome, but not them being burdened by their illness.

The closing section of the paper is called “Social Factors of Dementia.” It emphasizes that we should not rely solely on the biomedical model. Our approach should not be fixed and set in stone. The disease of dementia needs a socially structured definition, not in absolute terms. An example is shown of self fulfilling prophecy where the diagnosed person tries to save face by complying to what the caregiver knew that there was no learning to be accomplished by the demented person. This is a result of the biomedical reality of dementia. If problems arise in care giving, a solution might be able to be found sociocultural care context and caregiving relationship.