

## **AFTER ALZHEIMER:**

### **The strange history of “Alzheimer’s Disease” and advice on maintaining cognitive skills**

**This is an expanded version of the talk for “Future Lives” for the u3a Office, 3<sup>rd</sup> February, 2026**

Dr. Michael Bender is a retired consultant clinical psychologist, who was awarded the British Psychology Society’s Fellowship for his contribution to British psychology. He headed a team providing psychological services to older people in Plymouth, that was well-known for its innovative approaches. For the last thirty years, he has extensively researched this area and written many articles and books, the best known being *Understanding Dementia: The Man with the Worried Eyes* (1999, with Rik Cheston) and more recently, the first self-help guide for people worried about their memory loss, *A New Understanding of Dementia* (2024). He is currently studying the autobiographies of people diagnosed with “dementia”.

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#### **Introduction**

Good afternoon and welcome to this talk. Which is in five parts:

I think you need to be up to reasonable speed with the history of “Alzheimer’s Disease” if you are to have an understanding of what’s going on.

So, I start by telling you about Dr. Alois Alzheimer’s work in Frankfurt and Munich at the start of the twentieth century, and his “discovery” of “early onset” or “middle age” dementia.

We then jump to America in the 1970s: how the disease was redefined and given its contemporary meaning; and the paradigm of amyloid damage.

However, this paradigm, despite billions of drug companies’ money, has not led to any successful treatments, as it is flawed.

So, in the third section, I discuss a more useful approach – that the cognitive difficulties experienced in old age are not due to a disease but to ageing processes.

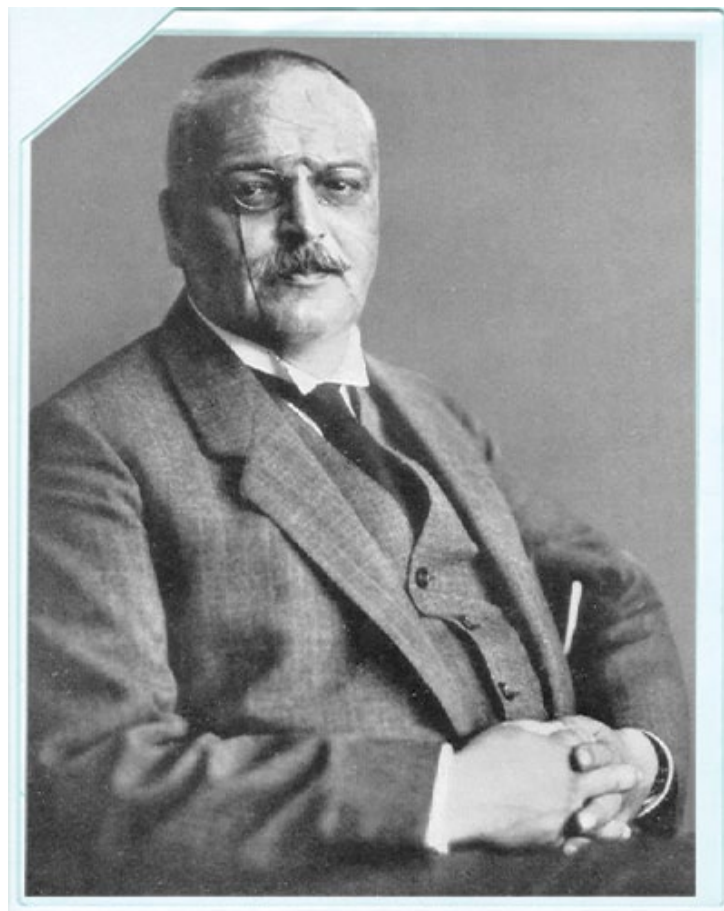
And I then report on the research that has shown various ways in which we can slow down some of the negative effects of the ageing process.

Finally, I end with a suggestion - a plea - that, if u3a groups want to avail themselves of these beneficial processes, members will have to develop and offer groups to help other members.

**PART ONE: Alzheimer's "discovery" of Early Onset Dementia  
and Emil Kraepelin**

**Dr Alois Alzheimer**

**1864 - 1915**



Alois Alzheimer was born in 1864, a notary's son, in a town in Bavaria. He graduated in medicine and became a clinician at the asylum in Frankfurt-am-Main in Germany in 1888, when he was 24, and worked there till 1903.

## Frankfurt Asylum



It was quite common when a member of a rich family was poorly for them to hire a physician to accompany them on a holiday. Alzheimer had accompanied a rich man on a holiday to North Africa but he died as they returned home; Alzheimer married his widow in 1894, and they had three children.



In 1901, a 51-year-old woman, Frau D, was admitted to the asylum in a disturbed state. Part of Alzheimer's job was to clerk in new admissions.

### Frau D.



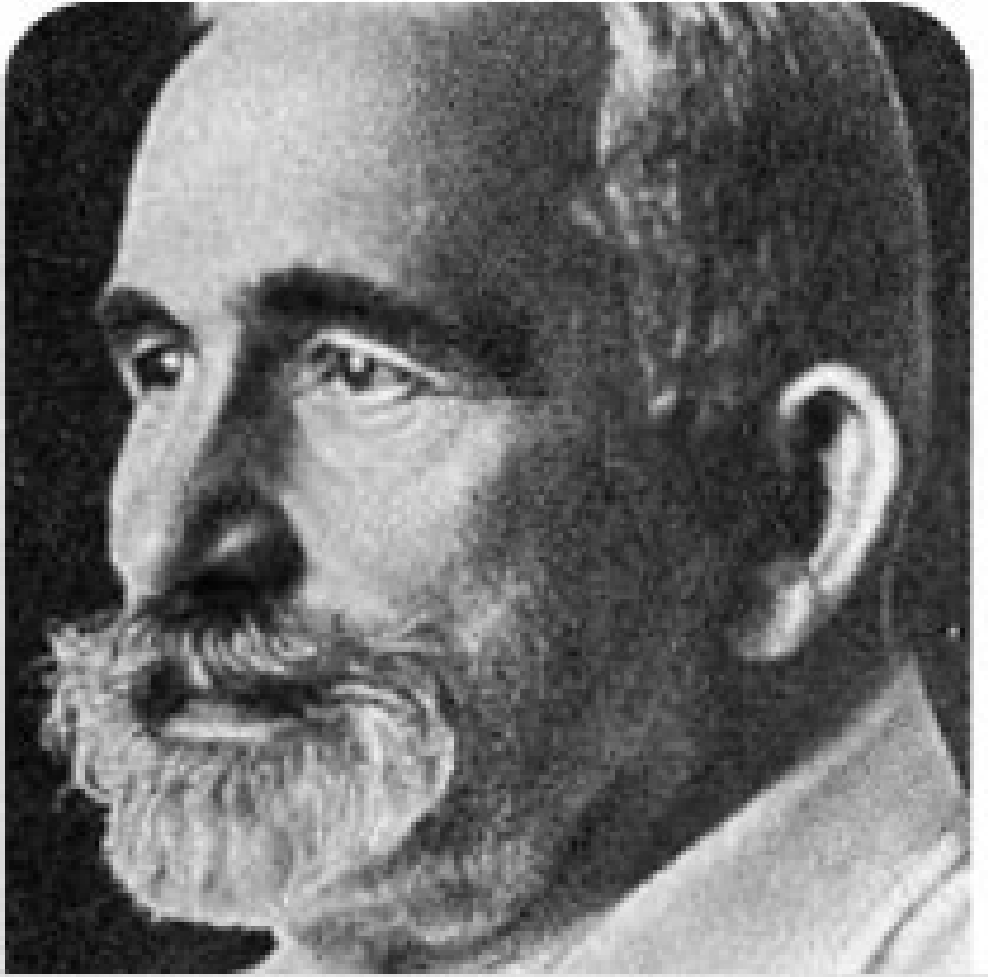
Now you or I would not look elegant in a hospital gown, especially as this was taken of her on her bed – you can see the pillow and her drawn up knees.

But, more important, this woman is only 51 and she looks far older. In fact, she looks as if she has prematurely aged, which, as we will see, may be highly relevant.

Alzheimer interviewed Frau D on numerous occasions. Why was he so interested in trying to understand her?

To make sense of dysfunctional behaviour – “mad behaviour” if you like – you need a theory, an approach that explains it. And one way is to classify the various ways in which people go mad – the major “mental illnesses”.

## Emil Kraepelin (1856-1926)



Kraepelin was the author of the most used psychiatric text in German speaking countries, its first edition coming out in 1883 and which he regularly updated. And its purpose was to name mental illnesses and specify their symptoms.

In a way, Kraepelin is the central figure in this story, and Alzheimer, as we shall see, only a pawn in the game played, and won, by organic psychiatry over psychodynamic approaches. For it is Kraepelin who defines four central tenets of organic psychiatry, that are still held by many psychiatrists to this day

### The four central beliefs of organic psychiatry

1. There are a number of clearly defined mental illnesses
2. which have no overlap with normality
3. These illnesses are caused by brain dysfunctions, not by one's biography or environment
4. Each mental illness has a definite course

And these central beliefs still explain dementia research today.

By the second edition, in 1887, Kraepelin had divided severe mental illness – the psychoses – into two types: *manic depression*, which we now refer to as “bipolar disorder”; and *dementia praecox*, which was fairly quickly renamed “schizophrenia”.

*Dementia praecox* means *early or premature dementia*, “senility of the young”, because Kraepelin thought it developed when we were young adults; and he contrasted it with *senile dementia*, which was a disease of old age, which he wasn't very interested in.

Dementia as he described it was a mixture of psychotic symptoms – hallucinations, unusual beliefs etc. but also “an irreversible deterioration of the intellectual functions” (Bentall. *Madness Explained*, 15).

The disease, he said, followed a similar pattern in all the patients with the same diagnosis. He followed up hundreds of hospital patients to show this was the case; but there's a problem here, as if your patients are in a mental hospital, and you aren't providing any therapy, the effects of living in an institution may be greater than any potential course of a disease (Goffman, 1961; Wing and Brown, 1970)

Alzheimer was an ambitious, hard-working young doctor. Across his lifetime, he published over a hundred papers, on a wide range of topics. And the superintendent of the hospital, Professor Emil Sioli encouraged his assistants to undertake research. Alzheimer worked with Frank Nissl, who had arrived a year after Alzheimer to take up the post of Assistant Medical Director; and Nissl was a pioneer in staining techniques (he was also Alzheimer's best man at his wedding.)

Now, Frau D had an illness that looked suspiciously like dementia, but she was neither young or old. Could this be a new form of dementia, attacking persons of middle age? In which case, the “discovery” would do Alzheimer’s reputation no harm at all.

So, when her husband said that he couldn’t afford to keep her in Frankfurt Asylum and would have to find a cheaper place, Alzheimer made up the difference.

Alzheimer interviewed her on a number of occasions, asking a lot of cognitive questions. He never took a decent case history. He didn’t need to because it was irrelevant to an organic explanation of mental illness.

So, for example, she said her husband was having an affair with a neighbour. When she died in 1906, within a year he had married that neighbour. She was afraid of being cut – domestic abuse; she had one daughter, a difficult childbirth?

Sadly in 1901, Alzheimer’s wife died shortly after the birth of their daughter.

In 1903 Kraepelin left his post as head of the Heidelberg Asylum and became the head of the prestigious Munchen Psychiatric Institute.

Kraepelin offered Alzheimer a deal – no salary but to become head of research with his own research space. Alzheimer’s marriage had made him financially independent. So Alzheimer accepted the deal and rapidly his research laboratory became a centre of excellence.

**Alzheimer with his colleagues (including Friedrich Heinrich Lewy on front row, far left)**

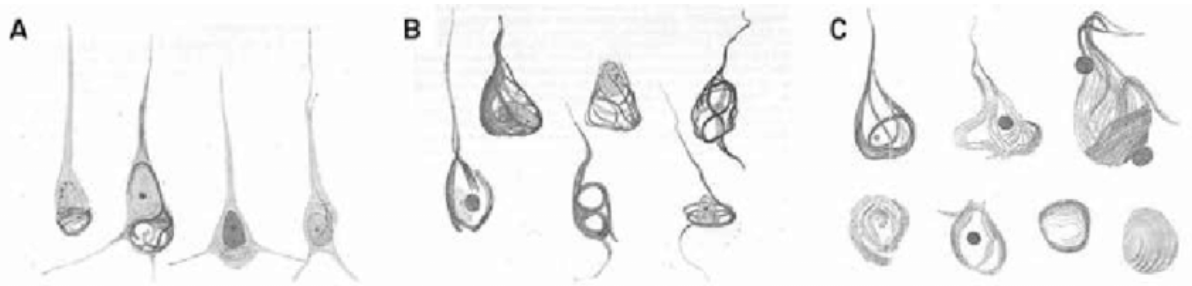


Alzheimer was an encouraging head of department – stories abound of him helping a colleague at their bench, putting down his cigar, and staring down their microscope. And, thanks to his friendship and work with Franz Nissl, he could advise them on the advances in staining techniques to allow better analysis of cell structures.

This was a pretty distinguished crew – Hans Kreutzfeld, Alfons Jakob, and Friedrich Lewy among others.

In 1906, Frau D died. (You'll also find her referred to by her surname, which I consider a breach of her confidentiality and an indication of the low status of people with dementia.) As I've recounted, Alzheimer had thought her case unusual and wanted to investigate her case further. So, when he left, he had asked for her brain to be sent to him.

Professor Sioli kept his word and sent Alzheimer her brain and some of her backbone, most probably in formaldehyde and in those thick circular jars you see in museums. Alzheimer then took brain slices and drew by hand what are still thought of as the defining characteristics of Alzheimer's disease – damaged plaques and fibrils.



Alzheimer wasn't sure what they signified. But Kraepelin wanted the prestige of a new medical advance, namely a new disease that fitted in between dementia praecox and senile dementia.

Since every disease should honour its medical discoverer, he named it "Alzheimer's disease". Who was conveniently working in his institute.

So, into the 1908 edition of his textbook it went.

It didn't matter that *lots of people with different conditions might also show damaged plaques and fibrils*

It didn't matter that *there might be no relationship between these plaques and fibrils and Frau D's strange behaviours.*

And while "early onset dementia" became accepted, it generated little interest because pre-senile dementia – dementia occurring before the age of 60 – was so rare. By 1910, the Munich Clinic had only found, at best, ten patients. (Some cases may have been reported twice.)

Over time, Kraepelin's combination of schizophrenia and intellectual loss as defining "dementia" separated out. The mental illness aspect faded away although still referred to, especially with regard to the later stages, and since it adds a bit of horror, to fictional accounts. And so, the intellectual damage became paramount.

And then nothing much happened till the 1970s in the United States of America.

**PART TWO: America in the 1970s: the creation of the dominant  
“disease” narrative**

A whole lot of currents came together in the 1970s and 1980s that determined the present understanding of “Alzheimer’s” and the research into memory conditions.

**Relevant events leading to our present understanding of  
“Alzheimer’s Disease”**

1. **1976.** Katzman’s editorial, equating “senile dementia” with “Alzheimer’s” and renaming it “Alzheimer’s Disease”
2. **1974.** Creation of the National Institute of Aging, Robert Butler its first director. Great increase in Congressional funds.
3. **1980.** The publication of the *DSM III*- the third edition of the American Psychiatric Association’s *Diagnostic and Statistical Manual*, resulting in
4. Research funding bodies demanding evidence that the samples or groups studies fulfil the criteria specified in *DSM III*, and
5. American medical insurance companies demand evidence that the patient fulfilled a *DSM III* category before payment
6. American psychiatrists leave psychotherapy to psychologists, counsellors etc. and define their expertise solely in terms of diagnosis and the prescribing of drugs.
7. Drug companies fund research to create pills “magic bullets” targeted at the major *DSM III* categories – schizophrenia, depression, Alzheimer’s

The impetus towards a present-day definition of Alzheimer’s occurred in America in the 1970s. A small group of American doctors started to ask: why is cancer so well-funded and dementia gets so little research money?

This campaign was remarkable as it was spearheaded by only four people: Robert Terry, Robert Katzman, Robert Butler and Zaven Khachaturian.

In Alzheimer's work, the new staining techniques had provided an impetus. Now, once again, a technical advance was an important factor. This was the development of the electron microscope, allowing for greater definition.

Robert Terry used it to elucidate important aspects of brain conditions, including Alzheimer's. Interestingly, just as the friendship of Alzheimer and Nissl was important, so was the friendship of Robert Terry and Robert Katzman, another neurologist, "the two Bobs".

If they wanted to raise the profile of dementia, one problem was that "dementia" was too large, perhaps too scary, and too vague to appeal to Congressmen to allocate funds.

**1. Robert Katzman**, a West Coast neurologist, came up with a whiz solution. In 1976, he wrote an incredibly influential editorial, a mere two pages long: **'The prevalence and malignancy of Alzheimer's disease. A major killer.'** *Archives of Neurology*, 1976; 33: 217-8.



He recommended that we forget about the rare “pre-senile dementia” (Alzheimer’s) and merge it into senile dementia. They were the same disease, just the age varied. This was incorrect, as early onset dementia causes faster decline and almost certainly has a different origin, probably due a protein abnormality, prions. But no odds.

Then he replaced the non-sellable term “senile dementia” with the focussed, medically orientated “Alzheimer’s”.

In Katzman’s editorial, in a straight line from Kraepelin, “Alzheimer’s” is a brain disease, nothing to do with biography or environment; and, as the title intended, usefully put the fear of God up the congressmen’s constituents – it rots your brain (“malignant”) and kills you (“a major killer”).

## **2. The National Institute of Aging make it a high-profile disease**

Enter Robert Butler, a well-regarded gerontologist (He had developed the concept of “life review”). In 1974, he was appointed as the head of the newly created National Institute of Aging and needed a central message.

This new Katzman-inspired “Alzheimer’s” filled the bill nicely; and Butler started seeking funds from Congress, for this definite disease with boundaries and a medical name.

Butler told Congress: “If polio can be cured – with the Sabin and Salk vaccine in the 1950s – so, if properly funded, why not dementia?” An appeal that was incredibly successful. Between 1978 and 1995, funding grew from near zero to roughly \$300 million annually.

Butler appointed Zaven Khatchaturian to head up the Neurobiology of Aging programme at the National Institute of Aging. Khatchaturian created a very successful research network. He set up the five Alzheimer’s Disease Research Centers, five regional research centres.

Khatchaturian also realised the importance of creating a powerful consumer organisation.

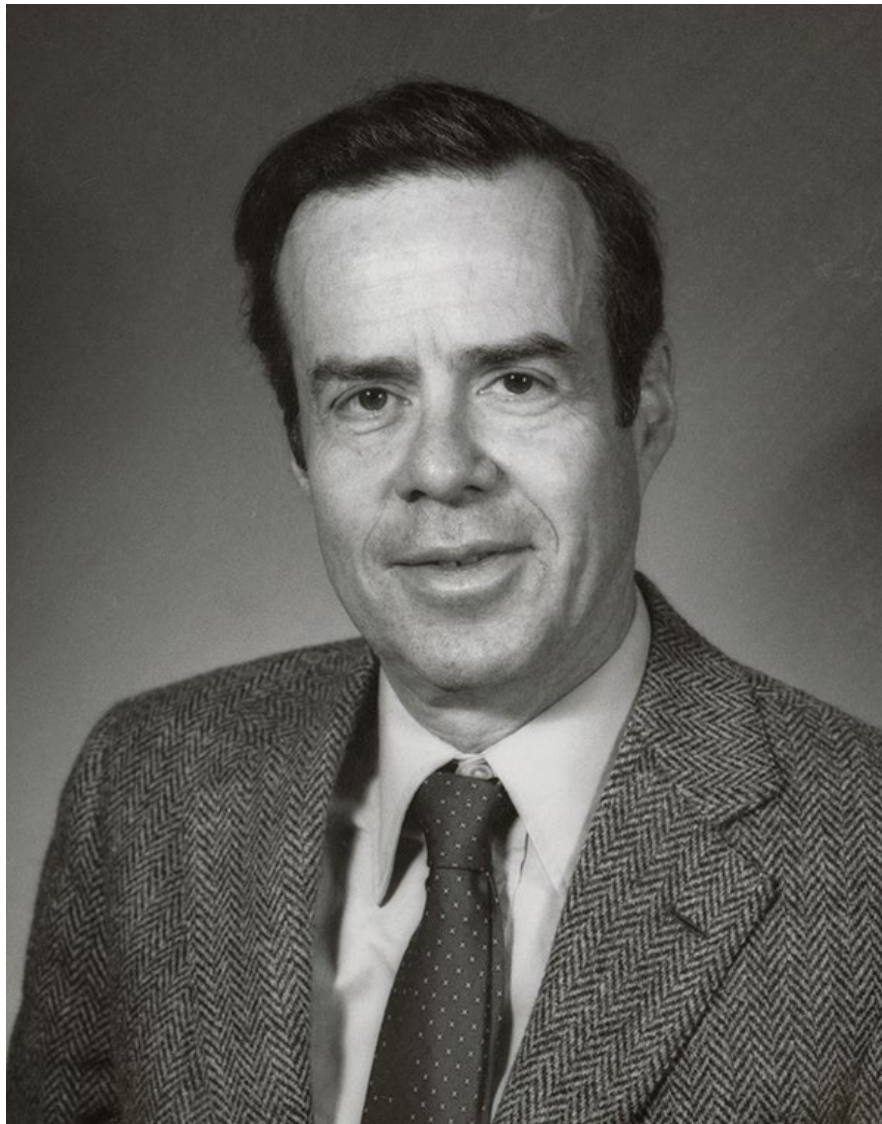
He actively encouraged the development of a national Alzheimer’s charity, the Alzheimer’s Association, which was a very useful way of influencing Congress and became very powerful lobbying organisation. As with the equivalent organisation in this country, it focussed on

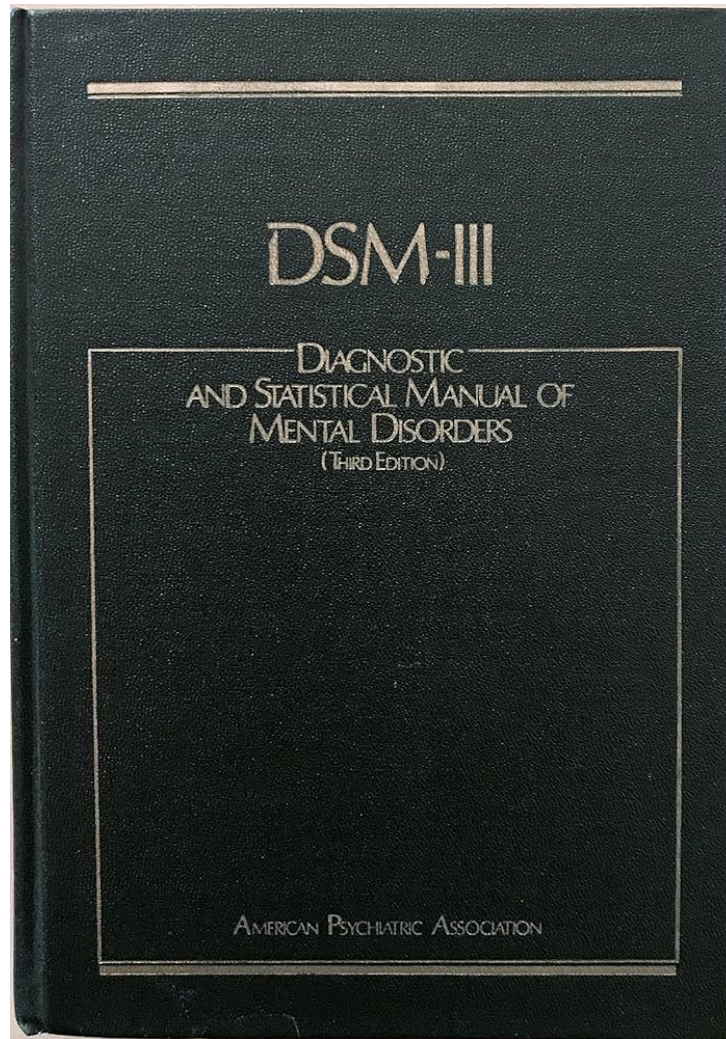
research and cure, but *not* on campaigning for earlier preventive services or better social care.

### 3. Spitzer's *DSM III* defines the symptoms of the revised Alzheimer's

The next key development was the publication of the third edition of *The Diagnostic and Statistical Manual* by the American Psychiatric Association in 1980, its classification of mental illnesses.

There had been earlier editions in 1952 and 1968, which had attracted little attention; but this time the collation was headed by **Robert Spitzer**.





I love the seriousness conveyed with the Roman numerals

He was quite clear what needed to be done. It was to get rid of all the psychodynamic waffle about early childhood causation, and, more generally, the biographical approach. This had also been the case with dementia, where the psychoanalytic approach, dominant in the USA till the 1960s, saw the condition as a mixture of brain deterioration and psychological factors.

The second task was to create a reliable diagnostic system – one patient, two psychiatrists, one diagnosis. It was embarrassing that “schizophrenia” was twice as common in New York as in London, because basically the psychiatrists in those two cities had different ideas what “schizophrenia” consisted of.

So, for each mental illness, Spitzer got together leading experts of that disease and got them to spell out what they saw as the key symptoms.

Nothing to do with science or research-proven findings, just a bunch of experts in a smoke-filled room, agreeing and disagreeing with each other, and Spitzer deciding what to write down.

Then after an excellent lunch, they would listen to what Spitzer had decided were the major symptoms and make suggestions and alterations (a process described in Kutchins and Kirk's *Making Us Crazy*).

So, for each mental illness, *DSM III* specified a checklist of symptoms. Then all the psychiatrist, or even the G.P., had to do was see if the patient scored above the cut-off. Kraepelin's formulations were alive and well, and indeed those espousing these ideas, which was most of the profession, were known as neo-Kraepelinians, espousing "scientific psychiatry".

And what were the criteria or symptoms for "Alzheimer's"?

### **Defining characteristics of "Alzheimer's" or "Primary Degenerative Dementia"**

- **A significant loss of intellectual abilities** (such as memory, judgment, and abstract thinking) severe enough to interfere with social or occupational functioning.
- **Insidious Onset:** A slow, creeping beginning of symptoms rather than a sudden event like a stroke.
- **Progressive Deteriorating Course:** A steady and continuous decline in cognitive function over time.
- **Exclusion of Other Causes:** The diagnosis required the clinical exclusion of all other specific causes of dementia, such as cerebrovascular disease (stroke), metabolic disorders, or brain tumours, through history-taking, physical examination, and laboratory tests.

While researchers often used "Alzheimer's disease," the *DSM-III* used the term, "Primary Degenerative Dementia" to emphasize that the cause was a degenerative process in the brain rather than external factors. No

need to spend time looking for possible causes in the person's life or current environment.

And note *the other causes to be excluded* are all physical. No need to worry too much about the fact that 15% of the elderly suffer from depression as opposed to only 5% with dementia, and that depression and anxiety also cause inattention and memory difficulties (as I'll elaborate on later.)

*DSM-III* was a runaway success, remarkably a best seller. No doctor's office could be without it being prominently displayed on their shelf.

4. It re-defined mental illness. As *DSM III* criteria became the defining criteria, so **research funding bodies demanded that research proposals demonstrated that the subjects and groups studied in clinical research fulfilled DSM III criteria.**

This should have the benefit of making the studies' results much more comparable.

5. As you know, most medical treatment in America is private and expensive. Now, **if you wanted access to medical insurance, you had to meet the *DSM III* criteria and have a diagnosis.**

6. **From hereonin, psychiatrists gave up their dominance of and interest in psychotherapy, handing the field over to clinical psychologists and counsellors.**

The need to get a medical diagnosis before the insurance companies paid up was good news for old age doctors. But there were costs.

Because there was no interest in biographical or environmental factors, there was little interest in developing therapeutic techniques.

Nowadays it is easy to forget that the development of theories of mental illness and schools of therapy were pretty much a monopoly of psychiatry – Freud, Jung, Adler; and in America, Harry Stack Sullivan's Interpersonal Theory of Psychiatry; Eric Berne's Transactional Analysis (Remember *The Games People Play*, 1964?); Irving Yalom's Group Psychotherapy; and, the most important currently, Aaron Beck's

Cognitive Behaviour Therapy, his first major statement coming out in 1975. And in this country, Anthony Ryle's Cognitive Analytic Therapy and S. H. Foulkes' Group Analytic Psychotherapy.

So, the profession gave up on trying to understand how a person's memory difficulties might have arisen and how the person made sense of them. And that meant it also gave up on an awareness of life factors, such as the long-proven relationship between social class and the frequency of mental illness (Hollingshead and Redlich, 1958); difficult attachments (Bowlby, 1969), etc.

All they now had to offer was diagnosis and prescribing the relevant drugs. Now they were dependent on the drug companies to deliver successful drugs. They were tied to advocating the use of drugs as the cure for mental illness; and where there was no drug, assuring the public that one would come along.

## **7. Drug companies fund research to create pills that are magic bullets targeted at DSM III categories**

*DSM III* was great news for drug companies. They could now fund research into a defined group with a clearly defined illness. The race was on among the pharmaceutical giants to be first in developing a drug that cured, or at least positively affected the symptoms of the major mental illnesses and thereby reap billions of dollars of profit.

The model of drug development by drug companies was not specific to dementia. It was the same model for explaining any mental illness. There were *definite illnesses*, due to *a brain dysfunction* (Kraepelin was alive and well) and the drug companies were desperate to find *the relevant medicine*.

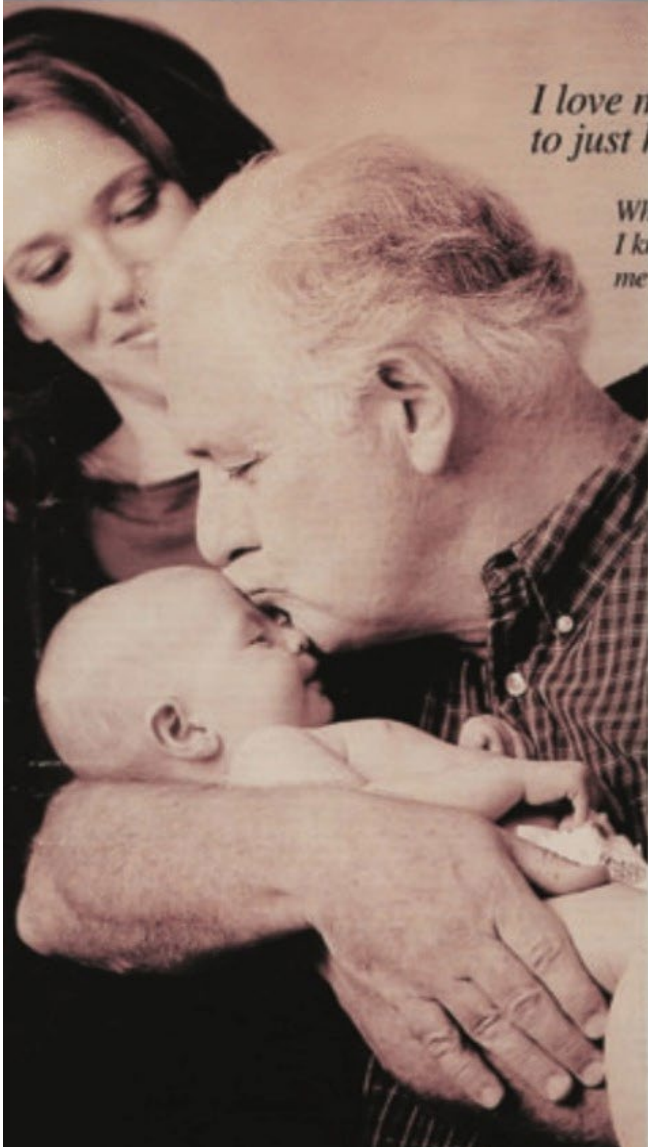
<b>Model of mental illness post-DSM III</b>		
<b>Illness</b>	<b>Brain dysfunction</b>	<b>Pill</b>
Schizophrenia	Neurotransmitters (Dopamine)	Antipsychotics
Depression	Serotonin Imbalance	Serial Serotonin Reuptake Inhibitors
Alzheimer's	Plaques and Fibrils (amyloid accumulation)	Cholinesterase Inhibitors; more recently, amyloid removers

With Alzheimer's, the first wave of drugs functioned by inhibiting the enzyme acetylcholinesterase, which increases the concentration and duration of action of acetylcholine ("a memory chemical") in the central and peripheral nervous system.

### **The dawn of success and failure**

At first, the model and the way forward – all seemed fine. A number of drugs, heavily advertised by the drug companies, seemed to be effective and were surely just the front runners of even more successful drugs.

## Fighting Back with Aricept®



*I love my life way too much  
to just hand it over to Alzheimer's.*

*When my memory started failing,  
I knew I had to see my doctor. He put  
me on ARICEPT®. Now I'm doing better.®*

If a person forgets names, places or facts – and has trouble with everyday things like reading or shopping – it may not be normal aging. It could be Alzheimer's disease. So it's important to see a doctor as soon as you can.

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“Fighting back” and presumably winning – a nice mixture of sporting and illness metaphors.

However, the degree of improvement was bogus. Already by the turn of the century, it was well known that drug company research data was suspect. The English G.P. turned medical journalist, Ben Goldacre, had shown this quite clearly in two best-sellers, *Bad Science*, 2009, and even more relevant to today's topic, *Bad Pharma*, 2012.

And indeed, sadly, this was the case. The drug was never licensed in France for public services, and was shown to have serious side effects such as falls and D&V.

This sequence was not unique to dementia. For schizophrenia, and depression also, the efficacy of the drugs has been shown to be limited, and the causal sequence disputed. In fact, the serotonin explanation is now discredited.

### **The disease model is incorrect**

We've been told now for forty years that a drug breakthrough is imminent. Yet none is even in sight. How come?

Let's turn to the causal sequence in Alzheimer's. To recap, the drug companies needed a single cause of the disease, so that they could then try and attack that cause.

The Amyloid Cascade Hypothesis was proposed by the British biochemist, John Hardy and Gerald Higgins, a Professor at the National Institute of Aging, in a 1992 paper of that name. They proposed that the accumulation of amyloid protein was the start of the degenerative process and all the other negative changes were "downstream".

The hypothesis was so simplistic that one researcher ridiculed it as "dead on arrival". For example, the relevant protein for the fibrils is tau protein, not amyloid.

However, the beauty of the Cascade hypothesis for the drug companies was that if you could prevent the build-up of amyloid, you would prevent all the negative effects down-stream.

Why didn't the model work?

### Why didn't the model work?

- Crucially, at autopsy, post-mortem, half the people diagnosed with dementia don't have plaques and fibrils; and half the people with no evidence of dementia do (The Newcastle studies in the late 1960s)
- By the 1970s, it was known that most people over the age of 40 have plaques and fibrils
- So, in no way, were plaques and fibrils specific to cognitive loss in old age
- Removing amyloid causes brain bleeds. Rather than being causal, it looks as if plaques and fibrils are protective.
- There have been no new minimally effective drugs for Alzheimer's, certainly since the modestly effective drugs of the 1990s.

An American Alzheimer's expert, Professor Peter Whitehouse, was telling us all this in *The Myth of Alzheimer's*, first published in 2008.

Regarding removal of amyloid: this is the "scientific" basis for the recently produced drug, Lecanemab, marketed as Leqembi, a very expensive drug launched in the UK in 2024, which has very little benefit.

And removing amyloid was tried by a pioneering neurologist, Dale Schenk, around the turn of the century, and then it had to be withdrawn because of the bleeds. (See David Shenk. *The Forgetting*.)

### How did this play out in the United Kingdom?

The politicians in Westminster, doubtless pressurised by the lobbyists of the drug companies and major Alzheimer's charities, bought the initial "promises" and became fearful that the queues of old people wanting this drug would stretch round the block.

So, if you wanted the wonder drugs, you needed to be diagnosed; and Memory Clinics were set up. The politicians and the civil servants,

believing the hype about the imminent arrival of the curative drugs, probably thought they were being very smart in being one step ahead of their arrival.

And this policy was spelt out in a 2001 government white paper.

### Cover of the *National Service Framework for Older People* (2001)



GPs were and are tied into contracts specifying exactly what they can and what they can't do. And what they can't do is off their own bat, is to experiment or innovate.

This document specified that, if you go to your G.P. because you are worried about memory difficulties, they may give you a checkup and, if there is something obviously wrong, prescribe some medication.

If not, the flow diagram, the algorithm they have to work to, means that they will refer you to the regional Memory Clinic.

You will probably then wait somewhere between six to twelve months in a state of fear and anxiety. Eventually you will get an appointment to be assessed probably by a clinical psychologist or a mental health nurse, who will take a history and give you some tests.

You will then be told if you have or have not got dementia. There are many types but by far the commonest diagnosis – some 70% of the time – is “probable Alzheimer’s”. It’s called “probable” because they believe that, if they opened up your brain, they’d be able to tell you *definitely*; but you’d probably object to the procedure.

At which point, since the clinic’s job is purely to diagnose and not to treat, (well, it would treat you, if it had any useful drugs to treat with) you will be shown the door, with a list of local voluntary organisations.

Minimal or no follow up, no therapy. If you read autobiographies of people living with dementia, you will read of their not surprising distress at this treatment.

The most eloquent writer concerning the experience of dementia is Wendy Mitchell, who records people’s sense of abandonment after diagnosis in *Somebody I Used to Know*. And, although she praises highly her local support group, she seems to have had no therapeutic input. I was in communication with her and when I read her *One Last Thing: How to Live with the End in Mind*, I knew she would end her life; and when she fell down the stairs and broke her wrists, she chose to starve and dehydrate herself to death. So, after a gap of some months, I and obviously many others got an e-mail, “When you read this, I shall be dead...” Chilling.

Thus, for the last quarter of a century, old people have had to put up with a system lacking its main purpose – to control the use of a non-existent drug; and the government, has offered no alternative.

*It’s important you understand how public awareness and understanding of memory loss in old age is determined. Otherwise, you will still believe that your memory difficulties are due to a disease which you can do nothing about. You need a clear head so that you can affect change in your lives. You need to get out from under.*

You may well be asking: why, as the years passed, were no doubts being raised about the lack of validity of the dominant disease and doom narrative? Where was the stream of academic papers casting doubt on the importance of Amyloid and foregrounding alternatives? Where were the psychiatrists and clinical psychologists objecting to the ethics of

diagnosis without treatment? Or about the lack of preventive, therapeutic services?

And the answer is, because the drug companies had invested billions. *The narrative of very common, killer disease, soon to be treated by a pill had to be true.*

*And they had to make people believe it was true.*

This was a two-stage process. Or more exactly, a single process with two major aspects – *regulatory* and *narrative capture*.

*Regulatory capture* – the capture by a commercial group of the relevant policy makers. (It can also be used to describe the capture by the government of independent bodies, as is currently happening in America.)

### **Regulatory Capture**

**Leading firms in a given field work to gain control of:**

- Relevant political decisions
- Relevant legal decisions
- Funding bodies
- Thereby controlling direction of academic work
- And their “message”

So, flood Parliament with lobbyists.

Encourage a revolving door between your people and positions on quangos and government inquiries.

Fund the relevant charities, so that if you pulled the plug, they’d collapse. The implicit threat will be enough to keep them “on message.”

Get laws passed that allow you freedom of activity, and then indignantly plead your adherence to the law

Fund much of the research done on memory work.

Buy academics with lucrative contracts to work part-time with you (part-time, as you don't want them losing their academic prestige); and let universities charge huge "admin" costs so that they need your money.

The drug companies' regulatory capture went hand in hand with near total *narrative capture*.

(If you like historical analysis, Antonio Gramsci, an Italian M.P. imprisoned by Mussolini, describes *the hegemonic narrative*, where the state uses increasing levels of persuasion till it moves into legal and physical means such as arrest and imprisonment.)

### Narrative capture

- To provide the explanation of a disease
- To keep the need for their product (curative pills) in the public's consciousness
- To control the mediums of dissemination (TV, radio, social media)
- To prevent or dismiss alternative explanations

The "disease" has to be kept in the public consciousness. And, of course, the fear factor is continually played up – straight back to Katzman's tags – it's malignant. It'll kill you.

You've all seen those adverts showing people "dying from dementia". Except they don't. The area controlling breathing and your heart rate, the brain stem, is quite separate from the areas controlling cognition. You may die having dementia – *with* dementia – but you won't die *from* dementia.

So why all the death certificates specifying dementia as the cause of death? As Peter Whitehouse has pointed out in *The Myth of Alzheimer's*, because G.P.s don't like writing "old age" or "cause unknown" and, if the dead person was admitted to a residential unit or hospital ward with "dementia", it seems logical.

This narrative is silently or actively complied with by academics, who need drug company money.

As a result, if researchers did not relate their work to the Amyloid Cascade hypothesis, for the last twenty years it was hard for them to get funding, as detailed in Christian Behl's lengthy *Alzheimer's Disease Research* and in Karl Herrup's more forthright *How not to Study a Disease*.

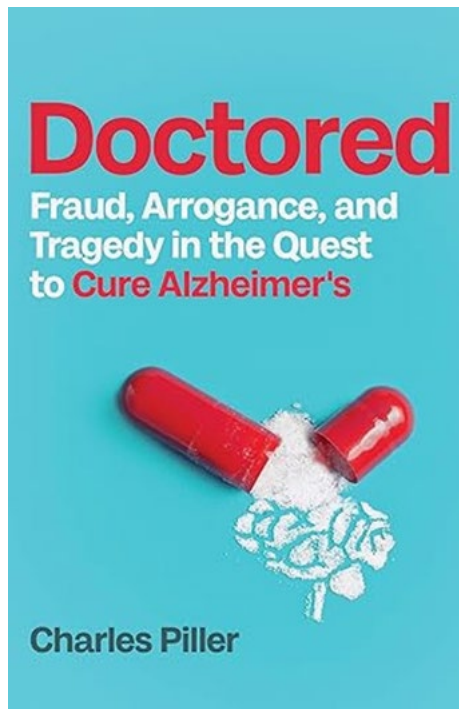
Sadly, the situation has deteriorated still further.

Scientists like to tell you that science is about a community of like-minded, highly trained individuals sharing ideas and their excitement of scientific advances. Perhaps that was always a little rosy – think of the great academic rivalries in the past; but now this picture is even further from the truth.

No more. Forget people in different laboratories wearing white coats all sharing ideas.

Since research into Alzheimer's was, by the 2010s, an essentially commercial exercise, it was played according to the rules of big business. So, the idea of a scientific community sharing ideas and information became impossible, as the drug companies demanded confidentiality (see David Shenk, *The Forgetting*, 2002; Joseph Jebelli, *In Pursuit of Memory*, 2017).

And, as in big business, lying and cheating became if not commonplace, frequent enough to make every finding uncertain. This is well documented in Charles Piller's *Doctored*.



Piller documents two major “discoveries” that were bogus and many other bogus papers.

The two most upsetting stories in the book are when the scientist that Piller relied on for his inside information, Matthew Schrag, discovers his old, revered mentor has faked some of his papers; and that an epidemiologist, seeking the best treatment for his father, enrolls him in a trial of a drug, whose history of promise is invented.

And equally upsetting is that a month before the seminal Hardy and Higgins paper, Higgins with colleagues published a paper in the very prestigious science journal, *Nature*, about a transgenic mouse whose brain appeared to have the amyloid plaques and tau tangles associated with Alzheimer’s disease. Here was apparently an animal model of the human disease. But the pictures in the paper were from a human not a mouse brain, not the sort of mistake you’d make by chance. Higgins denied wrongdoing, but the paper was retracted. As was almost the custom in 1992, the university employers of Higgins and the others never said anything publicly.

And this is another problem highlighted by Piller. Universities are very unwilling to go public on rogue scientists as it damages their reputation and ability to get research funds.

Science, certainly in the field of memory loss, is fragile.

### **PART THREE: The new paradigm of the ageing process**

The unity that initially surrounded plaques and fibrils became harder harder to maintain, certainly after around 2015, when it was clear that the plaques and fibrils paradigm was not going to produce a curative, or even a slowing down, drug.

For those of you who know Kuhn's *The Structure of Scientific Revolutions*, you'll remember that scientific advances aren't linear. Rather, the theoretical framework that scientists agree to work within, has to be jettisoned by a new approach that has different and non-compatible assumptions. And while this change is taking place – the revolutionary phase – the defenders of the old paradigm, who benefit from academic advance and prestige, fight off these new prophets. Since the established figures are the editors of journals, sit on academic appointments and on research grant-making boards, their manoeuvres can certainly delay things for years.

Attempts to block advances in research in dementia have been successful – it's still a sterile desert, with no possibility of real benefit to patients.

The new paradigm is coming from a different area – advances in brain biochemistry.

Technical advances again paved the way. MRI scans and PET scans allowed much closer analysis of brain activity, but the real breakthroughs came in the understanding of cellular processes and cell reproduction.

We age because our cells and important cell particles and processes are reproduced less reliably.

There are a whole lot of key intracellular bodies, such as ribosomes, which are needed for protein manufacture and cell membranes for border integrity and quite a few others, too complicated for me to understand.

Throw in an important role for prions, folded back proteins that were first shown to be the infective agent in Mad Cow Disease but are now known to be involved in many neurological conditions. Including, ironically, young onset dementia, which, of course, is the original Alzheimer's.

Pretty complicated stuff, but what these developments show is that **there is no one disease, Alzheimer's, that causes cognitive decline.** We can see the differences between the two approaches.

<b>Differences between the Ageing and Alzheimer paradigms</b>	
<b>Ageing</b>	<b>Alzheimer's</b>
Memory related difficulties very frequent among the elderly	A killer disease extremely common among the elderly
Gradual, slow loss of brain processes, due to reproductive failures	A quite rapid malignant disease process
100s of different cellular processes	One cascading cause

Rather than forcing us to believe that the disease or the illness is the unit of analysis, an explanation based on ageing uses the individual cell and the key cellular parts – the DNA, the ribosomes – etc. as the base units.

**It's incredibly complicated. There are dozens of cellular particles that need to be reproduced accurately; changes in brain structures will often or usually involve more than one particle; and these particles' processes need to be activated in the correct sequence** if we are to stay cognitively competent. Their reproductive fidelity and the reliability of sequencing both decrease with ageing, and so the cognitive processes become less reliable.

(I like the epigram in Eric Kandel's *In Search of Memory*, 55, where his first mentor, Harry Grundfest tells him, "to understand mind, we need to look at the brain one cell at a time." Kandel later modified that to "one molecule at a time", indicating how the unit of understanding has to be far, far smaller than "a disease".)

Let's see what the new paradigm means in terms of psychological approaches.

<b>Loss of skills in old age</b>	
<b>Ageing explanation</b>	<b>Alzheimer's explanation</b>
Skills loss is slow and affects specific skills	A fairly rapidly disease likely to affect all major cognitive domains
Your skill changes are individual to you	Everyone has the same disease
The rate at which skills decline is individual	You can do nothing to slow the disease
At any age, you can learn and re-learn	Brain plasticity ignored

*Ageing sounds like a lump, but it isn't.* We have hundreds of different cognitive and manipulative skills. And some of them stay unchanged and some get weakened over time as brain processes become less reliable.

Crucially, *the rate of the loss of skills is slow* as there is no disease process but just gradual aging. Which is why research gives figures of two-thirds or more of people diagnosed with dementia who are living in their own homes.

The rate at which you lose those skills will differ from others with similar losses. For example, education seems to protect against skill loss, and, of course, alcohol misuse accelerates it.

Of course, the rate of losing skills can be quite fast and therefore your cognitive performance can decline quite quickly; and this is where the "Alzheimer's disease" narrative will say this decline is due to a *disease*, rather than you being unfortunate with the rate at which you are ageing.

Indeed, you may be told that you have Mild Cognitive Impairment, indicative of further decline. Once again, you are being sold an untested diagnosis. Of course, *you have mild cognitive impairments as you get older. You would be totally deviant if you didn't. What you don't have is a disease.*

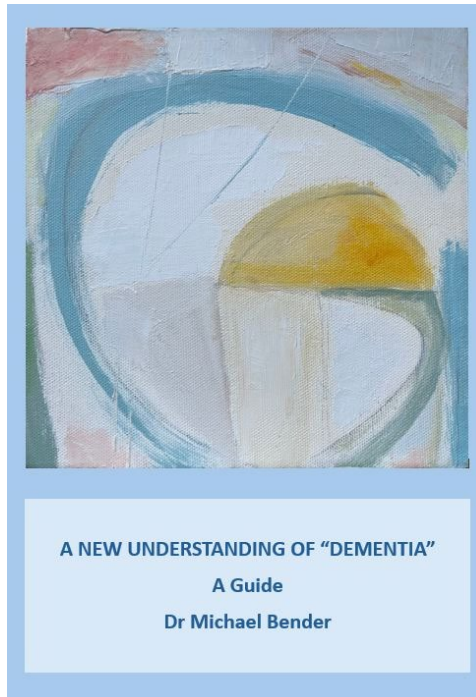
And what is so annoying is that brain plasticity and behavioural plasticity – that the brain can form new pathways and people can demonstrate new behaviours even when they have suffered negative brain changes – has been known for many years and been proven, for example with people who've lost their speech or their mobility and with intensive rehabilitation, reclaimed these abilities.

So, old dogs can learn new tricks, and they forget their old tricks slowly.

So, let's turn to what you've been waiting for – how can we slow cognitive decline?

## **PART FOUR: How can we slow cognitive decline?**

There are a number of successful strategies, all of which are all in my *A New Understanding of Dementia*, published by AgeWise Books.



**What slows cognitive decline? How can I best handle my cognitive problems?**

**Accepting one life's cycle**

**A good physical and mental health workup**

**Seeking calm**

**Maximising cardio vascular health**

- **Restorative sleep**
- **Exercise**
- **Nourishing food**

**The Social Cure**

**Problem analysis and problem solving**

## **Accepting one life's cycle**

You don't want to make the mistake of seeing ageing as just biological, so let's look at the psychological side of **ageing well**.

If we understand increasing memory and cognitive difficulties as due to the ageing process, then, thinking psychologically, we can and should see it as part of the life cycle. (Some of you will have read Erik Erikson's *Childhood and Society* in your younger days.) You are born, you grow, you die.

I would suggest that our society is handling death very badly and we don't like talking about it; we actually prefer to think we may get dementia than that we will die. Presumably, because dementia allows for the possibility of a cure. Not logical but there you are.

If you can frame where you are and who you are within your life cycle, you may well find that the procedures that I'll be outlining will make much more sense.

You are not trying to live for ever; you are trying to maximise your enjoyment and health in the time you've got left.

We are trying to limit morbidity – poor quality of life, poor health in our later years - and accept mortality.

## **A good physical and mental health workup**

There is one finding from autopsies that is worth holding onto. **Eighty percent of people with those plaques and fibrils also shown signs of strokes big and large (cardiovascular events).**

So now life becomes simpler. We know what prevents heart attacks and strokes.

So, if we don't want to decline faster than necessary, we need to minimise the likelihood of strokes and heart attacks. Heart attacks – because once your blood stops circulating, it can't get to your brain.

So, the first thing to do is to get **a proper physical and mental health workup**. There are conditions relating to dementia that can be considered as "diseases". Ironically, researchers that worked in Alois Alzheimer's laboratory did discover valid forms of "dementia", namely

Jakob-Kreutzfeld disease, a rapid killer, caused by prions; Lewy Body Dementia, which is closely related to Parkinson's Disease.

Both fortunately are rare. Note that persons with Lewy Body dementia will react badly to medication for Alzheimer's.

Less dramatically, *you need to get all the information you can about any risks to your health* that could affect your brain functioning, such as being overweight, high cholesterol in your arteries, high blood pressure etc.

And you need to be sure that the frequent **mental health conditions** of old age – anxiety and depression – aren't relevant for you; grief is, of course, common in old age and has similar effects to depression in causing memory difficulties.

All these conditions cause cognitive difficulties – anxiety by damaging your planning ability; depression by damaging your motivation.

And if they apply to you, you should consider getting professional psychological help.

As we get older, often without willing it, we go back over events in our lives; and often it's not the successes that flash up but the missed opportunities, the times you made the wrong decisions or were unkind... Some of these are painful and traumatic

The "rule" with traumatic material is 'Don't tell, don't ask' – we don't ask as we can sense we are being warned off. So the material stays unprocessed, locked up inside their minds.

For women, this can be particularly painful, as sexual assault, domestic abuse and coercive control were common up to the ninety sixties and of course continue to this day.

Such memories are deeply unpleasant, but they also interfere with your working memory – the ability to concentrate your mental resources on the tasks and problems you are faced with.

So, do seek professional help with these traumatic events. A well-regarded and reasonably brief therapy is Eye Movement Desensitization and Reprocessing (EMDR).

And be careful about taking the psychotropic medication. Your brain is fragile. These medications are powerful stuff and are quite likely to cause side effects.

## Reaching calm

Now that you have sought all the relevant information you can about your state of health, you need to plan. And **to plan, you need to reach and find calm.**

I hate to contradict the jolly slogan of “learn, laugh, live” or to put you off your wine-tasting group, but old age is probably the most problem-filled time of your entire life; and, one of God’s little jokes is that he gives you more problems and fewer resources to deal with them.

One of the factors we take into account when we plan is to place our activities within a time scale; and another of God’s little jokes is that he also doesn’t tell you how long you’ve got and how bad things might get, which makes navigating old age even more tricky.

All of which can make you pretty anxious, and anxiety makes it very difficult to plan calmly and rationally.

**Seeking calm**  
**Work out how you can get to calm**

- Experiment lightly – don't beat yourself up when it doesn't work
- No twin tracking
- Use lists to reduce memory load
- Put gaps between events, even enjoyable ones

*So the overriding need is to get to calm.*

*It has to be individual, it has to suit you.* It could be meditation. It could be a brisk walk before breakfast. A wild swim? I don't know but you can find out by experimenting.

You may well not find out what works for you first time out. So my second message is: *don't beat yourself up* if you put effort into what you think might work and then it doesn't. You've learnt something valuable about yourself. My colleague, Ron Burns, has the mantra: *mistakes are information rich*.

And besides, ruminating uses up your working memory.

We can look at calm more widely. Our working memory is the brain's system for temporarily holding and manipulating a limited amount of information for immediate use in cognitive tasks like reasoning, learning, and problem-solving.

The capacity of the working memory decreases as we get older. Like the usual example of going upstairs and then not remembering what we came up for.

So we need to maximise its efficacy and minimise all forms of noise.

- Twin tracking is a no-no. It's doing two things badly, because each task is only getting half your attention.
- Making lists reduce memory load and also reduce anxiety.
- Put gaps between events, even if they went well. You need time to process them. You really enjoyed your granddaughter's wedding, but you will still take time to process it and move on. If you put major tasks too close together, you'll still be processing the first as

you try to tackle the second. All this is usually outside consciousness. So, keep major events a few days apart.

Overall, see reaching calm as seeking a dignified pace of life, where you have time to enjoy and savour each event, your children, your grandchildren, meeting people, a sunset or walk in the park or whatever you enjoy.

Let's look again at the other ways to maintain brain health.

### **Maximising cardiovascular health**

*Restorative sleep* – you can find out the hints from a quick browse of the internet: no coffee before bed, slowing down and switching off some time beforehand, no computer stuff near bedtime etc. etc. And don't underestimate the link between *dysrhythmia* – poor sleep patterns – and depressed mood.

And the next one is also pretty obvious: *nourishing food*. By which I mean food that is good for your circulation system. If your arteries foul up with fatty stuff or highly processed food, if you poison your brain with too much alcohol, then your aging processes will move quicker and nastier. Again, experiment; widen your diet, try new recipes etc.

*Particularly beware of sugar*. Excess sugar of course causes diabetes and similarly can foul up your brain blood supply vessels.

*Exercise* is so obvious I don't need to spend time on it. You must keep your skeletal system from seizing up. Never more than 45 minutes at a time at a computer; engage in physical games and/or walking. Dancing seems to be under-valued. Good exercise and a form of ritualised hugging – doubly useful.

Again, experiment.

It's useful to keep a diary, so that you have an honest record and don't just remember your successes.

**The social cure** is one of the most interesting and best researched preventive measures.

There's a new book out, Ben Rein's *Why Brains Need Friends*, so, if you want neurological evidence, it's in there. And, if you want mental health evidence, try Jetten and the Haslam's *The Social Cure* – the isolated

person is at risk, both with regard to their physical health and, not surprisingly, their mental health.

Also, to get the benefits of socialising, it has to be for real. By mixing with and in groups, I mean real people, not zoom images. Our systems are millennia old. We are glorified apes and that means we are built to meet, greet, discuss, argue and hug real people, not computer images.

One or two wrinkles. Social isolation among the elderly has undoubtedly increased among the elderly, as many did not “come out again” after COVID. So, they are at serious risk.

And research, for example by Clare Wenger has shown that, as you get older, your social circle shrinks quite quickly, be it within the family, your friends or up the pub or club.

So you have to work at it –you have to think of joining in groups new to you in your 70s and 80s, and not just stay in your safe, but very small family unit. And this “going out and meeting new people” may be more difficult for older women but is still necessary; and beware of groups where “we all have to be happy and optimistic”.

As with almost all psychological phenomena, social isolation overlaps with other factors. Psychological conditions vary rarely stand alone. The reason it looks like that is that academics make their name by becoming well-known for their work with one variable. For example, they may be experts on “anxiety” and ignore the fact that anxiety and depression invariably go together. (See Bentall’s *Madness Explained* if you want the many studies demonstrating this fact.)

Another is findings like “the more education, the less likelihood of dementia”. Education may help, but it costs, so it goes with higher social class and that means good childhood nutrition and access to medicine, and these factors continued throughout life.

If you like epigrams:

<b>Bender’s First Law of Psychology</b>
Factors concerning mental health never stand alone (Only academic empires and diagnostic categories do)

In like vein, social isolation can be caused by bereavement, not just of partners, but also relatives, of the house you had to move out, and, quite often, your pet.

And don't try and combine socialising with exercise. Remember the old saw: twin tracking is doing two things badly. If you're playing golf whilst chatting, you're not playing golf as exercise; the rules of the socialising and of exercise usually conflict.

The opposite of socialising is *social isolation*, which all too often goes with low levels of cognitive stimulation and it's literally a killer of cognition.

Nicci Gerrard (better known as the female half of the "Nicci French" thriller story writer) wrote *What Dementia Teaches Us about Love*. Most of it is about dementia, but it is also an account of "losing" her father as a social being. This did not derive from "dementia" but from him going into hospital to sort out his leg ulcers. Then there was an outbreak of norovirus on the ward "which meant that for days on end he was alone".(p.2)

It was just days, but she lost him:

His leg ulcers were healed, but ... surrounded by strangers and machines, he swiftly lost his bearings and his fragile hold upon his self.

When at last he came home, he was a ghost of himself, skeletal, immobile, inarticulate and lost. (2-3)

Social isolation often occurs where an elderly couple have lost touch with most of their friends – many are ill or deceased, the couple no longer drive; and then one of the couple die; and the bereaved person doesn't go out much and, because of their grief, doesn't do very much. This is a dangerous situation – an under-stimulated brain can start closing down, as per Nikki French's father. And since, on average, women live longer than men, social isolation is a greater threat to their well-being.

<b>Problem analysis and problem solving</b>
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***Problem analysis and problem solving*** is a major part of my book. They are important, because they focus on the things that actually worry you and which you can do something about.

What you need to focus on is the actual problems you have, no more, no less. Problems like forgetting what's been said, little prangs in the car, not keeping track of your expenditure – particular, specific problems.

You are not suffering from a disease; you do have definable problems.

Decide on two or three problems where you think you stand a reasonable chance of improving the situation. These may or may not be your most pressing problems. The point is that we want you to get some success under your belt, and become familiar with Problem Analysis and Problem Solving, before you tackle the big stuff.

Write down those two or three problems you want to tackle first.

You can use the following protocol for undertaking Problem Analysis and Problem Solving:

<b>PROBLEM RECORD</b>
<b>The problem I want to tackle is:</b>
<b>Problem analysis:</b>
<b>Possible problem solution:</b>
<b>Frequency of tackling problem:</b>
<b>Progress Review date:</b>
<b>Dates tackled and outcome:</b>

Obviously, this is a table, but you could easily turn it into a useable form.

What it does is to take you through **problem analysis** how does the problem occur – where, when, with whom?

Most problems are situation and time specific. I forget where my car is only when I go to a large carpark; I prang my car when I reverse out of the supermarket carpark, not in my garage etc.

So you start by observing yourself and getting an answer to those questions.

And, of course, you don't have to problem analyse (or think of problem solutions in the Problem Solve phase) by yourself. You may have a trusted friend or friends; you never too old to see a counsellor etc.

Take 'forgetting where I left my car': **Analysis**: because I'm thinking ahead as I get out of the car what I need to buy, so I don't note where the car is.

Then you move onto **problem solving**: how do I solve this problem?

So, you set yourself the task of getting your bearings before you go away from the car. (My car will be on the second row to the left when I come out. I might even make a note of it.)

You decide on the frequency of this solution – even if it means seemingly unnecessary trips to the supermarket.

You record your successes and failures.

You set a review date.

Never more than two, maximum three problems at a time.

Of course, not all problems are solvable. Problems in relationships may be particularly difficult.

And for those of you who studied Piaget, you can assimilate – change the world to achieve your aims, or accommodate – change yourself; probably most of your solutions will be a mixture of the two.

And if not solvable, remember the Serenity Prayer. Don't beat yourself up. Rather, work out an acceptance strategy for handling that skills loss – can't drive, I've saved £7000 pounds. How will I spend it?

*A New Understanding of "Dementia"* goes into far more detail about Problem Analysis and Problem Solving than is possible here, so consult it if you think these processes will be useful for you.

**PART FIVE: Working with others; helping others**

**Bender's Law of Older People**

**For politicians of whatever party, old people are good things  
when they spend money.**

**If they cost money, they are to be neglected.**

We're nearly at the end of this account of growing old. Clearly the new paradigm of ageing is likely to grow in importance, but there are problems ahead – the commercial model dominates, with the rush to copyright and register patents by individual scientists, their universities and the drug companies. This will delay cross-fertilisation and, if the model of mental illness seeking a single cause and pill prevails, could give rise to a new, incomplete, dominant narrative.

And dominant the current narrative certainly is.

Not realising that the world had changed, when I finished writing *A New Understanding of Dementia*, I thought it a simple matter to re-connect with the workers I knew a few years previously who had wanted to understand and help people in the early stages of their difficulties.

I tried talking to GPs and clinical psychologists to see if we could work together, but they are tied into contracts specifying exactly what they can and what they can't do. And what they can't do is off their own bat, experiment and innovate.

The original, small, radical-thinking voluntary agencies actually probably "do know better", but they are now all on short-term grants, and rocking the narrative would result in non-renewal.

The silence was deafening. You could almost smell the fear.

Returning to older people today, I am well aware that the societal dimension has been underplayed in this paper. Looking after yourself requires security – personal safety, financial security, housing security,

job security – the old Maslowian hierarchy. Psychology never stands alone. It is always in the shadow of contemporary realities.

And what is also clear is that there will be no real change when it comes to elder care.

*If we want improved services, then we ourselves will have to provide them.*

The u3a is a nation-wide organisation, an organisation, which has a membership with a huge range of real talents.

Can't we develop preventive services for our members who are starting to worry about cognitive changes?

With a social work colleague, I've run a focussed group for people worried about their memory in Ivybridge for 12 members. We called it "Aging in Body and Mind" – six fortnightly sessions of two hours and it was very well received.

We called it "focussed", to make it clear that we were tackling problems, Likewise, we held it in a community hall, not someone's home where socialising is inevitably confused with the task.

The method was simple. Each member had bought a (cost-price) copy of *A New Understanding of "Dementia"*, and before each session, read and thought about a section of it on a health-giving process. Then, at the sessions, they worked in small groups discussing their ideas and what would work, or wouldn't work, for them.

There were two periods of forty minutes with a coffee break between – 40 minutes is the longest a student concentrates.

Once again, we're talking about problems an individual has, and the solutions that work for that individual.

The course was very well received. Incidentally, the problems the members brought were often nothing to do with their memory but with driving, relatives, handling upcoming social events, such a family gathering when you have hearing loss, etc.

I believe that the goal of helping u3a members develop techniques that allow them to feel in control of their lives and tackle cognitive problems that come with old age can be achieved.

*You can run a similar group in your local U3A area where you discuss how individual members can handle their cognitive difficulties.*

“All” it needs is six or so like-minded “Memory Pioneers” with similar aims and the will and the cooperation to gradually develop the service.

You may feel that you do not have the knowledge or skills to lead a group. But if you have experience of being in groups and knowing what is needed in groups, that’s the basis for getting started.

The Memory Pioneers would work together to build up the course. The reading matter and the session topics are all in my book, and of course you can, and may well want to, add your own material.

Once established, you may well find the need for other, different types of group.

It would be marvellous to see such groups being offered in every u3a area.

I’ll be happy to explore these possibilities further with interested members; and happy to talk to you all again about such groupwork.

### **Conclusion**

We’ve come to the end of the strange history of “Alzheimer’s Disease”. To finish with the man who discovered early onset dementia, but not its cause; a man who encouraged many researchers’ talents; and who was then used as a pawn to further the interests of organic psychiatry, which, of course, he took as his theoretical base.

You can visit the house where Alzheimer was born in Marktbreit, Bavaria. Make an appointment with the town’s tourist office.



He always wanted to head up a psychiatric facility and in 1913, against Kraepelin's advice, accepted the post of professor of psychiatry in Breslau, in the far east of the Hapsburg empire, which is now Wroclaw in Poland. When travelling there, he contracted influenza that he never shook off. He died on December 19, 1915, at the age of fifty-one, from heart and kidney failure. His children, whom he was always close to, brought his body back.

He is buried alongside his wife, Cecilie, at the Frankfurt Main Cemetery in Germany. Find out the location from the cemetery office – it's a very large cemetery.



So, there we are. The problems, the skills losses you are experiencing are due to you getting older and nearer to death. But the changes are slow and your brain is flexible. You can work on staying healthy. You can analyse and tackle your problems and find solutions, or, at the least, decrease their impact on your life.

Which means that you can do something about them and thereby enjoy your old age more.

## Thank you and age well!

I should like to thank Alison Bender and Kay Harding for their considerable help in preparing this paper for publication

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