

Bridging the gap between clinical and critical sociological perspectives in dementia

Noel Collins  & James Rupert Fletcher

ARTICLE

SUMMARY

There is a widening gap between the medical model of dementia and critical sociological perspectives of the condition. Given the relative failure of reductionism in dementia and its rising prevalence, consideration of the utility of these critical viewpoints is warranted. This article considers how these ideas, which challenge some prevailing assumptions about dementia, can be meaningfully applied in conjunction, rather than in competition, with conventional clinical ideas. To illustrate this, current perspectives on selfhood, biopolitics, citizenship and post-humanism are discussed. This article may also help to articulate sociologically oriented approaches already used by some clinicians and legitimise the time and attention needed to explore and deliver these. We support the view that dementia is an episteme in the making and that different traditions and dispositions can fruitfully collide to enliven interdisciplinary conversations about dementia and dementia care.

KEYWORDS

Critical psychiatry; sociology; gerontology; dementia; citizenship.

LEARNING OBJECTIVES

After reading this article you will be able to:

- explain how different models of the self in dementia suggest its resilience and may help in diagnostic counselling
- explain how citizenship is influenced by everyday activities and material objects
- consider dementia from a post-humanist perspective, offering some clinical initiatives, but also the possibility of iatrogenic harm.

The rising prevalence of dementia (from 57.4 million worldwide in 2019 to a predicted 152.8 million in 2050) due to population ageing poses a wide range of social and health challenges (Nichols 2022). Increasing dissatisfaction with the medical model's inability to account for the wide variation

in the individual experience of dementia has led to a proliferation of alternative theories of dementia arising from sociological and critical theory viewpoints. Some have accused the medical model of dehumanising people with dementia and failing to deliver treatments with substantive clinical effects (Fletcher 2023). In this article we consider how some of these perspectives, which challenge many prevailing medical assumptions about dementia, can be used alongside more traditional clinical ideas to improve the experience of diagnosis and post-diagnostic care for people with dementia. Although the use of 'dementia' as a singular umbrella term is almost as nonsensical as 'cancer' (given the multitude of aetiologies and varied individual experiences that it subsumes), it is used here for heuristic purposes. This article is most pertinent to late-onset early- to mid-stage dementia and may have less applicability to the challenges faced by younger people with the condition or those in more advanced or terminal phases of the condition. Finally, we introduce clinicians to some conceptual and practical implications of contemporary social science. This is valuable but, nonetheless, we must remember that most dementia care is 'informal', provided by family members and taking place beyond the clinic.

Acknowledging current limitations

The unstable nosology of dementia

Ever since a group of influential German physicians (Alzheimer, Pick, Krapelin et al) reframed senility as a neurodegenerative disease over a century ago, the neurocognitive positioning of dementia has been contentious (Herrup 2021). This relates, in part, to the long-standing pathophysiological, cognitive and epidemiological challenges of differentiating the pathological and the normal to define a categorical dementia syndrome (Brayne 2007). The nosology of dementia remains unstable, with blurred and dynamic distinctions between aetiological subtypes (Morris 2000) and ever-changing diagnostic criteria, with limbic-predominant age-associated TDP-43 encephalopathy (LATE), vascular

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