AN ALTERNATIVE PERSPECTIVE

Alzheimer's Disease & The Dementias

David McMillin, M.A.

BASED ON THE EDGAR CAYCE HEALTH METHODS

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DISCLAIMER: This book is directed primarily to health care professionals who are interested in alternative perspectives on the causes and treatment of mental illness. This book should not be regarded as a guide to self-diagnosis or self-treatment. The cooperation of a qualified health care professional is essential if one wishes to apply the principles and techniques discussed in this book.

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Introduction

America is entering an era of health care crisis. While politicians debate alternatives, insurance companies and hospitals feel the pressure to find less expensive and more efficient ways of doing business. Financially beleaguered citizens are often forced to forego medical services as the cost of treatment continues to rise. At all levels, there appears to be a growing concern that our health care system is failing and may eventually collapse.

We are offered a foretaste (although for most of us second hand) of this impending dilemma via the current AIDS crisis. As a society and as individuals it is easy to become preoccupied (or even terrorized) by the possibility of contamination by this menacing virus which incapacitates our immune system.

However, AIDS is only a forerunner of the difficulties before us. There is increasing evidence of a more ominous crisis. We are becoming more aware of diseases which preferentially afflict the aged, a group of disorders called the dementias.

In particular, tremendous resources are being focused on the

most widely recognized of the dementias—Alzheimer's disease. Unlike the AIDS dilemma, our present level of understanding does not allow us to forego the risk of Alzheimer's dementia by simply abstaining from certain behaviors or taking precautions when risk is inevitable. The bottom line is that we are all at risk and remain at risk until we can achieve significant advances in the treatment and/or prevention of this form of dementia. We will discuss some of the staggering statistics associated with the impending Alzheimer's epidemic in Chapter One.

I am not alone and certainly not the first to ring the alarm concerning this devastating illness. However, my angle is definitely unique and I assure you that this is not a doom and gloom tale. To the contrary, it is a statement of cautious optimism tempered by a realistic assessment of the seriousness of our predicament and the limitations of our resources.

Of course, like ostriches we can stick our heads in the proverbial sand. Or in a more typically American fashion, we can optimistically hold down the fort of modern medical health care and wait for the clinical cavalry to come to our rescue.

Adopting this strategy, our hopes would have to ride heavily on medical research. Although we strongly support such research, we must also be realistic and look at the track record of science in regard to chronic, degenerative disorders. It is certainly a mixed bag. Having invested years of research and billions of dollars, we have failed to conquer a multitude of major illnesses such as multiple sclerosis, muscular dystrophy, cancer, cardiovascular disorders, arthritis, etc.

Certainly, gains have been made. This is especially true in disorders involving serious mental symptoms. However, most of the primary therapeutic advances in the field of major mental illness have resulted from serendipity. The right person happened to be in the right place at a fortuitous moment.

For example, the discovery of the antipsychotic properties of the phenothiazines (such as Thorazine) can be traced back to the French physician Henri Laborit. He was looking for a drug to prevent a drop in blood pressure during surgery. Although the drug he used failed in that respect, it did have noticeable sedative effects. Subsequent research by French psychiatrists was by trial and error—they gave the drug to persons suffering a wide range of disorders to see if it had any effect. The medication had potent calming effects on agitated psychotic patients and thus: "The first powerful drug

available to treat serious mental illness was discovered in much the same way as was penicillin: by accident. The discovery was the happy consequence of a chance finding being observed by a person with a fertile mind who could recognize its larger implications." The preceding observation was noted by Nancy Andreasen, M.D., Ph.D., a leading researcher in the field of mental illness.

The efficacy of lithium carbonate, a naturally occurring salt useful in the treatment of mood disorders such as manic-depression, was also a fortuitous accident. Its therapeutic potential was discovered by an Australian researcher seeking a neutral solution to serve as a control substance in experiments with rats. Fortunately, he was astute enough to notice that the substance, intended to have no effect, actually affected the rats' behavior in a specific and useful manner. He had a difficult time convincing his colleagues to give lithium a try—it had been used in previous experiments with humans and its propensity for toxicity had resulted in several deaths. Eventually, its therapeutic value was acknowledged and now is widely used by the medical profession in treating mood disorders.

Finally, the use of "monoamine-oxidase inhibitors" (or MAOIs, a class of drugs used to treat depression) can also be traced to a lucky side effect. One of the MAOIs is an antibiotic used to treat tuberculosis. Clinicians noted that the drug helped to relieve the depression which also plagued the patients. Subsequent trial and error experiments further refined the applications of anti-depressant drugs.

Compared to these serendipities, the list of major therapeutic breakthroughs resulting from a concentrated study of a mental illness and thorough understanding of the problem is meager. The fact is, we *still* don't know for sure what causes these disorders or exactly how the drugs suppress the undesirable symptoms. So the image of successful research (i.e., a team of knowledgable researchers who produce an effective treatment based on a thorough understanding of the condition—and millions of dollars in government funding) is not necessarily accurate or comforting.

With this in mind, we should remain open to any source of information which offers a reasonable possibility of making a contribution. A premise of this book is that the psychic readings of Edgar Cayce are such a source. Naturally, readers will have to judge for themselves the plausibility of this material. No attempt will be made to convince or convert anyone to this perspective. The readings themselves acknowledge the necessity of seeking such information:

> No one should be . . . coerced. No one should be sought. But EVERYONE should be given the opportunity that would sincerely seek. (254-96)

Thus, the purpose of this book is to make the information readily available to anyone seeking and open to this source. This work is merely presented as a service to those desiring an alternative perspective on the treatment of dementia.

It will not appeal to most. We are an impatient society spoiled by the illusions of miracle cures. We tend to seek an easy and quick, non-involved remedy for our ills—a pill, injection, or some other straightforward medical intervention.

The perspective presented in this book is not so detached. The therapeutic process requires a great deal from the caregivers who implement it. However, it also has tremendous potential.

This book is directed primarily to the families and support persons dealing with dementias such as Alzheimer's disease. It is nontechnical in style and seeks to make the Cayce material accessible to those who are interested in alternative perspectives on this disorder.

This book does not pretend to present a cure. Yet, the readings do offer some extremely optimistic possibilities for those who patiently and consistently apply the recommendations. Thus, this information will be presented—but not without acknowledgment of how extremely difficult such a process is.

I will not attempt to address the causes and treatment of dementia in any deep or scholarly fashion. I will leave that to the clinical researchers. However, I will include some references in Chapter One regarding demographics. The projected statistics for the dementias (and especially Alzheimer's) are so consequential that I feel it best that readers have the opportunity to follow up on this literature if they desire. Therefore, I have referenced some of the more imposing data concerning future rates of occurrence and the projected financial burden this will incur.

I have also referenced all of the selections from the Cayce readings. Recognizing the need for confidentiality, each reading is assigned a number corresponding to the person or group requesting information. The identifying number is followed by another number designating the sequence of the reading. For example, a reading cited as 182-6 indicates that this reading is the sixth in a series of readings for an individual or group designated as 182. Although

many of the early readings were not recorded, over 14,000 were stenographically transcribed and have been preserved by the Association for Research and Enlightenment (A.R.E.) in Virginia Beach, Virginia. Readers seeking a deeper understanding of this material may pursue their interest at the A.R.E. Library—it is open to the public on a daily basis.

This book may be viewed as an introduction to the dementias from a unique, alternative perspective. The Appendix contains a list of resources including books and articles for persons wishing further information on the subject. The chapters which follow merely present a way of looking at the problem which may help those who have to deal with it on a daily basis. At this level of daily involvement, relief of symptoms and delay of degeneration is a significant contribution. The readings may have something to offer in this area.

The suggestions are "low-tech" in nature and for the most part can be provided at home (if such is the desire of those providing care). The assistance of health care professionals is required for some treatments. However these therapies are not beyond the resources of most families. For example, an osteopath or chiropractor may be able to provide the primary treatments recommended in the readings. The services of a massage therapist may also be helpful (even this therapy may be provided by a family member willing to learn some basic techniques).

This book is also about attitudes—how to think about the problems posed by a chronic debilitating illness. How to make the best of a bad situation. The psychological and spiritual aspects of treatment are important and will be emphasized.

This approach deals with all levels of human experience and is especially helpful in addressing the *meaning* of illness. Disease can be a pathway to growth in consciousness. In this sense, dementia may offer an opportunity for soul growth for the suffering individual as well as family, friends, and professional caregivers.

1

Our Dilemma

BEFORE LAUNCHING INTO the psychic readings of Edgar Cayce, it will be helpful to get an overview of our topic. This preliminary survey will define key terms, explain important concepts and theories, and provide some statistics which will convey the seriousness of the impending medical crisis.

Thus, this brief chapter will set the stage for a consideration of Edgar Cayce's alternative perspective of the dementias. A basic understanding of the facts, as they are currently discerned, will provide a baseline with which to evaluate the potential contribution of the readings.

What Is Dementia?

Dementia is a medical term referring to a deterioration of mental functioning due to progressive organic disease of the brain. Persons suffering from dementia typically experience loss of intellectual abilities such as memory, language use, and the ability to learn,

solve problems, and make judgments. In its more severe forms, dementia may also produce disorientation, hallucinations, and paranoia. Social functioning is impaired and emotional responses may be atypical or inappropriate. For example, irritability and agitation may be present with occasional verbal and physical aggression toward family or caregivers.

Family members often describe the deterioration of a demented relative as a gradual death—as a loss of the higher qualities of the mind which distinguish us as human beings. This is an ironic observation since dementia often strikes while the individual still has good physical health.

Eventually, even the body succumbs. Dementia is a leading cause of death among U.S. adults. (1)

Dementia is an acquired illness (as contrasted to disorders present at birth such as mental retardation). Alzheimer's disease (a widely publicized dementia which we will look at more closely later in this chapter) accounts for about 50 to 60 percent of all cases of dementia. Vascular disease contributes around 10 to 20 percent.

Dementia may be caused by a multitude of factors including brain injuries, nutritional deficiencies, epilepsy, infections, hormone disorders, and drug effects. The list of causes is extensive and still growing with at least sixty known factors or conditions which can lead to dementia. There is still much to be learned about the causes of dementia. Even extensive postmortem examinations fail to reveal the cause of dementia in about five percent of all cases.

The outcome in cases of dementia is variable. Many dementias are reversible—that is, if a correct diagnosis is made and appropriate treatment provided, the deterioration can be halted or even reversed. This is particularly true in cases of malnutrition and vitamin deficiencies. Because many elderly people develop poor eating habits due to limited finances, difficulty in chewing, and other factors which often affect dietary choices, this area should be thoroughly assessed by the health care professional making the diagnosis.

Dementia is closely linked to the aging process—as we become older, we are at greater risk for developing dementia. Currently there are approximately two million patients suffering from dementia in this country. As the "baby boom" generation moves into its golden years, this number will increase dramatically. Based on current rates of occurrence (that is, if there are no major breakthroughs in the treatment or prevention of dementia), in the year 2040 there will be approximately 7.4 million Americans suffering from dementia. (2)

The total cost of caring for demented persons runs into the billions of dollars (many estimates focus on the $25-$30 billion range).(1) If the projected increase in frequency is accurate, the financial burden of providing medical services could bankrupt the health service system of our country.

In the past, dementia was viewed as a normal consequence of the aging process. Just as the body tended to lose its strength and suppleness with the passage of time, aging was also thought to naturally result in brain degeneration and decline in mental abilities. This view was (and still is to some extent) reflected in the term senility. Although in our daily lives we commonly associate senility with aging, technically it is not a useful medical term. With the increased understanding of the role of the dementias in the aging process, senility has fallen from favor. It is simply too vague in its implications to be useful to health care professionals.

Only a few years ago, senility was employed for diagnostic purposes. To understand how the change in medical terminology took place, we must look back almost a century. In 1907, Dr. Alois Alzheimer published research findings based on a case study which indicated that biological deterioration was linked to the psychological symptoms of certain forms of dementia. This important demonstration of biological causation was a crucial step in recognizing that mental illness can have a physical origin. His description of the tangled and degenerated nerve fibers clearly established the biological dimension of a process then labeled senility.

The curious feature of Alzheimer's case study was that the patient was only fifty-one years old. The woman's age was far too young to be considered normal for such extensive degeneration. Alzheimer believed that he had discovered a separate illness occurring before old age. Therefore he called the disease presenile dementia—dementia before old age.

Although his findings were controversial, his diagnostic category was eventually accepted. An arbitrary age limit (sixty-five) was chosen. Sixty-five years of age was thought to reflect the age at which "normal" senility began. Thus, cases of dementia of unknown causation before the age of sixty-five were diagnosed as presenile dementia, while those sixty-five or older were considered senile dementia.

This bit of historical information is very important to our consideration of Edgar Cayce's perspective in Chapter Two. Alzheimer's disease was not a formal diagnostic category during Cayce's lifetime.

As one would expect, when he did use diagnostic labels, Cayce tended to use terms commonly in use among the health care professionals of his era.

Therefore, many of the readings which appear to be describing Alzheimer type pathology simply mention senility as the problem. Apparently, he did recognize the generally accepted medical distinction between presenile and senile dementia. For example, he used the term "premature senility" to distinguish dementia with an earlier onset. However in terms of treatment, he adopted a position more in line with modern medical thinking. He tended to ignore the distinction by treating them as one disorder. We will continue this discussion of the problem of diagnostic classification in the readings in later chapters.

Until the late 1960s, arteriosclerosis ("hardening of the arteries") was viewed as the major cause of senile dementia. This view changed when researchers established that large amounts of fatty deposits could be found in the brain's arterial walls of both demented and normal elderly individuals. Furthermore, approximately half of the brains of persons suffering from dementia showed no signs of significant arteriosclerosis. So, while some cases of dementia could be attributed to vascular disease, it was not viewed as a major factor.

Research also clarified the nature of the brain lesions in both presenile and senile dementia. The brain pathology was identical. Apparently, the age distinction of sixty-five years was not relevant in making a diagnosis. Medical terminology was modified to reflect this recognition. The two groups were combined and called dementia of the Alzheimer type (DAT).

With further research, this nomenclature could change again. While medical science tends to focus on diseases as specific conditions (with specific causes and specific cures), there is a growing recognition of the complexity of major illnesses such as Alzheimer's dementia. This is sometimes referred to as "nonspecificity." Nonspecificity is an important concept in the readings of Edgar Cayce and we will be looking more closely at its implications for both causation and treatment in subsequent chapters. For now, it is only necessary to grasp that Alzheimer's dementia may not be a single illness. Dr. Leonard L. Heston and associates have noted: " . . . that widespread etiologic heterogeneity exists in nature and that eventually evidence will be found to support extensive subdivision of DAT (dementia of the Alzheimer type)." (3) In other words,

this dementia may consist of a group of related diseases with different causes and course of illness which result in the characteristic destruction of brain tissue associated with Alzheimer's dementia.

The possibility that a variety of factors may be involved in Alzheimer's dementia is apparent from the list of suspected causes. We will briefly consider the most prominent of these suspects.

Some Possible Causes of Alzheimer's Disease

While the cause of Alzheimer's dementia is unknown, there are several theories which have attracted considerable attention. Researchers have proposed that it may result from *viral infections* which attack brain cells and cause slow deterioration of nerve tissue. Parallels have been drawn to two similar diseases of the brain (kuru and Creutzfeldt-Jakob disease) which are known to result from viral infection. Scientists at the National Institutes of Health have explored the possibility of a viral link in Alzheimer's dementia by taking brain cells from deceased victims and placing the diseased cells in laboratory dishes containing normal cells. In certain cases, the diseased tissues appeared to cause the normal cells to die.

In related experiments, diseased cells were injected into the brains of chimpanzees. Two of the six experimental animals developed a progressive neurological disease.

Unfortunately, further research failed to support the results of either of these types of experiment. As we shall see, this pattern of apparent initial breakthrough followed by failure of experimental confirmation is common in research of this disorder.

For example, it is widely accepted that aluminum toxicity can produce brain degeneration similar to the lesions of Alzheimer's dementia. Findings on experimental animals have shown that injections of aluminum compounds produce neurological tangles in the brain similar to those found in Alzheimer's dementia. Early in the 1970s, researchers at the University of Toronto explored a possible connection between aluminum and Alzheimer's dementia. Their findings were dramatic. Autopsies of brains from patients who had been diagnosed as Alzheimer's dementia contained as much as 30 times more aluminum than normal brains.

However, subsequent research has clouded these findings. Investigators at the University of Kentucky failed to find significant amounts of aluminum in the brains of Alzheimer's patients even though these individuals had spent a lifetime drinking local water

containing high levels of aluminum.

So we are left with the question of whether aluminum toxicity might be a cause of Alzheimer's dementia. This is a particularly fascinating aspect of the Alzheimer's puzzle since the Edgar Cayce readings were cautioning against the use of aluminum cooking utensils decades before researchers became aware of its potential link with a major brain disease.

Currently, scientists are focusing a great deal of attention on the genetic aspects of Alzheimer's dementia. Research indicates that children of parents with the disease have a 50 percent chance of developing the illness. Furthermore, these individuals are more likely to exhibit the symptoms much earlier with a more rapid progression in the degenerative process.

The genetic link is further emphasized by studies connecting Alzheimer's dementia with Down's syndrome. Down's syndrome is a developmental disorder in which a child is born mentally retarded. It is caused by a flaw in the genetic material of the afflicted person. These individuals have an extra copy of chromosome 21.

Persons with Down's syndrome who survive beyond the age of forty typically suffer brain degeneration similar to Alzheimer's dementia. Furthermore, the frequency of Down's syndrome is 10 times higher among families of persons who experience early-onset Alzheimer's dementia.

As persuasive as the genetic studies are, we should be cautious in interpreting their meaning. Genetics is not likely to hold all the answers to the Alzheimer's puzzle. For example, even with identical twins, one twin may develop the disease while the other does not. Obviously, there are additional factors at work here. Perhaps certain genetic factors can make an individual vulnerable to developing Alzheimer's dementia while other factors (such as environment or lifestyle) can increase a person's vulnerability. We will address this possibility in a later chapter which focuses on preventing dementia.

Direct brain insult is another possible cause of Alzheimer's dementia. It is known that persons whose brains have been seriously jarred or who have experienced repeated blows to the head may develop the symptoms of Alzheimer's. For example, prizefighters who have received numerous punches to the head over a period of years may develop "boxer's dementia," an irreversible dementia with symptoms and brain degeneration very similar to Alzheimer's.

Glandular abnormalities have been linked to Alzheimer's dementia. Researchers at Duke University have found a significantly higher

frequency of prior thyroid disease in women patients suffering from Alzheimer's than in control subjects. Furthermore, studies at the University of Minnesota suggest that the immune system may play a part in Alzheimer's dementia.

These findings result from statistical analysis of biographical data collected from patients and control subjects. Correlating life history patterns with specific biological pathology has been more difficult. One of the most promising models links certain forms of Alzheimer's dementia with "disorders comprising the thyroid-gastricadrenal-thymic autoimmune syndrome." (3) It is likely that future research will uncover more extensive connections between glandular dysfunction and Alzheimer's dementia.

We have looked at only a few of the most prominent theories explaining the causes of Alzheimer's dementia. New hypotheses and variations on the older theories are being proposed continually. The bottom line at this point in time is that we really do not know what causes Alzheimer's dementia.

Symptoms of Alzheimer's Dementia

Like many of the other dementias, Alzheimer's disease results in the progressive loss of "higher" functions such as thinking, reasoning, and memory. It destroys the distinctive qualities of mentality which make us human.

The deterioration is usually gradual, beginning with mild symptoms (such as forgetfulness of minor things like phone numbers or dental appointments). This decline is often accompanied by difficulty in learning new information. As the nervous system becomes more incapacitated, patients may have difficulty controlling their bodies or moving smoothly. Emotional problems commonly develop. The degeneration in functioning may produce deep depression, crying spells, or temper tantrums.

The Demographics of Alzheimer's Dementia

Nursing homes contain many cases of Alzheimer's dementia. Researchers estimate that as many as half of the patients in nursing homes are suffering from it. (1) Furthermore, it is the fourth leading cause of death among older people. (4)

The number of cases of Alzheimer's dementia has increased dramatically during this century. It is currently 10 times more frequent

than it was during the first decade of the twentieth century when it was identified by Dr. Alzheimer. By the end of the century the number of cases will likely increase by an additional 60 percent. (2)

Ironically, this alarming increase is due, in large measure, to the success of medical science in extending the human lifespan. Because people are living longer, the number of elderly people at risk for Alzheimer's dementia is greater.

Consider these facts: 9 out of 10 persons afflicted with the disorder are over 65 years of age. It occurs in about 1 percent of all persons between the ages of 65 and 74 years of age, 7 percent in those individuals 75 to 84 years old, and 25 percent in the population who are 85 years or older. (2)

Since the average age of persons in our society is steadily increasing and will dramatically accelerate with the aging of the "baby boom" generation, we may soon find ourselves in the midst of an Alzheimer's dementia epidemic. Some researchers and family members affected by the disease have suggested that we are already experiencing such an epidemic. Some doctors refer to Alzheimer's dementia as the "disease of the century." With the increasing threat posed by the AIDS virus, this unflattering designation is certainly debatable.

However, if we are unable to make major breakthroughs in the prevention and/or treatment of Alzheimer's dementia in the next couple of decades, it will certainly deserve the title of "disease of the 21st century." If the present trend continues unabated, by the year 2034 the incidence of Alzheimer's dementia in the American population will more than triple. (2)

By the year 2040, there will be 7.4 million Americans stricken with dementia (mostly suffering from Alzheimer's dementia). In such a scenario, half the American population would suffer from Alzheimer's or some other form of dementia before they die. (2) As it stands today, at least 10 percent of the readers of this book will eventually develop some form of dementia.

The National Institutes of Health estimates that Alzheimer's dementia costs about thirty billion dollars each year, the bulk of the expense going to institutionalization of chronic Alzheimer patients. (4) The financial burden is likely to double or triple in the next thirty to fifty years as the "baby boom" generation advances into old age. (1) Unless medical science can produce a major breakthrough in the prevention or treatment of Alzheimer's dementia, America will soon be confronted with an age-related medical emergency, spear-

headed by an Alzheimer's dementia epidemic.

There is a natural tendency to be overwhelmed by such incredibly large numbers stretching forward into an uncertain future. Furthermore, researchers and experts in this field sometimes add to our confusion by quibbling over specifics of the demographics we have just reviewed. However, there does seem to be a consensus on the general trend we are experiencing. Dementia is presently a very serious health care problem confronting us all, individually and collectively. The problem will likely become significantly more difficult in the next few decades.

The Course of the Disease

While the course of Alzheimer's dementia may vary in individual cases, the ultimate prognosis is the same—incurable with progressive decline in functioning at all levels. Premature death can be expected, either directly as the result of the organic deterioration or by related syndromes which are caused or exacerbated by the dementia.

Treatment of Alzheimer's Dementia

Whereas some of the other dementias are treatable (and even curable if the cause is detected and amenable to therapy), the therapeutic options available for Alzheimer's dementia are mainly limited to adaptive measures. That is, when faced with an incurable progressive illness, the usual strategy is to minimize the effects on patient and family. Rather than directly treating the illness, therapy involves adapting to it.

These adaptive measures range from behavioral interventions (which organize and simplify daily activities) to general physical interventions (such as basic health maintenance). For example, basic health maintenance might involve bowel regulation. Constipation is often a problem for persons suffering from Alzheimer's dementia. Dietary changes, drinking adequate water, and the use of laxatives can help to address this problem.

Individual counseling and support groups for caregivers are two additional forms of therapy which can facilitate the process of adaptation. For many families, institutional care (such as nursing homes) represent the final stage of adaptation.

Research has yielded some promising medicinal therapies over

the years. Unfortunately, these drugs have not produced consistent results under the rigors of scientific standards of confirmation. Consequently, the therapeutic effectiveness of drug therapy for Alzheimer's dementia is controversial.

Antidepressant medications are commonly prescribed for persons with Alzheimer's dementia since depression is one of the most frequent and debilitating symptoms associated with the disease. Again, however, these drugs do not directly treat the dementia—they are only adaptive measures intended to provide limited symptomatic relief.

Summary

The personal devastation caused by dementia is extreme—it destroys the essence of our humanity, our mental processes. It is a progressive degeneration often taking years to complete its wrecking of the brain. This process unfolds as slow death, day by day, culminating in the disintegration of the person. This biological and psychological desolation typically parallels the toll taken on family resources—emotional and financial.

The social fallout from dementia may be just as devastating. As we live longer and the baby boom generation approaches the stage of life where risk of dementia is greatest, our social resources will be stretched to the limit—perhaps beyond the limit. Unless we can achieve major breakthroughs in the prevention and/or treatment of dementia (and particularly Alzheimer's dementia), we face an alarming future.

Although we recognize the causes of some of the dementias, we do not know what causes Alzheimer's dementia. However, this is a "hot" research area. Hopefully medical science can make major breakthroughs in understanding this disorder.

Likewise, medical science has not yet produced a cure for Alzheimer's dementia. New drugs are constantly being tested. Some medications appear to suppress certain symptoms in some individuals. However, there is no widely acknowledged treatment which is effective in halting or reversing the course of the illness.

Therefore, it behooves us to be open to alternative perspectives on the causes and treatment of the dementias. In the next chapter, we will be examining the psychic readings of Edgar Cayce—a remarkable source of information on this important subject.

2

An Alternative Perspective of Dementia

Edgar Cayce gave many readings for persons suffering from various forms of dementia. In this chapter, I will provide some definitions and descriptions of Cayce's view of this group of neurological disorders. In order to clarify the distinctiveness of this approach, I will compare and contrast this point of view with modern medical concepts. Finally, I will provide real-life examples of Cayce's perspective in the form of case studies taken from the readings.

What Is Dementia?

The readings are in close agreement with modern medicine on the physical pathology of the dementias. Repeatedly, Edgar Cayce provided graphic descriptions of the nervous system deterioration indicative of these disorders. One almost gets the sense that Cayce used his consciousness as a modern researcher might use a high-tech probe or brain scan. Often, Cayce's perspective was from the inside of the body, moving freely among the organs and tissue. His

portrayal of the delicate interactions within and between the nervous systems are particularly fascinating. We will be taking a closer look at these reports later in this chapter. For now, the important point is that from Cayce's perspective dementia involves a progressive degeneration of nerve tissue. Consider these brief excerpts from the readings which explicitly convey the physical pathology involved in dementia:

> Dementia in the act that the repressions are as magnified, and will eventually—without correction—bring the softening of cell tissue in brain itself. Hence we find there are periods when the body is not controlled by any reaction in self . . . unless corrections are made . . . we may expect a continued reaction . . . then the general breaking down of the gray portion of nerve tissue, nerve cell matter, in the body. (3997-1)

> . . . there are distresses caused in the coordination of the sympathetic and cerebrospinal nerve system produced by pressure in the lumbar and sacral region . . . (we need) the application of those properties as will bring for the replenishing of the white tissue in the nerve cells themselves—these, we find, would be aiding and bringing the nearer normal reaction, will these be taken in time, before the pressure produces the softening of the brain tissue itself; until there is dementia in its reaction. (5715-1)

> This, then, is the difference between an unbalanced condition in a mental reaction (a nervous breakdown) and that of dementia—which destroys the reaction in the plasm of the nerve as fixed from the blood supply itself . . . (386-1)

Many people are surprised by such graphic accounts of physical deterioration. Apparently, there is a strong expectation that psychic readings from such a renowned seer should emphasize the nonphysical (i.e., mental and spiritual) phases of the condition.

Certainly, this is not an unreasonable expectancy, for the readings do speak to the condition of the whole person. In fact, Edgar Cayce has been widely acclaimed as the "father of modern holistic medicine." This title derives from the readings' perspective of the human condition. According to this view, we are each triune beings consisting of body, mind, and spirit. The readings go so far as to talk

of mental and spiritual bodies which coexist and connect with the physical body at definite anatomical centers within the physical body.

Coordination among these aspects of the self—the physical, mental, and spiritual—is essential for a normal functioning human experience. Incoordination among these aspects can manifest as a variety of illnesses, including the dementias.

Even when the readings consider a single aspect of the triune, for instance the physical, the emphasis is on taking a broader view of the body. This is even true in cases of dementia, where brain pathology is undeniable:

> Too little importance is too often given by those who would aid in bringing a normal force for a body suffering under even dementia, that relationship between the sympathetic and the cerebrospinal nervous systems . . . (5475-1)

So even in illnesses of the brain, the readings insisted on taking a broader perspective and looking at the peripheral systems—in this case, the nerves running within and along the spinal column.

The language of the readings can be a stumbling block in certain cases because the entranced Cayce utilized the medical terminology of his day. During the early decades of this century, the central nervous system (which includes the brain and spinal cord) was referred to as the cerebrospinal system. The autonomic nervous system was referred to as the sympathetic system. So if you encounter these terms in a reading, it may be helpful for you to translate cerebrospinal into its current equivalent—the central nervous system. Likewise, you may wish to think of the sympathetic system as the autonomic nervous system. This is a bit of an oversimplification since the readings present a much deeper appreciation of the way the nervous systems interact (and particularly the role of the sympathetic system). However, for purposes of our discussion this will suffice.

There are a couple of important reasons for expanding the discussion of dementia beyond the brain. First, the brain does not exist entirely in isolation from the rest of the body. True, it is surrounded by bone (the skull) and protected by a chemical boundary (the "blood-brain barrier") which allows in only those substances essential for brain functioning. However, the brain is constantly reliant upon the rest of the body for nourishment and removal of metabolic wastes.

The brain is also reliant upon the peripheral nervous systems for information about our external and internal environments. I am speaking here primarily of the sensory nervous system. If the sensory system is faulty, brain functioning will also be compromised. As computer programmers have noted—garbage in, garbage out.

Finally, because the readings insist that we are each triune beings or "ENTITIES," we might benefit from considering the interactions among these aspects of ourselves. For example, ponder the following excerpt which addresses the physical and mental dimensions of dementia:

> . . . for in almost every condition—even as in this (dementia)—there is found that the centers from which the radial forces of impulse by reaction of the mental body—that is, the sensory system—to the sympathetic forces, in those centers where they connect with the cerebrospinal—the cerebrospinal, then, is as the brain's reaction to the physical, or the material body; while those of the sympathetic system are more those of the reaction to the mental being, or the mental body; these must coordinate, that the reactions in a physical body bring about the proper reactions. (5475-1)

Note the references to the sensory and sympathetic nervous systems. Even while the brain is the primary focus of pathology, the peripheral nervous systems are important. The reading actually identifies these peripheral systems as embodying the "reaction to the mental being." In other words, the incoordination of the mental being (or mental body) with the brain's reaction is affected by the nerve connections along the spinal column and throughout the body. The deterioration of mental faculties (such as memory and intellect) are likewise linked to the coordination of the nerves at these important centers or plexus in the body.

In other readings involving dementia, the coordination of the spirit connection to the body was emphasized. In these cases, the glands (which Cayce regarded as "spiritual centers" within the body) was often dysfunctional in some manner.

Thus, the interface of mind and spirit with the body is regarded as quite literal—mind functioning primarily through the nervous systems and spirit manifesting through the glands. From this perspective, the intimate interaction between the nervous and glandular systems is emphasized. These systems work together to maintain

the integrity of the whole self.

Consequently the readings digress from modern medicine on the meaning of disease and how physical degeneration is related to the broader context of the human experience. This context may be designated as holism, a term expressing the importance of considering all facets of human functioning.

Even strictly at the physical level, this alternative perspective has practical implications. The whole body is taken into consideration since mind and spirit manifest at various centers throughout the body. This is particularly significant with regard to the types of therapies which were most commonly suggested in the readings. We will explore these therapeutic implications in the next chapter. For now, we shall focus on some of the causes of dementia by looking at a few exemplary case studies from the readings.

Some Case Studies of Dementia

The Case of Mrs. (1553)

Mrs. (1553) was 71 years old when she received a series of 26 readings on her demented condition. A concerned son-in-law (Mr. (1561)) wrote to Edgar Cayce on April 17, 1938, stating that her:

> . . . "mind" remains not clear . . . The illness is commonly call(ed) "stroke"—and hardening of the arteries, plus chronic constipation . . . I do not know how to ask pertinent questions, but could her brain cells function, either "renewed in life" or compensatory cells take on the work . . . Now she has little control over her emotions—yet at times her mind seems clear and then it is (that) her thoughts return to "service" to others—as has been her life's experience . . .

This description is certainly indicative of dementia, possibly multi-infarct dementia resulting from stroke. Subsequent letters indicated that portions of the left side of her body were paralyzed and that her caregivers could not understand her speech. She exhibited frequent fits of "crying and yelling."

Her readings noted the paralysis and nervous system dysfunction. To address these conditions, the readings recommended electrotherapy and suggestive therapeutics:

Q. Is it possible to restore the cellular structure of this brain or to bring about compensatory action whereby the mind may again function perfectly in this body?

A. As indicated, if there is the ability for sufficient of the properties to be absorbed through the vibratory forces of the Gold impulse, and the suggestions for creative activities in the system are kept, it may be done. (1553-5)

There were also frequent recommendations pertaining to diet, massage, hydrotherapy, and laxatives. These were all commonly prescribed therapies in the readings and we will address them in the next chapter.

Fortunately in this case, abundant correspondence was exchanged which provides valuable insights into the progress of Mrs. (1553). A few excerpts are provided to convey the general direction of treatment and therapeutic outcome:

May 23, 1939:

Mrs. (1553) seems to, at times, gain in strength and have a clear mental coordination—less emotional—less crying—yes, much less.

Her inability to speak articulately, except a very few understandable words, of course makes it difficult to know her feelings and her thoughts—but generally—there is improvement—great improvement as compared to a year ago when the first readings were had—you see, she started back from very close to "zero."

July 5, 1939:

Mother is certainly improving mentally—coordination. Now she asks to be read to—much of the time—but seems to be losing strength—vitality—seems languid.

September 10, 1939:

We feel mother is better, she now enjoys being read to very much, but constipation seems to be a big problem as it has always been.

December 19, 1939:

When I think of last Christmas time and then see how much better Mrs. (1553) is today it hardly seems possible, but it does

make me so very thankful . . .

The extensive group of readings given for (1553) is exemplary in its depth and scope (a total of twenty-six readings were given). Virtually every issue which may arise in the treatment of dementia is addressed in this series.

While there was apparently significant progress made over a period of about 56 months, the condition was not cured. The question of additional progress was raised in reading 1553-26:

> Q. How much progress can we expect if we follow instruction?
>
> A. We may find fifty to seventy-five to ninety percent advance in the body becoming more normal again.
>
> We do not know how much further progress, if any, was made in this case—there is insufficient follow-up data to allow a full evaluation.

In reading 1553-26 the question of diagnosis was also raised:

> Q. What would be the proper diagnosis of this case?
>
> A. As we find, in the present it is a complication arising from the old conditions caused first by the breaking of cellular forces, producing spasmodic conditions, then plastic conditions in portions of the body, and partial paresis (paralysis) to the nerve forces and to brain centers . . .

It is not clear whether the "breaking of cellular forces" referred to a stroke or some other acute illness. Paresis usually refers to a "partial or incomplete paralysis" *(Tabor's Cyclopedic Medical Dictionary).* However, it can also refer to *dementia paralytica* (general paresis of the insane). This form of dementia is caused by syphilis and produces typical dementia symptoms including memory deficits, delusional thoughts, and depression.

The Case of (5204)

Mrs. (5204) was 51 years old when her husband wrote to Edgar Cayce requesting help for his wife:

> A personal friend of mine has recommended you to me as

one who may be able to tell me what is wrong with my wife. For 4 years now, my wife seems to have been losing her memory. She is unable to utter very many coherent sentences, and yet, she seems to understand what is being said to her. We have had her before innumerable doctors, and their diagnosis of her case has varied. We have been married 25 years and we have had a very happy home life, although the last 4 years have been very trying. She has forgotten how to do her housework and seems unable to cook a meal, although she always cooked our meals before. She has forgotten how to light the gas in the range, and we are fearful that something may happen to her. We no longer permit her to cook or attempt to cook. For a while, we thought that she was going through her menopause and this was causing the disturbance; but the doctors tell us that she has passed that stage . . . I am turning to you as a last resort . . . My wife is a very well-educated woman. She is kindly and sweet in disposition, and she went through college with honors, obtained Phi Beta Kappa honors, and was also a teacher of English in high school for a while. I have read Mr. Sugrue's book about you, and it has given me hope that I may still be able to save the life of a very sweet woman . . .

A subsequent letter written prior to her reading provided additional information which was addressed in her reading:

I am answering for my wife, because she does not feel well enough to do her own writing. She is anxious to know whether a blow on the head, caused by the falling of a flag-staff, has caused a tumor which makes her forget in the middle of a sentence when she attempts to converse. Or, also, if there is such a thing as the atrophying of the brain which may cause loss of memory; or whether her present period of forgetfulness is caused by menopausal period . . .

Edgar Cayce provided a reading for the woman on June 8, 1944:

As we find, there have been outside influences which have produced a real nervous shock to the system in such a nature that the reflexes from the cerebrospinal centers, and the cerebrospinal center itself, have received a condition which prevents their coordination.

> These, as we find, reflect from clots which have formed on the capsule of the brain itself. They are not as tumors, rather as clots.
>
> As we find, these may be removed by absorption or by operative measures. While it would require much longer for this to be done by absorption, it would be much more in accord with the insuring of longer experience in the earth . . . (5204-1)

The reading went on to recommend electrotherapy utilizing gold solution and spinal massage to induce "absorption" of the "clots." A positive prognosis was given provided the treatments were applied consistently:

> These (treatments), if they are kept regularly, prayerfully, we may bring back memory, bring back coordination between cerebrospinal and sympathetic and the reflexes to the sensory system.

Given her history of brain insult (as documented in her husband's letters) and the connection between brain injury and dementia (see Chapter One), one wonders if the "outside influences" and "shock to the system" noted in her reading might have been caused by her being hit on her head by a falling flag-staff. Interestingly, an autopsy of her brain following her death in 1949 indicated that her condition was Alzheimer's dementia.

The suggestions in the reading were never followed completely. The family waited for one year after the reading was given to attempt applying the recommendations. The physician who was recommended by A.R.E. secretary Gladys Davis was never contacted.

Mrs. (5204)'s condition continued to deteriorate and was complicated by seizures. The correspondence does not indicate whether there was any correlation between the attempt at applying the recommendations and the seizures. At any rate, she was institutionalized in a private hospital and eventually was transferred to a state facility where she lived until her death.

This is the only documented case of Alzheimer's dementia in the Cayce readings. There are very likely numerous cases which would fit current diagnostic criteria. However, it is impossible to say with certainty since brain autopsies were seldom performed in such cases.

From a strictly statistical point of view, it is highly probable that

several of the cases which we will discuss were Alzheimer's. The readings were given for thousands of individuals, many of whom were within the high risk area of the life span.

Even today, the only definitive means of identifying Alzheimer's dementia is by biopsy or autopsy. Unfortunately, (5204)'s case was the only one in the readings which was documented by this means.

The Case of (5299)

Mrs. (5299) was 57 years old when her daughter first wrote to Edgar Cayce requesting a reading for her mother. The excerpts which follow clearly indicate the seriousness of the situation:

> My mother just came home from Medical Center after being there 10 days for observation. Her case was called a rare brain disease and, as far as is known, there is no cure. She is losing the power of speech and has already lost the power to write, tell time or do any of the actions such as lacing shoes, etc. The doctors explained to me that between her brain and scalp there is only an air space and her brain cells are drying up one by one . . . According to Medical Center this case of hers is not a form of insanity, as what little brain she has functions, but it is so pitiful . . .
>
> Her diagnosis is Presenile Sclerosis, which is premature old age, along with hardening of the arteries and the part of her brain which controls the power of speech is affected. She is now getting pains in her head and we have no idea how long she will last. Her age is as of a woman in her eighties.

Her reading indicated a karmic and physical basis for her condition:

> As we find, here are disturbances which may not be other than materially aided. These are the results of karmic conditions for the body, as well as those about the body. We may help, yes.
>
> While there are the disturbances which are causing premature senile conditions, or the withering away of the control of mental reflexes, there should be care and loving kindness, gentleness and patience administered to the body. These will not only bring a greater attempt for the reactions but will bring

the greater ability for the soul-entity's development.

It would be well at times, as there are those bridges in the associations between the sympathetic and the cerebrospinal nerve forces, to be careful that the body does not injure itself or others; but do not put the body away, unless there becomes more of that which would be, or cause it to be, dangerous for others. (5299-1)

The treatment recommendations were typical for such cases—the use of the wet cell battery carrying a gold solution. This was to be followed by a thorough spinal massage.

A question posed near the end of her reading indicated that her symptoms were episodic—that is, she could function almost normally for short periods:

Q. In her present condition does she know what is going on around her, does she understand when spoken to or is it just certain times that her brain is completely normal?

A. Only at very small intervals. But we will find much improvement and a quieter reaction with the use of the Appliance and the massage. (5299-1)

Thus a cure was not promised, only "improvement and a quieter reaction." A request for a follow-up report was sent to her daughter. The letter was returned marked, "MOVED—LEFT NO ADDRESS." Thus, we do not know the outcome in this case.

The Case of Mrs. (3303)

We are not provided the age of Mrs. (3303)—only that she was over 50 years of age. A letter from her husband provided a medical diagnosis and a description of the primary symptom of her disorder—impaired memory:

She has not been told that she has cerebral arteriosclerosis, and seems to think she is all right—or at least near so—therefore she is a peculiarly hard case to deal with for doctors and myself. She was a brilliant professional pianist 35 years ago . . . but her memory had begun leaving her 10 years ago . . .

Edgar Cayce provided a reading for her which noted glandular

dyfunctions and pressures along the spine as key causes of the disease:

> As we find, there are disturbing conditions with this body. These have at times been called varied names, owing to the age or the advanced stages of same. But the condition here arises from pressures that exist in relation to those changes in the glandular activity of the body . . .
>
> Thus the body becomes forgetful, absent-minded, unable to recall. There is not the reflex in the white and grey matter (of the nervous systems). Thus these would eventually cause senility to the body, unless there are measures taken to supply new energies . . .
>
> Do these (treatments) and we will find much bettered conditions for this body; not only a retarding of this disintegration in nerve and blood supply but a replenishing and a building back to better conditions for this body. (3303-1)

The treatment recommendations were standard for such cases: spinal manipulations and massage, electrotherapy with gold, basic dietary suggestions, and exercise outdoors in the open.

This case is interesting since glandular dysfunction has been linked to Alzheimer's dementia (see Chapter One). Because the diagnostic system of that era did not recognize Alzheimer's dementia as a discreet pathological entity, but included cases of presenile dementia within the category of arteriosclerosis, this may have been a case of which would fit modern diagnostic criteria for Alzheimer's.

Cayce's acknowledgment that "These have at times been called varied names, owing to the age or the advanced stages of same" appears to recognize the diagnostic ambiguity of the disorder. He may have been referring to the distinction between presenile and senile dementia ("owing to the age or the advanced stages of same").

The Question of Senility

As we noted in Chapter One, until recently the term senility was commonly used synonymously with Alzheimer's dementia. Hence it is difficult to apply current diagnostic criteria to the conditions represented in the readings because at that time senility was generally viewed as a normal part of the aging process. Thus cases of dementia (and particularly Alzheimer's dementia) may not have been

recognized as such. Furthermore, as just cited in the previous case study, this ambiguity extends to cases of arteriosclerosis. "Hardening of the arteries" and the resultant brain damage was viewed as the primary cause of Alzheimer's dementia. Therefore, in considering the cases in the readings, we can sometimes glean valuable information about the causes and treatment of dementia from readings classified as senility and arteriosclerosis.

For example, consider the case of (3631), a 72-year-old woman suffering from "mental lapses and melancholia (depression) during which periods she seems to turn on those she loves the best . . . "

Her reading acknowledged the seriousness of her condition:

> Here we find it is almost too late to undertake to keep this entity in this particular experience.
>
> As we find, disturbances here are those contingent with senility, and thus there is a wasting away of the impulses or the active forces within the nerve cells themselves—those reflexes that would attempt to occur in the brain . . . as memory, activity of the salivary glands, activity of the bladder.
>
> As we find, help is possible, but it will depend upon how consistently and persistently there would be the applications made that may renew nerve tissue and give life itself in the body-reaction. (3631-1)

In this selection, the phrase "wasting away of the impulses or the active forces within the nerve cells themselves" is suggestive of an organic degeneration within the brain.

The description of pathology within the brain of Mr. (3701) is even more explicit:

> These have to do primarily with senility; that is, impulse in the gray matter in nerve force is lacking. Thus gradually, unless measures are taken, there must come the softening of the brain cells so that the reflexes will gradually become less and less active for the flow of blood as well as impulse in the circulation through the central portion of brain . . . (3701-1)

Note the reference to "softening of the brain," a phrase often used in cases of dementia. Senility was also associated with softening of brain tissue in the case of (5309), a 60-year-old male:

> Yes, here conditions are rather serious. From the injuries which have been received, there are the tendencies, from the jars to the body and the brain, for the softening or lack of virile energy being replenished; or senility. Thus tendencies for the lapses into a coma or semi-coma. (5309-1)

It would appear that in these cases the readings were using the term senility as it was commonly used during that era—as synonymous with an organic brain disorder manifesting as dementia. The readings noted that senility was usually age related, with senior citizens being more vulnerable. However, as we have noted and will reemphasize in the next chapter, Cayce also recognized the condition of "premature senility" (apparently in reference to the older classification of Alzheimer's disease, that is "presenile dementia").

Dementia Praecox

In addition to cases of senility, I would also recommend a consideration of cases of dementia praecox for those persons who are contemplating applying the Cayce suggestions. In the late nineteenth and early twentieth century, dementia praecox was the diagnostic category applied to persons suffering from chronic mental illness believed to be caused by brain disease. The term literally refers to an extremely early (precocious) form of dementia which is now included in the group of illnesses called schizophrenia. Whereas today the dementias are usually associated with the elderly, the symptoms of dementia praecox typically arose while individuals were in their late teens and early twenties.

It is not necessary for us to go deeply into this subject here and I only mention it for those individuals truly interested in understanding the readings' view of the dementias. I have written a treatment manual on schizophrenia which provides extensive documentation and a detailed consideration of the subject (see the Appendix for further information).

The primary value of this related material is in its application. The treatment suggestions for all the dementias were very similar. Since there was an abundance of readings on dementia praecox with explicit descriptions of therapeutic principles and techniques, this information represents an important source of supplemental data on the treatment of dementia in the elderly.

Cautious Optimism

It is crucial that readers recognize the difficulties involved in treating serious disorders such as the dementias. This book does not, in any way, suggest that Cayce's approach is "fool-proof" or easy to apply. To the contrary, Cayce often remarked that the suggestions provided in the readings would have to be carried out patiently and persistently if progress was to be achieved. He would then go on to say that if the persons administering the treatments were not dedicated to the healing process and willing to invest the resources necessary to follow the suggestions, it would be best that they not begin at all. However, for those willing to follow the suggestions in the readings, hope was provided.

The most unfortunate aspect of the Cayce readings in this area is the lack of application of the suggestions. For a variety of reasons (often of a financial nature; many of the readings were given during the "great depression"). Family members could not afford the recommended therapies. These cases were often chronic—the individuals involved came to Edgar Cayce as a last resort after years of failed treatment from numerous doctors and hospitals. Cayce's insistence that recovery would require patient and persistent treatment for a minimum of several months was apparently too much to ask of people discouraged by years of suffering.

In the few cases where there was consistent application of the suggestions provided in the readings, positive results were often produced. The previously discussed case of Mrs. (1553) is exemplary in this regard.

A letter from Edgar Cayce dated April 9, 1942, effectively conveys the cautious optimism with which he approached such cases:

> Am in hopes you have found the information for Miss (2721) of interest. Of course I realize what it means to raise false hopes in the minds of others. I realize anything I may say would appear as if I were blowing my own horn, but please know I realize too that it is not of myself the work is done, but only as the Spirit of Truth may work in or through me. We have had several cases of this nature that seemed hopeless, where seeming miracles have happened. There have been a few people sent to the Macon hospital (Still-Hildreth Osteopathic Sanatorium), so the work there will not be entirely new to them. Do hope you will write them and if it is possible or practical, do hope

you will give it a try. Have had many where the condition was not such as real help might be given, but where help has been promised (by the readings) through a certain mode of treatment, or by certain places or individuals, when this was done the help promised has come. Am sure, of the many thousands of readings that have been given, this has been true in practically every case. Many have, of course, been persuaded that the suggestions were all wrong and that the help suggested could not come from such a treatment, but where tried, whatever amount of help was offered has come. We will be glad to try and help anywhere along the line with checkup readings from time to time.

Do hope we may be the means of help, and may HIS blessings, His Peace come to you.

The reference to the Still-Hildreth Osteopathic Sanatorium was significant in this case. On numerous occasions, Cayce foresaw that the requirements for effective treatment would exceed the resources of the family as caregivers. Often in cases of dementia (such as dementia praecox), he would make a referral to Still-Hildreth. This institution utilized many of the therapeutic principles and techniques commonly advised in the readings.

This is relevant because many persons currently suffering from dementia are in nursing homes. For any approach to have a widespread impact upon the treatment of dementia, it would have to be integrated into existing institutional facilities. Therefore, it is worth noting that the principles advocated in Cayce's readings are applicable to an institutional setting. We will come back to this point in Chapter Six.

Summary

This chapter has explored an alternative perspective of the dementias. While acknowledging the severe brain pathology present in these disorders, the Cayce material goes further to emphasize the importance of the whole body (especially the peripheral nervous systems). Coordination between the central and autonomic nervous systems was specifically noted in the readings as being of great consequence.

However, Cayce's perspective goes beyond a mere biological analysis of pathology. The term holism was presented in this chap-

ter to encompass the expansiveness of Cayce's perspective. All the aspects of the self are important—body, mind, and spirit. This emphasis on holism will become more prominent in the following chapters which focus on curative and preventative measures.

We reviewed several case studies from the Cayce material to get a firsthand look at his viewpoint. A variety of types of dementia were represented including a case of Alzheimer's disease. Since Alzheimer's dementia was not recognized as a formal diagnostic category during Cayce's lifetime, it is very likely that numerous other individuals received readings addressing this illness. However, they would likely have been diagnosed as "senility" or cardiovascular disease. Some examples of each were also presented to illustrate the similarities to present criteria for Alzheimer's dementia.

Finally, the theme of cautious optimism was introduced and balanced by the recognition of the difficulties involved in treating the devastating group of illnesses known as the dementias. The therapeutic approach underlying this hopeful perspective will be presented in the chapters which follow.