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Theorizing and Social Gerontology

BY VERN BENGTSON

Theory is increasingly important in social gerontology. Thus it is gratifying to see the debut of a new journal that encourages theorizing about age and aging. The papers in Volume 1, number 1 of the *International Journal of Ageing and Later Life* reflect a concern for developing theory that is laudable. I hope that in the future researchers who submit manuscripts to *IJAL* and the reviewers who evaluate them will share this concern for building theory. This is because we are at a tipping point, a watershed, in the development of knowledge about the social and psychological dimensions of aging.

Theorizing as A Mystique

What is theory? It is simply *an attempt to explain* what we find out from empirical research.

But there is a mystique about theory. To my PhD students, theory often seems formidable, a difficult-to-access collation of abstract ideas that cannot be understood without monk-like contemplation of ancient texts. I think it is important to de-mystify theory.

All theory is an *attempt*, an initial step in the process of developing an account of the *how* and the *why* leading to *what* we have observed in our research. Such attempts are not final solutions. They are rough drafts, to be revised and revised again in the course of our investigations and in response to further empirical research findings.

Theories involve *explanation* – or substitute the term *understanding* if you feel explanation implies too much of a positivistic or scientific paradigm. To me, explanation and understanding are much the same. Each requires an intellectual leap from the content of data collected to the interpretation of what these data mean.

Theory-building is courageous because it requires that we think that we go out on a limb beyond our visible data. Ph.D. programs train very well in technologies, the best ways to collect and analyze data. These lead to the "findings" we report—empirical generalizations or constructs based on Ph.D.-level research. But graduate programs may not prepare us well to jump from empirical generalizations to explanations. This is a courageous leap. It requires thinking, putting ideas together, and creating narratives about what goes with what...

Theorizing as A Process

I like the term "theorizing" rather than more passive phrases such as "using theory" or "applying theory. I like the focus to be on theory as a verb, rather than a noun or modifier.

Unfortunately "theory" is often associated with some solidified set of ideas, detached from the processes that led up to these ideas; or theory is associating memorizing ideas and names of scholars long dead. One of my students wrote in the evaluation at the end of my theory course that "theory is some arcane body of reasoning associated with a name that you have to memorize in order to appear knowledgeable in this class." No; that is *not* what I mean by theory.

The process of theorizing begins first with intuition, an awareness of ideas, and the development of hunches about how these ideas are linked. The second step is to formalize these hunches into hypotheses, models, or expectations about what goes with what. Third is empirical research—research that allows us to test the hypotheses or the expectations we have about associations. A fourth step in theorizing is revising the model or explanation in light of what we have seen in our empirical study. From these steps, theory emerges as a tool to help us explain, understand, and give meaning to the data we have collected.

Theorizing as Honest (Explicit)

I believe that researchers should be explicit in theorizing—that is, they should put in words or symbols the links they believe they have observed between variables or concepts. They should be honest and direct about the linkages they see or feel.

Unfortunately much that has been published in social gerontology to date makes no reference to theory. A review of the literature in social gerontology from 1990 to 1994 revealed that the vast majority—72% of all publications in eight journals—made no mention of *any* theoretical tradition in the literature as relevant to the empirical findings reported (Bengtson, Burgess & Parrot 1997). The authors caution that "the *ad hoc,* descriptive, model-based (rather than explanatory or theory-based) approach to research is ineffectual, over time" and that "if authors, journal reviewers, and editors ignore the need for explicit explanation in data analyses, it is not likely that we will achieve much cumulative knowledge development" in social gerontology" (Bengtson et al. 1997: S75).

An unfortunate result is that social gerontology may be accumulating a vast collection of empirically-based generalizations without the parallel development of integrated knowledge. But the development of explanations—theories—is central to both the creation of cumulative knowledge *and* the application of that knowledge to interventions such as therapy, support, and public policy in aging. For without good explanations about how and why problems arise, it is impossible to develop effective interventions to change them for the better.

Theorizing as A Game

I like to think of theorizing as putting together a puzzle. The data I collect are pieces of a giant jigsaw puzzle. Each piece by itself is incomplete, meaningless, confusing. But in trying to understand how the pieces fit together I arrive at a larger and more coherent picture.

Theorizing is fun. It is an intellectual game that can be played by everyone involved in gerontological studies, from the neophyte student to the experienced scholar. Fitting the pieces of the puzzle together is fun, though sometimes frustrating, particularly when the overall picture is vague or elusive and often you have to create your own puzzle, instead

of simply solving one that someone has handed you. This is where the real creativity comes in.

Theorizing as Trying on Lenses

I am not saying that there is *an* explanation to be discovered, a reality of causes and effects "out there" that can be uncovered by persistent thinking. This is the stereotypic claim of positivism. But obviously we *create* theories; we do not *discover* them.

I think of theories as lenses. We create lenses to better see the world around us. Put on one kind of lens and we can see one object; put on another lens and we can see something different. I believe that social gerontology is a multiple-paradigm field, with several different paradigms and theories operating and changing all the time. It is necessary to try on several lenses in order to see and understand the complexity and diversity of aging.

Promising Prospects for The International Journal of Ageing and Later Life

Because (from my perspective) explicit theorizing is the best way to build cumulative knowledge, I was very pleased to see the articles in this inaugural number of *IJAL.* Each reflects, in different ways, the ongoing process of theorizing.

In his article Lars Tornstam de-mystifies "ageism" as a theoretical concept by examining it as a constellation of perspectives. His analysis reflects the process of theorizing, and he is quite explicit (honest) in describing the genesis of his conceptualization. He presents a typology of constructs that are both conceptually novel and can be empirically tested: the consistently negative, the consistently positive, the pitying positive and the "no fuzz."

Liz Schwaiger examines relationships between body and mind (subjectivity) in mid-life. She uses theoretical lenses associated with social constructionist, psychoanalytic, and feminist thought to view a historically contingent and ageist perspective on older age.

In their article the Bangladesh team of researchers (Biswas, Kabir, Nilsson, and Zaman) provide well-founded empirical generalizations that can be the basis for future theorizing. What can be done to ameliorate the position of elders at need of health care? How and why are current health care systems (familial or governmental) becoming inadequate; and what might alter this—policies and programs to ameliorate these problems?

The Nyqvist, Gustavsson and Gustafson paper examines an important theoretical construct, social capital, and its linkage to several dimensions of health. This is an example of explicit theorizing, and the results suggest that additional theoretical development could lead to more useful intervention strategies.

Conclusion

I think we are now at a tipping point, a historical watershed, in the historical development of accounts concerning age and ageing. In the past we have amassed an impressive number of empirical generalizations—well-conducted research findings – concerning many aspects of social gerontology. But these studies, with their increasingly sophisticated research designs or tools for qualitative analyses, are not enough. In the future we must pay more attention to theory – de-mystified, as a process, being explicit, played as a game, using multiple lenses.

If we focus on theory as *an attempt to explain* we might be able to provide more useful interventions to improve the quality of life for older people – and for us, their children and the aged of the future.

Bengtson, V.L. Burgess, E.O. & Parrott, T.M. (1997). Theory, explanation, and the third generation of theoretical development in social gerontology, *Journals of Gerontology,* B52:S72–S88.

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To Be Forever Young?

Towards Reframing Corporeal Subjectivity in Maturity

BY LIZ SCHWAIGER

Abstract

In this paper I examine the relationship between the body in midlife and subjectivity in contemporary western cultures, drawing on both social constructionist and psychoanalytic perspectives. Referring to recent theoretical accounts, I take the position that how we are aged by culture begins in midlife, and that this period is therefore critical in understanding how the body-subject in western consumer cultures is aged and gendered through culturally normative discourses and practices. I also address the gendering of ageing bodies, and argue that, like the 'feminine', ageing has been marked by ambiguity and lack. This ambiguity has presented a problem for dualistic age theories, in that it has been difficult to theorize the ageing body productively since the binary language used to theorize it already devalues old age both male and female based on cultural gender norms. Finally, I inquire whether alternative, non-dualistic perspectives might be developed that redress this problem, and disrupt the alignment of ageing with negative associations such as lack and loss, perspectives that, rather than associating gendered ageing with decline, loss or lack, associate it with the goal of living an abundant life into deep old age.

Keywords: gendered ageing, cultural norms, body-subject, midlife, mature subjectivity.

Introduction

In contemporary western consumer cultures, a plethora of industries has emerged that caters to the care of the body in order to preserve its youthfulness of appearance. The proliferation of so-called 'anti-ageing' skincare products, cosmetic surgery to lift and tuck recalcitrant lines and folds, and the increase in popularity of exercise regimes such as gym and Pilates classes among the baby boomer generation are some examples of the increased focus on maintaining the youthfulness of the body's appearance in midlife in the presentation of the self in a social context.

At the same time, the medicalization of old age in Western societies and its association with disease and decline underpins the association of ageing with decline, a decline to be warded off in a culture that privileges optimal bodily competence in these areas. For example, Hareven (1995) notes that in late nineteenth-century American society, old age was no longer accepted as a natural process (with admiration for those who lived to a great old age) but became a time of "decline, weakness, and obsolescence." It also became increasingly medicalized, as Hareven (ibid:120) comments:

> Advanced old age, which had earlier been regarded as a manifestation of the survival of the fittest, was now denigrated as a condition of dependence and deterioration ... Beginning in the 1860s, the popular magazines shifted their emphasis from attaining longevity to discussing the medical symptoms of senescence. By the beginning of the twentieth century geriatrics emerged as a branch of medicine.

Thus the ageing body-subject faces a dilemma when theorized in relation to this culture of conspicuous consumption. For, while some theorists have suggested that midlife presents new opportunities for prolific consumption, and a stage at which performance and presentation of self is focused on signifying youthfulness (e.g. Featherstone & Hepworth 1991a, 1991b; Turner 1994), this presents a problem for ageing body-subjects as the material body becomes increasingly unable to emulate (i.e. perform) youthfulness. Further, the ageing subject must negotiate cultural age- and gender-based norms, and, it has been argued, is never really 'free' to

choose or revise an identity at will (Biggs 1999; Mansfield 2000). Bearing this in mind, I will examine what possibilities there might be for embodiment of a coherent, 'authentic' subjectivity in later life, by drawing on both social constructionist and psychoanalytic perspectives on ageing, where the former emphasize the 'outer' self, the latter concentrating on the self's 'inner' aspects.

Constructing Ageing in Midlife: Recyclable Identities and Revisable Selves

The midlife period is significant inasmuch as it is one in which the body-subject's age status becomes ambiguous. Here 'midlife', previously known as 'middle age', is characterized as the life period between 30 and 60 years (Featherstone & Hepworth 1991b), a period during which the individual is culturally constituted as 'no longer young, and not yet old' (Gullette 1998). Midlife therefore represents an important transitional period, when the attitudes, comportment and practices that mark social identity in our youth and early adulthood are challenged, and where we become marked by our destiny of 'old age'.

In the 1980s and 1990s, several researchers, including Featherstone and Hepworth, began to consider the relationship between ageing and consumerism in western societies. Featherstone and Hepworth suggest that during midlife the 'spectre' of old age and decline haunts the lives of ageing people, compelling them to maintain their bodies in a perpetually youthful state, because western cultures valorize youth. As part of this research, Featherstone (1991) identifies a new type of subject, a 'performing self' that emerged at the beginning of consumer culture and roughly coincided with what Christopher Lasch describes as a culture of narcissism in the 1920s (Lasch 1979). This 'performing self' is driven by consumption and preoccupied with the body's appearance and presentation – the 'outer' aspects of the self.

The performing self therefore seeks to enhance her or his health and marketability by engaging in constant self-scrutiny for signs of 'failure' to ensure a youthful state. Featherstone (1991:189–190; 178) argues that:

> Within consumer culture individuals are asked to become role players and self-consciously monitor their own performance.

> Appearance, gesture and bodily demeanour become taken as expressions of self, with bodily imperfections and lack of attention carrying penalties in everyday interactions [...]The wrinkles, sagging flesh, tendency towards middle-age spread, hair loss, etc., which accompany ageing should be combated by energetic body maintenance on the part of the individual—with help from the cosmetic, beauty, fitness and leisure industries.

We witness this monitoring and disciplining of bodies in the numerous women's, and more recently, men's magazines. According to Featherstone and others, the individual's 'failure' to remain youthful is taken as a sign of moral laxity, leading to a culturally endemic paranoia of the signs of ageing.

Featherstone and Hepworth further suggest that, in western consumer cultures, using the term 'midlifestyle' is a discourse of *resistance* to this spectre, focused on defying ageing in midlife (Featherstone & Hepworth 1991b:201):

> This new orientation towards the middle years represents the endorsement of a new style of life ... which suggests the middle years (30–60) are replete with opportunities to achieve new goals, fulfilment and personal growth ... Self-renewal therefore is accorded a central place within this lifestyle.

However, some theorists have argued that the constitution and production of the midlife body has become a historically specific site of conflict between a youthful inner self and an ageist society, which does not value older adults (Featherstone 1991; Turner 1984, 1994). Featherstone and Hepworth represent this dualistic tension between the 'inner self' and the 'outer body' as the 'mask of ageing'.[1] They suggest that the ageing body is conceived as an increasingly inflexible 'mask' which progressively prevents social participation through prolific consumption. That is, the

1 Note that the notion of an 'external' versus 'inner' self in ageing has recently been challenged (de Medeiros 2005). Instead de Medeiros proposes an alternative framework in which the 'externally presented' self coexists with the 'complementary self', but that the latter is largely unarticulated if it risks the violation of cultural norms.

physical changes that accompany and mark bodies as they become old, such as wrinkles, sagging skin, osteoarthritis, and so on, prevent people from engaging in the lifestyle of consumption that characterized their youth and early adulthood.

Like Featherstone and Hepworth, sociologist Bryan Turner (1994) also argues that the midlife phenomenon in postmodern consumer societies that followed post-industrialism has triggered a 'proliferation' of possible lifestyles and identities. Turner contends that identities have become 'recyclable' and selves 'revisible', rather than roles being well defined by the life course. As Turner (1994:110) notes:

> Even the concept of the life-course is a somewhat rigid notion of a coherent progress through life. Postmodernity suggests rather that we live in a situation of contingent life trajectories. This idea of contingency in life projects better expresses the uncertainties, ambiguities and diversity of post-modern life styles.

Turner situates the potential conflict in self versus social identities clearly (ibid:111). He notes that:

> The central issue in ... the postmodernisation of ageing is the question of identity. In a society where social roles are highly structured and where rites of passage are clearly known, identity follows status without any ambiguity. In postmodern societies these status transitions within the life-cycle have been fractured and rendered ambiguous. The maintenance of identity is further complicated by an emphasis on the body beautiful. With the inevitable ageing of the body, the continuity of self and identity is exposed ... If postmodernisation means the reversible body, it also implies a revisible self. From this complex of relationships there emerges the idea of a multiplicity of projects for the body and the self.

Turner and others (e.g., Biggs 1997, 1999) thus argue that postmodern social identities have become more fluid in response to the lack of social role structuring; the life-course is no longer seen as 'linear', and social roles and relations are no longer clearly defined. This poses a challenge for maintaining a continuous, coherent subjectivity in older age, as the coherence and continuity of the self becomes compromised when there are no defined guidelines for an age-appropriate identity or lifestyle.

Radical social constructionist theorist Margaret Morganroth Gullette also perceives the midlife period as a site of conflict between a youthful subjectivity, a lifestyle of consumption and the apparently limitless revisibility of the self (Gullette 1998). Her model of discursive ageing focuses on the discourses that produce what she argues is a culturally endemic fear and dread of ageing, which takes the form of a self-vigilant paranoid concern with the body's visible signs of ageing. This paranoid self-vigilance is precocious (that is, it occurs earlier than expected, as one anticipates being marked as aged when those marks are not yet visible), hence the fear of ageing precedes the onset of what we understand as the visible signs of ageing (ibid:17):

In the United States in the twentieth century [ageing] no longer means a geriatric physical process, and it can begin long before marked events like retirement or the last of the children leaving home. Although widely shared, its core is a private emotion: fear of being not-young. In other words, it is a culturally cultivated chronic disease with an adolescent exposure and a no-later-than-midlife onset.

Gullette contends that we age discursively, via the midlife 'decline narrative', which she argues is culturally taught through feelings and 'lore' from puberty onwards. This, and her claim that the 'natural' midlife transition is portrayed to be as inevitable as, and as indistinguishable from, biological ageing, is based on the argument that everything underlying the construct 'midlife decline' is learned, and that "our very feelings depend on culture" (ibid:9). She further argues that the social construction of feelings of agedness in contemporary US culture is discursively mediated, has become naturalized and unquestioned, and is subject to historical-cultural influences.[2]

It is important to note that these perspectives on ageing are underpinned by a mind-body split, a split that has been present in the history of western thought since Descartes. However, traditional modes of understanding the body-subject were disrupted when western post

2 It is worth while noting, though, that in her argument she universalizes a fairly distinct group, rather than a population: American middle-class women, like herself.

structuralist theories of the body in the second half of the twentieth century replaced the mind-as-subject and body-as-object duality with the notion of the 'corporeal subject'. As corporeality and subjectivity became increasingly interlinked and the body-mind duality loosened, the problematic question of how 'the body' and 'the mind' might interconnect in achieving a 'mindful corporeality' has therefore arisen, and we can see a tension in some theories of the ageing body, such as the mask of ageing theory.

The question of the nature of the mind-body relationship impacts not only on gender, which has been a key focus of feminist research in sociology and philosophy, but also in how bodily ageing is understood (and feminized) in western cultures. Because the splitting of the mind from the body, and of 'inner' from 'outer' aspects of the self underlies ageing theories, the 'inner, youthful self' is accordingly seen as in binary opposition to the 'outer, ageing body', presumably resulting in a splitting of subjectivity in midlife. Therefore, if, as theorists such as Featherstone and Hepworth have suggested, the lifecourse is no longer predictable through fixed milestones and the distinctions between age cohorts have become blurred, these binary distinctions between 'young' and 'old' underlie the discursive delineation of bodies as aged in western cultures.

For social constructionist theorists the ageing body therefore becomes a site of conflict in the search for a coherent corporeal subjectivity in maturity – however limitless the choice of identities appears, it demonstrates a progressive inability to emulate a lifestyle of prolific consumption that requires a youthful body. A major problem for these theories is that the body-self has become progressively split in maturity due to the body's visible changes, a phenomenon itself attributable to a pervasive underlying dualism. Perhaps theories that place more emphasis on the inner, psychic self than on the (bodily) performing self, in cultures where performance must signify youth to be valued, might then be more useful. I therefore turn to psychoanalytic approaches to subjectivity in midlife, to ascertain whether they hold more promise for developing a more productive corporeal subjectivity in later life.

Negotiating a Mature Subjectivity in an Age-Hostile Culture: Persona and Masquerade

Neo-Jungian analytic psychologists take a radically different approach to midlife from that of theorists such as Featherstone and Hepworth, Turner and Gullette. They perceive the period of the second half of life as one involving a re-evaluation of one's life rather than one characterized by a frustrated desire to continue to define the self through prolific consumption.

Simon Biggs, in his book *The Mature Imagination*, examines how some form of coherence, continuity and authenticity of a mature identity might be maintained (Biggs 1999). He is among those who are critical of approaches to ageing that stress the notion of a 'reversible' or 'revisible' self, and of a multiplicity of identities that, in an environment of prolific consumption, can be changed virtually 'at will'. Rather, he is among those who argue that it involves a tension between the 'reversible' self's compunction to select from a multiplicity of 'ageless' identities, and the increasing inflexibility of the ageing physical body, one that makes it more difficult to continue participation in this process of identity selection. Those who succumb to the demand to maintain a youthful body and a socially acceptable identity rely on the social 'mask' or 'persona' to conceal ageing and protect the self from social stigmatization and humiliation within an ageist society. In doing this they reflect the fact that ageing in western consumer-driven cultures is not an opportunity to 'reinvent' one's self at liberty; rather, it represents a conflict between the desire for social recognition and value and the negotiation of culturally normative imperatives that devalue ageing.

Developing a coherent mature subjectivity thus becomes increasingly difficult as, while the 'ageing' body-self seeks youthful identities for as long as possible through various body projects, with time the mask becomes more inflexible. As Biggs (1999:62) argues:

> Even though the postmodern 'self' is characterized as being capable of infinite expression, the ageing body needs to be progressively managed if this possibility is not to be lost. Old age increases this contradiction to a point at which participation in consumer lifestyles is significantly compromised. As ageing gathers pace, it is

> increasingly difficult to 'recycle' the body and it becomes a cage, which both entraps and denies access to that world of choice.

Biggs poses vital questions about possibilities for developing a coherent, 'authentic' subjectivity in maturity (Biggs 1997, 1999), a theme that social constructionist theorists have generally neglected. He draws on the concept of 'masque', which incorporates both that of masquerade and the Jungian derived concept of the persona,[3] defining 'persona' as "an essentially social phenomenon which encompasses the roles we play and the compromises we make for the sake of 'fitting in' ... a device through which an active self looks out at and negotiates with the world, to protect the self and to deceive others" (Biggs 1999:76). According to a psychoanalytic framework, persona or masque is a means of social accommodation, of protecting the self and others from unacceptable parts of one's personality. It also provides a means of social conformity in order to achieve social acceptability in an age-hostile social environment.

For theorists such as Biggs midlife therefore becomes a productive period in which to develop a mature subjectivity. He draws on Jung's framework to contend that the second half of life promises a re-evaluation of subjectivity in that it involves shedding self-preconceptions that are now 'false' wrappings of the self: "it is a necessity for older persons in this second half of life 'to devote serious attention' to themselves as psychologically distinct, developed and spiritual beings, which itself requires that the Self is divested of the 'false wrappings' of the persona" (Biggs 1993:30). In postmodern culture this becomes more prominent because the self's potentially unlimited freedom in 'inventing' an identity, and any increased opportunities for psychological development of the mature self, become compromised by the 'increasingly marginal and restrictive social roles' available to older people. As Biggs suggests, "the advent of

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3 'Masquerade' as a concept was first used by psychoanalyst Joan Riviere in "Womanliness as a Masquerade" within a feminist context, in which masquerade operated as a display, or performance, of normative femininity to defend against perceived retribution by (father-figure) men (Riviere 1929). The ability to disguise was particularly important in instances where women occupied 'masculine' (e.g., intellectual) positions.

postmodern conditions has made a plethora of identities available. However, these appear to be drained of significance and easily become a means of avoiding an encounter with existential questions of ageing" (Biggs 1999:80).

'Persona' reflects a strategic attempt to overcome this dilemma in an ageist social climate that threatens to marginalize the ageing person's social presence and value and to restore a degree of individual agency in negotiating a coherent, mature body-self as people age. The issue, as Biggs sees it, is to "allow engagement with social expectation, whether multiple or restrictive, and ... protect personal coherence and continuing personal development". He argues that ageing offers an 'experiential sophistication' in an individual's later years, which allows a flexible and contingent identity to adapt itself to the nature of contemporary society: "According to this viewpoint ... maturity gives rise to an expanded capacity for self-experience" (ibid:81). The ability to negotiate a multiplicity of social situations and simultaneously retain a sense of personal cohesion and continuity are seen by Biggs and others to be the strengths of ageing, comprising an increased capacity for greater self-knowledge coupled with a greater flexibility in negotiating social norms. Biggs also connects masquerade with hegemonic (patriarchal) social codes, according to which ambiguity of age status is not acceptable, ageing is a 'difference' to be erased, and youthfulness is the desired, valued outcome (ibid:75):

> In the deployment of the masque, youth becomes a normative state to which the body has to be restored. Age becomes a process of dispossession and the cover-up, an exercise teetering on the brink of the grotesque. Through this intrinsic ambiguity, masquerade again becomes a process of submission to dominant social codes and resistance to them ... It is a thing that is played with, which while obscuring signs of ageing is also drawing attention to the fact that a deceit is taking place.

In her book *Aging and its Discontents: Freud and other fictions*, Kathleen Woodward applies Riviere's concept of masquerade to old age. Masquerade for Woodward is "a coverup through which old age nonetheless speaks ... As pretense, masquerade is a form of self-representation ... A mask may *express* rather than hide a truth. The mask *itself* may be one of

the multiple truths" (Woodward 1991:148). She explains masquerade as follows:

> In a culture which so devalues age, masquerade with respect to the aging body is first and foremost a denial of age, an effort to erase or efface age and to put on youth. Masquerade entails several strategies, among them: the addition of desired body parts (teeth, hair); the removal or covering up of unwanted parts of the body (growths, gray hair, "age spots"); the "lifting" of the face and other body parts in an effort to deny the weight of gravity; the molding of the body's shape (exercise, clothing).

Woodward argues that being confronted with ourselves as 'aged' is a form of "return of the repressed", in psychoanalytic terms. She posits a 'mirror stage' of old age, as a kind of reverse scenario of the Lacanian 'mirror stage' of infancy. In the mirror stage of infancy, the sight of the body as a cohesive unity experienced by the infant is in contradiction with his or her experienced lack of bodily control as a condition of ontological immaturity, and the child feels joy at perceiving her or his image as a harmonious whole. Woodward suggests that, on the other hand, in old age the mirror reflects an image which the viewer rejects, and which, if encountered unexpectedly, evokes an experience of 'the uncanny' (*das Unheimliche*) in the face of what Woodward argues is the familiarity of the repressed—old age.[4]

Woodward (1991, 1999) recommends that, while the social realities of fear, denial and attempted defiance of ageing still exist, they should be seen from the perspective of the psychic significance of the ageing body in a social context. Importantly, Woodward (1991) is concerned with the nexus between gender and ageing, and applies the notion of 'masquerade' to gendered ageing, which she conceptualizes as an outcome of the development of the psyche in response to the social world, a mode of self-presentation by concealment. She refers to two functions of masquerade: "as *submission* to dominant social codes and as *resistance* to them"

4 One of Woodward's (1991) arguments is that Freud could not come to terms with his own ageing and this influenced his lack of concern with older people in therapy.

(ibid:153). By contrast, in advanced old age masquerade instead functions as a 'bridge to the past', to a momentary (and private) reconnection with past selves, in an attempt to secure coherence and unity of identity (ibid:157). Significantly, Woodward suggests that it is the *body* which has become fragmented (into parts which manifest progressive biological decline) and which the (youthful, unified) self experiences as a threat to its integrity, to the internalized 'ideal body'. In relation to the body, the mirror stage as a site of subject formation is therefore countered by another mirror stage later in life, a site of subject destruction.

The body, Woodward argues, has thus become the 'other' alienated from the experienced, 'inner' self, and perhaps also alienated from a mythical 'other' body, the much cherished cultural fantasy of the idealized, *whole* body image of ourselves, what feminist philosopher Moira Gatens calls the 'imaginary body' (Gatens 1996). Gatens' concept of the 'imaginary body', a notion developed from psychoanalytic studies of hysterics, is a body that is "developed, learnt, connected to the body image of others, and is not static" (ibid:12). It is a culturally constructed *ideal* self-image that conforms to predominant cultural norms, a psychical image of the body-self or what Lacan and Freud call a libidinous and narcissistic relation to one's body (ibid:12):

> The imaginary body is socially and historically specific in that it is constructed by: a shared language; the shared psychical significance and privileging of various zones of the body (for example, the mouth, the anus, the genitals); and common institutional practices and discourses (for example, medical, juridical and educational) which act on and through the body.

The imaginary body thus reflects culturally normative and intersubjectively shared phantasies and modes of thinking.

In summary, as in the sociologically informed 'mask of ageing' theory, psychoanalytic frameworks theorize the self as striving to retain temporal continuity (i.e. agelessness), and is in tension with the increasingly inflexible ageing body. However, it is significant that, unlike the 'mask of ageing' account, psychoanalytic perspectives on ageing such as those of Biggs and Woodward attempt to portray the second half of life in constructive terms, as a form of psychic productivity (re-evaluation of the self) rather than in terms of a progressive failure at consumption.

They do this by taking into consideration the cultural and social constraints which the ageing body-subject negotiates in its quest for a mature subjectivity that is both socially and personally valued.

Gendered Ageing

My discussion so far, with the exception of Woodward's argument on masquerade, has addressed the ageing body-subject in a gender-neutral way. However, gerontologist Sarah Harper (Harper 1997) is among those who argue that the social construction and experience of ageing is inextricably gendered and that it is therefore meaningless to treat age and gender as discrete categories in age theory. For example, gender relations appear to function to disadvantage women in later life in terms of their reduced capacity to represent culturally normative attributes of their gender, and it is to a consideration of gendered ageing that I now turn.

It has been shown that representations of ageing in forms of mass media in western cultures, such as in films, markedly differ for men and women, to the social disadvantage of women (Markson & Taylor 2003). Film theorist Patricia Mellencamp describes a discursive practice she terms "age-tagging" that works to age-grade men and women, and one that is perpetuated in the mass media (Mellencamp 1992). From a philosophical perspective, Esposito links women more than men with the social perception of 'obsolescence', due to their lack of social status relative to men (Esposito 1987:129). He suggests that:

> In societies that continually measure status ... the struggle to maintain or acquire status continues as individuals age. And insofar as women have been marked traditionally for attractiveness and men for authority, the aging process has had a greater impact on women. Older women become obsolete as women, whereas men acquire greater stature with age.

Sociologist Mike Bury concurs with this view, noting that the late twentieth-century western youth culture of consumption tends to mask the gendered inequity of remaining youthful (Bury 1995:27). Bury contends that:

> As a dominant form of 'youthful' middle-aged ... culture holds sway, the message seems to be that we are all capable of being

> young now. This process may be particularly disadvantageous to older women, as youthful glamorous looks and sexuality are emphasized as positive attributes of this youthful culture. The implication remains that women's value is still strongly influenced by sexual attractiveness, and youthful appearance, in contrast to older men.

Theorists such as Woodward and Gullette have also suggested that the experience of ageing for women is more difficult than for men, and that its onset is perceived to occur earlier. Woodward argues that the combination of being a woman and being older exacerbates the experience of ageing for women, and draws on Susan Sontag's observation of women and ageing to suggest that: "Women are also subject to what I call 'double aging' or 'multiple aging.' Unlike men, women in mainstream culture in the United States today are struck by aging as it is defined by our culture far earlier than men" (Woodward 1999:xiii). Some of those feminist theorists who have addressed ageing, such as Woodward, Mellencamp, and Gullette, have therefore contended that the construction of older bodies is gendered, and that this binary construction of 'older' + 'woman' serves to further marginalize women.[5]

However, some theorists also contend that bodily ageing can also be a difficult issue for men, and as different for men than for women. For example, sociologist Jeff Hearn contends that the category of 'old men' involves the loss of two forms of empowerment: the organizational power of the middle-aged and the physical strength and virility of the young, and he locates the ageing of men in what he calls a 'disruption of intergenerational relations': "In this construction older men are gradually diverted from the centre of youth and the heterosexual family; they become the *other* of this centre, as they approach death" (Hearn 1995:112). The category of 'older men' is linked with gender: "It connects oldness to

5 While it has been a traditionally neglected concern of feminists, more recently feminist gerontologists have focused on gendered ageing. See, for example, the papers by Biggs, Twigg, McMullin & Cairney, Ray and others in the *Journal of Aging Studies* special issue, New Directions in Feminist Gerontology (*Journal of Aging Studies* (2004), 18(1): 1–121), also Barrett (2005), Calasanti (2005, 2004, 1999) and Ray (1999, 1996).

gender, to men, and to men's social power". Hearn also suggests that the category of 'older men' may contradict dominant constructions of men and masculinities, such constructions being linked with youth, physical strength, and another marker of sexuality, that of virility.[6] It therefore becomes possible to contend that, if older men become 'other', ageing male bodies are 'feminized' in western cultures in which masculinity is equated with bodily control, social power, and youthfulness. At the same time, they become subject to the 'ambiguity' of ageing bodies.

The two notions of 'ambiguity' and 'control' are useful in theorizing how women and men are aged within contemporary western cultures. Therefore, the remainder of this section is devoted to exploring the concept of ambiguity, in the ways in which older people perform cultural norms through self-presentation, followed by a consideration of the function of bodily control in relation to gendered ageing.

One way in which ambiguity is discouraged in the bodily signification of age and gender norms in western cultures is through the common practice of age-tagging referred to earlier. Age-tagging is a discursive practice that, together with gender identification, grades individuals into a chronological age cohort, which is conflated with other, naturalized characteristics, including those referring to social power and bodily control. In western cultures, through our everyday practices, we unselfconsciously classify or 'tag' others, the strangers we meet or whose images we encounter in the media, effectively 'interpellating' the other (as the middle-aged, middle-class, female, or as the elderly, working-class male). Because it constitutes a culturally normative 'reading' of visible physical attributes with chronological age, age-tagging is therefore a means of unambiguously identifying bodies as belonging into particular age groups.

The way in which 'old' bodies are perceived in contemporary western cultures suggests that the materiality of the older body can pose a challenge to the concept of a continuous, unified and coherent subjectivity. In her discussion of age-tagging, Patricia Mellencamp contrasts the

6 Ramsay Burt has also linked the representations of the male dancer with contradictory constructions of masculinity (Burt 1995).

classical body, which she defines as "monumental, static, closed, sleek and quiet" against another type of body: the grotesque, carnivalesque body (Mellencamp (1992:279). "The classical body is young, the grotesque body is old", she writes. She contends that older bodies are characterized by lack, but here this lack or loss is not primarily the loss of physical capital, if by that one refers to 'what the body can do'. Rather, Mellencamp suggests that older bodies disturb us because they lack the 'monumentality' and unity of form inherent in young (classical) bodies. That is, they are characterized by *ambiguity* and are not easily 'read' or classifiable. For norms require that the ways an older person performs her or his social self, whether through comportment, body shape, dress, and other practices, must also be internally consistent, in order to allow others to identify him or her unambiguously as aged and therefore 'uphold the norm'. In other words, ambiguity in body performance of self is not normative, and therefore not within the bounds of what is considered 'normal' within western cultures (see Diprose 1994).

To illustrate this further, I refer to poststructural queer theorist Judith Butler's notion of performativity of gender and extend it to ageing and ambiguity of self-performance. According to Butler's theory of gendered subjectivity as performative, what we understand by gender is a performance of the modes of dress, behaviors, speech, and all the other ways gender-specific norms are discursively and behaviorally enacted in order to successfully fabricate the cultural myth of a gendered (i.e., masculine or feminine) subjectivity (Butler 1990, 1993). These normative enactments of gender become normal within a culture. However, for Butler, reiteration of one's gender can be used subversively, by "working the weakness in the norm" (Butler 1993). For example, we can change the norms that prescribe one's gender by performing them 'imperfectly', by undermining our masculine or feminine modes of dress, behaviors or speech through the subtle inclusion of gender-inconsistent elements – for norms as cultural constructs exist precariously and require correct reiteration to reify and perpetuate them, and for them to become naturalized, embodied and lived. Therefore, this very ambiguity can potentially be used to disrupt the normative category of 'age', for bodies that do not (or cannot) normatively perform their age weaken the category of age by

the ambiguity inherent in their performance, and I will further address this point later in this paper.

The second concept crucial to ageing is that of 'control', and its relationship with ambiguity and abjection in relation to the permeability of the body's boundaries. Earlier I briefly referred to the notion of control, specifically bodily control, as an attribute that has become allied with the performance of both masculinity and youthfulness. Bodily self-control, the ability to control the body's comportment, movements, and emissions, has been an important concept in defining social status in western cultures. For example, anthropologist Mary Douglas in her book *Natural Symbols* linked the notion of two bodies—the social body and the physical body—to bodily control. She argued that "the physical experience of the body, always modified by the social categories through which it is known, sustains a particular view of society". Douglas then makes the link between bodily control and social control, arguing that bodily control is an expression of social control (Douglas 1973:93). Bodily control therefore carries important social meanings that become disrupted as both men's and women's bodies enter older age.

Douglas' perspective is arguably essentialist, in that the relationship between bodily control can be generalized to affect all members of a culture. However, it also suggests that control over one's body, like all forms of knowledge and experience in western cultures, has traditionally been defined (and valorized) through male experience, a position also argued by feminist philosopher Elizabeth Grosz (1994) and others who drew on the work of poststructural feminist Luce Irigaray (Irigaray 1985a, 1985b). The defense of this notion of 'control' as masculine finds expression in statements such as that women cannot control menstruation, whereas men can control ejaculation (Douglas 1966), and from the traditional concept of women's biological enslavement to their bodies ('anatomy is destiny'). However, Irigaray and her followers have argued that a binary distinction is fundamental to patriarchal cultures and mediated through the very structure of language, according to which bodily control is associated with men and masculinity (in terms of unity and stability), whereas 'lack of control' (and therefore lack of bodily agency) has been traditionally associated with women and femininity (in terms of plurality and fluidity).

Psychoanalyst Julia Kristeva draws upon Douglas' argument in her analysis of male representations of female bodies as 'leaking' and 'draining' and therefore as abject (Kristeva 1982). She has defined such representations as a key cultural concept behind patriarchal control. Further, both the issue of bodily control, and the concept of the body's (real or imagined) boundaries, have been used to theorize women's bodies as posing a threat to a masculine culture. Bodily control and the permeability of the body's boundaries have been linked, according to Douglas and Kristeva. That is, unlike men's bodies, women's bodies' boundaries are not configurable as 'closed' and definitive of 'inside' versus 'outside' (and therefore they signify ambiguity in relation to these boundaries). Some have argued that this permeability of the female body's boundaries is feared by men and incites abjection in them (e.g., Theweleit 1987).

Abjection here is a response to an ambiguous form of signification, a signification that does not refer to culturally accepted gender norms, but that through its very ambiguity of performance throws these culturally cherished norms into question. Abjection is dangerous because it is always ambiguous, and is therefore seen as (merely) transitional. According to Kristeva (1982), the abject is that which threatens the *corps propre* (translated as the 'clean' and 'proper' body), the body that is knowable and predictable, the body with clearly defined boundaries between 'inside' and 'outside', and the body as both a subject *of* institutional control and as subject *to* self-control.

The concept of 'abject masculinity' subverts the notion that masculinity is an unproblematic, unambiguous category. Klaus Theweleit (1987) and others have argued that western heterosexual masculinity is structured by oppressive (oedipal) boundaries. According to this framework, women through the ambiguity of their signification of clear boundaries and bodily control pose a threat to men, the threat of being engulfed in a boundaryless pre-Oedipal state of polymorphous perversity. The concept of masculinity in western cultures has therefore been theorized as vulnerable and in constant need of reification through 'cor

rect' performance and bodily control (see e.g., Burt 1995; Connell 1983, 1995).[7]

This notion of ambiguity eliciting abjection through the threat posed to the 'clean and proper' (clearly bounded, masculine) body is important in relation to gendered ageing, as the relationship between social power, bodily control and masculinity breaks down when essential control over bodily emissions starts to fail in men as they age. Some have argued that the ageing body, whether male or female, finds itself progressively unable to express itself in the conventional, normative gender codes, the successful performance of which marks our gender in everyday life (see Harper 1997). One might then be able to theorize that the ageing of men is aligned with femininity through 'lack' of bodily control, that men become 'the other', joining the non-privileged half of the gender binary that women have (always, already) been subsumed under. Where absolute control of the body, as defined through male experience, constitutes the overarching marker of (masculine) adulthood, the concept of lack of bodily control associated with advanced old age (in both women *and* men) therefore becomes stigmatized. As they age, men can no longer emulate the bodily control and competence of their youth, within in an androcentric culture that prizes and discursively perpetuates bodily control and fixity and stability of boundaries as normative attributes of the *corps propre*.

Men therefore must find the experience of their bodies ageing as difficult as women, albeit in different ways, and feminist gerontology has recently begun to acknowledge this (see Calasanti 2004).[8] If, as Harper argues, it is only "through acknowledging the embodiment of male sexed

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7 For example, Robert Connell connects the construction of masculinity with 'the social power structure of patriarchy', through qualities that represent the body as a whole: "What it means to be masculine is, quite literally, to embody force, to embody competence" (Connell, 1983:27).

8 Some feminist gerontologists also address the ageing of men. Toni Calasanti here argues that the perception that feminist gerontology is only concerned with women to the exclusion of old men is incorrect, as "even if women are the focus of research, their positions are intrinsically tied to those of men, and vice versa" (Calasanti 2004).

knowledge as the dominant paradigm within which the ageing body is interpreted, [that] the relationship between knowledge, control of the body and lived experience can be further understood" (Harper 1997:161), the experience of old age in men is one that, unlike women, they have not been adequately prepared for in their youth. In this sense they are disadvantaged in relation to women, who have not been socialized into the importance of high bodily control in defining gendered subjectivity. As noted earlier, developing a culturally valued subjectivity would therefore be difficult for *both* older men and older women, due to the differential ways in which gender and ageing have been constituted and understood in western cultures.

To sum up, I have contended that both ageing female *and* male bodies can be construed as a potential threat to the phallic order, as anathemical to it, and therefore as abject. For, as Mansfield (2000:71) argues:

> The idea that anything may have a dynamically changing or inconsistent identity, or have contradiction as its very essence or animating principle, is defined as monstrous and abominable to a phallomorphic culture that can tolerate only the homogeneous, the defined, knowable and consistent.

It can further be argued that, while both male and female bodies are marginalized as 'feminine' as they age, the ageing female body is doubly marginalized; first by virtue of feminine lack, and secondly by virtue of the loss of youth, a youth that has been defined in masculine terms of power (including sexual power) and bodily control. If, as I suggest, ageing, like femininity, disrupts the masculine order through this very ambiguity and fluxus of subjectivity, how can ageing subjectivities be more productively delineated? How can an increase in ambiguity of signifying the *corps propre*, and a concomitant decrease in bodily control, produce a mature subjectivity that evades the abject? How can old age be anything but as a threat to the very notion of gendered personhood? This will be my concern in the final section of this paper.

Bodily Agency and Age Performance in Later Life

In order to explore how ambiguity of body-performance and bodily control might be productively theorized in old age, I explore two frame

works. The first framework suggests potential for the harnessing of ambiguity in subverting culturally normative and marginalized age-gender performance by a development of Butler's concept of performativity, and the second, contrasting framework presents a radical valuing of old age as a prime stage of attainment of caring for oneself, which is found in the later writings of French philosopher Michel Foucault.

Earlier in this paper I referred to Butler's performativity theory in relation to performing gender and ageing. Shannon Sullivan takes up Butler's model and the notion of 'working the weakness in the norm' in arguing that, as habits can be embodied and performed differently, slight variations ('imperfect' reiterations) are possible that displace and, over time, gradually lead to change in cultural norms (Sullivan 2000). As Sullivan notes, "we can reconfigure our culture in and through the ways we embody it. We alter, however slightly, the grooves engrained in our selves when we re-trace and re-groove them through our habitual actions" (ibid:33). That is, the subject is conceived as subject(ed) to cultural norms that are in turn subjected to individual variations in their performance by (aged, gendered, classed) bodies. Therefore, any ambiguity inherent in the reiteration of norms, whether in performing one's gender or one's age, can be used to undermine and question the status of these norms, and gradually lead to a change in the cultural perceptions and valorization of older body-subjects through strategically subversive bodily performance. Therefore, according to Sullivan's model, ageist perceptions of older people *can* be changed over time by the ways in which people perform age, although this cultural change is very gradual.

A contrasting perspective occurs in the later work of Foucault, in which he concerned himself with the issue of self-care and how one might turn oneself into a subject. Foucault's historically situated references to the ageing self, although not a primary concern in his writings, suggest that the cultural devalorization of older age is historically contingent and therefore mutable. Although his concern with ageing is tangential, in a remarkable analogy to the Jungian concept of the second half of life as a period of reevaluation of, and introspection on the self, his later writings depart from his earlier emphasis on the impact of cultural power on individuals whose subjectivities are constituted exclusively through this power. Instead, he moves towards a position that attributes some

thing approaching individual agency towards a self that one 'cares' for and nurtures throughout one's life to the very end.

According to Foucault's earlier writings (Foucault 1972, 1980), subjectivity as a 'stable', interior truth is an illusion, a construct, a cultural fabrication. Rather, the corporeal subject is constituted through techniques of the body that reflect institutional regimes of power that are imposed on, perpetuated by, and fully constitute that subject through the 'correct' performance of norms. However, in *Technologies of the Self* (Foucault, 1988) and *The Care of the Self* (Foucault, 1990), Foucault's writings show a radical departure from his earlier emphasis on subjectivity as a product of historically contingent forms of institutional power, by focusing on a genealogy of the concept of 'self care' throughout the history of western thought on the development of modes of being for the self, between the care of oneself and the quest for self-knowledge (Foucault, 1988, 1990).

Foucault's concern here is with how one might "take care of oneself", how "a human being turns him- or herself into a subject", through practices through which individuals "acted on their own bodies, souls, thoughts, conduct, and way of being in order to transform themselves and attain a certain state of perfection or happiness, or to become a sage or immortal" (Foucault, 1988:3–4).[9] He demonstrates that the principle of self-knowledge (*gnothi seauton*) has historically evolved to take precedence over that of self-care (*epimeleia heautou*). For example, self-knowledge became defined under Christian moral principles of self-renunciation in order to attain salvation in a future (after)life, whereas in Greco-Roman culture self-knowledge was a *product* of the practice of self-care, rather than something that was achieved through an ascetic practice of self-renunciation.[10]

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9 It would be interesting to compare this perspective with the Jungian concept of the second half of life as a period in which to devote serious attention to the self (Biggs, 1993), which I discussed earlier, but this is beyond the scope of this paper.

10 Foucault, in 'Friendship as a Way of Life', distinguishes between asceticism and askesis: "Asceticism as the renunciation of pleasure has bad

Most significantly for ageing, at certain historical junctures care of the self was not confined to youth but practiced throughout one's life by means of a range of 'techniques', such as introspection, vigilance, care of the body and soul, and writing as a practice of narrating the self. This perspective does not deal with changing ageist cultural perceptions over time; rather, it enables a view of older age as inherently productive rather than degenerative. It suggests an embodied lifelong ethos: to 'live well'—not in the sense of conspicuous hedonistic consumption in a culture that valorizes youthfulness, but to live an 'abundant life' into deep old age. Thus even extreme old age offers the potential for completing a self, as Foucault (1988:31) points out:

> Since we have to take care throughout life, the objective is no longer to get prepared for adult life, or for another life, but to get prepared for a certain complete achievement of life. This achievement is complete at the moment just prior to death. This notion of a happy proximity to death—of old age as completion—is an inversion of the traditional Greek values on youth.

Foucault addresses the relationship between old age and care of the self most directly in his lectures at the College de France in the early 1980s (Foucault 2005), where he explores the notion that the highest form of care of the self occurs when one is old. Old age thus becomes a positive goal of existence, in the face of having lost the capacity and desire for physical pleasures or ambition (ibid:109).[11] Referring to a letter by Seneca, he notes that Seneca does not believe that living one's life should conform to one's age; rather, life should be lived running away from the 'enemies' pursuing one: desire for pleasure, power, money, etc. Here,

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connotations. But the askesis is something else: it's the work that one performs on oneself in order to transform oneself or make the self appear that happily one never attains" (Foucault 1989:206).

11 Note of course that Foucault refers to the ageing of men, and refers to old age as a stage where "an old man delights in nothing but himself" (ibid:109). 'Old age' in the period of antiquity with which he is concerned was also defined as 60 years of age, a life stage defined in contemporary western culture as 'young-old'.

Foucault importantly states that "Old age no longer appears as the ambiguous end of life, but rather as a focal point of life, a positive focal point towards which we should strive... We should live to be old, for in old age we will find tranquility, shelter, and enjoyment of the self" (ibid:110), and that "we should place ourselves in a condition such that we live it as if it is already over" (ibid.).

Old age thus becomes productive rather than merely a senescent stage restricted to a generativity necessitated through physical decline; it is "an old age we produce... which we practice" (ibid.). Further, he suggests that old age is a point at which (through a long practice of the self) the self "finally arrives at itself, at which one returns to one's self, and at which one has a perfect and complete relationship to the self of both mastery and satisfaction" (ibid:109). Significantly, here Foucault not only directly concerns himself with old age, a condition that he notes is surrounded by a "tradition of ambiguity and limited value", but also delineates old age as a life stage offering the highest capacity for self-realization, in arguing that old age can be a highly productive state for self-care, a pinnacle of experiencing and practicing *epimeleia heautou*.

Prima facie, such a framework holds promise for age theories as it credits the body-subject, even in advanced old age, even in the face of drastically limited bodily competence, with a remarkable agency as yet unavailable to the young and physically fit, and in this way establishes the 'final' stage of existence as inherently (self-) productive, as significant in the potential it offers for personal agency through the practice of self-care. However, while it represents a counter-narrative to the traditional contemporary western narratives of decline and obsolescence, it presents obvious problems.

Firstly, it implies an abstinence and disengagement from participation in social life in old age by retreating into the self, a stage at which the individual no longer actively participates within her or his community and contributes to social cohesion and improved quality of life. It is a version of disengagement theory that has been abandoned by gerontology in favor of more 'active ageing' approaches. Secondly, I am uncomfortable with the term 'mastery', because it suggests a 'masculine' way of

ageing, of transcending increasing physical frailty, not by coming to terms with it, but by a process of disembodiment.[12] The notion of 'mastery' in old age is still linked to 'control': not bodily control which has diminished, but a form of meta-control that is nonetheless a derivative of 'control' as being a defining characteristic of youthful masculinity. Finally, the utopian prospect of experiencing mastery and satisfaction in old age obviously does not apply to those aged body-subjects who live in abject poverty and/or who might experience their immobility, pain and sensory impairment as a considerable burden to their ability to enjoy life and find very little meaning in their bodily 'decline'.

In theorizing the corporeal subject in old age, this framework as it stands has some serious shortcomings. However, it attempts to offer a useful counter-narrative to the medicalization of age as a period of decline, and therefore has value in allowing us to theorize old age in more positive terms. It resonates well with Biggs' (1993) model of the persona and the shedding of the false wrappings of the self in older age, but it requires a critical consideration of the cultural marginalization and devaluation of old age, not a submission to it, and this may be one productive path for further research.

Conclusion

In this article I have suggested that the deep-seated cultural valorization of youth and bodily control and culturally ingrained intolerance of ambiguity in body performance marks (and perhaps masks) a historically contingent, ageist perspective on older age, one that is informed by the same patriarchal value system that privileges the masculine over the

12 Certainly Foucault has been subject to feminist critique, largely on the grounds that his account of the corporeal subject lacks sexed specificity (see e.g., Butler (1990), Grosz (1994). Grosz, for example, argues that Foucault "rarely ... talks about the issue of sexual difference or specifies that the objects of his investigation are implicitly male bodies and subjectivities, men's practices and modes of social organization" (Grosz 1994:156). Therefore, she contends that Foucault's framework needs to be reworked by feminists.

feminine. It is a perspective that can be linked to a culturally-based devaluing and feminization of both female *and* male older bodies, one that can be argued to be an outcome of contemporary western cultures' understanding and differential valorization of masculinity and femininity, and one that is fundamental to dualistic accounts of ageing and gender. Further, in perpetuating this status quo those of us who are 'not yet old' risk our own future by devaluing and marginalizing old age. As Woodward (1999:x) points out, "Our disregard of age is all the more curious because age—in the sense of *older* age—is the one difference we are all likely to live into".

Therefore, we need to find ways to transcend dualistic perspectives of ageing, to value ambiguity and flux over stability and fixity of boundaries, and to draw on the strategies used by poststructural feminists in order to develop age theories of difference rather than of loss (of equality). Secondly, we need to adopt a critical position by constructive questioning (or 'queering' in the broadest sense of the term) of normativity in relation to gendered ageing, by situating 'normativity' within the historical context and the specific social and historical conditions that engendered this particular matrix of cultural norms. It is possible to do so not only through developing critical genealogies but also – and importantly – through practice. For if we can theorize the ambiguity of body performance in maturity productively – as *different* from the stability and unity of the classically masculine subjectivity, rather than as falling short of it – it might then become possible to avoid the cultural loading of the binary positioning of 'age' with 'decline', and perhaps begin to develop more ethical understandings of gendered ageing and mature subjectivity in western cultures.

Finally, and most importantly, the issues explored in this paper suggest that further empirical research is needed to develop frameworks that are mindful of the issues and pitfalls outlined, and that productively theorize body-subjects in advanced old age, body-subjects in the face of whose reduced bodily competence embodied agency takes on a new meaning. In my PhD thesis I targeted western theatrical dancers as a focus of study as theirs is a body-based discipline – as is that of elite athletes – and they therefore face the challenges of the acceptance of bodily changes over time much earlier than those in other professions that place

less emphasis on the body, and may therefore be more accommodating of their bodies ageing (Schwaiger 2005b).[13] Further research is needed to generalize from this group to more 'representative' groups in western cultures in order to answer questions such as how the meanings of bodily control and competence in relation to the ageing self might be more productively reconfigured within their historical and cultural contexts.

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13 In the case of dancers, I argue that age-attributed 'decline' in bodily competence ('what the body can do') as an elite performer is not the only consideration in their relatively early retirement from performing, but contend that a more hidden category – that of culturally perceived decline in 'sexual capital' (a gendered concept, 'how the body should look') is significant although masked by the cultural discourse surrounding bodily competence in explaining why dancers retire so early (in their 20s and 30s) and so few continue to perform in later life (Schwaiger 2005b). Of course, there are other considerations not associated with the loss of normative physical or gender-signifying competence with age, considerations that impact on midlife dancers who also often have to negotiate different lifestyle demands to those of young dancers.

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The Complexity of Ageism

A Proposed Typology

BY LARS TORNSTAM

Abstract

Comparing data from a contemporary (2002) study and a study from 1984, it was found that, now as then, people display seemingly contradictory constellations of attitudes toward old people. Large proportions of respondents, now as then, advocate more influence and space for the 65+ group, at the same time as many feel that no one in the parliament should be above the age of 65. This contradiction becomes intelligible when the conceptions of and behavioral dispositions toward old people are combined in a new proposed typology of ageism, which is the result of a study conducted in 2002 and reported in this article. This new typology includes the *Pitying Positive*, the *No Fuzz*, the *Consistently Negative* and the *Consistently Positive*. These types are empirically described, and use of the typology is exemplified by focusing on ageist attitudes toward parliament membership.

Keywords: Ageism, attitudes, typology, gender.

Background and Aim of the Study

When Butler (1969) introduced the term ageism, which he described as prejudices against other age groups, social gerontology gained a new and stimulating concept, even though other kindred concepts had been used earlier to target similar phenomena. In our early Swedish research, the theoretical point of departure was the traditional concept of attitudes. Based on pioneer writings on this subject (e.g., Thurstone 1929; Kretch & Crutchfield 1948; Green 1954; Katz 1960), we decided to include the three classic dimensions in our definition of attitudes toward old people and to focus on them: 1) the emotional or evaluative dimension, 2) the cognitive or "knowledge" dimension and 3) the behavioral disposition dimension (Tornstam 1984). Adding to the several definitions of ageism, our argument is that ageism may be fruitfully described in terms of these three dimensions – how people *feel* about and evaluate old people, *conceptions* of old people, and the *disposition to behave* or actual behavior in relation to old people. When Butler (2001), in his contemporary writings, describes what ageism is, he certainly touches upon the content of the three abovementioned dimensions, just as do Kite and Smith Wagner (2004), who explicitly state that ageist attitudes are best understood as a constellation of these three dimensions. Even Palmore's (1999) definition of ageism, with the distinction between prejudices and discrimination, can accommodate both prejudiced conceptions as well as dispositions to behave in a discriminating way. The focus in the present study is however more on the social psychological level and on behavior dispositions than on factual discriminatory acts.

When we, back in the 1980s, carried out studies on attitudes toward old people, with particular focus on behavioral dispositions, we found inconsistencies in the attitudes of Swedish respondents. At the same time as 97 percent of respondents thought that one important duty of old people is to share their experience with younger people, no less than 61 percent felt that no politician in parliament should be older than 65 (Tornstam 1984).

Stimulated by these and other related findings, the SOM Institute (Society Opinion Mass Media) at Göteborg University used some of our

original survey items in one of their surveys in 2002. Despite the time difference of almost 20 years, the SOM study reveals a similar pattern in which 87 percent of Swedish respondents would like to see more places where young and old can meet, while 26 percent of the same group think it is a good or very good idea that no politician in parliament should be older than 65 years of age. Without diving into any discussion on the deeper meaning of the two items, it can be observed that a generally positive attitude toward the participation and visibility of old people in society seems to be combined with a quite negative attitude toward their participation and visibility in parliament, which we will refer to below as "parliament ageism".

The fact that the proportion of respondents negative to parliament membership for persons 65+ seems to have decreased from 61 percent to 26 percent during the 20-year period is at least partly due to methodological differences. In the 1984 study, respondents were only given an "agree" or "not agree" alternative, while respondents in the 2002 study were given a scale with five response alternatives ranging from "very good suggestion" to "very bad suggestion". In the 1984 study, 61 percent agreed with the statement that no one in the parliament should be older than 65, while in the 2002 study, 26 percent regarded this a "good" or "very good" suggestion. If the middle "neither good nor bad suggestion" is added, this figure increases to 72 percent.

It may be worth mentioning that the "parliament ageism" described above also exists among established politicians. A Swedish member of the European Parliament, Nils Lundgren (68 years of age), was recently criticized by some Swedish opponent politicians, who recommended that he withdraw to a lifestyle more appropriate for pensioners. Lundgren (2005) defended himself in a newspaper article by pointing out that some of the most influential politicians in history have been well above the age of 65. For instance, Winston Churchill returned as Prime Minister at 77 and withdrew when he was 81, and Ronald Reagan was 74 when elected to his second term as President of the United States. It is just as interesting that the age of 68 may still be considered an argument for withdrawal from parliament as it is that a parliament member feels the need to defend his position in the above manner.

When talking about ageism, the attitude toward 65+ membership in parliament is crucial. The perceived non-legitimacy of parliament membership may be seen a major indicator of ageism, and as a manifest behavioral inclination to support a corresponding legal regulation. Such a regulation, however, may by many be difficult to understand as ageism. Due to accustomedness with a socially constructed norm system, some of us feel it is right that old people leave room for the young. Many of the rules governing today's labor market imply this, even if the European Union is now trying to encourage member countries to regard compulsory retirement at a certain age as illegal discrimination – ageism. Yet there is some reluctance with regard to this new rule, as many of us still regard it as "natural" to stop working at 65, and consequently natural that old members of parliament should leave room for younger persons, just as did the above-mentioned political opponents to the 68-year-old Swedish member of the European Parliament.

Consider, however, what would happen if 26 percent of the population were to advocate a rule that no member of the parliament should be a woman: we would react with a riot (as did many women and some men in the past). If we free ourselves from our accustomedness with the hidden ageism inherent in some norms of exclusion, it may seem defendable, for the moment, to label those who have the above-mentioned attitude as "parliament ageists".

In any case, this persistency of contradictory attitudes has prompted us to take a closer look at this pattern. From a theoretical point of view, our approach is to consider ageism as a complex phenomenon rather than as a simple, one-dimensional phenomenon. Part of what characterizes ageism (or attitudes toward old people) is probably that it is comprised of seemingly contradictory discourses. As suggested in the present study, a focus on these discourses could produce a fuller understanding of the anatomy of ageism. And we may even find a hidden logic behind some apparent contradictions.

Thus, the major aim of this study has been to further the conceptual discussion on ageism by suggesting a new ageism typology based on combinations of the cognitive and behavioral disposition components. This constellation has been forced to the fore by the above-mentioned contradictions. At the same time, this means that, in this study, we have

left the emotional component of attitudes aside for future consideration. Unfortunately, the SOM study, on which we build, did not include any measurement of the emotional dimension.

The aim has also been to describe the profiles of respondents belonging to the different types in the typology and to exemplify use of the typology by applying it to the "parliamentary ageism" described above.

Material and Methods

The analysis below is based on the above-mentioned SOM Institute study conducted in 2002, which was a postal survey sent to a random sample of 3000 Swedes between 15 and 85 years of age. The net response rate after attrition due to death, emigration, etc., was 69 percent (1899 individuals). In the analyses below, the respondent base for the calculations will vary depending on internal dropouts and index calculation rules.

The Conceptions of Old People Scale

In order to tap the degree to which respondents have correct conceptions of old people or have negatively biased beliefs, the statements below were used. These statements were, in the SOM study, the remaining ones from our original study from the 1980s, which in part originated from Palmores (1977) first quiz on aging.

Respondents were asked to indicate whether each statement was correct or incorrect:

- *More than one third of all retirement pensioners live in their own private houses*[1] (Statement correct. More than 50 percent of all retirement pensioners do so,[2] but 61 percent of the respondents marked the statement as incorrect).

1 Original Swedish wording: Mer än var tredje ålderspensionär bor i småhus.

2 Statistics Sweden (SCB), Statistikdatabasen: http://www.ssd.scb.se/databaser/makro/start.asp.

- *Half of all retirement pensioners have impaired hearing*[3] (Statement incorrect. Less than 30 percent have impaired hearing,[4] but 56 percent of the respondents marked the statement as correct).
- *Almost half of all retirement pensioners feel bored and dissatisfied with their situation*[5] (Statement incorrect. Around 85 percent are rather or very satisfied with their situation,[6] but 42 percent of the respondents marked the statement as correct).
- *Almost three quarters of all retirement pensioners often see relatives and friends*.[7] (Statement correct. Almost 75 percent of retirement pensioners see relatives and/or friends on at least a weekly basis,[8] but 44 percent of the respondents marked the statement as incorrect).

On the basis of the responses to the above statements, a simple additive conceptions or "knowledge scale" was constructed. Those who gave correct responses to all items scored the maximum of 4 on this scale (8 percent), while those who gave incorrect response to all items scored 0 and, at the same time, demonstrated a negative bias in their conceptions of old people (16 percent). Those who scored 4 have either really known or, perhaps, displayed a positive bias.

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3 Original Swedish wording: Hälften av ålderspensionärerna har nedsatt hörsel, dvs. svårigheter att uppfatta ett samtal mellan flera personer.

4 Statistics Sweden (SCB), Statistikdatabasen: http://www.ssd.scb.se/databaser/makro/start.asp.

5 Original Swedish wording: Nästan hälften av alla ålderspensionärer känner leda och otillfredsställelse med sin situation.

6 Specially computed from a year 2001-study of 1770 Swedes in ages 65-104 years. Study otherwise reported in Tornstam (2005).

7 Original Swedish wording: Närmare tre fjärdedelar av ålderspensionärerna umgås ofta med släkt och vänner.

8 First time documented in *Pensionär -75* [The Retirement Investigation].

The General Pro-Old Behavioral Disposition Scale

In order to tap a general pro-old behavioral dispositional attitude, an index has been constructed based on responses to the following statements:

- *Increase the proportion of retirement pensioners among Swedish political decision makers!*[9] Twenty-five percent of respondents considered this a good or very good suggestion. (Five response alternatives ranging from "very good suggestion" to "very bad suggestion").
- *Elderly people are underrepresented in Swedish politics!*[10] Twenty percent of respondents marked this statement as "absolutely right". (Ten response alternatives ranging from "absolutely wrong" to "absolutely right").
- *The experiences of elderly people are not utilized in Sweden!*[11] Twenty-eight percent of respondents marked this statement as "absolutely right". (Ten response alternatives ranging from "absolutely wrong" to "absolutely right").
- *Sweden would be a better country to live in if elderly people were given more authority!*[12] Twelve percent of respondents marked this statement as "absolutely right". (Ten response alternatives ranging from "absolutely wrong" to "absolutely right").

9 Original Swedish wording: Öka andelen ålderspensionärer bland politiska beslutsfattare i Sverige.

10 Original Swedish wording: Äldre människor är underrepresenterade i svensk politik.

11 Original Swedish wording: Äldre människors erfarenheter tas inte tillvara i Sverige.

12 Original Swedish wording: Sverige blir ett bättre land att leva i om äldre människor får mer att säga till om.

An additive index was constructed based on the above items according to the rules given by Galtung (1969).[13] The Cronbach's Alpha for this scale is 0.70, which is generally considered satisfactory.

Ageist Attitude Toward 65+ Members of Parliament

In contrast to the above pro-old behavioral disposition scale, which targets a general, more unspecific behavioral disposition, we have also targeted the very specific and certainly important question of ageism in practice – respondents' opinions regarding eligibility for parliament. Should individuals 65+ be eligible for parliament or not?

The attitude toward politicians 65+ was measured using a single item:

- *No politician in parliament should be older than 65!* Twenty-six percent of respondents regarded this as a good or a very good suggestion – an attitude we call "parliament ageism" (Five response alternatives ranging from "very good suggestion" to "very bad suggestion).

In addition to the above items, several single item measures, e.g. questions about work, education, etc., have been used in this study.

Intercorrelations between major measures

If the attitudes and the signs of ageism were one-dimensional and simple in their logic, we would expect to find strong and consistent correlations between conceptions of old people, general pro-old attitudes and opinions regarding 65+ membership in parliament. As seen in Table 1, the empirical reality does not support this assumption.

One of the correlations in Table 1 (top left cell) is quite contrary to what might be expected. The more correct (or positively biased) concep-

13 The procedure includes a tricotomization of the items (with the series of response values turned in the same logical direction) before adding them up to an approximate Likert rank order scale.

Table 1. Spearman's rho correlations between major measures

	Pro-old behavioral disp. scale	Conceptions/ Knowledge scale
Conceptions/Knowledge[14] scale	-.10** (n = 1 735)	1
Against 65+ parliament item[15]	-.22** (n = 1 731)	-.08** (n = 1 815)

** p < .01

tions the respondent has on the above-described conceptions scale, the *lower* the value on the general pro-old scale. In other words, negatively biased beliefs about old people are associated with high pro-old attitudes. The expectation was rather to find it the other way around. The obtained correlation is not strong, but could still indicate that the pro-old attitude is complex, since it to some extent seems based on negatively biased conceptions of old people.

Furthermore, the correlations that are in the expected direction are not particularly strong. Our data show that the higher value respondents have on the conceptions scale (accurate knowledge or positive bias), the less likely they are to recommend 65 as the upper age limit for members of parliament. This is, however, a very weak correlation of -.08.

In the same vein, even if our data show that a pro-old attitude makes it less likely to recommend 65 as the upper age limit for members of parliament, the correlation expressing this "self-evident" relationship is only -.22. A very much higher correlation would be expected for expressing a "self-evident" correlation between two variables measuring more or less the same thing. Together these observations indicate that the phenomenon of attitudes and ageism is more complex than sometimes believed.

14 The more knowledge about old people, the lower score on the pro-old behavioral disposition scale.

15 The higher value on the pro-old behavioral disposition scale and the better knowledge about old people, the less likely to recommend age 65 as upper limit in parliament.

This indication is strengthened when we look at some correlates to the main measures.

Table 2 shows, for example, correlations between educational level and all three major measures. As expected, we find a correlation indicating that those with higher education levels are better informed about old people and less likely to recommend a 65+ upper age limit for parliament members, but at the same time score lower on the general pro-old scale. As suggested above, this indicates that showing a positive attitude toward old people by scoring high on the general pro-old behavioral disposition scale may be something different from having positive conceptions of old people (fewer negatively biased beliefs) and being against a 65+ upper age limit for parliament members.

Pointing in the same direction, age differences show that the older the respondent, the more positive he/she scores on the general pro-old scale, but at the same time with a slight tendency to advocate a 65 age limit for parliament members. Our suggestion is that the general pro-old scale and the conceptions scale are measuring two dimensions that must be understood in non-additive ways. That is, these aspects of ageism cannot be *added* together to form a one-dimensional measure, but must be regarded as components of a constellation or interaction of attitudes.

This suggestion paves the way for experimenting with a typology based on these measures. This typology may offer new ways of understanding the seemingly contradictory response patterns.

A Typology of Attitudes

By means of dichotomizing the conceptions scale and the general pro-old scale, we have been able to construct a typology of "conceptions"/pro-old attitudes as shown in Table 3.

If the general pro-old scale and the conceptions scale consistently measured some common aspect of ageism/non-ageism, we would expect to find almost all observations along the main diagonal (Type 1 and Type 4). In the empirical reality, however, we find that 52 percent of the observations fall along the opposite diagonal. Out of all the observations, 22 percent are of Type 2, where a negatively biased conception of old people is combined with a pro-old attitude, and 30 percent are of

Table 2. Eta-correlations between major measures and background variables

	Pro-old behavioral disp. scale	Conceptions/ Knowledge scale	Against 65+ parliament item
Left-right political[16] orientation	ns	.12***	ns
Education[17]	.08**	.07**	.20***
Civil status[18]	ns	.10**	ns
Age[19]	.27***	ns	.08**
Gender[20]	.11***	ns	ns
Occupational group[21]	ns	.11*	.21***
Working/ Unemployed[22]	.15***	.07**	.08**

* p <.05 ** p< .01 *** p< .001

Type 3, where good knowledge (or positively biased conceptions) of old people is combined with a low score on the general pro-old scale.

16 Left wing orientation lower on the conceptions/knowledge scale (more negatively biased).

17 Those with higher education are less positive on the pro-old behavioral disposition scale, but higher on the conceptions/knowledge scale and less negative toward 65+ parliament membership.

18 Married respondents higher on the conceptions/knowledge scale.

19 The older the respondent, the more positive on the pro-old behavioral disposition scale, but the more negative toward 65+ parliament membership.

20 Women more positive on the pro-old behavioral disposition scale.

21 Workers lower on the conceptions/knowledge scale (more negatively biased) and more negative toward 65+ parliament membership.

22 Unemployed higher on pro-old behavioral disposition scale, lower on the conceptions/knowledge scale (more negatively biased), more positive to 65+ parliament membership.

Table 3. Typology of "knowledge"/pro-old attitude

		Value on pro-old disp. scale	
		Low	High
Value on Conception/ knowledge scale	Low (negatively biased beliefs)	*Type1* *The Consistently Negative* n=207 12%	*Type 2* Pro-old with negatively biased beliefs. *The Pitying Positive* n=378 22%
	High (good and/or positively biased knowledge)	*Type 3* Good knowledge but no pro-old attitude *The No Fuzz Group* n=524 30%	*Type 4* *The Consistently Positive* n=626 36%

One way of understanding the four types of attitudinal constellations may be the following:

Type 1 means being *Consistently Negative* in the sense that a negatively biased image of old people is combined with a generally more negative image of what role old people should play in society.

Type 4 means being *Consistently Positive* in the sense of being quite well informed (or positively biased) about the real conditions for old people, while having a positive attitude toward their participation in society.

Type 2 holds individuals who are inclined to think (a) that older people do not live in their own self-contained houses, have impaired hearing, feel bored and dissatisfied, and seldom see their relatives and friends – at the same time as these type 2 individuals think that (b) there should be more older people among decision makers, that they are underrepre

sented in politics, are under-utilized and should be given more authority in order to create a better country to live in.

There might seem to be a contradiction between the (a) and (b) sets of opinions, but it could make sense if we borrow and adopt some ideas from the Norwegian philosopher, Harald Ofstad (1972) and from his thought-provoking book Our Contempt for Weakness. Ofstad argues that the different types of conflicting values in society may produce a tendency to look down with condescending pity on those who do not measure up to society's values of productivity, efficiency and independence. But the value patterns of our society also include a tradition in which old age and wisdom are held in high esteem. This tradition is in conflict with value patterns that generate contempt for old people. According to Ofstad, we tend to "resolve" this conflict by hiding the contempt, or by changing it so as to unite it with the respect for old people found in, for example, the Hebrew tradition.

What happens is that some of us transform our contempt into condescending pity. We feel sorry for "the poor, feeble, sick and lonely old people". Moreover, our pity for old people forces us to "construct" them in such a way that the correctness of our pity is validated. We produce a negatively biased image of old people at the same time as we think their conditions ought to be improved.

This line of thought allows us to make sense of our findings: negatively biased conceptions (low on the conceptions scale) combined with a wish to make better use of old people in society (high score on the general proold behavioral disposition scale).

We might call this Type 2 attitudinal constellation Pitying Positive, which, following Ofstad's line of thought, could be related to a hidden or disguised contempt for weakness. This Type 2 attitudinal constellation is also reminiscent of Kalish's (1979) concept of "The New Ageism," which alludes to the patronizing manner in which some care providers and researchers define reality on behalf of old people and decide what they are in need of – particularly by identifying problems and disadvantages. It must be emphasized that the above interpretation is creatively suggestive rather than empirically proved and that other types of qualitative data are needed to confirm the above interpretation.

The Type 3 constellation also appears as a contradiction involving being quite well informed (or having positively biased images of old people), but not being positive on the general pro-old scale. This contradiction too may make sense if we interpret it as follows: Because those who belong to the Type 3 con-stellation have no negatively biased images of old people, there is no need for the fuzziness of the pitying positive – or, expressed another way: "Why coddle the well-to-do elderly?" We call this constellation No Fuzz. Another interpretation of the inner logic of this type is that there is a feeling of rivalry or competition with these well-to-do elderly. With such an interpretation, type 3 might alternatively be labelled 'Jealously negative'. As with the type 2, some qualitative studies are needed for the further exploration of this group.

Looking at each of the above-described attitudinal constellation types, they all make sense in their own way, thus rendering intelligible the contradictions of Type 2 and Type 3. In both of the contradictory categories, we have utilized the new concept Pitying Positive as a key to our understanding. In Type 2, being Pitying Positive is construed as a means for handling the conflict between con-tempt for weakness and a need to honor old age. In the case of Type 3, the positive conceptions do not allow a Pitying Positive solution, paving the way for the No Fuzz position instead.

Who Belong to the Four Types in the Typology?

As a first step in finding out which respondents express these four different attitudinal types, we have checked a number of background variables against these four attitudinal types. Table 4 gives a summary of where we found statistically significant differences.

The table shows that education, age, gender and employment/ unemployment seem to be related to the attitudinal type the respondent belongs to. Being younger as well as being male seems to increase the probability of belonging to the Consistently Negative constellation (Type 1), whereas being older as well as being unemployed seems to be connected with belonging to the Consistently Positive (Type 4).

Table 4. Types of attitudes in certain groups (%)

	Typology of "knowledge"/pro-old attitude (%)				
	Type 1 *Consis-tently negative*	Type 2 *Pitying positive*	Type 3 *No fuzz*	Type 4 *Consis-tently positive*	n
Total	12	22	30	36	1 735
Low	ns	25*	ns	ns	807
Medium		20			382
High education		19			501
15–29 years	20 ***	ns	37***	23***	315
30–49 years	13		35	31	604
50–75 years	8		25	43	693
76–85 years	3		21	53	122
Men	14 **	18 ***	33*	ns	893
Women	9	26	28		842
Work	ns	ns	34***	32***	1000
Unemployed			24	42	688

* p<.05 ** p<.01 *** p<.001 *ns* no significant difference.

The interesting Type 2 constellation, *Pitying Positive*, seems to be defined by education and gender. Those with a low level of education as well as women are over-represented in this type. In the equally interesting Type 3, the *No Fuzz* group, younger respondents as well as men and the employed are over-represented.

In order to more precisely describe how the above attitudinal types are inhabited by different respondents, we have analyzed each type using a CHAID analysis,[23] which, in contrast to, e.g., log-linear models,

23 CHAID (Chi-squared Automatic Interaction Detection) is an algorithm with which a dataset is broken down into sub-categories according to the explanatory power a set of predictors has with regard to a dependent variable. The dataset is subdivided as long as any predictor can produce a statistically significant division, usually with the threshold set at p < .05. (Kass, 1980; AnswerTree, 1998).

gives an exact description of the subgroups in which a certain quality (e.g., belonging to a certain attitudinal type) is high (or low). The log-linear models, as well as ordinary regression analysis, only produce mathematical abstractions of the same.

Figure 1 shows the outcome of a CHAID analysis in which the *Consistently Negative* has been the target of analysis. Predictors in the analysis have been the variables shown to correlate with the attitudinal types, i.e., education, age, gender and being employed/unemployed.

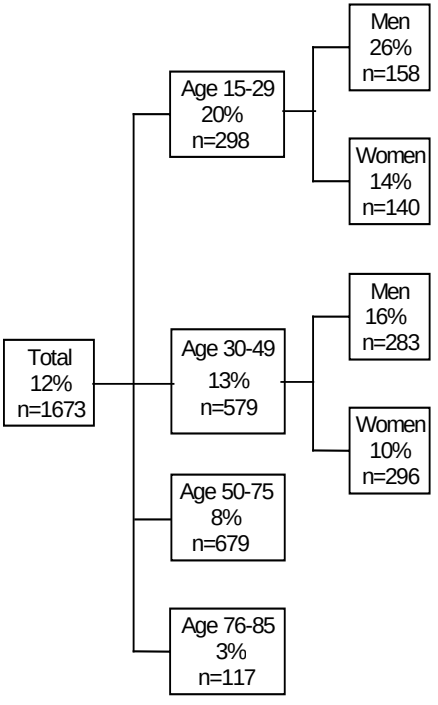
As in Table 4, Figure 1 shows the total percentage of Type 1 respondents to be 12 percent. A maximum of *Consistently Negative* respondents is found among the 158 men in the age category 15–29. In this subgroup, 26 percent of the respondents belong to Type 1, that is, they have both negatively biased conceptions of old people and score low on the general pro-old scale. What we see here is an age-gender interaction such that being a younger male increases the probability of belonging to the *Consistently Negative* attitudinal constellation.

In order to find the lowest proportion of respondents with Type 1 characteristics, we only have to look at the oldest respondents, among whom only 3 percent belong to the *Consistently Negative*.

If we for some reason, e.g. change in attitudes, wish to target the specific group in which the *Consistently Negative* attitudinal constellation is particularly prevalent, the CHAID analysis gives precise information on the make-up of this group. If we, for theoretical reasons, wish to explore the formation of this particular attitudinal constellation, the data suggest we should consider age/gender interactions. There seems to be something in society that produces a tendency toward this consistently negative attitude among younger men.

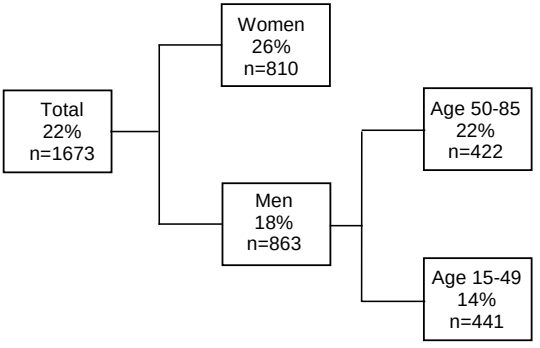
If we focus on the *Pitying Positive* attitudinal constellation, in which negatively biased conceptions of old people are combined with a high pro-old attitude, the CHAID analysis in part leads us to other conclusions than those drawn from Table 4.

Figure 1. The Consistently Negative (Type 2)



In the simple kind of bivariate analysis shown in Table 4, age shows no statistically significant correlation with the presence of the *Pitying Positive* attitudinal constellation (Type 2). In the CHAID analysis, however, the age variable regains significant explanatory power when the focus is on men only. It is in the sub-category of men between 15 and 49 years that we find the *lowest* percentage (14%) of respondents with the *Pitying Positive* attitudinal constellation. Again the CHAID analysis directs our attention to a gender/age interaction. In order to identify the largest proportion of respondents with the *Pitying Positive* attitudinal constellation, the CHAID analysis simply points to women, who have a larger proportion of Type 2 respondents than do men. Combining the

Figure 2. The Pitying Positive (Type 2)

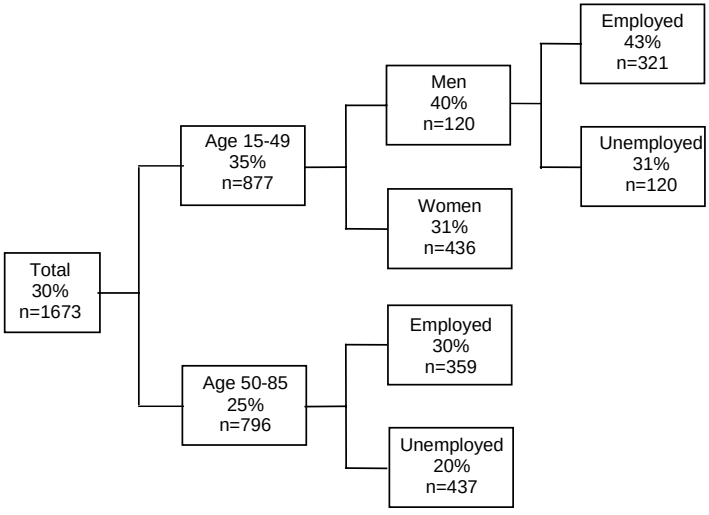


analysis of the Type 1 and Type 2 attitudinal constellations above, we begin to see how attitudes toward old people are gendered. While women, regardless of age, have a somewhat increased probability to be *Pitying Positive*, young men have an increased tendency to be *Consistently Negative*.

Turning to the CHAID analysis of the Type 3 attitude constellation, *No Fuzz*, we once again find that age and gender seem to interact, this time together with the working life situation.

The largest proportion of *No Fuzz* respondents – those who have good knowledge (or positively biased conceptions) of old people, but at the same time score low on the general pro-old scale – is found among "younger " (age 15–49) employed men. In this group, 43 percent belong to the *No Fuzz* constellation. When we consider this particular group as well as what this Type 3 attitude constellation stands for, we may again suggest that these men in fact express something like "why coddle the well-to-do elderly?" or "No Fuzz". Quite rightly they know, or think they know, that most old people have a rather good situation in life, and by knowing this they may be inclined to be averse to the suggestions made in the general pro-old scale. But why should this apply in particular to employed men under 50? Could this be a manifestation of a latent

Figure 3. The No Fuzz
Why coddle the well-to-do



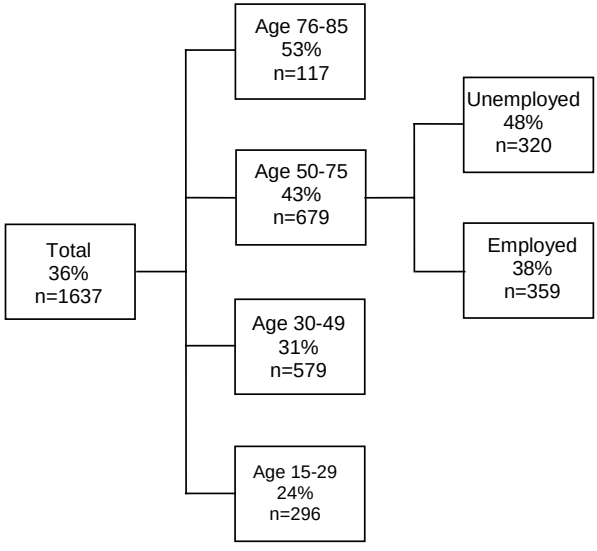
generational conflict, in which "younger" employed men are inclined to express aspects of a struggle for power and resources in relation to older people? We shall leave it to others to suggest an explanation for why this does not apply to young employed women.

Drawing on the suggestion that the *No Fuzz* attitude constellation expresses something like "Why coddle the well-to-do elderly?", it makes sense that the lowest proportion of respondents with this orientation is found among the "older" (50–85) unemployed, for whom it might be closer at hand to identify with a group of imagined "poor elderly" and thus easier to fall into another attitude constellation type.

As can be seen in Figure 4, the highest proportion of *Consistently Positive* (Type 4) is defined by age alone. Simply enough, if you are older yourself, you may have a disposition to be positive toward the advantages your own age group may offer society.

If, however, you belong to the 50–75 age category, your status on the labor market also matters. Being unemployed increases the probability of

Figure 4. The Consistently Positive (Type 4)



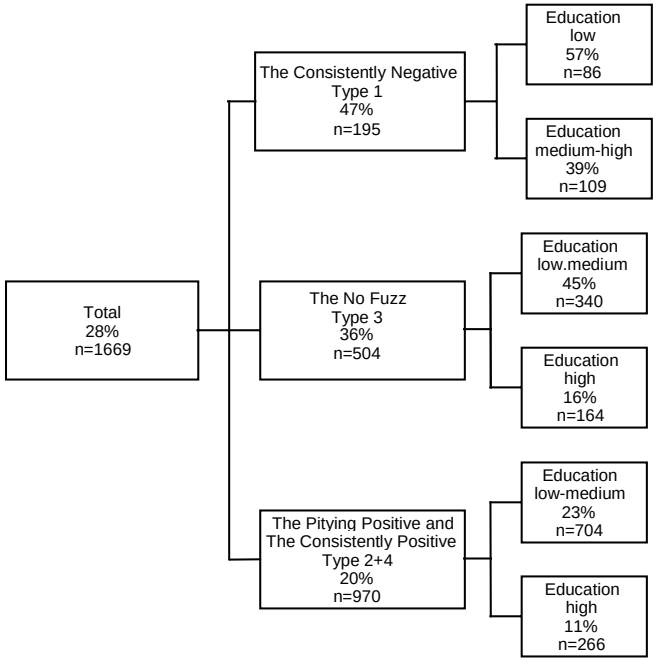
being consistently positive. In this latter category, the percentage of consistently positive respondents is almost as high as in the "top category" – those between 76 and 85 years. Also in this case, we may suspect that some kind of positive identification process is at hand.

The 65+ parliament membership?

As an example of how we could use the new ageism typology, we have targeted the afore-mentioned specific behavioral disposition referred to as "parliament ageism".

Figure 5 shows the result of a CHAID analysis in which the proportion of "parliament ageists" is the target of analysis and the attitudinal constellation typology is introduced as a predictor together with education, age, gender and position on the labor market.

Figure 5. Percentage of "Parliament Ageists"



The analysis shows that the attitudinal constellation typology is what first emerges in our search for subgroups with differing proportions of respondents who believe it to be a good or very good idea that no one in the parliament be older than 65 years of age. Among the respondents belonging to the *Consistently Negative* attitudinal constellation, the proportion of "parliament ageists" is 47 percent. In the group of respondents who not only belong to this Type 1 category, but also have a low education level, as many as 57 percent are positive toward this age limit.

When searching for the subgroup in which the above-mentioned ageist opinion is lowest, the CHAID analysis first collapses the Type 2 and Type 4 attitudinal constellations, where the percentage of "parliament ageists" is more or less the same – 20 percent. As regards *not*

being a "parliament ageist" it does not matter whether the high pro-old attitude is combined with negatively or positively biased conceptions.

The division of the above group continues and ends with the subgroup of Type 2+4, more highly educated, where the proportion of "parliament ageists" is 11 percent.

In order to begin to understand the relative importance of the attitudinal type and education, we have run a MCA-ANOVA analysis (not presented), which, in principle, produces an additive model, with all its shortcomings. This run produces a beta value of 0.23 for the attitudinal type variable and 0.20 for the education variable. Thus, within such an additive model, attitudinal type and education seem equally important. That is, regardless of educational level, position in the attitudinal typology is of importance, and regardless of position in the attitudinal typology, educational level is of equal importance.

Discussion

By referring to our own previous work as well as that of other more contemporary scholars, we have argued that ageism may be fruitfully understood and studied as a constellation of dimensions borrowed from the traditional concept of attitudes. In doing this, we have suggested a new typology. There is certainly a need to cross-check this typology and the inner meaning of its types, by means of qualitative studies of individuals belonging to each of the types. There is always the possibility that the inner meaning of a type will diverge from the interpretations we have made. This is a need that the present typology shares with all other theoretical and conceptual novelties. It is also the task of future research to connect the typology with the emotional dimension of attitudes/ageism, which we, lacking proper data, have not been able to address. With these remarks in mind, the following discussion may be justified.

When both the cognitive and the behavioral disposition components are considered at the same time, we find attitudinal constellations that at first glance seem contradictory, but that, when considered individually, have their own logic.

In particular we have identified the two constellations the *Pitying Positive* and the *No Fuzz*.

The *Pitying Positive* are those who have a negatively biased conception of old people at the same time as they seem prepared to act to give old people a greater role to play in society – thus combining negatively biased conceptions with a pro-old behavioral disposition. Empirically, nearly a quarter of Swedish respondents between 18 and 85 years of age belong to this category. This should alert researchers to consciously include this type of attitudinal constellation whenever studying ageism.

Also, the empirical analysis has shown that women are more likely to belong to the *Pitying Positive*. Men, on the other hand, are more likely to belong to the other opposite constellation – the *No Fuzz*.

The *No Fuzz* group, comprising 30 percent of the Swedish respondents, are those who combine positive conceptions of old people (no negative bias) with little or no positive pro-old behavioral dispositions. This can be understood as the mirror image of the Pitying Positive, such that positive conceptions are combined in an attitude constellation expressed as "Why coddle the well-to-do elderly?" or "No fuzz". The presence of this constellation is as high as 43 percent among younger employed men, signalling an age/gender/employment interaction, which may be worth exploring in future research on ageism.

Together the *No Fuzz* and the *Pitying Positive* constellations add up to no less than 52 percent of the attitudinal constellations, which again points to the need to distinguish and include these kinds of "contradictory" constellations in future research on ageism. By doing so, we may, as shown above, obtain a fuller understanding of why and how different groups of individuals include as high as 57 percent or as low as 11 percent "parliament ageists", who consider it a good or very good suggestion that no one in parliament be over the age of 65.

Our results also suggest the need to apply an age/gender perspective when studying ageism, as several of the ageist positions seem to be characterized by age/gender interactions.

With respect to our understanding of very specific behavioral dispositions, as "Parliament Ageism" in our example, it may be noted that the absence of such ageism may sometimes arise for "the wrong reasons". Being a *Pitying Positive* decreases the probability of being a "Parliament ageist". A question for future research concerns what the outcomes of information campaigns actually are. It has mostly been taken for granted

that proper knowledge about old people is beneficial for attitudes and ageism, but the present research reveals the possibility of other outcomes. With good knowledge, the probability of being *Pitying Positive* decreases, and instead the probability of becoming either *Consistently Positive* or *No Fuzz* increases. At this point, we know nothing about the degree to which increased information could increase the proportion of *No Fuzz* people, who, as mentioned above, are negative toward parliament membership for those above 65 years. A hypothesis derived from the above data is that more correct (or positively biased) information produces an increase in the proportion of *No Fuzz* young men, and perhaps also an increase in the proportion of *Consistently Positive* women, thus creating something of a polarization between men and woman. This is, however, merely a hypothesis, to be targeted in future research on how ageism may be both gendered and age-related and on the interaction between these two factors. As hinted at before, it is also a task for future research to explore which kinds of emotions are related with the various types. A preliminary hypothesis is that basically positive emotions go with the *Pitying Positive* and the *Consistently Positive*, while the *No Fuzz* and the *Consistently Negative* are connected with neutral or negative emotions.

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Pritti Biswas, Zarina Nahar Kabir, Jan Nilsson & Shahaduz Zaman

Dynamics of Health Care Seeking Behaviour of Elderly People in Rural Bangladesh

By Pritti Biswas, Zarina Nahar Kabir**, Jan Nilsson*** & Shahaduz Zaman*****

Abstract

Bangladesh is projected to experience a doubling of its elderly population from the current level of 7 million to 14 million by the end of the next decade. Drawing upon qualitative evidence from rural Bangladesh, this article focuses on coping strategies in cases of illness of elderly people and the contributing factors in determining the health-seeking behaviour of elderly persons. The sample for this study consisted of elderly men and women aged 60 years or older and their caregivers. Nine focus group discussions and 30 in-depth interviews were conducted. Findings indicate that old age and ill-health are perceived to be inseparable entities. Seeking health care from a formally qualified doctor is avoided due to high costs. Familiarity and accessibility of health care providers play important roles in health-seeking behaviour of elderly persons. Flexibility of health care providers in receiving payment is a crucial deciding factor of whether or not to seek treatment, and even the type of treatment sought.

Keywords: Health-seeking behaviour, elderly people, Bangladesh.

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Introduction

A changing demographic structure is occurring worldwide with a gradual shift towards a higher proportion of older people. With a few exceptions, more people—in both high- and low-income regions—are living longer than ever before. A declining trend in both fertility and mortality rates has increased average life expectancy and created a new set of challenges in today's society. The number of older people in the low-income countries is expanding rapidly. The net increase of older population worldwide is about one million every month—two-thirds of them in the low-income countries (Gorman 2002). In recent years, as population ageing has grown into a "defining global issue" (HelpAge International 2002), concerns have emerged regarding policy interventions appropriate for older people (Gorman & Heslop 2002; Barrientos & Lloyd-Sherlock 2002), especially in the area of elderly health care.

Bangladesh, with one of the highest population densities (985/km^2) (United Nations 2005) in the world, is projected to experience a dramatic growth in the absolute number of its population aged 60 years or older from the current level of approximately 7 million to 14 million by 2020 (WHO 2005; Solomons 2001). While a longer life may offer greater fulfilment in some ways, it also presents multifaceted health problems not commonly associated with low-income countries and thus creates unique challenges for the national health care service. Bangladesh faces a particularly complex situation. On the one hand, the health care needs of older people put increasing pressure on an existing system that is insufficient to meet the needs of all its citizens (Davies 2003). On the other hand, the government primary health care services remain underutilized (Vaughan et al. 2000), or poorly utilized (Pearson 1999), and older people often seek health care services too late, when "extremely ill", to obtain adequate treatment (HelpAge International 2000). The importance of understanding constraints to health care seeking behaviour of older people is of fundamental importance, if a responsive and efficient health care system is to emerge.

This article explores the underlying aspects of health care seeking behaviour of older people in rural Bangladesh. Drawing upon qualitative evidence from rural Bangladesh, the paper focuses on coping strategies of elderly people in case of illness and the contributing factors in determining their health-seeking behaviour.

Research Context and Methodology

In Bangladesh, an estimated 7.3 million people are currently 60 years or older, and it is projected that these numbers will increase by 173% by 2025 (HelpAge International 2000). Around 34% of the Bangladeshi population lives below the national poverty line[1] (UNDP 2003), and 36% of the population earns less then $1 a day. More than 85% of the poor live in rural areas (BBS 2002, World Bank 2002). Although it is one of the poorest nations in the world, Bangladesh has enjoyed an impressive rate of sustained economic growth. During the period 1992–2000, real Gross Domestic Product (GDP) per capita increased by 52 percent, although in a highly inequitable manner. The incidence of poverty and the levels of inequity have increased (DFID 2003), and the share of income controlled by the top 10% of the population is almost seven times more than the share of the bottom 10 percent (UNDP 2003).

Universal primary health care has been the central principle of the public health policy of Bangladesh since the Alma Ata declaration of 1978. Current health policy is articulated in the national Health and Population Sector Program (1999–2003), which emphasises a grassroots, decentralized approach to primary health care delivery. A significant amount of donor assistance has complemented government investment to support the implementation of this program. Primary health care in Bangladesh is provided through three main types of institutions. The *Thana* (sub-district) Health Complex (THC) is designed to bring the primary health care service to the doorstep of the rural people; secondly,

1 The national poverty line—based on 1999-2001 data—was established by national authorities using population-weighted subgroup estimates from household surveys (UNDP 2003).

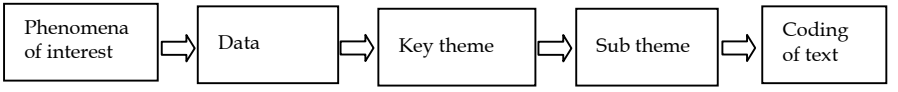
the Union Health and Family Welfare Centre (UNFWC) provides family planning outpatient service at the union level; and thirdly, hospitals and clinics serve as referral points for primary health care. As of 2000, Bangladesh had 460 rural *thanas* and 402 *thana* level health complexes (BBS 2002). In addition to the public health care services, a wide range of private health care services are also available, which include services provided by the non-government organisations (NGOs) and other non-profit entities, traditional and homeopathic providers, qualified pharmacists, and unlicensed drug sellers (World Bank 2002, Ahmed et al. 2005).

The evidence in the present paper is drawn from a qualitative baseline study which was a part of a multi-country health care intervention study, Primary Health Care in Later Life: Improving Services in Bangladesh and Vietnam (PHILL), aimed at improving health and quality of life of elderly people. The project was conducted in the south-eastern part of Bangladesh, in four villages in Chandpur district. Primary health care in the project was defined not only in terms of the government health care system, but also the wide range of health care sources available for the older people in the study area, including community-level health care, private and public services, and self-care at household and individual levels.

Qualitative analysis is widely accepted in health and old age research (Fry & Keith 1986; Sokolovsky & Vesperi 1991, Hutchinson 2001, Pope & Mays 1995). Methods such as focus group discussions (FGDs) are usefully employed to identify the aspects of health care that users value the most from their own perspectives (Schneider & Palmer 2002). Moreover, interviews with older individuals in anthropological studies often provide greater insights since older people retain "in-depth information about the subject" (Shield & Aronson 2003:27) and often reveal the "reasons" behind the facts (Jones 1995). Thus, in this study, semi-structured interviews and focus group discussions with participant respondents were the principal research tools.

The sample for this study included elderly women and men over 60 years of age and their caregivers. Age estimation of older persons can be a difficult exercise due to the non existence of written or numerical

Figure 1. Thematic analysis



Health-seeking behaviour of older people	5 FGD (elderly 4 FGD (care givers) 30 interviews (elderly)	Old body – Ill health Severity of illness Health-seeking experience of two elderly individuals Decision making in health care	Illness severity Accessibility to health care provider Familiarity with health care provider Financing treatment

records, as well as the higher time demand for estimation on the researchers (Howell 1986). In the present study, older individuals' chronological age was estimated using an events calendar which lists key memorable events such as the partition of India, liberation war of Bangladesh, a devastating tornado, flood, and famine in the area. The older persons' biological events were also taken into account to estimate their chronological age.

The qualitative data collection took place during February-November 2003. Two non-random sampling strategies were followed: stratified purposive sampling and opportunistic sampling (Rice & Ezzy 1999). The research team sought out sources of maximum variation, such as gender and economic status, ensuring that older women as well as older men and the different wealth categories were included. The team also took advantage of interviewing opportunities, which arose in the course of the fieldwork. For example, in cases where the selected individuals were absent or did not participate for any reason, the person was replaced by other individuals who fulfilled the research selection criteria and were keen to take part in the interview. Also, both the physical and mental abilities of the elderly participants were taken into consideration while selecting respondents. During the fieldwork, nine FGDs (five with elderly groups and four with caregivers with an average of five individuals per session) and 30 interviews with elderly people (15

men and 15 women) were conducted. The interviews were semi-structured and informal, and respondents were provided ample opportunity to talk about the issues in a flexible and friendly environment. As Gubrium and Sankar (1994) point out, "flexibility" and "sensitivity" to the qualitative research process allow the important issues and discussion to emerge in the course of the research.

The fieldwork focused on elderly persons' perceptions of health and illness and their health-seeking behaviour in the event of illness. The interviews focused on two main aspects. First, the team depicted the pathways of health-seeking strategies, which effectively described the decision-making patterns of the elderly respondents. Then the team focused on the motives for these health-seeking decisions. Taken together, these aspects provided comprehensive insights into how health-seeking behaviour by elderly persons is determined. The heterogeneous nature of the existing primary health care services in rural Bangladesh as well as the unique socio-cultural characteristics of the rural population is explored in this qualitative methodology.

Each individual was interviewed at his/her own premises at his/her preferred times. Some respondents were interviewed several times on different topics related to their health care using personal experiences, preferences, and satisfaction. The interviews were taped and transcribed soon after the interviews. An interactive process between data collection and analysis was maintained (Donovan & Sanders 2005), and the analysis was carried out in three sequential stages. First, a preliminary analysis was conducted based on the initial themes identified in the original research protocol (Grbich 1999; Boyatzis 1998). As these themes were coded in the text, they were situated in a larger thematic context, highlighting the sections and responses as appropriate to an individual respondent's coded identification (Miles & Huberman 1994). Each theme was then divided into sub-themes to identify cluster responses with more specific focus. Finally, an electronic 'scissors and paste' technique was applied to create a table of responses (Green & Thorogood 2004), and each table of response was analysed for generalisable patterns and propositions. The process revealed similarities and differences across the respondents and enabled the documentation of health-seeking patterns

for various types of illness episodes as well as for the recording of the individual illness stories.

Research Findings

Old Body — Ill Health

The qualitative data suggest that, in general, respondents use "old age" and "ill-health" as inseparable entities. When older people's illnesses do not respond to treatments, they tend to explain it by their "old age". As one female respondent stated:

> His (village doctor) treatment is very good; he takes good care of the patients and his medicine is good too. I like him a lot but as I have said, medicine is not effective in old age… (64 year old female respondent, a traditional health care provider—kabiraj).

> He (village doctor) does not pay as much attention to me as he used to... does not touch the pain areas with care either… …well, it is a ripened body and cannot get totally cured…(72 year old female respondent).

Health-seeking behaviour depends on the "perception" of health and ill-health, and there is a fine line between the normal health status of an older person and that of an older person suffering from an ill condition. A number of respondents classified specific health crises as old age illnesses, such as cataracts, toothache and gastric pain, body pain and arthritis, fever, uterine problems, loss of appetite, and general weakness.

Severity of Illness

The perceived severity of old people's health problems is another key factor affecting health care seeking behaviour, and we sought to define the threshold at which an illness is considered severe enough to be treated. The data shows that sudden dramatic deterioration of a "regular" health problem is considered severe. For instance, if someone who has chronically experienced a feeling of "unwellness" suddenly falls

and loses consciousness, it is treated as a severe condition. A 62 year old male respondent uses "donkey" for a metaphoric comparison. In his words:

> …donkeys do drink water but before that they will stir it to make the water dirty...that is our situation, we don't have much money, visiting doctors means expense, so we wait and wait, until it is unbearable...I had stomach pain, with diarrhoea, I suffered the first three days without treatment, then it got worse... I went to the toilet about 30 times and then I decided to go to the doctor and seek treatment... my stomach pain became totally unbearable, so I had to go actually...

Such behaviour seems to be common across respondents, as the excerpt below reveal:

> ... I have been suffering from chest pain... it started about 6 months ago, a constant pain, I felt very bad; however, I did not do anything and just suffered... it got worse and I had to go to the doctor...(62 year old male respondent).

Other cases are considered severe when the condition affects the ability to work and look after oneself physically or, even more importantly, requires the care of other family members.

> …I buy and sell small baskets (tukri/ora), I buy from one market and sell in another on market day. I walk to the market...but I am very weak now, too weak to walk...(80 year old male respondent).

When discussing professionally trained medical physicians, commonly known as MBBS doctors, terms like, "*too expensive*", "*have to have money upfront*", were used. The overall tendency is to avoid going to qualified doctors with formal medical training because they are expensive and hence not consulted unless the situation deteriorates too much. Even if MBBS doctors are consulted, follow-up visits are rare due to financial constraints. Box 1 describes how a 60 year old man suffering from rheumatism handles his illness and how this is related to his family and financial situation.

Box 1: Illness experience of Aziz, a 60 year old man

Aziz suffered from rheumatism for about a decade but learned to live with it. It had not bothered him so much during the previous year (the year before the interview), but he suffered from fatigue and lack of strength. He tended to spend the day reclined, and when he got up, his head spun and he had a burning sensation in his body. He felt as if someone was pushing him from behind. He attributed this to his arthritis. After suffering for about four months, he went to a *kabiraj* (herbalist) recommended by his neighbours. His brother took him to several *kabiraj*, who treated him with holy oil and water and one of them told him that he was suffering from the force of evil spirits (*porir asor)*. The *kabiraj* asked for a payment of Tk. 5000[2] for a cure, but he did not have money, so he paid Tk. 50 for the first day's consultation fees. For all the *kabiraj* visits, he spent around Tk. 500 in total but still remained ill. Finally, when he became too weak to even walk, his brother took him to the Chandpur (local) general hospital. His brother and his sister-in-law stayed with him, and he had to stay there two days and two nights. The doctor examined him by doing an ultra-sonogram and giving him a blood transfusion. One of his brothers donated a bag of blood and bought another bag for him. In two days, they spent Tk. 4000 for the hospital bill, rickshaw fare, and blood. He did not work for a year due to the illness, and he spent all his savings on subsistence and *kabiraj* treatments. He had to sell part of his land worth Tk. 2000. He said he felt better during his time in the hospital, and the doctors and nurses were good, but he started to feel ill again after returning home. He could not walk easily, felt depressed and anxious, and he only wondered why he did not get well.

Health Care Seeking Experience of Two Elderly Individuals

The dynamic and complex reality of health care seeking behaviour is exemplified by two neighbours and friends, one of them a *kabiraj* (herbalist). Saleha is 65 years old and lives with five other family members. Early June the previous year, she became ill. She had a large

2 The exchange rate at the time of the study was approximately US$1= Tk. 60.

painful spot on the spine near her waist, and it bothered her for months. People in the neighbourhood said she had a *pistok* (locally known/used term for this health problem). She agreed but was unsure about the reason, thinking perhaps it was due to fate or bad luck. After a while, the spot became too painful and needed to be dealt with.

First, she went to her sister-in-law Rohima, who was a *kabiraj* in her neighbourhood. Using a blade, the *kabiraj* cut the spot open and squeezed out the bad blood, then put some plant paste on the spot. Five days later, it worsened, and the *kabiraj* took her to visit a doctor. The doctor, who was well-known in the village, cleaned the infected spot with warm water and treated it with an injection and medicine. He also suggested that she returned every other day to get the wound dressed and cleaned. She continued to visit him for about two weeks and then when the pain got better, she stopped. The infection had not totally cleared up, but the pain got better and she started to put plant paste on the spot again. After two more weeks, she was better. In her words:

> The kabiraj is good, but it was my fate that I did not get well. The doctor was good too, I was half-cured with his medicine, perhaps if I continued it might have been cured quicker, but I did not have much money to continue that treatment. It might have taken longer to cure, but with God's blessing, I got well at last….

Rohima (Saleha's sister-in-law), on the other hand, is a 64 year old woman in Saleha's neighbourhood. Two of her sons work in Saudi Arabia, but she does not receive remittances from them. Another son lives in the village but is poor and unable to help his parents financially. Rohima's husband is frail and ill, so he can't work. Rohima is known as a *kabiraj* in the village. She treats an array of health problems for different age groups—problems ranging from cataracts in old people to uterus problems in younger women. She also treats such things as fever, arthritis, body pain, and toothache. She uses diverse plants and other materials and also uses *jhar-phuk* (spiritual healing) and *mantra* (incantation). During the interview, she insisted on maintaining secrecy regarding the specific characteristics of the plants that she uses for treatment. Recently, Rohima began suffering from a kind of arthritis (*aguinya bat).* Her fingertips were swollen and very painful, and some type of infection was visible. She also complained of body pain. Since

Rohima had been suffering from high blood pressure for 30 years, she thought that the cause of the arthritis was linked to her high blood pressure.

Although Rohima was a *kabiraj* herself and provided treatment for a wide range of health problems to patients of all ages, she did not treat her own health problem. She first went to a homeopathic practitioner whom she had known for a long time and had visited for a similar problem before. She reported that despite her not getting well the last time from his treatment, she prefers to go there because she can acquire medicine on credit. She believed that he was a good doctor for younger patients, and his treatment did not resolve her illness because of her old age. She has also been treating her high blood pressure with another allopathic doctor for years. For the most recent illness, Rohima had to borrow money from relatives and neighbour. She noted with sadness:

> whatever I earn from my kabiraji (herbal practice), goes to doctors for my own treatment.

These two cases demonstrate a very interesting scenario. Clearly Rohima enjoys a significant level of trust and influence from her patients; however, for her own health problems, she does not use her own treatment, instead spends most of her earnings to pay for other types of treatments. In this case, health care seeking is determined more by personal relationship rather than medical outcome. Even though Saleha is aware of her *kabiraj's* personal health care seeking practice (i.e., not using her own treatment), she maintains trust in Rohima's treatment. Despite the severe pain and cost of curing her infection, she attributes it all to her own "ill-fate" (*kopaler dosh*), not the inadequacies of her neighbour. While the two women suffered from problems locally known to be similar, they pursued different health care seeking trails.

Decision Making in Seeking Health Care

Illness Severity: Severity is perceived as either low or high. If it is regarded as low, then self-care is most commonly practiced, using home remedies and drugs bought from a drugstore, often by a family member.

> …I was feeling unwell for some time, I had fever, I was shivering, my body had some burning feelings, I was coughing as well…I

> thought it was just normal fever, and my family had poured water on my head to reduce the temperature. After eight days, my son brought me some medicine from a village doctor, I took that but it did not work either…in fact, for 20 days I did not go to any doctor... then I went to the doctor, and he said I had typhoid and gave me medicine…I am better now but feel very weak …(80 year old male respondent).

When the severity of illness is perceived as high, several factors enter into the decision making process. At this stage, the three key decisions of health-seeking behaviour for older people are "where" to take the person, "who" can accompany the older individual and "how" the finances can be managed. The decision about where to go is based on several factors including the treatment outcome, although it is not given first priority. In general, cost flexibility by the health care provider is the most important factor. A service provider who is flexible about the treatment cost and payment options is more attractive to the respondent than others.

> …I like him (village doctor) because he is flexible… if we pay Taka 20 he will accept it, if we pay Taka 10, he will accept that too. He understands poor people's problems and also gives good medicine ...(70 year old female respondent)

Accessibility to health care providers: The mobility and accessibility of older people are also critical. Especially for older women, a cultural stigma is attached to visiting a male doctor who is not directly a family member. In such cases, even if it is possible to take the doctor to the patient, that is not always an option for the older women patients. If the doctor insists on seeing the patient, he may have a counter-productive effect, such as deeper anxiety of the older patient. As a 90 year old woman puts it:

> I have pledged ('manot') to God not to be seen by any doctors… all big doctors (qualified) want to see patients, my family members explained my problems but they demanded to see me…(90 year old female respondent)

For some, it is important that the doctor is available during day and night for home visits. It brings a sense of confidence to the older patients. One respondent stated,

> … we always go to him… he is our regular doctor (village doctor), he is available whenever we need him, day or night… he also comes to our home when needed… we are happy with him...(68 year old male respondent)

Familiarity with health-care provider: Another pattern emerging from the data is that older people tend to go to the doctors who are well-known and are friends of the older person's male family members. Often the family members take the elderly patient to be treated.

> ... it is very convenient…the doctor knows me, he does not need to see me in person…he gives good medicine…(90 year old female respondent)

> …I like his (village doctor) treatment, we always go to him, he treats everyone in my family, whenever we have any problem he comes running ... I am very satisfied with him...(70 year old male respondent).

Sometimes this "known" status runs through generations. Intergenerational health care provider and receiver relationships appear quite strong, and the reputation of a service provider can be inherited by the next generation. As one 81 year old woman respondent asserted,

> ...we always go to him (village doctor), we used to go to his father (another village doctor)…he was a very experienced doctor... they are oldest in this area...(81 year old female respondent)

Financing treatment: How to finance the older person's treatment is another part of the decision-making process in seeking health care. Strategies of paying for health care include the use of savings, help from adult children, sale of livestock and poultry, and a formal or an informal loan from a friend, relative or NGO. Because older individuals generally do not have direct access to loan, a female family member or relative who belongs to a NGO acquires the funds.

> ...I have been suffering for a month with this diarrhoea, and it cost me Taka 700. I have no savings, no assets, and my shop is my single source of income. I borrowed Taka 2000 from my cousin… she is a member of Grameen Bank (Non-government organisation)… and visited the doctor. Now I am better and paying her

instalments... thank God I got better and now can pay her off...(62 year old male respondent)

Box 2: Health care seeking experience of a stroke victim

A 60 year old male, Shofiq, had been suffering from diabetes for some years. One day during Ramadan, while fasting he felt dizzy, his head was spinning and he lost his balance. He could not understand what was going on. Early morning he prayed as usual, and went to sleep; however, he woke up feeling that he couldn't move the left side of his body. In his words, "*I could not move my left side, it was senseless, and my left side was totally paralysed*".

The next morning, Shofiq's brother took him to a doctor who gave him medicine and asked him to take blood and urine tests as well as take an X-ray. After examining the results, the doctor informed him: "*You have had a stroke, from cold weather, blood pressure and diabetes…*". The doctor gave him medication for two months during which time he was totally bed-ridden. As his situation did not get better, he went to see another doctor and was given more medication. In order to manage his treatment expenses, he sold most of his belongings and capital assets, including his cows. One of his nephews helped him with some money as well. The hospital treatment cost him around Taka 5,000. After five months, his condition remained unchanged. His brother-in-law suggested to seek treatment from a *kabiraj* who gave him some medicine and ointment to massage. It cost him Taka 1,200 but he felt a bit better. He visited another *kabiraj* who gave a holy bracelet which cost another Taka 420, and following his advice, he bought some tonic which did not work. He is still following any advice he gets from his neighbours and often tries new forms of treatment. So far he has spent about Taka 20,000 and feels very depressed that he can't get well.

If the older person gets better at this point, they try to recover the financial losses and liabilities over a period of time. If the initial treatment does not work and the elderly patients are referred or advised to seek specialized treatment, they go through the same decision-making process. The families with available means and connections (i.e. children living in cities and having jobs) provide assistance. Sometimes even the

neighbours help with some money, as an 80 year old male respondent said,

> …My sons are poor and they have their own families to take care of, so they can't help me… my neighbours helped me, gave me some money for treatment....

An illness may leave a longer term financial burden on older people, moving from the comfort of having some savings to carrying a debt, as one of the 62 year old male respondent stated,

> …I had some savings, I spent that for my treatment, then I sold my wife's ornaments and used up the business capital... finally I had to take a loan from the cooperatives... my illness cost me Taka 2500 and now I am paying Taka 300 per week to repay my debt.

Poorer families face yet more liabilities and very often resign themselves to their ill fate. At this point they do not seek any health care services and are forced to cope with increasing discomfort as described by the case in Box 2.

Conclusions

The changing demographic structure in many low-income countries has resulted in the rapid increase of the elderly population. This is followed by an epidemiologic transition from communicable diseases to non-communicable and chronic conditions (Kinsella & Philips 2005). Research from Bangladesh indicate a high proportion of elderly people reporting health problems (Kabir et al. 2003), yet the health care system in the country does not explicitly cater to this population (HelpAge International 2000).

This study uses qualitative data to describe the complex nature of health-seeking behaviour of older people. Most significantly, old age is found to be an accepted explanation of ill health and the decisions taken to seek health care are influenced by factors such as perception of severity of illness, familiarity and accessibility to health care providers, and financing of health care. In the absence of specialized knowledge in geriatric health care, multiple sources of health care, such as allopathic care, *kabiraji* and homeopathic care are sought by the elderly people as

also reported in an earlier survey on health-seeking behaviour of adults in rural Bangladesh (Ahmed et al. 2005).

The qualitative data of this study suggest that, in general, respondents use "old age" and "ill-health" as inseparable entities. A study from the United States has also shown that older people expressed lower expectation regarding physical and mental health with ageing, as a result placing less importance on seeking health care (Sarkisian et al. 2002). Respondents in the current study were resigned to the belief that illness in old age was not completely curable and sometimes even incurable when their illnesses did not respond to treatments.

Multiple factors influence elderly people's choice and use of health care services. The perceived severity of old people's health problems is a key factor affecting health-seeking behaviour. As in many countries, self-care including self-treatment (or treatment by family members) is common when severity of illness is perceived to be low (Stoller & Forster 1992, Stevenson et al. 2003, Tuan et al. 2005). Data from the present study indicates that sudden deterioration of a "regular" health problem is considered severe, particularly if it affects the ability to work, to be physically independent and/or necessitates care from a family member. Once the level of severity is defined, a course of action is taken—more severe cases taken to the formal health care system, less severe cases treated traditionally or at home. Stoller et al. (1993) also report that depending on the degree of pain or discomfort caused by the problems and whether or not it interferes with their activities, older people decide upon the action to be taken regarding their health problems.

Family members in this study are reported to play an important role in the dynamics of seeking health care by the elderly individuals. Elderly women in particular in rural Bangladesh are reported to be in a vulnerable situation due to their dependence on the male family members (Rahman 2000). In the present study, in some cases, family members and even friends play an additional role in facilitating the treatment process of the older persons through their acquaintanceships with the health care providers. This is done in terms of financial help or in terms of the health care provider showing respect and consideration towards the elderly patient. Personal relationships with the health care providers, even through generations, play a very important role.

However, when there is no positive outcome from a certain treatment option, the explanation is often centred on fate.

Empirical evidence from Bangladesh and elsewhere indicates that socio-economic status is a strong determinant of health-seeking behaviour (Khe et al. 2002, Ahmed et al. 2003), even among the elderly (Ahmed et al. 2005). Similarly in this study, financing health care for an elderly individual is found to be one of the crucial deciding factors of whether or not to seek treatment, and what type of treatment to seek. The high cost of formally trained allopathic physicians is normally the reason to avoid them unless high severity demands it as also indicated by other studies from Bangladesh (Ahmed et al. 2003, Ahmed et al. 2005). Qualitative data from the present study shows that flexibility of the health care provider in receiving payment is, in fact, the most important factor deciding upon the kind of health care to seek. A service provider who is flexible about the cost of treatment and payment options is more attractive to the respondent than those who require immediate cash payment. Strategies of paying for health care include the use of savings, help from adult children, sale of livestock and poultry or other assets, and loan from friends and relatives.

Findings from this study provide a unique insight into the rationale behind health-seeking behaviour and the strategies employed by the elderly people in seeking health care in a rural area in Bangladesh. Financial factors play a crucial role in seeking health care in the backdrop of poverty of the elderly individuals and their families. However, flexibility within the informal health care system in rural Bangladesh in terms of payment provides a minor but insufficient recourse to the elderly patients. As treatment of even curable illnesses is forcibly discontinued due to financial constraints, the elderly persons resign themselves to the erroneous notion that ill-health is inevitable in old age.

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Fredrica Nyqvist, Janna Gutavsson & Yngve Gustafson

Social Capital and Health in the Oldest Old: The Umeå 85+ Study

By Fredrica Nyqvist, Janna Gustavsson** & Yngve Gustafson***

Abstract

The aim of this study was to measure social capital in the oldest old, and its association with different dimensions of health. The Umeå 85+ study is a cross-sectional study of 253 people, aged 85 years, 90 years and 95 years or older. A principal component factor analysis was performed to assess classes of information measuring the structural and the cognitive components of social capital on an individual level. In the final model, one factor consisting of attachment, social integration and social network emerged which accounted for 55 per cent of the total variance. We analysed the association between structural social capital and various dimensions of health. Structural social capital may partially explain depressive symptoms but not functional ability or self-rated health. We conclude that social capital is a relevant resource for the oldest old, but we suggest a different approach when measuring social capital in this age group, such as conducting a longitudinal study or including retrospective questions in the study. The oldest old may have had a high level of social capital, but our study could not identify this statistically.

Keywords: social capital, functional ability, self-rated health, depressive symptoms, oldest old.

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Introduction

There is a long research tradition and prominent evidence that sociodemographic characteristics such as educational level, socio-economic status, marital status as well as psycho-social characteristics including social networks and support have an effect on different health outcomes (e.g. Berkman & Syme 1979; Kaplan et al. 1987; Mendes de Leon et al. 2001; Unger et al. 1999; Fratiglioni et al. 2000). Researchers are also increasingly aware that social capital can be important in understanding differences in health in the general population (Kawachi & Berkman 2000) and may be of particular importance for older age groups (Cannuscio, Block & Kawachi 2003).

Social capital is a multidimensional concept and is usually defined on a micro (Putnam 2000; Lin 1999; Bourdieu 1986) or macro level (Putnam 1993; Putnam 2000; Coleman 1990) depending on the theoretical approach and scientific discipline. In the sociological tradition, social capital is usually seen as an individual resource including social networks, support and trust in local environments and in relations between individuals (Coleman 1990; Bourdieu 1986), whereas in the political science tradition, social capital is seen as the key characteristics of communities, regions and states rather than of individuals (Putnam 1993). A society with high levels of social capital is characterized by high levels of social participation, trust in other people and reciprocity that enhance interactions with other people. In this tradition one can gain the benefits of living in an area with a high level of participation even if you do not participate yourself.

Although social capital has been approached in diverse ways, the core concepts within the social capital literature both theoretically and when it comes to operationalisation of social capital in empirical studies are social networks, that is the structural aspect of social capital and trust, the cognitive aspect (Stone 2001). Some authors stress the structural aspect of social capital as the essence of the concept rather than the cognitive aspect while others argue the opposite. This study concerns both aspects of social capital.

There is a long tradition that examines the nature of social networks (Coleman 1990; Granovetter 1973; Burt 1992). In social capital, a distinction is usually made between strong and weak ties and between bridging and bonding ties. Coleman (1990) argues that strong and dense networks affect the access to information and facilitate sanctions, which makes it safer for people in the network to trust each other. Hence, social networks are seen as a source of trust and commitment. Burt (2001), on the other hand, sees the advantage of weaker ties between individuals especially when seeking work. A person who holds a connecting position between two unconnected groups gets information faster than others. Putnam (2000) distinguishes between bridging and bonding social capital. Bridging social capital refers to inclusive networks and is usually outward looking (e.g. diverse associations) whereas bonding social capital refers to exclusive networks and constitutes homogeneous groups (e.g. professional groups).

The second central dimension of social capital, trust, may be subdivided into two aspects: trust in other people and trust/confidence in institutions (Putnam 1993; Luhmann 1979; Seligman 1997). Trust in other people is usually further divided into generalized trust (Putnam 1993) and particularized trust or trust in familiar people (Uslaner 2002). Put simply, particularized trust exists with known people, whereas generalized trust is an abstract trust in others and is seen as the hard core of the social capital concept. Institutional trust refers to trust or confidence in institutions of governance (Seligman 1997).

Since Putnam's *Making Democracy Work* (1993), a pivotal text with regard to the macro approach of social capital, research on social capital has escalated, not only in the field of political science but also in a broad variety of disciplines including public health (Macinko & Starfield 2001). As mentioned earlier, social capital is usually regarded as a resource on the individual or collective level, although Macinko and Starfield (2001) have proposed that social capital functions on four different levels within public health research. On the macro level, the historical, social, political and economic contexts are important for understanding how social capital is produced. At the neighbourhood or meso level, the focus is on characteristics of the neighbourhoods or communities that may affect social capital. The third level consists of individual level behaviours such

as social participation and cooperation with others. The forth level consists of individual attitudes of psychological characteristics such as trust and confidence.

To date, social capital seems to be associated with a great variety of health outcomes, including individual self-rated health (Hyyppä & Mäki 2001; Kawachi, Kennedy & Glass 1999), individual physical health (Hyyppä & Mäki 2001; Rose 2000), psychological health (McCulloch 2001) and mortality (Kawachi et al. 1997). However, contradictory results have also been published (e.g. Veenstra 2000; Kennelly, O'Shea & Garvey 2003), and some have questioned the value of the concept within health research (Hawe & Shiell 2000). The concept has been criticized to be too vague and difficult to measure and operationalise. Furthermore, the common survey design, cross-sectional studies, does not reveal the casual relationship. However, these empirical and methodological concerns are shared with other areas of social science research. We argue that, in line with Macinko and Starfield (2001), a first step to improve this concept is to clarify on which level we measure and operationalise social capital. Theoretically, individual as well as collective levels are appropriate, but different techniques are used depending on whether social capital is measured on the micro or macro level or on both levels.

Although one challenge in social capital and health research, as we see it, is to disentangle the effect of macro and micro social capital (e.g. Veenstra 2005), individual-level studies can still shed some light on the relationship between social capital and health, especially in rarely studied research groups, like the oldest old. Studying the oldest old means investigating a selected group: the "survivors". One could argue that sociodemographic and psycho-social associations with health outcomes may be weak or non-existent due to prior selection, but contradictory results have been published (Grundy, Bowling & Farquhar 1996; Martelin, Koskinen & Valkonen 1998). Even in the oldest age groups, sociodemographic characteristics as well as psycho-social characteristics are differentiated with regard to health and mortality, which indicate that reducing mortality and increasing health and well-being even in the oldest old is possible.

Issues relating to social capital on an individual level are of particular relevance to the oldest old age group for a number of reasons. First,

social capital constitutes aspects of family relationships, social networks, trust and a sense of belonging, which has been proven to be relevant for older people's everyday life, health and well-being (Bowling 1994; Glass et al. 1997). Secondly, people in the oldest age groups are especially vulnerable to decreasing social networks since they are at greater risk at loosing their spouses and friends, which at the same time makes them more dependent on available social capital at different levels in society (Cannuscio, Block & Kawachi 2003). Thirdly, research that links social capital with health hypothesizes that social capital affects health through various mechanisms, which are of relevance also for the oldest old. The presence of social capital may influence health behaviour, help people to access better resources and services (e.g. medical service) or act as a buffer against stressful events (e.g. loss of a spouse) (Kawachi & Berkman 2000).

Consequently, in this study we examine social capital on an individual level including structural and cognitive components as an important aspect of health research for the oldest old. The objective is to examine if there is an independent association between social capital and multiple measures of health, when taking into account gender and age.

Methods

The study sample

This study was part of the Umeå 85+ study, which is described in detail elsewhere (von Heideken Wågert et al. 2006). A random sample, comprising half of the population born in 1915 (85 year olds), the total population born in 1910 (90 year olds) and between 1897 and 1905 (≥ 95 year olds) living in the municipality of Umeå, Sweden, on the 1st of January, 2000 was selected for participation (N=348). Twenty-nine out of the 348 died before they could be asked to participate. During recruitment, 66 (or their next of kin) of the remaining 319 declined home visits. These 66 were more likely to be younger ($P = 0.008$), married ($P < 0.001$) and to live in ordinary housing ($P < 0.001$). There were no gender differences compared to the studied sample, either in total, or in the three age groups. The final sample studied consisted of 253 participants, 79.3 per cent of the

319 who were asked to participate. The present study consisted of 163 subjects, whose cognitive function, measured by the Mini-Mental State Examination (MMSE) screening function (Folstein, Folstein & McHugh 1975) was above 19 points out of 30. Subjects with only slightly impaired cognition and subjects with rather intact cognition were assumed to be most likely to understand the questions. 41 out of 163 participants, 25 per cent, lived in institutions including service houses care, skilled nursing homes and group dwellings. Assessments were performed during two or three home visits performed by one of four different investigators (two medical students, one nurse and one physiotherapist). All assessments, questions and scales were interviewer administrated and conducted in the same order for all visits.

Measures

Social capital

Social networks, social integration and attachment were designed to measure the structural component of social capital whereas trust and confidence the cognitive component of social capital. Social networks in this study were used to measure family ties or strong ties to other people (Granovetter 1973). Social integration, in turn, taps into what Putnam (2000) calls bonding relationships, whereas attachment reflects strong ties outside and/or within the family (Granovetter 1973). Social networks, social integration and attachment measure behaviour on the individual level, whereas confidence and trust measure individual attitudes, according to the Macinko and Starfield (2001) classification.

Social networks. Respondents were asked about the quality and quantity of their social relationships. Specifically, quantity assessed whether the respondents had living children and siblings. Quality assessed whether respondents had a close friend or family to talk to if needed (yes or no).

Social integration and attachment was assessed using the Revised Social Provision Scale (Cutrona & Russell 1987). The scale was originally developed to assess the four relational provisions identified by Weiss (1973). In this study, two of the provisions were used as two separate

scales: social integration and attachment. According to Weiss (1973), *social integration* is provided by membership in a network of people with similar interests, whereas *attachment* results from relationships that provides emotional security and safety. Social integration and attachment were each assessed by four items, two worded positively and two negatively. Responses were made on a four-point Likert scale ranging from "strongly disagree" to "strongly agree". For scoring purposes, the negative items were reversed and summed together with the positive score to form a score for social integration and attachment (see Appendix One).

Confidence in care-giving institutions. Six questions investigated confidence in care-giving institutions. Respondents were asked about their attitudes towards different institutions, such as home-help service, service houses, health center, nursing homes, facilities for the elderly and medical care. Responses were made on a five-point scale ranging from "very negative" to "very positive".

Trust. The single statement "I trust in people" assessed trust. Responses were made on a five-point scale ranging from "almost not at all" to "almost completely".

Three dimensions of health

We included three measures of health in this study: self-rated health, depressive symptoms and functional ability. These are three important domains of health measures for older people (Smith et al. 2002; Lundberg & Manderbacka 1996), and all three have been shown to have significant social capital outcomes among the adult population (e.g., Kawachi et al. 1999; McCulloch 2001). Functional ability was measured by the Personal and Instrumental Activities of Daily Living index (P-ADL/I-ADL; Katz et al. 1963; Sonn & Hulter Åsberg 1991). Psychological health was measured by the Geriatric Depression Scale (GDS; Sheik & Yesavage 1986) and self-rated health by asking the respondents to grade their general health status. Self-rated health has frequently been used as a proxy for measuring other aspects of physical and psychological health (Manderbacka 1998). The strong association between depression and disability has repeatedly been shown in different studies (Berkman et al. 1986; Ormel et al. 2002).

Functional ability was studied by means of a cumulative scale containing six personal activities of daily living and four instrumental activities of daily living assessed functional health status. The six personal activities of daily living (Katz Index of ADL; Katz et al. 1963) were based on an evaluation of the functional independence or dependence of the individual with regard to following variables: bathing, dressing, going to the toilet, transfer, continence and feeding. The item of continence was excluded from the present study for two reasons. First, continence may be regarded as a physiological function rather than an activity and secondly, to avoid systematical errors in the cumulative activity scale (see Sonn & Hulter Åsberg 1991). Instrumental Activities for daily living (I-ADL) were based on an evaluation of the functional independence or dependence with regard to four variables: cleaning, food shopping, transportation and cooking (Sonn & Hulter Åsberg 1991). Scores of the personal and instrumental activities on the daily living scale ranged from 0 (not dependent in any activities) to 9 (dependent in all activities).

Self-rated health status was measured by responding to the question "In general, would you say your health is excellent, very good, good, fair or poor?". This variable contained five categories, where 1 is the category with the highest health status.

Depressive symptoms were assessed by a 15-item Geriatric Depression Scale (GDS-15; Sheikh & Yesavage 1986), a questionnaire especially developed as a screening instrument for depression in elderly populations. The subjects describe their feelings towards 15 statements such as "Do you feel your life is empty" and "Are you in good spirits mostly?" using a yes/no format. Scores on the GDS ranged from 0 (no depressive symptoms) to 15 (severe depressive symptoms). The cut-off point for depression is 5 (Sheikh & Yesavage 1986).

The following *sociodemographic variables* were examined: gender and age (as of the 2000 interview), marital status (married/cohabiting, never married, divorced or widowed), housing (house/apartment, service house, nursing home or group dwelling) and living circumstances (living together with someone or living alone).

Analysis

Factor analysis (using principal component analysis) with Varimax rotation was employed here in an attempt to determine whether the constructs of social network, social integration, attachment, confidence and trust assessed the two underlying and related dimensions of social capital. Factor analysis is a variable reduction procedure that allows one to explore the interrelationships between variables in a data set. Factor loadings represent the degree of correlation between the variables and a factor. Values range from –1 to +1, with a larger absolute value indicating a stronger contribution of a variable to that factor. Variables that share positive factor loadings all relate to each other in the same direction. A prevalence percentage for social capital was calculated for gender, age group, marital status, housing condition and living circumstances.

Inter-correlations between three dependent variables, self-rated health, GDS and I-ADL/P-ADL, were calculated using Spearman's correlation coefficients. A multivariate analysis of variance (MANOVA) was used to examine the main and interaction effect between gender and age and social capital with the dependent health variables. MANOVA was chosen since it can evaluate multiple mean differences between groups while maintaining the type I error rate constant at 0.05. Multivariate results are reported using Wilk's Lambda, a standard multivariate test statistic. One-way analyses of variance (ANOVA) were performed on the significant main effects, followed by Tukey's Honestly Significantly Different (HSD) testing.

Results

Description of the Sample and Study Variable

More than two thirds were women and 48 per cent of the subjects were in the youngest age category. The majority of the sample (75%) lived in a house or apartment, whereas 23 per cent lived in service houses. Only a few people lived in skilled nursing homes or in group dwellings. Most of the oldest old were widowed (80%) and lived alone (85%).

Table 1 shows the distribution of the health variables for men and women and three age groups. The total self-rated mean scores of 3.4 fell between the response categories "good" (3) and "fair" (4). Most subjects had no depressive symptoms and were independent in all activities or dependent in one or several instrumental activities. Women rated their health worse than men. The health status decreased with increasing age. An exception to this generalization could be found on self-rated health for the age group 95+.

Table 1. Distribution (mean ± SD) of the health variables: self-rated health, GDS and I-ADL/P-ADL

	Range	85-year-olds (N=66)	90-year-olds (N=48)	95+-year-olds (N=41)	Men (N=41)	Women (N=95)	Total (N=136)
Self-rated health	1–5	3.4 ± 0.9	3.5 ± 0.8	3.0 ± 1.1	3.2 ± 0.8	3.5 ± 0.9	3.4 ± 0.9
GDS	1–10	3.4 ± 2.1	3.8 ± 2.2	4.1 ± 2.4	3.2 ± 2.0	3.8 ± 2.3	3.6 ± 2.2
I-ADL/ P-ADL	0–9	1.6 ± 1.8	2.3 ± 1.8	3.3 ± 2.0	2.0 ± 1.9	2.2 ± 1.9	2.1 ± 1.9

Social capital factor

Inter-item correlations (Cronbach's α) were carried out between the original items within each of the four domains: social networks, social integration, attachment and confidence in care-giving institutions. The four summary variables were created by calculating the mean score of items within each domain. The initial step in the factor analysis was to compute a correlation matrix to assess whether factor analysis could be usefully carried out including the summary variables social networks (N=163), social integration (N=147), attachment (N=148, confidence (N=143) and the single item trust (N=96). The matrix showed (Table 2) that neither trust nor confidence significantly correlated with any of the other items. They were therefore excluded from the final model.

One factor with an eigenvalue greater than 1.0 emerged from the factor analysis when social networks, social integration and attachment were included in the model. The Varimax rotated factor accounted for 55 per cent of the total variance. Cronbach's α reliability coefficient of the index was 0.6901, an acceptable level of internal consistency. In Table 3,

Table 2. Correlations between social networks, social integration, attachment, confidence and trust

	Correlations			
Social capital dimensions	2.	3.	4.	5.
1. Social networks	0.3*	0.22*	0.11	0.07
2. Social integration	-	0.46*	0.10	0.08
3. Attachment	-	-	0.12	0.12
4. Confidence	-	-	-	0.12
5. Trust	-	-	-	-

* p<0.01.

the factor loadings and the correlations between the three social capital dimensions are given.

As can be seen in Table 3, social integration and attachment have particularly high factor loadings. Correlations between social networks, social integration and attachment were moderate (0.22–0.46). Hence, these three dimensions were identified as sharing a common underlying factor, which in further analyses is referred to as social capital. Next, the social capital factor was categorized as low (25%), medium (50%) or high (25%) using the inter-quartile as the cut-off point. In Table 4, the distribution of social capital is presented for men and women, age group, marital status, housing and living circumstances.

Table 3. Factor loadings and correlations of the three social capital dimensions

Social capital dimensions	Factor loadings	Correlations	
		2.	3.
1. Social networks	0.63	0.3*	0.22*
2. Social integration	0.82	-	0.46*
3. Attachment	0.78	-	-

* p<0.01.

Table 4. Distribution (%) of social capital by gender, age group, marital status, housing and living circumstances

	Low social capital	Medium social capital	High social capital
Gender			
Men (N=42)	26	55	19
Women (N=105)	24	52	24
Age groups			
85 (N=70)	17	54	27
90 (N=52)	27	56	17
95+ (N=55)	36	44	20
Marital status			
Married/cohabiting (N=19)	16	79	5
Widowed (N=118)	26	47	27
Divorced/never married (N=10)	20	80	0
Housing			
House/apartment (N=111)	21	52	27
Service house/nursing home/group dwelling (N=36)	36	56	8
Living circumstances			
Together with someone (N=21)	10	81	9
Alone (N=126)	27	48	25

The social capital distribution differed along the sociodemographic lines. More women, subjects in the age group 85 and those living in a house or apartment belonged to the high social capital group. The distribution of social capital with marital status and living circumstances revealed that

being married or living together with someone did not automatically result in high prevalence of social capital.

Structural social capital and health

To address the research question examining the relationship between social capital and health, a multivariate analysis of variance (MANOVA) was run. First, inter-correlations between the dependent variables self-rated health, GDS and I-ADL/P-ADL were calculated using Spearman's correlation coefficients (Table 5).

The results revealed that there was a statistically significantly inter-correlation between the health variables, which supports the use of MANOVA to test the association between social capital and health.

Age and gender play central roles in health issues (Arber & Ginn 1993). Therefore the MANOVA was run with social capital, age (age groups 85, 90, 95+) and gender as independent variables and self-rated health, GDS and I-ADL/P-ADL as dependent variables without covariates. The multivariate F was significant for the main effect of age (Wilk's lambda F (6, 226) = 2.406, p = 0.028) and social capital (Wilk's lambda F (6, 226) = 3.426, p = 0.003), but not for the main effect of gender (Wilk's lambda F (3, 113) = 2.589, p = 0.056). No interaction between the independent variables was significant. Having established the overall multivariate significance of this model, each dependent measure was submitted to a univariate analysis of variance (ANOVA) to determine its individual contribution to the multivariate significance.

Table 5. Correlations between all predictors, N=136

	GDS	I-ADL/P-ADL
Self-rated health	0.43**	0.16*
GDS	-	0.18*
I-ADL/P-ADL	-	-

*p<0.05, **p<0.001.

A series of univariate F tests revealed that age was associated with I-ADL/P-ADL, and social capital with GDS (Table 6).

As can be seen in Table 6, age was a significant variable for functional ability. Tukey's HSD tests revealed that there was a significant

Table 6. Univariate ANOVAs of self-rated health, GDS and I-ADL/P-ADL by age and social capital

	SS	df	F	p
Self-rated health				
Age	1.11	2	0.69	0.51
Social capital	5.11	2	3.19	0.06
GDS				
Age	6.55	2	0.80	0.46
Social capital	63.45	2	7.69	0.00
I-ADL/P-ADL				
Age	43.12	2	6.64	0.00
Social capital	4.94	2	0.76	0.47

difference in P-ADL/I-ADL between the youngest and oldest age group (M 85 = 1.83 versus M 95+ = 2.37). Social capital was a significant variable for GDS, which was also illustrated in Table 6. Post hoc analysis using Tukey's HSD test showed that there was a significant difference in GDS between the low, medium and high social capital groups. (M low social capital = 4.58, M medium social capital = 3.56, M high social capital = 2.70).

Discussion

Our initial objective was to examine the relationship between social capital and health in the oldest old. The results lend some support to the view that the structural component of social capital measured on an individual level is associated with depressive symptoms, but not with self-rated health or functional ability. The association of social capital with multiple health measures was tested with multivariate and univariate analysis of variance (MANOVA, ANOVA). MANOVA tests the effect of social capital on the mean scores of the combined distribution of the outcome variable, which means that three health variables were examined simultaneously. In the ANOVA analysis, age was associated with functional ability and social capital with depressive symptoms.

Social capital in the oldest old

Since the Umeå 85+ study was not originally designed to measure social capital, we had to construct a social capital factor to be used in the analysis. We included in this study structural components such as social networks, attachment and social integration as well as cognitive components such as confidence in care-giving institutions and trust measured on an individual level (Macinko & Starfield 2001). Trust and confidence, the cognitive aspect of the concept did not fit in the final-factor model.

A common assumption is that the cognitive aspect of social capital, such as trust and confidence, is a part of the concept, although different approaches have been established (Fukuyama 1999; Woolcock 2001). Fukuyama (1999) sees trust as a key by-product of social capital and not as a central part of the concept, whereas Woolcock (2001) refers to social capital as networks and norms that facilitate collective action and trust as an outcome. This would indicate that the structural and cognitive components of social capital do not always go together, which may explain our finding.

It is generally assumed that social capital indicators measure the same thing in different groups and places. However, research has demonstrated that there are marked differences in the questions about social capital that are considered appropriate for various groups depending, for instance, on the subjects' age (Cattell & Herring 2002). Traditionally social capital measures like membership in organizations and civic engagement are likely to diminish with increasing age and decreasing functional status (Bukov, Maas & Lampert 2002; Strain et al. 2002). The cognitive aspect of the concept, such as trust and confidence, may take different forms for the oldest old than for a less dependent and vulnerable age group (Mechanic & Meyer 2000). It is apparent that these types of questions are context related. Networks, support and trust are important with a decreasing health status, although the interaction may take a different form from younger age groups, especially when we note that the oldest old usually have lost their spouses and most of their friends in the same age group. For the oldest old, the structural aspect of social capital probably reflects current living conditions, while trust and confidence reflect attitudes and individual traits often acquired decades ear

lier, which would support the idea of social networks and trust as separate parts of social capital.

Since social capital is produced and maintained through contacts with others (Putnam 1993), we may hypothesize that social capital was generated in earlier years and the oldest old benefit from the return of social capital during their old age. We have to consider that we are studying a selected group, "the survivors". Due to prior selection, the older persons in this study have already been affected by social capital, which may explain the distribution of social capital by marital status and living circumstances in Table 4. For the oldest old, the influence of those widowed or living alone on social capital may be different from younger age groups. Consequently, this would indicate the need for a different approach when measuring social capital in the oldest old. To compare social capital with younger age groups or to investigate one's cohort and the social history through which they have lived is thus crucial for measuring social capital in a selected age group who, in a way, have aged successfully.

Social capital as a health resource

In this study we used different dimensions of self-reported health. In previous research, social capital has been associated with self-rated health, functional ability and psychological health (Hyyppä & Mäki 2001; Kawachi, Kennedy & Glass 1999; Rose 2000; McCulloch 2001). Of these three health measures, self-rated health is the most commonly assessed in health research since it measures overall health including functional and psychological health (Manderbacka 1998). Social capital and multiple measures of health research have provided evidence that social capital has different effect by the indicator of health (Lindström 2004; Pollack & Knesebeck 2004). This indicates that the mechanism between social capital and health may vary with respect to different states of health, which is an important notion with regard to health improving policies.

Structural social capital was found to contribute to depressive symptoms, which is consistent with previous research (McCulloch 2001). Unsurprisingly, structural social capital, including social networks, plays a significant role in psychological health. Studies have shown that individuals with strong social ties and networks are in better psychological

health (Dean, Kolody & Wood 1990; Grundy & Sloggett 2003), and that psychosocial stress factors like rare contact with one's family may affect the development of depression among the oldest old (Päivärinta et al. 1999). Our findings in this study showed that particularly people living in institutions belonged to the medium or low social capital group (Table 4). They experience a decreased network, are less socially integrated and are less attached to another person, which could put them at greater risk to develop depression.

An unexpected finding was the non-significant association between social capital and self-rated health. If we regard self-rated health as a measure of overall health, it would be logical to assume that social capital would relate to depressive symptoms as well as to self-rated health. One reason why this may not be the case for people in the oldest old age range is that research has revealed that older people self-rated their health more positively than objective evidence would suggest (Johnson & Wolinsky 1993; Leinonen, Heikkinen & Jylhä 2001). The Geriatric Depression Scale (GDS) in turn, which we used as a measure for current depressive symptoms, has been proven to be a reliable and valid scale for elderly people with regard to diagnosed depression (Yesavage et al. 1983). This would indicate the importance in using several health measures in research among older people in order to create a comprehensive picture of their health status (Smith et al. 2002).

Quite unexpectedly, gender was not associated with different health outcomes. Only age was significantly associated with functional ability, which is well known in this age group (e.g. Harris et al. 1989). One reason why age had no indirect or direct relation to depressive symptoms may be due to the restricted age range of the sample. Comparisons with the young old might show increased psychological ill-health with advancing age (Kessler et al. 1992). Another plausible reason may be the use of antidepressants among the participants (von Heideken Wågert et al. 2006). Previous studies on the total sample showed high prevalence, especially in the age group 90-year-olds, of those prescribed antidepressants.

It is important to address two limitations of this research. First, this study was cross-sectional and confined to one point in time, thus we have no information about causal relationship between social capital and health. A decline in social capital may not only be a predictor of deterio

ration in health, it may also be a consequence of deterioration in health. Secondly, while the sample consisted of the oldest old whose MMSE screening points were above 19, the generalizability of our finding to older people in general might be limited. We excluded the severely cognitive impaired, which meant more than one third of the study sample from the analysis to receive higher reliability.

Conclusion

The new feature this paper has brought to light is an understanding of the relevance of individual social capital as a resource in the oldest old. Based on our findings, we conclude that structural social capital, i.e. social networks, social integration and attachment, is a relevant resource for the oldest old, especially with regard to depressive symptoms, but a different approach when measuring social capital for this age group has been suggested. The oldest old may have had a high level of social capital, but our study cannot identify this statistically. Conducting a longitudinal study or including retrospective questions about the subjects' life history, despite the risk of a lower reliability would be a fruitful line for future research, as well as including multiple levels of social capital. Clearly, more comprehensive research with a focus on social capital is needed to capture the meaning and outcome of social capital in the life stage of the oldest old.

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Appendix

The four statements assessing *social integration:*

I feel I am part of a group of people who share my attitudes and beliefs.
There are people who enjoy the same social activities as I do.

There is no one who shares my interests and concerns.
There is no one who likes to do the things I do.

The four statements assessing *attachment:*

I have close relationships that provide me with a sense of emotional security and well being.
I feel a strong emotional bond with at least one other person.
I feel that I do not have close personal relationships with other people.
I lack intimacy with any other person.

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Anne Leonora Blaakilde (2005). *Livet skal leves – forlæns, baglæns og sidlæns* [Life shall be lived – forwards, backwards and sideways]. Gyldendal, 272 pp. ISBN 87-02-02593-0

REVIEWED BY KARIN LÖVGREN

The cultural gerontologist Anne Leonora Blaakilde's popular science book *Livet skal leves – forlæns, baglæns og sidlæns* consists of a number of interviews on life course and ageing. The life course is like a journey, she writes, her interviewees tell of their respective journey and how they perceive societal norms on ageing, and a prescribed timetable for the normal and normative life course. The interviews are interspersed with Blaakilde's summing up and reflections on different life course phases and on what ageing can mean in cultural and social terms.

The interviews with Danes are with a number of persons, from a 17 year old student to the oldest, in her nineties. In other words, a chronology from young to older is followed. Some of the people interviewed are well known in Denmark: an actor, a politician, a journalist, an author for example.

The interviews focus on where in life the interviewed is and what he or she thinks about age, life experience and ageing. They are asked to reflect forward, what expectations they have for life, as well as backwards, how life has shaped itself. Here, and in the book's title a quotation from the Danish philosopher Sören Kierkegaard is alluded to: life can only be understood looking back but has to be lived forwardly.

The book is addressing an interested general public, it contains no scientific jargon, and all scientific terms are explained in plain Danish. Blaakilde invites the reader to reflect on age-related expectations and age norms, generational and cohort experiences.

It is striking that all the interviewees are satisfied with their own lives, mature and in balance they look back on their lives without bitterness or regret; increasing age has given them experiences that

have allowed them a soothing distance to what others may think of them. With confidence they reflect on the future. Where is all the hesitation and doubt? Where are reflections on wrong choices at the cross-roads of life, the feeling that if I had done this, or had the opportunity to do that, life would have evolved differently? With a smile even the random ageist attitudes encountered are commented.

As an underlying current in Blaakilde's intersecting texts is a notion that thirty-five, forty is an inexplicitly expressed age boundary at which, to quote the author, the count-down commences and one is perceived as being older in Danish society. With common sense, the interviewed are reflecting on this without any one of them appearing to be affected in any way by a, as the Danish expression formulates it, köreplan, timetable where they have missed the train and got stuck at the station. Perhaps this has to do with the genre and outline of the book: friendly questions and answers, without ever getting heated. "All my dreams have come true", is a quotation also forming the heading of a chapter.

Perhaps there is also a connection with an underlying agenda of Blaakilde's. She wants to rouse an interest for issues regarding age and ageing as a perspective, how we culturally define ageing, and show the rich experiences that can come with age, perhaps in dialog with a perceived ageist environment. The age course is represented as a funnel in inverse proportions with fewer opportunities with increasing age, writes Blaakilde, and perhaps as a rejoinder to this conception all the interviewees get to convey and mediate such nuanced mature and positive accounts of ageing.

This though, gives an impression of oversimplification, plucky pleasantness. Not even the surroundings, the social structures the agent has to act within and negotiate, is described and conveyed as hindrances in the staging of a good life and dreams come true. The life course becomes upwards, forwards, onwards.

At the same time Blaakilde's text is distanced from this benevolent picture of ageing. The social timetable of society has a built-in default, that we should have reached completion by the age of thirty-five. We do not believe in fresh ideas and new approaches in people over thirty-five, we are neofil as never before, we worship the new as equivalent with the best, she writes. Today, age matters far more then ever, states Blaakilde.

We focus more on exact chronological age than previously and this exposes people to an age stress tied to expectations and norms of what to have achieved at a certain age, and most importantly, before thirty-five. The linkage of new and young as contrast to old reflects a depreciating attitude to elderly.

One of the books benefits is its authorial voice, the reflexive tone Blaakilde adopts; that she doesn't hide behind academic jargon or choices of word that would exclude the layperson. Her interlacing text parts are inviting, openly formulated thoughts, putting perspective on what age and ageing can mean in our society, and here the author invites a broader public to ponder on gerontological issues.

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Merryn Gott (2005). *Sexuality, Sexual Health and Ageing*. Berkshire: Open University Press, 176 pp. ISBN 0-335-21018-X (pbk).

REVIEWED BY EVA REIMERS

In the twentieth book in the Rethinking Ageing series, *Sexuality, Sexual Health and Ageing,* Merryn Gott presents a critical and challenging discussion concerning sexuality and ageing.

The book consists of three parts. The first part explores two stereotypes, or 'myths' concerning sexuality and older age. These are the 'asexual old age' and the 'sexy oldie'. The second part consists of a critical account of available literature on sexuality and old age, plus a presentation of a qualitative study of older people's views on sexuality. The third part presents studies on the meaning of 'sexual health' within the context of ageing from the perspective of professionals working with older people.

The first part, which to my mind is the most thought-provoking and interesting part, is predominantly theoretical and forms a background to the other two more empirical parts. By deconstructing the two contradicting stereotypes, the asexual old age and the sexy oldie, Gott discloses the intersection of notions concerning sexuality, biology, medicine, normality, health, age and youth. She convincingly asserts that the discussion about sexuality and sexual health in later life strongly enforces a medicalised discourse and that it rests firmly upon a heterosexual norm. When sex is understood to be equivalent to heterosexual intercourse, other forms of sexuality and intimacy become obscured. She furthermore elucidates the connection between sexuality, health and youth. The dominance of the medical discourse has encouraged a notion of old age as equivalent to being unhealthy or dependent. This means that youth and health are linked to each other. To be young is to be healthy; to be old is to be unhealthy. Furthermore,

sexuality and youth are linked. According to Gott, this is part of the reproductive emphasis in the notion of sexuality that, despite effective contraceptives and test tube babies, has encouraged judgements about sexualities based on a reproductive norm. To be sexy, and sexually active, is, according to the dominant notion, therefore a sign of youth, and as Gott writes "deep old age is never sexy".

In a time when society is permeated by images and notions concerning the value of keeping a fit and able body, bodily signs of ageing run a risk of becoming a marker of individual failure to maintain a youthful body. Resisting old age hereby has become a demand, and old age is presented as something, which can be avoided by lifestyle choices and consumerism. Part of this is, according to the dominant discourse, to be sexually active. This view is, according to Gott, founded on a notion that sexuality is biologically determined and deeply rooted in every individual. To have sex is therefore seen as natural for every person, and not having sex is perceived as unnatural, and even unhealthy. There is consequently a link between sexual activities as something natural and sex as something healthy. Furthermore, the link between sex as a sign of youth makes sexual activity an antidote against old age. Sex is regarded as an activity of the young and healthy. The stereotype of the asexual old age therefore becomes a means of labelling older people as unhealthy, unproductive and dependent, and in addition partly responsible for their position. Even if the seemingly opposite stereotype of the sexy oldie could be expected to contradict this, Gott shows that it reiterates the same fundamental norms as the asexual old age. The image of the sexy oldie is founded on an assumption that sexual function is a primary component of successful ageing. According to Gott, the medical community and pharmaceutical companies have a part in this discourse, especially in defining the right to sexual fulfilment as matter of public health. It is a discourse that presents being sexually active both as a human right and as a means to promote and demonstrate a meaningful life. Gott delineates five pillars on which the notion of the sexy oldie, are built. These are: "(1) sexuality is fundamental to healthy ageing; (2) sexual intercourse represents the sexual 'ideal' for older people; (3) expressing sexuality is about expressing love and is always a positive (and overwhelmingly heterosexual) experience; (4) ageing can, but need not

cause sexual dysfunction, which can be 'fixed' by medical intervention, and (5) to be sexually active at any age you have to conform to a youthful notion of beauty (particularly if you are a woman)." (p.25). A case is made for the need for adults to be sexual in order to stay young. The sexy oldie hereby becomes equivalent to an older person who has resisted old age by remaining sexually active. A pertinent illustration of this is that older people (women) can be sexy only if they do not look their age. Gott maintains that the stereotype of the sexy oldie is ambivalent; on one hand it might inspire older people to affirm sexual lust into old age, on the other it might shut off the exit to a relentlessly sexualised world that old age might offer.

In the second part of the book Gott employs the deconstructive perspective outlined in the first in order to discuss some influential studies about sexuality and old age. She demonstrates how these studies reiterate a biological and heterosexual bias. In assessing whether or not people are sexually active, sexual activity is equated with heterosexual intercourse. They also presume essential gender differences and that sex is healthy. Gott stresses the importance of recognising that older people do not necessarily equate sex with intercourse, and that satisfying or fulfilling sexual functioning therefore can, and ought to, be understood as more diverse than heterosexual intercourse. The findings of the presented studies erase the relational context of sexuality and ignores that it is intimacy, not erection that lies at the root of sexual satisfaction. As an alternative to generalized survey studies Gott presents a qualitative study on how older people themselves describe their sexuality. As expected, the result evinces a much more diverse picture, where sexuality is more seen as an option than as a necessity.

The last part of the book presents studies about how medical practitioners describe sexuality and old age. Several of the basic tenants in the field that are presented in the first part of the book are here found to serve as a foundation also in this context, especially those that are connected to the asexual older person, with the result that sexual function becomes equated with the ability to perform heterosexual intercourse and sexual health is understood as a concern only for younger age groups. This means that medical practitioners do not regard older people as subjects for information regarding STI, and therefore

avoid given older patients information about how medication might influence sexual lust, and that signs of sexual abuse might be neglected.

I have found the book both thought-provoking and interesting and I recommend it to anyone who has some interest in the field. In the introduction Gott writes that her intention is not to prove that older people are nor should be sexual, but to open up this area for debate. I think she has succeeded in this endeavour.

IJAL

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The International Journal of Ageing and Later Life (IJAL) serves an audience interested in social and cultural aspects of ageing and later life development. The title of the journal reflects an attempt to broaden the field of ageing studies. In addition to studies on later life, IJAL also welcomes contributions focusing on adult ageing as well as relations among generations.

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