International Journal of Ageing and Later Life

Volume 3, No. 1, 2008

IJAL

International Journal of Ageing and Later Life

Volume 3, Issue 1, 2008

Published with the support of the Swedish Research Council (Vetenskapsrådet, 423-2007-7691)

Linköping University Electronic Press

ISSN 1652-8670 (www)
URL: http://www.ep.liu.se/ej/ijal/

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International Journal of Ageing and Later Life, 2008 3(1): 5–19. © The Authors

The interface between formal and informal support in advanced old age: a ten-year study

By FRANCA ARMI, EDITH GUILLEY & CHRISTIAN J. LALIVE D'EPINAY

Abstract

The aim of this paper is to investigate the interface between the formal and informal support provided to very old people against a background of increasing need for care and a decreasing number of potential informal caregivers. We used a sample of 323 community-dwelling octogenarians participating in the Swiss Interdisciplinary Longitudinal Study on the Oldest Old (SWILSOO) ($n = 1441$ interviews). Descriptive analyses and a multilevel model were used to test whether formal and informal services complemented or substituted one another. The study revealed that the amount of informal services increased significantly as the frequency of formal aid increased, indicating that the two networks were complementary in the majority of the cases. In 21.2% of the cases, the formal network partly substituted the informal network (as an adjustment) and only in 6.4% of the cases did the informal support end after the formal support had increased (radical substitution). The concern that the introduction of formal services may curb the readiness of relatives and friends to provide care is thus unfounded.

Keywords: social support, longitudinal study, oldest old, formal care, informal care.

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Background

Since the 1980s, the relationship between formal and informal support networks has been widely studied. Nevertheless, how the two networks coexist continues to present researchers with numerous conceptual challenges. Various theoretical models have been devised to describe the interface between formal and informal services (cf. Davey & Patsios 1999; Travis 1995; Vézina & Membrado 2005). The *substitution* model hypothesizes that formal services replace part of the support provided by informal networks. It thus implies a negative correlation between the evolution of formal and informal services. According to the substitution model, the introduction of formal services may prompt relatives and friends to curtail their informal caregiving efforts and curb their feeling of responsibility for care. In contrast to the substitution model, the *complementary* and *supplemental* models hypothesize that the introduction of formal services does not induce a significant drop in the amount of services provided by the informal networks. By applying a task-oriented approach, the latter two models can be differentiated: in a complementary arrangement, one given task is performed by both networks while in a supplemental arrangement, some tasks are performed by both networks while others are specifically performed by one or other network. Lastly, the *hierarchical compensatory* model details older adults' hierarchical preference for assistance. Elderly people are more likely to look first to spouses, next to adult children, then to other relatives and friends, and finally to formal services for support. The last-mentioned generally come into play solely when no informal network is available (Cantor 1979).

Previous studies on the relationship between formal and informal networks relied mainly on cross-sectional data (e.g. Davey & Patsios 1999; Penning 2002; Sundström et al. 2006). While cross-sectional studies are very informative with respect to care utilisation differences between individuals, only longitudinal data can throw light on the effect of changes in the formal network on the amount of informal social support. In order to study the interface between formal and informal networks, longitudinal data are thus required. Furthermore, the previous studies mentioned above were essentially devoted to the younger elderly. For this population, empirical evidence of the substitution hypothesis was seldom documented (cf. for instance, Logan & Spitze 1994). The substitution was found to occur

only over the short term (Tennstedt et al. 1996), and therefore tended to be temporary. To our knowledge, no study has examined the formal–informal interface specifically among a very old population. This population needs more assistance with personal care than the younger elderly, and therefore lends itself to a study of the relationship between formal and informal networks. Cases of substitution may be more frequent in a very old population when contemporary caregivers are also very old and are likely to have assumed the role of caregiver for a long time.

Aim

Our objective was to investigate the formal–informal interface in the context of an increasing need for care and a decreasing number of potential informal carers, within a population of Swiss octogenarians monitored over a period of ten years. In other words, we wanted to see how help from informal networks evolves when the utilisation of formal services increases. We tested the following three models: (1) *complementary*: the increase in formal support is associated with an increase in, or stability of, informal support; (2) *substitution as an adjustment in the informal network*: the increase in formal support is associated with a relative decline in informal aid; and (3) *radical substitution*: the increase in formal support is associated with the disappearance of informal aid. It was impossible to differentiate the complementary model from the supplemental model because we did not ask who provided help with each of the tasks considered.

Methods

Participants

The Swiss Interdisciplinary Longitudinal Study on the Oldest Old (SWILSOO) is a study covering the fields of sociology, social medicine, social and cognitive psychology, and econometrics (e.g. Guilley et al. 2005). The initial sample comprised 340 community-dwelling persons aged between 80 and 84 years. Participants were randomly selected from the lists of octogenarians of the State Offices of Population living in the canton of Geneva (an urban area) and in the central Valais (a semi-rural

area) in Switzerland. The sampling frame was stratified at baseline by geographical area and gender. Participants were interviewed up to nine times (i.e. nine waves) on an approximately yearly basis (every 12 or 18 months) over a period of ten years (from 1994 to 2004). Analyses were limited to the 323 participants who provided sufficient data for computation (see Table 1 for the number of participants at each wave). The octogenarians answered a trained interviewer, either in person or, if unable to do so, through a proxy (the proportion of proxy reports ranged from 8.7 to 26.2% in the course of the study period). After the ten-year period, there were 59 (18.3%) surviving participants (of whom 45 were still community-dwellers) and 37 (11.4%) surviving dropouts, while 227 (70.3%) of the original participants had died.

Measures

We defined informal support as the help received from family members and friends and/or acquaintances, excluding help received from household members. Two series of questions assessed the frequency of six instrumental aids[1] that the very old person received from such sources. A choice of four possible answers was given: 'never', 'rarely', 'sometimes', and 'often'. All community-dwelling participants were questioned. For the formal network, which is provided by subsidized or fee-paid professionals, a series of six types of service[2] was put to all community-dwelling

1 Performing household tasks; bringing or preparing meals; doing the shopping; doing repairs, odd jobs and gardening; help with completing income tax returns and insurance claims; help with toilet activies.

2 Care from a nurse; help from a household/family helper (with everyday tasks such as housework, washing, shopping, preparing meals, and going to see the doctor); counselling from a social worker (e.g. to help complete formalities, fill in forms, apply for aid from other agencies, manage his/her money); home-delivered meals; day-care or voluntary centres; help from an association. (Various associations such as Pro Senectute offer services to older people. The associations' staff and volunteers deliver such services as social counselling, the provision of practical information, and assistance in arranging home help, and in addition make available a range of suitable activities.) The services most used were household/family helper and care from a nurse.

Table 1. Number of interviews with the community-dwelling participants across the nine waves of SWILSOO

	Waves									Total
	1	2	3	4	5	6	7	8	9	
Self-respondents	295	224	190	162	124	99	75	51	42	1262
Proxy respondents	28	27	29	28	29	16	10	9	3	176
Total	323	251	219	190	153	115	85	60	45	1441

participants, with six possible answers: 'never', 'rarely', 'every month', 'every two weeks', 'once a week', 'every day'. Those questions enabled us to construct frequency scores for each of the three networks (family, friends and formal) by averaging out the different answers given. The mean frequency scores for family members and for friends and/or acquaintances were merged to obtain a score for the non-household informal services.

The formal–informal care interface was analyzed with controls of potential confounding factors such as socio-demographic variables, need factors, and household and informal network composition.

- The socio-demographic variables used were age, gender, geographical area (urban or semi-rural area) and socio-economic status (working-class or middle/upper-class). Socio-economic status was assessed as a composite of education, income and socio-occupational categories.
- Need factors were assessed by means of a three-tier health status: ADL-dependent, ADL-independent frail, and robust. A participant was considered ADL-dependent if he/she was unable to perform alone at least one of five activities of daily living (washing, dressing and undressing, eating, rising from and going to bed, and moving from one room to another) (cf. Katz et al. 1963). Participants having no ADL incapacities but suffering from two or more deficiencies in five health domains (sensoriality, mobility, memory, energy and physical ailments) were considered ADL-independent frail; participants without ADL incapacities and with less than two deficiencies in the above-mentioned health domains were considered robust (for more details, see Guilley et al. 2008). SWILSOO publications had

already demonstrated that each health status was associated with a specific 'everyday life-world' (specific well-being, social activities and relationships as well as different risks of adverse health outcomes) (Lalive d'Epinay & Guilley 2006).

- Although this paper deals with the services provided by non-household caregivers, the household composition (living or not with a cohabitant) was taken as a control in the analysis of the formal–informal care interface.
- Finally, the composition of the informal network was assessed by means of standard questions about the existence of living siblings, descendants (children, grandchildren or great grandchildren), and close friends.

Plan of Analysis

Before analyzing the interface between the two networks, we assessed how the need for care and the composition of the informal network evolved over the study period. Multilevel analyses were used to assess the relationship between (a) the need for care or the composition of the informal network and (b) the age of participants. The regression coefficients (β) indicate whether the need for care or the percentage of persons having potential caregivers increases ($\beta > 0$), decreases ($\beta < 0$) or stays the same (β not significantly different from zero) across the study. Analyses were performed on 323 participants (representing 1441 interviews across the nine-wave follow-up). Multilevel analyses were developed for the purpose of analyzing data with multilevel sets (e.g. repeated measures within an individual). They allow the use of repeated measures where both the number of interviews per participant and the time intervals between interviews vary. Furthermore, multilevel analyses can tolerate an incomplete data set because they use all available data (instead of restricting the analysis to individuals who participated in the nine waves of the study) and therefore limit the selectivity effects (Raudenbush & Bryk 2002; Snijders & Bosker 1999).

Subsequently, we tested whether formal and informal networks substitute one another or are complementary. We evaluated the relationship between the frequencies of formal and informal care using a multilevel analysis on 1441 interviews controlled by socio-demographic variables,

need factors and the composition of informal networks. The substitution model implies a negative relationship between formal and informal services, while an insignificant or positive relationship is expected in the complementary model. Age (centered on its grand mean), household composition, variables on the presence of an informal network, health status and the frequency of formal care were included as level-1 time-varying predictors, and gender, socio-economic status, and geographical area as level-2 time-invariant predictors. Multilevel models were fitted by the method of restricted maximum likelihood using HLM version 6 (Raudenbush et al. 2004) and results were reported with a robust estimation of the standard errors.

Work carried out previously was useful in assessing the relationship between the amount of informal and formal supports with control of variables, but it provided only general information on the formal–informal care interface. To clarify this interface we adopted a different approach: we examined the proportion of interviews (one individual can be represented more than once) whose pattern of support was consistent with each theoretical model of formal–informal interface. To assess the exact percentage of cases falling into the categories of complementary (increase or stability of the informal network), substitution as an adjustment or radical substitution, we used the following analysis. When the frequency of formal services increased at two successive waves (i.e. periods between waves 1–2, 2–3, and so on), we counted the number of cases for which the frequency of informal services simultaneously (a) increased, (b) stayed the same, (c) decreased, or (d) ceased. This analysis was limited to 236 interviews (those for which one of the two networks was lacking and those presenting no increase in formal help were thus excluded).

Results

Table 2 reports the characteristics of the sample and Table 3 their evolution over the ten-year period. While 60.8% of the participants lived with a cohabitant at baseline, this percentage fell during the study, illustrating the growing number of single people in need of non-household care. The vast majority of very old participants had the benefit of a potential informal network (97.5% at baseline had at least one potential caregiver: a

Table 2. Characteristics at baseline ($n = 323$)

	n (%)*
Household composition	
Lives with a cohabitant	194 (60.8)
Potential informal network	
Has at least one descendant	263 (81.4)
Has at least one sibling	227 (70.7)
Has at least one close friend**	213 (73.2)
Need of care	
Is robust	126 (39.1)
Is ADL-independent frail	166 (51.6)
Is ADL-dependent	30 (9.3)

*Percentages are given for subjects without missing values.
**Only self-respondents included.

descendant, a sibling or a close friend). However, the network composed of siblings and friends, who were likely to be the participants' contemporaries, shrank over the period. In parallel to those changes, the need for care increased. At baseline, only 9.3% of the persons interviewed were

Table 3. Evolution across the nine SWILSOO waves ($n = 1441$ interviews)

	Evolution across the nine waves†: β (*SE*)
Household composition	
Lives with a cohabitant	–0.05 (0.02)**
Potential informal network	
Has at least one descendant	0.01 (0.01)
Has at least one sibling	–0.09 (0.02)***
Has at least one close friend‡	–0.07 (0.02)**
Need of care	
Robust versus ADL-independent frail	–0.12 (0.02)***
DL-dependent versus ADL-independent frail	0.19 (0.03)***

*$p < 0.05$, **$p < 0.01$, ***$p < 0.001$.
†β: unstandardized regression coefficient between the characteristics listed and the age of participants estimated by multilevel analyses.
‡Only self-respondents included.

ADL-dependent, 51.6% were ADL-independent frail, while 39.1% were still robust in spite of their age. During the study period, the proportion of robust individuals fell sharply while that of ADL-dependent subjects rose.

Table 4 shows how the help provided by non-household informal services evolved in relation to changes in formal help, with controls for socio-demographic variables, need factors, and household and informal network composition. As could be expected, having one or more descendants substantially increased the frequency of the informal services. Persons living with a cohabitant – who, when present, is often the principal caregiver – received fewer services from the other caregivers. Irrespective of their living arrangements, women were better provided with informal care.

Table 4. Frequency of non-household informal services as a function of the frequency of formal care and controls: multilevel analysis ($n = 1441$ interviews)

	Unstandardized regression coefficient β (SE)
Socio-demographic factors	
Age (years)	0.00 (0.00)
Gender (woman)	0.06 (0.03)*
Socio-economic status (middle/upper-class)	–0.05 (0.02)*
Geographical area (urban)	–0.10 (0.02)***
Household composition	
Lives with a cohabitant	–0.10 (0.03)**
Potential informal network	
Has at least one descendant	0.11 (0.02)***
Has at least one sibling	0.01 (0.02)
Has at least one close friend	0.00 (0.01)
Need of care	
Robust versus ADL-independent frail	–0.02 (0.02)
ADL-dependent versus ADL-independent frail	2.01 (0.10)*
Age*ADL-dependent	–0.02 (0.01)*
Formal network	
Frequency of formal care	0.08 (0.02)***

*$p < 0.05$, **$p < 0.01$, ***$p < 0.001$.

The region of residence and the socio-economic status were also determining factors in receiving informal services: persons living in the urban area and persons in the middle and upper socio-economic groups received fewer services. ADL-dependent participants received more informal services than ADL-independent frail persons, who received an amount of services similar to robust persons (previous work has shown that, without controlling for frequency of formal care, persons having different health statuses received different amounts of help, at least among younger old participants). In contrast, the frequency of aid offered by the informal network was the same for both ADL-independent frail and robust persons, at a fixed frequency of formal care. The results also showed that on average the amount of informal services rose in line with increasing frequency of formal aid, thus lending weight to the complementary model. For the oldest ADL-dependent participants, the relationship between formal and informal networks remained positive but was less marked.

As the above analysis yielded only general information on the formal–informal care interface, we assessed the proportion of cases whose pattern of support was consistent with the complementary and substitution (radical or as an adjustment) models. Table 5 presents the changes in the frequency of informal services between two successive waves when the frequency of formal services increased. A greater use of formal services was associated with increased informal care in 47.0% of the interviews, with unchanged intensity of informal care in 25.4% of the interviews, with less extensive informal care in 21.2% of the interviews, and with cessation

Table 5. Changes in the frequency of informal services between two successive waves when the frequency of formal services increases, number of interviews (%)

Changes in the frequency of informal services between two successive waves	*Complementary*	
	Increase	111 (47.0)
	No change	60 (25.4)
	Substitution as an adjustment	
	Decrease	50 (21.2)
	Radical substitution	
	Cessation	15 (6.4)

'Successive waves' means periods between waves 1–2, 2–3, and so on.

of informal services in 6.4% of the interviews. The two networks were hence complementary in 72.4% of the interviews, and the formal network substituted (radically or as an adjustment) the informal network in 27.6% of the interviews.

Discussion

This study, based on data obtained by monitoring a sample of octogenarians over a period of 10 years, was mainly motivated by the following question: in parallel to an increasing need for help and a dwindling number of potential informal helpers, does the help provided by formal services partly replace the informal support? We found that formal and informal supports were on the whole positively related, thus lending weight to the complementary model. By testing three models (complementary, substitution as an adjustment, and radical substitution), we found that the formal and informal networks were complementary in the majority of cases (72.4%). Our results are in harmony with most previous research based on younger old persons, which demonstrated that formal and informal networks were complementary resources (e.g. Davey & Patsios 1999; Denton 1997; Penning 2002). We showed further that additional needs were catered for by formal networks in 25.4% of the cases and by both networks in 47.0%. However, the formal network substituted the informal services in 27.6% of the cases. In 21.2% of the cases, there was an adjustment and only in 6.4% of the cases was there a radical substitution. In the cases of adjustment, the reduction of the informal services was probably a sign that an elderly parent who had become more severely impaired needed professional care which could no longer be provided by the relatives. Indeed, the informal network tends to continue caring for old persons as long as it is capable of doing so, with formal networks coming into play essentially when professional skills are necessary (Armi et al. 2007). The introduction of formal networks may then lighten the task of the caregivers or redirect them to other forms of care. For the instances of radical substitution (6.4%), two hypotheses are possible. The first would be to postulate a disengagement, which may occur in the case of caregivers for whom the help has become too burdensome. However, results from previous research indicate that the

disengagement of caregivers is a rare occurrence (e.g. Garant & Bolduc 1990), even after the institutionalization of a dependent parent, where families continue to provide a high level of help (Cavalli 2002) or in generous welfare systems, which foster rather than undermine family solidarity (Künemund & Rein 1999). The second hypothesis could relate to situations where a caregiver had died or had serious health problems.

We also observed the determinants of informal network use which may influence the interface between formal and informal support. Our results are consistent with previous studies which found that women and persons with a lower socio-economic status received more help from the informal network (e.g. Broese van Groenou et al. 2006; Litwin 2004). This gender effect may be explained by the fact that women receive less support from their husbands (Gurung et al. 2003), partly because they tend to outlive their husbands and thus are more likely to resort to the non-household informal network. As for the effect of socio-economic status, the relative neediness of persons in the lower-status category prompts more informal help than that given to persons of a higher socio-economic status (Broese van Groenou et al. 2006). We also found that persons living in the semi-rural area received more informal services than the city-dwellers. Indeed, in a semi-rural socio-cultural context, 'being together' tends to imply the sharing of domestic chores and the exchange of services, while in an urban context it implies the sharing of a leisure activity (Lalive d'Epinay et al. 2000).

In spite of its major strengths (longitudinal design and long-term tracking of very old persons who displayed widely different health statuses), this study was limited by the lack of information on the services provided by the cohabitant, who is likely to be the primary kin caregiver. However, this limitation obviously does not concern older persons living alone, who represented half of the sample from the fifth wave onwards. For persons living with their spouse, the amount of help provided by the latter is likely to decrease with time and with advancing age. Those couples may then require more help from non-household caregivers.

Conclusion

This study showed that, in a context of increasing need for care and a declining number of potential informal caregivers, informal and formal

networks of support for the very old were complementary in the majority of the cases. Cases of radical substitution were rare. The concern that the introduction of formal services may curb the readiness of relatives and friends to provide care is thus unfounded. Future research should examine how formal networks could share knowledge with informal networks and how the former can act to better support stressed informal caregivers, especially when the latter are also very old and have assumed the role of caregiver for a long time.

Acknowledgements

This study was supported by the Swiss National Science Foundation (SNF) (Principal Investigator Profesor Christian J. Lalive d'Epinay). We thank Ian Hamilton for his editorial assistance.

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International Journal of Ageing and Later Life, 2008 1(3): 21–44. © The Authors

Residential Mobility in Older Dutch Adults: Influence of Later Life Events

By Brigitte Bloem, Theo Van Tilburg & Fleur Thomése

Abstract

In this study, we examined life course events of older Dutch adults in relation to three types of moves and the moving distance. Using the frameworks developed by Litwak and Longino (1987) and Mulder and Hooimeijer (1999), we stipulated life events or triggers and conditions in various life domains. We selected a total of 1160 men and 1321 women (aged 54 to 91) from the Longitudinal Aging Study Amsterdam. We conducted multinomial logistic regression analyses to predict moves to a residential care facility, adapted housing or regular housing and to predict the moving distance. Retirement, an empty nest, widowhood and a decline in health each triggered specific moves. In additional analyses, the effects of triggers, especially health changes, were moderated by conditions. There is no indication of a specific trajectory of moves associated with consecutive life events, as suggested by Litwak and Longino. By combining triggers and conditions, however, the framework developed by Mulder and Hooimeijer allows for a more valid analysis.

Keywords: residential mobility, older adults, longitudinal, life course events.

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Introduction

Moves are recognized as influential life course events. They often occur in the context of other life events, such as job, marital status or family size changes (Schachter 2001). The life events and other conditions in people's lives put demands on their future housing. For example, getting married and having children often trigger a need for more space (Clark & Huang 2003). The purpose of the present study is to explore how events in later life contribute to various types of moves in older Dutch adults. Although distinctive types of moves, such as retirement migration or institutionalization, have been researched in a life course context, a broader theoretical and empirical understanding of the trajectories in later life leading to various residential moves is called for.

Research into later-life migration often starts from the life course framework developed by Litwak and Longino (1987), which has distinguished three types of moves following various events in the lives of older people, i.e. *retirement* moves to a nicer environment after parental or economic duties decrease, *comfort* moves, often to the vicinity of children in the face of moderate disabilities, and *care* moves to a residential care facility due to chronic disabilities. Each type is thought to occur at a successive point in the life course. An attractive feature of this framework is its linkage between life events and specific types of moves. The path to residential mobility can, however, be conceivably more complex than the framework suggests. People may go through a broader range of life events in various life domains (Elder 1985). This makes simple associations between specific events and moves less likely.

The framework of residential mobility in the life course developed in the Netherlands by Mulder and Hooimeijer (1999) may help differentiate the effects of life events on residential mobility. It has distinguished between triggers and conditions of moving and, like the Litwak and Longino framework, departs from a life course perspective, but assumes an interdependency between various life course domains. It has differentiated between triggers and conditions that may occur in these life domains. A change in one domain can trigger a move. Conditions in other domains may stimulate or restrict the actual move. We distinguished the domains of employment, family, health and the home.

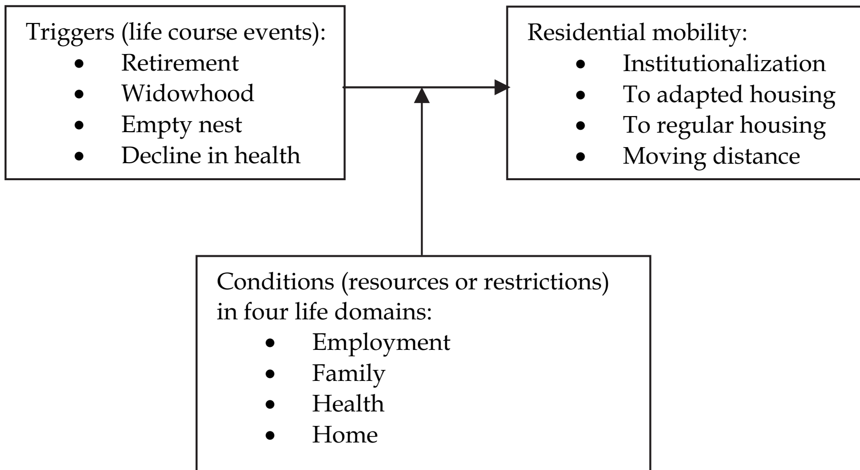

Figure 1. Theoretical framework of residential mobility in the life course.

For example, retirement can be seen as a change in the employment domain that may trigger a desire to move to an attractive environment. Whether one actually moves depends on circumstances such as income level or the proximity of children that condition the action of the individual. Residential mobility may be triggered by events in several domains, such as employment and health, resulting in multidimensional trajectories to residential mobility. There is no fundamental classification of triggers and conditions. For example, retirement may serve as a *trigger* to consider moving in one case, and as a *condition* in another case, if moving closer to the children is postponed because one of the parents is still working. The model indicates that the effects of triggers or changes in certain life domains on residential moves are moderated by conditions in other life domains.

Our theoretical discussion has led to two research questions: (1) What triggers in various life domains affect the probability of moves as distinguished by Litwak and Longino (1987)? (2) Is there an accumulation of triggers and conditions in one or more life domains that affects the probability of a specific move?

Litwak and Longino (1987) have based their classification of moves on the underlying motives (leisure, support and care) as well as the distance to the new location. Since the motives underlying a move are closely related to the triggers, we classified the moves via objective characteristics of the housing at the old and new sites. We distinguished moves to residential care facilities (institutionalization), moves to adapted housing and moves to regular housing. At residential care facilities, care is provided by professionals in a sheltered environment. At adapted housing, homes in the community are equipped with special adaptations. Older adults are expected to move there in the event of an increased need for support or care, a decline in health or a lack of help from children in the immediate vicinity. Older people who move to regular housing without any special provisions for the elderly or the disabled may have various reasons for doing so, such as leisure activities and wanting to be near their children. In addition to housing characteristics, we classified moves by distance, i.e. in the neighborhood, outside the neighborhood but in the town, and outside the town.

We selected triggers in three life domains. In the employment domain, we identified retirement as a trigger. In the family domain, we identified the last child leaving home and widowhood as triggers. Although the importance of wanting to be near the children is generally acknowledged, very little attention has been devoted to its effects on moving (Walters 2002). Some researchers show that children who live nearby act as a constraint on moving (de Jong et al. 1995), but we have not found any research on the effect of children leaving home. In the health domain, a decline in health acted as a trigger.

Conditions were selected in four life domains that can serve as triggers in similar or different life domains. We conceived them as resources or restrictions related to the triggers. For example, having children nearby might be a different conditioning situation for individuals in poor health than having children far away, since children living nearby can be of assistance. In the employment domain, the influence of income was addressed. In the family domain, we included the presence of a spouse as a conditioning situation. We also included having children or not, and the distance to the child living nearest. In the health domain, we considered the health status and age of the older adult. The home domain included

physical characteristics of the home, home ownership, the attractiveness of the environment and the degree of urbanization as conditions. We generally assume that less favorable conditions promote residential mobility. Retired people, for example, may move to a nicer area to improve their living environment.

Before turning to our empirical sections, we should note that the Dutch housing market is characterized by low mobility. The annual percentage of movers is around 10% of all the households in 2000–2005 (Statistics Netherlands 2007), as compared to 12% in the UK and 14% in the USA (Census, Office of National Statistics 2001; U.S. Census Bureau 2006). For older movers, the mobility rates are considerably lower and only 1% of Dutch adults above the age of 50 move as compared to 5% in the USA and around 4% in the UK. One reason for the low mobility is that the Netherlands has a relatively large amount of affordable rental housing for middle-income as well as low-income households. Data of Census, Office of National Statistics (n.d.) across the European Union for 2000 show that in the Netherlands, the percentage of owner-occupied housing (53%) is low compared to the UK (71%) and the USA (66%, U.S. Census Bureau 2000). This probably serves to limit mobility. In addition, it is the aim of Dutch care policy to stimulate people to live independently as long as possible. The Dutch government subsidizes home adaptations as well as formal care, stimulating older Dutch adults to postpone moving to residential care facilities. The lengthy assessment procedures for residential care and long waiting lists also delay the actual move to a care facility.

Method

Respondents

Data were derived from the Longitudinal Aging Study Amsterdam (LASA), an ongoing longitudinal, multidisciplinary research project focused on a wide range of topics related to the physical and cognitive health, and social and psychological functioning of the aging population (Deeg et al. 1993). This program used a stratified random sample of men and women born from 1908 to 1937. The oldest participants, particularly the oldest men, were over-represented in the sample. The sample was

taken from the population registers of eleven towns, varying in religion and urbanization. The LASA sample was initially recruited for the *Living Arrangements and Social Networks (LSN) of Older Adults* research program (Knipscheer et al. 1995). Of the 6107 eligible individuals in the LSN sample (T0), 2302 (38%) were unwilling to participate due to a lack of interest or time; another 734 had died or were too ill or cognitively impaired to be interviewed. A total of 3107 LSN sample respondents took part in the first (T1) LASA cycle (1992/1993). In 1995–1996 (T2, $n = 2545$), 1998–1999 (T3, $n = 2076$) and 2001–2002 (T4, $n = 1691$) follow-ups were conducted. After T1, 1051 (34%) respondents had died, 222 (7%) refused to cooperate and 143 (5%) were ineligible or not contacted. The intervals between the observations were an average of 3.0 years (SD = 0.3) and the interval between T1 and T4 ranged from 8.2 to 9.9 years ($n = 1674$, M = 9.0, SD = 0.2).

In this study, we confined ourselves to respondents living independently at T1 with at least one follow-up observation available ($n = 2481$). From this sample, 58 respondents who were institutionalized and six who lived at a monastery are excluded. For 734 respondents data were partially missing at one or more observations. Most of them were too physically or cognitively weak to be interviewed with the full questionnaire. At T1, the 1160 males and 1321 females were between the ages of 55 and 86 (M = 69.5, SD = 8.5). Of these respondents, 65% were married and 24% widowed.

Instruments

Types of Moves

Based on the respondent's address, we could tell at each observation whether a respondent had moved in the previous three years. The interviewer could classify the type of housing as *regular housing* (e.g. attached row, detached, apartment building), *housing adapted for older adults* (e.g. apartment building with services, housing near an institution including services provided by the institution) or *an institution* (residential or nursing home). Several types of moves were derived from this information, i.e. *from regular to other regular housing*, *from regular to adapted housing* and *from regular or adapted housing to an institution*. A second

categorization was based on the distance of the move, i.e. *in the neighborhood*, *outside the neighborhood but in the town* (an average of 2.5 km), *outside the town but in the country* (an average of 42.3 km, with a maximum of 244 km) and *abroad*. The distance of the move was measured by the postal code and town boundaries; using only one of them would give a biased view, since both vary in size.

Triggers

At each observation, the respondents were asked whether they had a paying job, children living in the household and a spouse. With regard to the job, the children in the household and marital status, an altered situation at the follow-up was considered a life event or trigger.

We considered five aspects of health, which included objective and subjective indicators. The five aspects were covered in six questions about difficulty performing activities of daily living (ADL) such as "Can you walk up and down stairs?" The possible answers were *not at all*, *only with help*, *with a great deal of difficulty*, *with some difficulty* and *without difficulty*. The sum-score indicated the ADL capacity (reliability $\alpha = 0.87$).

A direct question assessed the individual's health related to limitations in functioning: "Are you restricted in your activities of daily living due to chronic illnesses, health disorders or handicaps?" The possible answers were *no limitations*, *slight limitations* and *severe limitations*.

Subjective health was assessed by asking "How is your health in general?" The possible answers were *poor*, *not so good*, *fair*, *good* and *very good*. Respondents could fill in any of seven chronic diseases, i.e. *pulmonary disease*, *cardiac disease*, *arteriosclerosis*, *stroke*, *diabetes*, *arthritis* and *malignant neoplasm*. Cognitive functioning was assessed using the Mini Mental State Examination (MMSE; Folstein et al. 1975). We constructed one composite variable for health, because we were not interested in the five specific aspects of health. A *decline* in health between two observations as a trigger was considered significant if the score on any of the five health aspects was poorer at the second observation and the difference from the first observation was more than one standard deviation. Since there were few respondents with a decline in more than three health aspects, we condensed decline scores of three or more points into one category of a *severe* decline in health. The other categories included a *moderate* (two

points difference) or *slight* decline in health (one point difference) and *stability*.

Based on these questions, we defined the following triggers: *retirement*, *an empty nest*, *widowhood* and *a decline in health*.

In accordance with the definition in the Introduction, we categorized conditions under four life domains: *employment*, *family*, *health* and *home*.

Employment

We considered income a condition related to the domain of employment. Net household income was divided into twelve classes. Missing values (6%) were replaced by the mean income in the neighborhood based on data provided by Statistics Netherlands. A monthly income of 800 euros or less was considered a low income.

Family

One of the variables indicated if the respondent has children. If so, the amount of time it takes to travel to each child using whatever transportation the respondent usually uses is the assessed travel time between parents and children. Travel time to the nearest child was determined and dichotomized as within ten minutes, excluding children living in the household and at a distance over ten minutes. Another variable assessed the presence of a spouse in the household.

Health

Unlike a decline in health as a trigger, we defined health status as a condition moderating the effects of other triggers. Based on the composite variable described above, health status as a condition was categorized as *severe health problems* (4% of the respondents had a score more than one standard deviation below the mean for three or more aspects), *moderate health problems* (two aspects, 9%), *slight health problems* (one aspect, 25%) or *no health problems*, i.e. no downward deviation on any health aspect (62%). Lastly, we interpreted age as an indicator in the life domain of health as well.

Home

The interviewer observed the accessibility of the home, i.e. with a ground floor entrance, or elevator access or an entrance via stairs. The extent of home adaptations was assessed, e.g. extra handrails or adaptations in the

kitchen, bedroom or bathroom. One variable pertained to home ownership. The percentage of recreational and nature areas in the town affected the attractiveness of the environment. The level of urbanization of the neighborhood was divided into five classes, ranging from *not urban* (less than 500 addresses per square kilometer) to *highly urban* (more than 2500 addresses). The data were derived from a database provided by Statistics Netherlands (den Dulk et al. 1992). A factor score derived from the mean household income, the percentage of households with a low income, the percentage of unemployed people and the percentage of households with a poor educational level indicated the social status of the neighborhood. This factor score was derived from a database provided by a commercial firm.

Procedure

To facilitate the statistical analysis, we accumulated the data of longitudinal observations and selected 710 respondents who moved between T1 and T2, between T2 and T3 (if not between T1 and T2), and between T3 and T4. Matching each respondent who moved with non-movers enhanced the study of the determinants of moving. For each moving respondent, we needed non-movers from the same observation interval for comparison. Matching non-movers was considered successful if respondents were observed at a minimum of two consecutive waves, if these observations were made at the same waves as for the mover, if they had not moved during any of the observations, if they had the same gender as the mover and if the absolute age difference with the mover was no more than five years. To obtain as much variance in the sample of non-movers as possible, we looked for two matching non-movers. A first match was available for all the movers, a second one failed for 59 older women who were institutionalized and another 19 women. The sample of matched non-movers included 1342 respondents. The matching procedure yielded subsamples of movers and non-movers that did not differ in gender composition ($\chi^2_{(1)} = 1.1$, $p > 0.05$) and average age (M = 73.3 for movers and M = 72.5 for non-movers, $t_{(2050)} = 1.9$, $p > 0.05$).

To answer the first research question, we conducted a multinomial logistic regression analysis of the three types of moves on each trigger, controlled for gender and age. The aim of this analysis was to determine whether triggers and relocation coincided in the same observation period.

The triggers were retirement, an empty nest, widowhood and a decline in health. Not having moved and not having experienced a life event were both categories of reference. The Wald statistic, which is χ^2 distributed, evaluated the significance of a predictor. The odds ratio (OR) expressed the effect of a specific predictor, which is positive if OR > 1, negative if OR < 1, and there is no effect if OR $= 1$.

As regards the second research question, we addressed whether an accumulation of triggers and conditions affected the probability of a specific move, and examined the effects of conditions separately for each trigger. Each of the analyses was restricted to older adults who had experienced a trigger related to the specific type of move. For example, we examined which conditions contributed to the retired respondents moving to regular housing. We conducted eight of the twelve possible logistic regression analyses (four triggers $\times$ three types of moves). The other four combinations of triggers and moves included too few respondents. We used a stepwise procedure because of the large number of explanatory variables in relation to the number of respondents. For the same reason, we only included the variable added first to the equation ($p < 0.05$). Conditions included the respondent characteristics (income in the employment domain; children, traveling time to closest child and marital status in the family domain; health and age in the health domain; gender), home characteristics (accessibility, adjustments and tenure) and neighborhood characteristics (attractiveness of the environment, urbanization and social status) in the home domain, all measured at the pre-move observation for movers and at the first selected observation for non-movers.

Results

Of the 2481 respondents, 89% lived in a regular home and 11% in adapted housing at T1. Before turning to the research questions, we describe the moves in greater detail. The results showed that older Dutch adults did not move frequently. In the nine years from T1 to T4, 739 (30%) respondents moved, 107 of them more than once. Except for 41 who stayed in the same type of housing, most of the multiple movers changed the type of housing. Eight multiple movers went from a regular home via adapted housing to institutionalization. At each observation, about 13% had moved once or

Table 1. Number of older adults who moved ($n = 2481$)

	T1–T2		T2–T3		T3–T4	
	Abs.	%	Abs.	%	Abs.	%
Did not move	2157	87	1770	87	1457	87
Moved, according to type of move						
Institutionalization	80	3	77	4	70	4
From regular to adapted housing	84	3	52	3	39	2
From regular to regular housing	147	6	122	6	84	5
Other move	13	1	20	1	24	1
Moved and not institutionalized, according to distance						
In the neighborhood	95	4	66	3	55	3
Outside the neighborhood, in the town	85	3	64	3	42	3
Outside the town, in the Netherlands	62	2	63	3	34	2
Outside the Netherlands	2	0	1	0	2	0
Deceased			319	–	633	–
No observation, otherwise			121	–	174	–

Multiple moves are included.

more in the previous three years (Table 1). Half the moves were to suitable housing for older adults: about 4% of the respondents were institutionalized and 3% moved from regular to adapted housing. The others moved from regular to other regular housing (6%) or made another move, for example from adapted housing to regular housing or to other adapted housing (1%). Due to the small number, the latter category ($n = 29$) was not taken into account in further analyses. In the cases of the remaining movers ($n = 710$), the first move was taken into account (note that the number of movers was smaller than the row totals in Table 1 suggest). We studied 327 older adults who moved from regular housing to other regular housing, 170 who moved from regular to adapted housing, and 213 who moved from regular or adapted housing to be institutionalized.

The new homes of respondents who moved to regular housing ($n = 327$) more often had special adjustments, such as an adapted telephone or an alarm (2% as compared to 0% in their former homes), adaptations to the stairs (24% as compared to 6%) and adaptations to the kitchen, bathroom

or bedroom (19% as compared to 4%). Some sold their former home and rented their new one (14%), others became homeowners (7%). Differences between former and new homes were more pronounced in respondents who moved from regular to adapted housing ($n = 170$). Almost all of them now had a ground floor entrance or elevator access (99% as compared to 87% of their former homes). Moreover, there were more often home adjustments: adapted telephone or alarm (40% as compared to 1%), adaptations to the stairs (66% as compared to 14%) and adaptations to the kitchen, bathroom or bedroom (55% as compared to 13%). Many sold their former home and now rented their new one (29%). One respondent became a homeowner (1%).

With regard to the moving distance, we excluded the institutionalized respondents ($n = 213$), as they have little choice in where they move to. Many moves from regular to other regular or adapted housing were local: 37% in the neighborhood, 34% to another often nearby neighborhood in the same town and 28% to outside the town ($n = 497$). Five respondents moved abroad.

The type of move was associated with the moving distance ($n = 493$, $\chi^2_{(2)} = 24.4$, $p < 0.001$). Older adults who moved to adapted housing more often stayed in the neighborhood (49%) and less frequently left the town (15%), as compared to those who moved to regular housing. For this group, the results were reversed; they more often left the town (35%) and less frequently stayed in the neighborhood (31%).

In the cases of the respondents who had left the neighborhood ($n = 308$), the new neighborhood had a higher status (M = 55.6) than the old one (M = 52.1, $t_{(307)} = 4.0$, $p < 0.001$). The degree of urbanization did not differ, nor did the attractiveness of the environment. Furthermore, older adults more often lived closer to a child after a move. Before leaving the neighborhood, 88 respondents lived close to a child, as did 108 after moving ($\chi^2_{(1)} = 44.2$, $p < 0.001$). Of these movers, 32 had a child close by in the old neighborhood and not in the new one, and 52 were in the opposite situation.

In response to both research questions, we compared 710 movers and 1342 matched non-movers. Of the four selected life events or triggers that determined a specific move, a decline in health was most frequently observed. A moderate or severe decline in health was observed in 11% of

the older adults: 3% were retired, 5% experienced an empty nest and 6% were widowed. Of the respondents, 60% had experienced no life event or only a small decline in health. The co-occurrence of these events was rare (4%). The average age when life events occurred differed: the mean age at baseline of those who had retired was 63.8 (SD = 7.7), of those with an empty nest 66.4 (SD = 7.7), of those who were widowed 74.9 (SD = 7.1) and of those with a decline in health 77.5 (SD = 7.3).

With regard to the first research question, we examined which triggers in different life domains could be associated with the three types of moves. Table 2 shows that each of the selected life events was relevant to a specific move. Institutionalization was more likely to occur if there was a decline in health, an event that occurs more often late in life. The odds ratio for a one-point decline in health was 1.51, indicating that older adults with the strongest decline in health are about three and a half times more likely to be institutionalized than those with unchanged health. In addition to a decline in health, an empty nest triggered institutionalization.

A move to adapted housing was more likely after the loss of a spouse. This type of move is characteristic of people at an advanced age. A move to other regular housing was more likely after retirement. The effects of all

Table 2. Multinomial logistic regression analysis of types of moves on life events in other life domains ($n = 2052$)

	Institutionalization ($n = 213$)		From regular to adapted housing ($n = 70$)		From regular to regular housing ($n = 27$)	
	Wald	OR	Wald	OR	Wald	OR
Age (54–91)	136.7***	1.17	9.9**	1.03	66.3***	.93
Sex (male-female)	11.7***	1.80	0.0	0.98	0.3	0.93
Retirement	0.3	0.57	1.6	1.90	5.5*	2.05
Empty nest	9.9**	3.86	0.5	1.36	3.2	1.58
Widowhood	1.8	1.48	4.2*	1.79	0.4	1.20
Decline in health (0–3)	33.0***	1.51	0.3	0.95	0.9	0.93

*$p < 0.05$, **$p < 0.01$, ***$p < 0.001$.

Did not move ($n = 1342$) and did not experience a life event are categories of reference. All the Wald statistics have one degree of freedom.

the triggers were controlled for age and gender differences. As is to be expected, the youngest older people are more likely to move to other regular housing and the oldest people and women are more likely to be institutionalized. The gender effect in institutionalization might apply to the oldest men, who more often live with a spouse than the older women.

The four triggers were related to the moving distance (Table 3). Retired people were more likely to move in the neighborhood as well as outside the town. After the last child left home, older adults predominantly moved in the neighborhood. The oldest ones were most likely to move in the neighborhood. Widowhood and a decline in health were not related to the moving distance.

The second research question addressed whether an accumulation of triggers and conditions affected the probability of a specific move. Table 4 provides an overview of the results of the logistic regression analyses. For four combinations of triggers and moves, the number of respondents was too small to conduct statistical analyses. For the remaining eight combinations, some samples were small due to the low prevalence of triggers. The first analysis pertained to the combination of retirement and

Table 3. Multinomial logistic regression analysis of distances of moves on life events in other life domains ($n = 1472$)

	In the neighborhood ($n = 186$)		Outside the neighborhood, in the town ($n = 168$)		Outside the town ($n = 143$)	
	Wald	OR	Wald	OR	Wald	OR
Age (54–91)	8.1**	1.03	3.5	1.02	3.1	0.98
Sex (male-female)	0.5	1.12	0.3	1.10	0.0	0.99
Retirement	7.4**	3.00	1.5	1.81	7.5**	2.91
Empty nest	15.6***	3.13	0.1	1.12	0.3	0.77
Widowhood	1.9	1.53	0.4	1.26	0.7	1.36
Decline in health (0–3)	0.1	1.02	1.7	0.87	0.1	0.96

*$p < 0.05$, **$p < 0.01$, ***$p < 0.001$.

Institutionalized respondents ($n = 213$) and the matched non-movers ($n = 367$) are excluded. Did not move ($n = 975$) and did not experience a life event are categories of reference. All the Wald statistics have one degree of freedom.

Table 4. Overview of logistic regression analyses of types of move on conditions among older adults who experienced a life event

	Institutionalization			From regular to adapted housing			From regular to regular housing		
	Moved (n)	Matched non-mover (n)	Identified condition (*)	Moved (n)	Matched non-mover (n)	Identified condition (*)	Moved (n)	Matched non-mover (n)	Identified condition (*)
Retired	1	4	(**)	5	0	(**)	22	23	(***)
Empty nest	9	4	(**)	7	8	(**)	28	38	(***)
Widowhood	18	26	Poor health status	17	22	(***)	18	27	Non-adapted house
Decline in health	120	151	Poor health status	59	111	Attractive environment	81	156	Entrance via stairs

*Variable added first to the equation ($p < 0.05$); **analysis not performed due to too few cases; ***no condition identified in the stepwise procedure ($p < 0.05$).

Conditions included in the stepwise procedure are the respondents' characteristics (income, having children, travelling time to child living closest, living with a spouse, health, age and gender), home characteristics (accessibility, adjustments and tenure) and characteristics of the neighborhood (attractiveness of the environment, urbanization and social status), all measured at the pre-move observation for movers and the first selected observation for non-movers.

moving from regular to other regular housing. As noted above, 327 respondents moved to regular housing, 22 of whom made a transition to retirement. Of the 647 non-moving respondents matched to respondents moving to regular housing, 23 made the transition to retirement. As shown in Table 4, the comparison of the 22 retired movers with the retired 23 non-movers did not reveal conditions that increased the likelihood of moving to other regular housing.

No conditions were relevant in respondents who experienced the trigger of an empty nest. In those who were widowed, health problems at the pre-move observation (OR = 2.25, $p < 0.01$) did increase the likelihood of institutionalization. For example, a moderate health status, i.e. a score of more than one standard deviation below the mean for two health aspects, increased the likelihood of institutionalization by a factor of more than five compared to widows and widowers without health problems. We did not identify any condition that increased the likelihood of widows and widowers moving to adapted housing. Living in a house without adaptations, such as extra handrails, increased the likelihood of a move to other regular housing among widows and widowers (OR = 5.50, $p < 0.05$). In those who experienced the trigger of a decline in health, conditions were identified for all three types of moves. A poor health status at the pre-move observation increased the likelihood of institutionalization (OR = 1.72, $p < 0.001$). Living in an attractive environment increased the likelihood of a move to adapted housing (OR = 3.45, $p < 0.05$). Having an entrance to the house via a staircase increased the likelihood of a move to other regular housing (OR = 3.12, $p < 0.05$).

Discussion

Our purpose was to examine various kinds of moves by older Dutch adults from a life course perspective. We used the conceptual frameworks developed by Litwak and Longino (1987) and Mulder and Hooimeijer (1999) as our starting point to examine the impact of life events or triggers and conditions on residential mobility. The focus was mainly on moves to an institution, adapted housing and regular housing, and on moving distance. Triggers and conditions were defined in the life domains of employment, family, health and the home. Our first aim was to find out

which triggers were related to specific moves. Subsequently, we studied the moderating effects of conditions.

Moves to residential care facilities were triggered by a decline in health, which is in accordance with the life course framework developed by Litwak and Longino (1987). Furthermore, the results showed that being older and having the last child leave home also increased the probability of institutionalization. These two additional factors are both indicative of the risk involved in living alone. In the case of health problems, the primary caregiver is most likely to be the spouse or children living in the household (Broese van Groenou & van Tilburg 1997). Freedman (1996) and other researchers (Pot et al. 2001) have noted that married older people are about half as likely to be admitted to a nursing home as older people who live alone.

Health status had a conditioning effect on the likelihood of institutionalization after a life event. Widowed respondents and those experiencing a decline in health were more likely to be institutionalized if they already had health problems at our first observation. The first effect is the most striking, as we did not observe a direct effect of widowhood on the likelihood of institutionalization. The moderating effect of recurring health problems is indicative of the important role of informal caregivers in the household in avoiding institutionalization. It is less surprising that a decline in health increases the likelihood of being institutionalized in particular when the older adult has poor health. It may mean the decline in health is less important in predicting institutionalization than the current state of health. We used a broad indicator of health, which fits our purpose of studying the impact of important life changes on various moves. However, this may not be sufficient for an in-depth understanding of the factors involved in institutionalization. Most notably, admission procedures and waiting lists impact the occurrence and timing of institutionalization. We can conclude, however, that of the life domains, health is the main factor in institutionalization as a trigger and as a condition in combination with widowhood. The other domains were irrelevant to this type of move.

Moves to adapted housing were triggered by widowhood. We did not observe any moderating effects of conditions in combination with widowhood. Nor were there effects on the moving distance. This suggests

that having children available to provide support does not play a significant role in this type of move, even though moving to adapted housing clearly involves a greater need for support and care. In this sense, the model developed by Litwak and Longino (1987) cannot be confirmed. We did observe that older adults who live in an attractive environment were more likely to move to adapted housing after a decline in health. These areas are most typically in rural surroundings, which can mean more limited availability of specialized services and other assistance than in urban areas. This stimulates people to move earlier to adapted housing in or outside their region than if they can arrange more care and adaptations in their original home. This is in line with the return migration observed by Litwak and Longino (1987), insofar as health considerations stimulate a move away from recreational housing.

A move to regular housing had several triggers. Retirement triggered a move in one's own neighborhood as well as over a greater distance. In the first instance, the latter seems in line with the life course framework developed by Litwak and Longino (1987). Older adults indeed move to a neighborhood with a higher status, thus improving their living environment. However, there is no evidence that people move to more rural or attractive areas. Moves to attractive, rural areas have been observed in the Netherlands (Fokkema 1996; Thissen 1995; van der Molen 1993), but the rates are low. Only 6% of the people who moved from urban to rural areas in 2001–2002 were above 55 (WBO 2002). The distance from the Dutch coast on the west to the border on the east is about 150 km, which takes about an hour and a half by car. The short distance may explain this low mobility. In the summer, many older adults remain for longer periods at caravan parks relatively close to their homes. A more common pattern for Europeans is also to spend part of the winter in Southern Europe without giving up their homes (Warnes et al. 2004). This may be perceived as a European variety of retirement moves observed in the USA and elsewhere, as older people seek out a better environment after retirement.

In addition to retirement, an empty nest could trigger a move, predominantly in the neighborhood. The most plausible explanation is that people move to a smaller house after their children leave home, but do not want to leave their familiar neighborhood. The proximity of children is not an important factor in choosing the new house, although we did note

bivariate differences in moving distance related to the proximity of children. The small samples in the multivariate analyses only yielded the most robust effects. It is more interesting to note that the effects of a decline in health and widowhood, neither of which were associated with moves to regular housing in the first analysis, were moderated by the home characteristics in our second analyses: people who were widowed or experienced a decline in health moved to other regular housing if their old home was not fitted with special adaptations or if the entrance was not on the ground floor. Here we find an echo of Litwak and Longino's comfort move: people do not move closer to their children, but we do see that events associated with the onset of old age trigger a move to housing that may be better suited to future needs.

In conclusion, we have found partial support for the life course framework developed by Litwak and Longino (1987). Each of the life events studied – retirement, empty nest, widowhood and a decline in health – triggered specific moves. There is, however, no indication of a specific trajectory of moves associated with consecutive life events. The motives Litwak and Longino have ascribed to the various moves, which are related to leisure and care from children or professionals, cannot be replicated either. Although we did not specifically inquire into the motives for moving, the observed patterns deviated from Litwak and Longino's life course framework on many points. It is obvious that moving distances play a different role in the Netherlands than the USA. The opportunities and restraints offered by the local context can also be an important condition moderating the effects of life events on specific moves.

The proximity of children, either inside or outside the household, is not a decisive factor in residential choices. Only the major effects were visible in our sometimes small samples. A theoretical consideration is also that the role of children in most migration and other studies is reduced to their actual or possible role as caregivers (Silverstein & Angelelli 1998; Stoller & Longino 2001). In addition to the social advantages, having children nearby is likely to entail the psychological benefits of grandchildren in the vicinity (Oswald & Rowles 2006). Since the distance to children as a reason not to move out of the neighborhood is left out of consideration altogether in most previous studies, we believe the role of children is underestimated in these studies.

As to our second research question, the accumulation of triggers and conditions, as suggested in the life course framework of residential mobility developed by Mulder and Hooimeijer (1999), is a valuable adjustment to the theoretical framework. As noted above, the impact of specific life events often depends on the presence of conditions. In particular, the effect of a decline in health on various types of moves was moderated by other conditions that were largely related to the availability of care and support.

The small number of movers and the relatively low frequency of co-occurrence of some events limit our analyses. This means our results can only be interpreted in an exploratory manner. The actual impact of events on residential moves may be underestimated. We measured events and moves in the same observation period and thus missed the longer-term effects of an event. It can be several years between the first idea of moving after an event such as widowhood and the actual move. We also had no observations on older adults who were institutionalized or deceased before the second observation.

Regardless of the possible underestimates, the scarcity of cases in an otherwise fairly large and representative sample of older adults keeps us from drawing up a normative account of moves in relation to specific events and conditions. As the model of Mulder and Hooimeijer (1999) also shows, there is no single path leading from a life event to a specific residential outcome. Important life changes may serve as reasons for moving, but the actual move depends on other events and conditions as well.

Focusing on the life course has two important advantages over more geographical models, such as the *push and pull* factor model applied by Haas and Serow (1993). First, it is analytically difficult to distinguish factors that push and pull at the individual level. Does a lack of adaptations push an individual out of the house? Is the presence of adaptations in a new home a pull factor that makes the individual move? What would the individual have done if a suitable new home had not been available? The same argument could be made about triggers and conditions, since these concepts do not guide empirical classification either. But unlike push and pull factors, triggers and conditions do help analyze how various factors may lead to specific residential changes. Second and more substantively,

push and pull factors are mainly focused on housing and area characteristics. The life course framework focuses, however, on how specific events and conditions affect individual choices in a social and spatial context. The more complex model developed by Mulder and Hooimeijer (1999) has the extra advantage of analyzing joint effects of various events and conditions, which makes it more valid than most simpler models.

There are also certain limitations to our approach. We limited ourselves to objective factors and triggers outside the person. We were unable to analyze the actual decision-making process leading up to residential relocation. Personal appraisals, for example, are important in how specific events generate a residential move (Oswald & Rowles 2006; Rowles & Watkins 2003). Where people live is linked in many ways to how they live and experience life, and a decision to move also touches upon many psychological areas. A fuller understanding of late-life relocation would be greatly enhanced by a combination of sociological and psychological approaches. A life course model could serve as a framework, since it would allow for the incorporation of subjective triggers and conditions.

Acknowledgements

This study is based on data collected in the context of the ''Longitudinal Aging Study Amsterdam'', a program conducted at VU University Amsterdam and largely funded by the Ministry of Health, Welfare and Sports.

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International Journal of Ageing and Later Life, 2008 3(1): 45–76. © The Authors

Discussing responsibility and ways of influencing health

By Outi Jolanki

Abstract

In this discursive study of four group discussions, I examine how the study participants respond to questions about the possibilities of individuals to influence their own health and their responsibility for health, and what is the role of old age in this context. One key finding was that the participants balanced between seeing health as a do-it-yourself matter and on the other hand as a matter of fate or chance. The participants did not question the idea that they could influence their health or assume responsibility for their own health, but they did raise several factors that limit individual influence. Focus groups proved to be an appropriate data collection method for studying morally laden and potentially sensitive issues. It is suggested that the findings of this small-scale study echo broader western discourses on health and old age and contemporary cultural and social developments.

Keywords: health, ageing, old age, responsibility, culture, qualitative study, focus group discussions, discourse.

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Introduction

Health and information about different health risks and ways to minimise them and enhance one's own well-being are frequent topics in public discourse, in the media and in everyday conversation. As Robert Crawford (2006) has argued, ''health may be reasonably described as social cynosure . . . both a goal and a source of anxiety, a value for self and others, integral to identity, a state of being that is continually assessed and the organising concept for a vast organisation of social action'' (Crawford 2006: 404).

Health also provides a common conceptual framework for views about ageing, old age and the lives of old people (Featherstone & Hepworth 1995; Katz 2000). Health discourses are not, nor have ever been, unitary or unambiguous. However, a distinctive feature of contemporary thinking about health is that this is a matter that every individual *can and should* ''do something about'', by means of their own actions and lifestyle choices. Accordingly, health talk has become talk about individual responsibility (Crawford 2006).

In today's social and cultural climate, which stresses individual effort and responsibility for health, seeing old age as a health issue easily leads to seeing it in terms of individual life choices and decisions. This view challenges the traditional discourse of decline, which has it that ageing is a common fate for all people and inevitably means physical and mental deterioration. Within this discourse, there is little room for individual action. The idea that health in old age can be influenced by one's own actions is not a new idea, either. For centuries, a healthy diet, exercise and moderation have belonged to the ''toolbox'' of anti-ageing strategies (Katz 1996). However, the modern version of this line of thinking, which can be called activity discourse, advocates the idea that, as with health in general, ageing and health in old age can and should be influenced through one's own actions and lifestyle choices (Featherstone & Hepworth 1995; Gilleard & Higgs 2000; Hepworth 1995; Katz 1996, 2000). It has been argued that activity representations of ageing and old age have increased in contemporary culture, in the media and in public discourse (Featherstone & Hepworth 1995; Gilleard & Higgs 2000; Katz 2000; Lee et al. 2007; Rozanova 2006; Williams et al. 2007). The growth of activity

representations does not mean that decline discourse has altogether disappeared. Instead, activity is offered as a remedy for all sorts of ills of old age.

At the individual level, remaining active is offered as a strategy to fight illnesses, maintain functional ability, minimise health problems, resolve loneliness and enhance individual well-being; and on the level of society as a strategy to prevent dependency and to minimise the costs of health and social care provision for the ageing population (Hepworth 1995; Katz 2000). Even though activity discourse promises a more positive view of old age, it also constructs ageing as a matter of individual responsibility, and thus ageing has also become a matter of moral evaluation (Hepworth 1995). The responsibility and the ability to influence one's own health even in old age have become part of the scientific discourse, talk in the media, and everyday conversations (Hepworth 1995; Katz 2000).

Cultural discourses are important in that they offer ''vocabularies'' with which individuals can think about their own ageing and construct their own identity as old people. However, cultural modalities (discourses), dominant codes, values or categories should not be understood in a unitary fashion, or as forces that dictate our concepts of health: as well as being internalised, these discourses are also resisted and transformed, and their meanings ruptured (Crawford 1984). In this research cultural discourses are seen as resources that may enable but also limit people's own thinking. Less attention has been paid to how people use these discourses in their own thinking, apply them to their own lives and own ageing, or on what basis people adopt or discharge certain views.

In this study, I have analysed group discussions in which Finnish people aged 70 or over talk about their health. My aims were, firstly, to analyse in detail how the participants discussed their ability to influence their own health and their responsibility for their own health; and secondly, in more general terms, to explore the role of old age in discussions of health. In doing this, I wanted to study how different views were developed in interaction between the participants and how these views were evinced, supported or refuted. Following the ideas of the discursive approach, my research therefore comprised both the content of different arguments and how they were used in talk.

Data and Methods

The data consist of four group discussions with six participants each, including myself in the capacity of moderator of these discussions. The research participants were recruited by convenience and purposeful sampling. First, I recruited participants to whom I had easy access (members of an art club that I attended) and asked them to recommend other suitable participants. On the basis of my experiences with the first group, I contacted the manager of a local service facility and with her help recruited more participants. The discussions were held in the city of Tampere in southern Finland in 2000. Lasting from 60 to 90 minutes, the discussions were audio-recorded with the consent of each participant and transcribed verbatim (~130 pages). Altogether there were 20 participants (eleven women, nine men), and their age ranged from 71 to 86 years. Background information (age in years, education and occupation at the time of retirement, marital status, housing, health status) was collected after the discussions by self-report questionnaires. Group 1 had five male participants, all of whom attended the same art group, and the discussion was held at the place where that group used to meet. The participants for the other three groups were resident and non-resident clients of one of the service facilities run by the city of Tampere, and these groups met on the premises of these facilities. Group 2 consisted of two married couples and one single woman, all of whom belonged to the same literature circle. Group 3 consisted of five women, two of whom lived at the service centre. Group 4 consisted of two men and three women, all of whom lived at the service centre in question. Groups 1 and 2 represent pre-existing groups, but in groups 3 and 4, too, the participants knew one another at least by sight, some of them were friends. The groups were thus rather heterogenous, since one aim of the study was to trace different perspectives and variation in experiences. All discussants took part voluntarily.

To initiate the discussions, I introduced myself and described the research project. I said I was interested in the participants' own views about health in general and their own health in particular, and also in what health means to them in their everyday lives. The discussions then proceeded according to a set agenda, although largely on each group's own terms. This procedure provided a common basis for the discussions, but allowed different views to emerge within and between the groups.

The discussions focused on the following topics:

- definitions of health, personal and general;
- the individual's own responsibility for health;
- to what extent can health be influenced by individual action;
- the most important things in one's own health, and possible future concerns about one's own health; and
- the relationship between age and health.

These topics were covered in all groups, although the weight they received differed from group to group. The exact wordings of the questions varied slightly between the different groups, because I adjusted the questions to best suit the interaction and the atmosphere in each group. Age was on the list of topics, but the participants brought up age and old age even without prompting. As a result, the discussions in each group were framed by ageing and old age. In the flow of their discussions, the participants also introduced and developed new topics. The transcribed text was loaded into Atlas.ti 5, a qualitative data analysis programme. The programme was used as a tool for organising and coding the data. The speech was transcribed word by word (see Appendix 1 for transcription conventions).

The study draws on the ideas of social constructionism (Gubrium & Holstein 2008; Gubrium et al. 1994), emphasising ''the dynamic contours of reality and the processes by which social reality is put together and assigned meaning'' (Gubrium & Holstein 2008: 3) and of discursive psychology (Potter 1996; Wetherell & Potter 1992), pointing out the importance of language as a means of constructing versions of reality, oneself and others. The discourse analysis perspective offers tools for exploring the different, sometimes conflicting meanings attached to health and old age, and how these meanings are brought forward, substantiated or refuted (Potter 1996; Wetherell & Potter 1992). More specifically, my approach combines ideas from situated and action-oriented discursive constructionism (Potter & Hepburn 2008) with Foucauldian-influenced discourse analysis (Wetherell & Edley 1999). In short, the view adopted here is that people's talk is about the local pragmatics of a particular conversational context, but also part of broader or more global patterns of collective sense-making (Wetherell & Edley 1999: 338). My approach to the data and my own role within that data was guided by the idea of ''active

interviewing'' (Holstein & Gubrium 1995). Active interviewing starts out from the idea that the researcher is never an impartial or neutral person, but the research data are produced jointly, in a collective exercise of meaning-making. My own role was a dual one. On the one hand, I was a moderator whose job it was to make sure that all participants got a say. On the other hand, I was an active participant in the discussions, encouraging and even provoking discussion. In this study, the notion of active interviewing was combined with focus groups as the method of data collection. The reason I chose to collect my data in the form of group discussions was that they offer an effective way of exploring the formation of shared beliefs and values and people's experiences, opinions, wishes and concerns (Barbour & Kitzinger 1999; Waterton & Wynne 1999). As Barbour and Kitzinger (1999) point out, the main idea of group discussions or focus groups is to address the group as a whole instead of asking questions of each person in turn and to make explicit use of group interaction to generate data. In this sense they differ from simple group interviews (Barbour & Kitzinger 1999: 4–5). The advantage of focus groups in comparison to some other data collection methods is that focus groups also constitute a contextual method. The participants are not approached as individuals acting in isolation from the social context, but as members of a social group interacting with each other. The social context of group discussion provides an opportunity to examine the process of meaning-making and how different views are formed, expressed, modified and debated with others (Wilkinson 1999: 67; see also Myers & Macnaghten 1999). In addition, focus groups have a potential to be a non-hierarchical method since the group situation reduces the researcher's influence and leads into a greater emphasis on participants' views (Wilkinson 1999: 70), allowing participants to generate their own questions, frames and concepts and to pursue their own priorities in their own terms (Barbour & Kitzinger 1999: 5). A special challenge in the context of group discussions is how to analyse interaction and talk of the group as a whole and the individual voices within the group (Barbour & Kitzinger 1999).

The questions concerning responsibility and the possibilities of influencing one's own health offered a morally loaded perspective for discussion. One key concern in the analysis was to see whether the participants accepted the interpretation I evinced, or whether they challenged it and

proposed other interpretations. Conventionally, morality refers to shared notions of good and bad, or right and wrong, which can be used to define both people and their behaviour. In philosophical discussions morality is also related to questions of individual agency and the nature and possibility of free will. These questions go beyond the scope of this article. However, the group discussion data and the discursive perspective adopted here present a useful opportunity to look at ''morality-in-use'' (Jayyusi 1991; Nikander 2002), which here means analysing the participants' talk in detail to see whether they construct the issue at hand as moral.

The findings of this study are based on an analysis of the whole dataset. The extracts presented were chosen to illustrate the commonalities and variation of meanings in talk, and on the other hand to show how the participants developed their views and joined or challenged others' views. Identifying names have been replaced with fictional names and R refers to researcher.

Is Health Fate or One's Own Doing?

The first extract comes from Group 2, which consisted of two couples (husband Henrik and wife Liisa, husband Taisto and wife Rauha) and one single woman (Sofia). Before the discussion reproduced below, I asked the participants to define health in general. The emphasis in these definitions (in all groups) was very much on the functional aspect of health, i.e. being able to cope in everyday life. Sofia then began to talk about her own health: ''well for the time being I've managed, I think I've managed *really* well (laughs), but then I don't know what's coming''. After asking the other participants how they assessed their own health, Henrik replied ''good for my age'', and Taisto ''satisfactory for my age''. Henrik explained his good health by saying that he had no ''internal diseases'', only ''the odd flu and things like that'' and ''wear and tear''. Taisto's ''satisfactory'' health status was explained (by his wife) by his cancer, for which he was still receiving treatment. His wife Rauha then went on to say ''for her own part'' that she had no ailments, no medication and that she had good mobility, but added that ''you never know what's around the corner''.

In summary, health was here defined broadly in terms of being able to function and having no real diseases, but only minor aches and pains. In this health context, old age was constructed as a time of deteriorating health, as was visible in the expressions ''good for my age'' and ''satisfactory for my age''. In the other groups this kind of talk was also common, and in earlier studies, too, ''good for one's age'' talk has emerged as a common discursive strategy that explains good health in old age but does not question the conventional view of old age as decline (Coupland & Coupland 1994; Coupland & Coupland 1999; Coupland et al, 1989; Jolanki et al. 2000). Sofia's and Rauha's remarks ''I don't know what's coming'' and ''you never know what's around the corner'' can be interpreted as being related to ageing, but also to illnesses in general. In this kind of talk health was constructed as a precarious state, and its

Extract 1. Group 2

1	R:	. . . Can you, is there something you can do yourself if you think that with
2		increasing age you get all sorts of ailments, is there any way you can influence ( )
3		your own health then?
4	Henrik:	at least your mental health (R: mm) you can't do much about your
5		physical health. They come and go (R: yes).
6	Liisa:	well I suppose you can actually to some extent I mean I was just thinking
7		that it would be nice to put my foot up on here, but *heaven above* if I accidentally
8		put this foot up (laughs) then I will, I have to take my other foot out (laughs). I
9		mean you have to remember what your *weak* points are (R: yeah).
10		(murmurs of approval)
11	Henrik:	and then I also thought that you can of course help yourself if you think
12		that they easily say that there's no point going to see a doctor with a minor
13		complaint like this and (R: mm) but if you go to the doctor even if it's just
14		something minor (R: yeah) to see a professional, you may well get help with
15		things that you don't understand (R: right).
16	Liisa:	and then there's like physical exercise. I mean if you've got healthy limbs
17		and you try to exercise, I'm sure that that will help. Helps your muscles stay fit
18		(R: yeah) but then this is definitely a factor (*unclear*) (R: right) you can't just, if

19 I think of myself, like in the wintertime when it was so slippery and I wasn't
20 allowed to move around, now I feel that (laughs) I can't get out and about any
21 more. But in the spring when I got out on my walks again, I mean everything was
22 all back on track again () in a completely different way (R: right) so I mean you
23 do begin to deteriorate *pretty* soon when you're older, not when you're *younger*,
24 but when you're older (murmurs of approval), if you don't get any exercise that at
25 least I,/I personally/
26 Sofia: /I/ know lots of people who when they've started to have these
27 problems with their aches and pains and what have you, they've just slumped
28 down in their armchairs, ''oh dear the pain in my arms, oh dear or dear oh dear''.
29 Sometimes I say, ''I say listen, try to lift your arm a bit, you know it could help. I
30 can't move it at all, I can't move it at all.'' *You really won't get anywhere* (R:
31 mm), I mean if you start going down this road, I mean with each and every
32 complaint you say that I can't get anywhere (R: yes). One day you *will* no doubt
33 get to the point that you *really can't* move, but that's *sometime* in the future.

alterations seemed to be beyond the individual's control. Next, I moved on to ask how the participants saw their chances of influencing their own health.

In this extract health was jointly constructed as something that can be influenced, but different explanations were evinced for the origins of good health as well as for the role of individual action. Firstly, Henrik's talk constructed mental and physical health as distinct areas, and the latter as something beyond the individual's control. However, I have interpreted his reference to ''they come and go'' (line 5) to mean diseases rather than health in general. In her response Liisa contrasted with Henrik's view, but her talk implied a more general view of health, that is, health as functional ability. Disagreeing with the former speaker, as she did, is often a delicate matter. She delayed her comment (line 6 ''well I suppose'') and toned it down in advance (''to some extent''), which in itself suggests that her talk will take a critical stance on what was said earlier. ''Influencing'' was also given a different interpretation in which it was related to individual differences and to the need to adjust oneself to one's limitations (''weak points''), which helps to avoid health problems. ''Weak points'' refers to inherited qualities, which in Liisa's talk serve as a self-evident cause constraining individual action.

After his wife's turn, Henrik also modified his view (lines 11–15) and suggested that one could try to enhance one's health by seeking medical advice, but received no support from the others. This topic was initiated by him on several occasions, but received little support. In his talk, Henrik implicitly contrasted ordinary people and their limited understanding (''you don't understand'') with ''professional people'', ''who know better''. His talk diminished the role of individuals as agents, and this social position was not perhaps one that the others were prepared to support. Liisa's talk, on the other hand, emphasising the importance of individual actions, received more support, and was followed by similar talk by other participants. In these discussion groups the view that seeking medical help might have beneficial effects was quite rare, and was only mentioned in the context of ''serious'' diseases (such as cancer) and their treatment.

Liisa continued the theme of physical exercise, which was then supported by the others and remained one pervading issue in the discussion. Liisa's first turn (lines 16–25) in which she advocated the beneficial effects of exercise, implicitly again mitigated her husband's view that there is nothing one can do to influence one's physical health. The laughter and the point she made that she was only talking about herself (''if I think of myself'', and ''at least I, I personally'' lines 19, 25), can be seen as a way of mitigating the implied criticism. Her talk could be heard not only as a criticism of her husband, but also as veiled criticism of other people who did not try hard enough to exercise. It is a delicate matter to accuse and blame others because that may be seen as a violation of the rules of interaction and the speaker may him/herself be blamed for praising him/herself and for being too judgemental about others. Liisa's emphasis on the personal aspect can therefore be interpreted as a move to try and avoid these interactional hazards.

On lines 22–23, her factual statement ''so I mean you do begin to deteriorate…'' marked Liisa's talk as a closure to the earlier theme of old age. Both weather problems, inherited qualities (''weak points'') and old age served here as external forces that were beyond individual influence. However, she modified this view by referring to the possibility of alleviating health problems and slowing down the ageing process by exercise (line 24).

Sofia's turn (lines 26–33) continued the exercise theme. Her talk contrasts herself with unnamed others who are harming themselves, refusing or lacking the willpower to try and resist the health problems brought about by ageing (''when they've started to have these problems'' lines 26–27). As a linguistic strategy, extreme case formulations (''I can't move it at all'', ''with each and every complaint'') (Pomerantz 1986; Potter 1996: 87–188) and vivid quotations of others' talk (Drew 1998: 319–322; Potter 1996: 160–162) serve to demonstrate others' exaggerated reaction to their health complaints. Sofia's talk constructs these complaints as common, minor and somewhat vague (''their aches and pains'', ''each and every complaint'' lines 27, 31–32) rather than as specific diseases. The expression ''if you start going down this road'' indicates that the unnamed others have (at least partly) chosen their lot, and also given in to indolence (''slumped down in their armchairs'' lines 27–28).

Sofia's talk has a judgemental tone and as was previously stated, it is risky to judge others' behaviour. However, the linguistic strategies mentioned and the description of health complaints as minor ones serve to justify her disapproval of others' behaviour. Also, she qualified her judgemental tone by referring to future effects of old age (lines 32–33 ''one day you will no doubt get to the point'', ''really can't move''), which in this context served to show that she was not being unreasonable. In summary, the participants' talk constructed serious diseases as a matter beyond individual control, but views about ageing and old age were more ambiguous. On the one hand, in this health context, old age was constructed as a process of inevitable deterioration accompanied by related health problems. On the other hand, individual decision-making and action was given an important role in enhancing one's own well-being and fighting the ''effects'' of old age in everyday life.

In Group 3 one of the participants talked about the literature circle in which she was involved and in that context raised the role of mental alertness in health (cognitive skills, social activity). I saw this as a chance to try and find out how the discussants would tackle question about mental aspects and their influence on health. My question was very loosely

Extract 2. Group 3

1	R:	yes. What about then () one's own () attitude and these kinds of *mental* factors
2		() how do they affect one's health? I was just thinking that if you take part in this
3		literature circle and, you know that this.
4	Lea:	well yes *I certainly* believe that this kind of mental side it, I'm sure.
5	Aira:	keeps up your mental agility ().
6	Lea:	yes and that it has a major influence on your health, at least you would *think*
7		it has some effect between your ears.
8		(talks about the pieces she writes for different magazines)
9		(. . .)
10	Aira:	so that you can make a difference by what you do.
11	Sylvia:	yes.
12	Aira:	to how you feel, to feeling good.
13	Lea:	yes so that you *don't just lie down/just/*
14	Aira:	/yes, that you *don't just stay there/*
15	Lea:	right and don't get in/touch with anyone/
16	Aira:	/yes that really is/, that gets you down.
17	Lea:	depressed.
18	Aira:	in no time at all.
19	Esteri:	yes and when I get this depressed feeling and I know it will go away, I
20		realise that and I notice it when it (laughs) starts to come (laughs), everything's
21		pretty dark when it creeps up on you, but at that point /I'll start to do something/
22	Lea:	/well I'm not/
23		*at all surprised* in your position.
24	Esteri:	mm
25	Lea:	when you're always there at home.
26	Esteri:	/yes right/
27	Lea:	/born and bred/in the same place/and never go anywhere/
28	Esteri:	/yes but it doesn't really, for me/*it*, it
29		doesn't for me *at all* because I'm comfortable there.
30	Aira:	/yes you/
31	Esteri:	/I'm comfortable / I don't miss.
32	Lea:	don't you get *bored*?
33	Esteri:	*no,* you see I'm not really the *outgoing* type.
34	Lea:	yes.

35 Esteri: and erm, I ( ) I do then *always* find *the help* () I don't know, but *it just*
36 *goes away*, I know it will, it only lasts a day or two. But it always comes and its
37 pretty *strong*
38 R: yes, I wonder what it is that /causes it? /
39 Esteri: /I don't know /what, what it is, but it all seems so
40 dark, but then again there are these good, sunny days that.
41 R: yes, yes so sometimes it's better/and sometimes/a bit worse?
42 Esteri: /yes, yes/
43 Aira: that goes for everyone if you're alone.
44 Taimi: and at least I mean if the weather's bad, then you do get depressed.

formulated in order to give the participants the chance to address those dimensions that they considered most relevant.

In theory, the loosely formulated question might have received different interpretations, and the participants could have interpreted my reference to ''mental factors'' as meaning something other than the individual's own outlook and attitude. One might imagine that belonging to a literature circle would produce all sorts of pleasant experiences that enhance well-being. Instead, mental activities receive a rather instrumental meaning here as a means of improving one's mental agility.

At first, Lea took to this issue very eagerly, and began to talk before I had time to finish my questions. She voiced the view that her writing had helped her retain her cognitive skills (lines 4, 6–7). Lea and Aira together constructed the view that mental activities and the preservation of mental agility have an effect on health, and secondly that mental well-being (''feeling good'') and mental agility are a result of one's own outlook and decision to be active. In this way, elements of everyday existence were converted into activities (Katz 2000: 140–141) that promote health in old age. Lea's and Aira's talk is rhetorically very effective, creating a vivid image of the unfortunate stagnation into which people may fall if they fail to lead an active lifestyle. Clearly, this kind of metaphorical expressions (lines 13–14 ''don't just lie down'', ''don't just stay there'') were ''doing far more than designating physical positions'', as Williams has stated (1993: 104). Lea's and Aira's talk carries the implicit message that mental

problems may be induced or avoided by one's own actions, and people can choose how to behave, i.e. whether to ''just lie down'' or be socially active. The view that social and physical activity and being ''positive'' somehow generates health was very common in these discussions. Similar findings have been made in earlier research as well. Crossley (2002) found that discussants in her focus group data linked good health with being extrovert, taking exercise and having a positive mental attitude to life (ibid: 1471).

Esteri joined the conversation (line 19) and began talking about her own depressive mood. Apparently, she was trying to show that she agreed with the former speakers by saying, ''yes and when I get'', and explaining then, ''but at that point I'll start to do something'' (lines 19–21). However, she was interrupted by Lea, who burst into the talk which constructed Esteri's sentiments as a natural and inevitable consequence of her own actions, namely staying indoors and avoiding social contact. The extreme formulations in Lea's talk (''not at all surprised'', ''always there at home'', ''never go anywhere'') underline the idea that Esteri is one of those people who has chosen to be socially inactive, and her conduct was in fact constructed as a lifetime habit (line 27 ''born and bred in the same place...''). Lea's interruption could be seen as offending, but it was not received as such by Esteri, who defended herself very calmly. Here, as in the earlier extracts, the fact that the participants knew one another, and the friendly atmosphere in the group, apparently made it possible for strong disagreements to be voiced and resolved.

Yet Esteri's response was defensive, which indicates that she interpreted Lea's talk as condemnatory. Her response was to define herself as someone who does not need social contacts to the same extent as a more ''outgoing type'' (line 33) might. Her talk introduced the idea that people are different, and what is good for one person is not necessarily so for another. In this way she rebutted any doubts that her situation might have been caused by her social inactivity. At a more abstract level, this whole episode can be heard as everyday theorising about what counts as activity, and whether social activity which is largely accepted as an important element in promoting older people's health can be taken as the standard applicable to all people (Katz 2000: 143). Furthermore, in Esteri's talk depression appeared as an active agent which comes and goes with

great predictability (line 36 ''it always comes''), and all she could do was to try to adapt. But by pointing out that ''I do then *always* find *the help*'' (line 35) she also constructed herself as an agent, not only as a victim of disease. It is potentially face threatening to confess that one suffers from mental problems, and Esteri's laughter can be seen as one way of reducing the seriousness of her revelation. However, the extreme case formulations ''everything's pretty dark'' and ''pretty strong'' (lines 20–21, 36–37) do construct her symptoms as serious, which can be interpreted as an interactional move to prove that she was not complaining for nothing. Towards the end of the excerpt, Aira and Taimi joined the discussion. Aira's talk mitigated her earlier strong view and constructed depressive feelings as natural for all people (''that goes for everyone''), but still as result of being alone (line 43). Taimi then continued the weather theme introduced by Esteri (line 40 ''sunny days'') and offered bad weather as an obvious cause for feeling depressed. Consequently, in their talk depression and depressive feelings are equated with natural forces, and as changeable as the weather. Aira and Lea did not seem to abandon their view that individual action has an influence on health, but they did soften it. As the conversation unfolded, the group moved towards a more moderate view, that is, that health may be a matter of individual action, but the same rules do not apply to all people and some things are beyond individual control.

Responsible or Not?

Questions of responsibility were often followed by lengthy accounts of appropriate or inappropriate conduct. Another very common feature of these discussions was that the participants talked at one and the same time about their own health and health in general, as happened in the following extract.

Extract 3. Group 2

1	R:	what about I mean () you must have you read () you watch television and
2		there's a lot about () these health matters () you should look after your health in
3		different ways I mean there's physical exercise, diet and things like this, what do
4		you think, to what extent are people responsible for their own health?

5 Rauha and Sofia: quite a lot.
6 Liisa: yes I agree quite a lot.
7 Rauha: I'm now thinking of him (refers to her husband), I mean like the doctor
8 said, if he'd been a smoker (R: mm) at the time he had the leukemia, I mean the
9 treatments they're always a shock to the (R: right) then () that if his lungs
10 hadn't been as clean as they were (R: right) then he would have suffocated with
11 the inflammation he had I think (R: yes).
12 Sofia: yes, I mean in my opinion food () physical exercise, physical exercise,
13 diet and () all these things that people like us consider part of a healthy life, I'm
14 sure it helps.
15 R: yes. So what do you count as part of a healthy life?
16 Henrik: well I, for me the personal experience is that a regular way of life.
17 Sofia: yes (murmurs of approval).
18 Henrik: that does help (R: yeah) I believe that I'm as healthy as I am () I mean
19 I've led a reasonably regular way of life since I mean since I was young, almost
20 since I was young. And I don't, I do not drink and I don't smoke and I do enough
21 physical exercise, although not very much, go for walks here and as I said I've
22 done some exercise with the war veterans and, and in this way you *can* make a
23 difference.
24 Rauha: yes/the average Finnish/
25 Henrik: /yes say if you're/a heavy drinker by fifty you're in a pretty bad
26 shape (murmurs of approval) let alone, I mean they don't even live to eighty
27 (murmurs of approval) I mean I used to drink sometimes quite a lot when I was
28 younger but fortunately I stopped (laughs) drinking, so that. And since then I've
29 felt absolutely () fine both physically and mentally.
30 R: yes right.

In the earlier extract from this same discussion, exercise was discussed at some length as a way of improving one's health (physical fitness). Here, my introduction offered exercise and diet as means of taking care of one's health, and connected them with individual responsibility. The introduction clearly stated that looking after one's health is the appropriate thing to do (line 2 "you should look after your health..."), but by embedding these demands in a wider social context I tried to keep the floor open to different views. The participants did not challenge the interpretation

offered, but they did qualify it during the discussion. At first, in response to my question, Sofia and Rauha replied in the affirmative, laying a heavy burden of responsibility on the individual's shoulders (lines 5–6 ''quite a lot''). Rauha's example was quite extreme, quoting her husband's non-smoking as the factor that saved his life. A doctor is called upon as an ''outside witness'', an authority whose words proved that what Rauha was saying was true. Later on, she moderated her rather extreme causal statement with the expression ''I think'' (line 11) that ends her turn. These extreme views about responsibility were also mitigated by Sofia and Henrik, who used the word ''help'' (lines 14, 18) to describe people's own influence. In their talk then, people's own actions do make a difference, but they are not the causes of good or poor health.

The participants talk constructed a division between we (''people like us''), who lead a healthy life and other, unnamed people (''smokers'', ''boozers'') whose lifestyle is healthy and even life-threatening. However, to talk about a ''regular way of life'' (line 16) and the ''average Finnish'' life (line 24) constructs a *moderate* lifestyle as preferable to extreme behaviour. The participants' talk here reiterates the findings of earlier research. This kind of talk can be called ''a harmony'' principle in health beliefs (Herzlich 1973). Backett (1992), too, said her respondents condemned excess in health-seeking behaviour and actually denounced it as unhealthy (ibid: 261–264). In this respect, Henrik's turn (16, 18–23, 25–29) is interesting in many ways. He introduced the idea of ''a regular way of life'' and pointed out that he did not overdo a healthy lifestyle, but took ''enough physical exercise''. He balances between confessing that he does not go very often for walks, but still takes enough exercise. In this way he shows that while he does assume responsibility for his health, he does not overdo things. In this extract then, as I see it, the participants constructed a morally grounded division between different factors that influence the individual's health, of which smoking and alcohol use are considered the most reprehensible. This division was constructed in other groups as well.

Henrik's confession of his earlier, sometimes heavy alcohol consumption (lines 27–28) is particularly interesting in this context. Earlier, he had made it clear that he is aware of what a healthy lifestyle implies (lines 16–23 and extract 1) and that he tried to lead his life accordingly. I construed that in this context, his admission did not threaten his image as a ''pro-health

person''. Also, it is more acceptable for a man than for a woman to admit to excessive drinking, especially if this is something that happened in one's youth (cf. Backett 1992: 260). The mention of personal experience softened the moralising tone, and strengthened Henrik's claim in two ways: it showed that he was not trying to set himself above the others; and also that he had first-hand knowledge of what he was talking about, lending added credence to his words (Potter 1996: 112–113).

Not all the participants claimed that they tried to lead a healthy life, understood as taking exercise and having a healthy diet. However, anyone who admitted to leading a not-so-healthy life always expressed the view that one should try to look after one's health. The following extract sheds light on this kind of talk. In Group 1, the discussion had revolved very much around social issues, and I framed my question of responsibility accordingly.

My question suggested that there is a contrast between the individual and the society, and offered social development and public expenditure as a

Extract 4. Group 1

1	R:	yes() so what about could you think then that () I mean there's been a lot of
2		talk in the media now that with money running out and with these questions of
3		priorities that() what costs should be covered and what society should pay for ()
4		is it fair to say that people are responsible for their own health I mean to what
5		extent are people responsible for being for () I mean if we talk not only about
6		being able to influence one's health but are people responsible for their health
7		and what is society's role in all this?
8	Paavo:	yes well if you mean that do I feel guilty for not going out for walks then
9		yes (muted laughter).
10	R:	yes, I mean for not going out, is that what you're saying?
11	Paavo:	yes because I don't go out.
12	R:	right.
13		(.)
14	Paavo:	yes it's true, I mean you do feel that you could do more for your own
15		health, you could do more.

16 Kalle: quite a lot (murmurs of approval).
17 Toivo: *yes it is your* own responsibility *for the most part* it is *for the most part*.
18 Others in unison: yes.
19 Kalle: yes I'm sure it is (R: right).
20 Toivo: and but there should be *more education* really from primary school
21 onwards about the maintenance of health () and like getting rid of smoking and
22 alcohol and all these (murmurs of approval) and like if somehow it would be
23 possible to find a way that people didn't fall into temptation and I mean that
24 would be.
25 Akseli: nowadays they're cutting physical exercise classes at school.
26 Toivo: yes and that's really *bad*.
27 ()
28 Akseli: /though on the other hand/
29 Paavo: /this thing with young people/and going back all that way () but those of
30 us who at this age, who are smoking at our age you can't get them to stop.
31 Akseli: I have to say that the fatalist in me thinks that society has to take over
32 and assume responsibility if these people don't have enough resources to (R:
33 right) to take the initiative, to take over and engage in some sort of activity and
34 work for their own health, then I do think that society, the people who are better
35 equipped for our journey here, they should take care.
36 Toivo: yes that's right.
37 Akseli: and look after.
38 R: yes if not everyone has the /resources/
39 Akseli: /yes not everyone/ they don't even have enough to
40 I mean the will the desire the skills they're just not there, we're not all the same
41 (murmurs of approval).
42 Paavo: we're not the same (murmurs of approval).

frame for discussing the question of personal responsibility. As the discussion shows, society was accepted as a key notion and vantage point for the discussants' definitions of responsibility, but different meanings of responsibility still emerged in the discussion.

Paavo answered (lines 8, 11) my question with a personal confession of not going out for walks. It is interesting that he formulated his answer to my question as a counter question, ''translating'' mine to contain an

explicit moral message of good individual behaviour. His concluding comment that one should and could do more for one's own health met with the approval of the others (line 16). With this talk, the participants constructed themselves as people who understand the value of looking after one's own health in spite of admitting to not doing enough. The discussion that follows (lines 17–19) confirms that they accept personal responsibility for their health. This is evident in Toivo's heavily stressed talk and repeated expression ''for the most part'' (line 17), which is joined by others and Paavo's closure ''yes I'm sure it is''. In spite their assertiveness Toivo's words (''for the most part'') leave some room for factors other than personal responsibility. These other factors were addressed when he raised the perspective that changed the course of the discussion altogether. Toivo's talk about the need for ''education'' (lines 20–24) reduced the demand for individual responsibility in that it constructed a healthy lifestyle as a matter of knowledge and appropriate education. Physical exercise and the avoidance of alcohol and tobacco were raised as self-evident issues in a healthy way of life, as in other groups.

Toivo's expression ''to find a way that people didn't fall into temptation'' and Akseli's remark about ''they'' who are cutting exercise classes at school implicitly constructed two kinds of actors in health, i.e. authorities and ordinary people. In the participant's talk ordinary people's responsibility and chances to look after their own health were dependent on the actions of some unnamed authorities. However, it is clear from the comments about school education, and from Paavo's comment on the futility of trying to change one's habits in old age, that the participants were talking about the health of young people. The participants' own talk seemed to implicitly confirm the view that ''old dogs don't learn new tricks''; attempts at lifestyle changes are best left to young people.

Akseli's turn (lines 29, 31–35, 37) shifted the emphasis to talk about people in general. His talk constructed a distinction between people who do not have the means or the resources to look after their health, and those who do (''people who are better equipped''). Differences in health were constructed as a matter of education, different resources and inherent qualities, which was confirmed later on (lines 40–42) in unison: ''we're not all the same''. Initially, the responsibility was mainly laid on the

individual's shoulders, but this view was qualified in Toivo's turn; and eventually Akseli's turn and the subsequent talk shifted much of the responsibility to society and to those individuals who were better ''equipped'' than others. In this extract I asked the participants to express their views on society's and individual's responsibilities. However, collective responsibility for people's health was raised in other groups too without prompting, even though the discussions of responsibility revolved mainly on individual responsibility.

Discussion

In this study the aim was to find out how the participants would respond to questions about the possibilities of individuals to influence their own health and their responsibility for health, what would be the role of old age in this context, and how these topics would be discussed in a group situation. Some participants agreed more strongly than others with the idea that people can influence their health and that they can and should bear individual responsibility for their health, while other participants offered more moderate views. However, during the discussions both oriented to each others' talk, and qualified and developed their views jointly.

It has been suggested that group pressure in group discussions tends to steer talk towards unified ''public'' views and to inhibit the voicing of sensitive issues or individual disagreement. My experiences do not fully support this view since in these discussions, disagreements were indeed expressed and delicate personal issues raised. The findings presented here concur with Kitzinger and Farquhar (1999) views that the composition of the group, the topic and the overall sentiments of the group and the role of the moderator play a decisive role in enabling or prohibiting discussion on sensitive issues. I conclude that the atmosphere of the discussions had a major role in enabling or impeding multidimensional talk, and this is something the researcher (or interviewer or moderator) can influence. In the present data the participants in each group knew one another at least to some extent, which may be one crucial factor (Barbour & Kitzinger 1999: 8–9). Instead of group pressure, I would be inclined to talk about interactional courtesy rules that people follow in order not to offend other discussants, and yet manage to express opposing views by subtle verbal and non-verbal means.

Even though the health talk in this data was ambivalent, it was clear from the analysis that the participants in these group discussions did not question the individuals' ability to influence their own health, or their responsibility for their own health *in principle*. This finding could be attributed to asymmetrical power relations in interaction. By this I mean that the participants may have seen me, the researcher and the questions I asked, as representing the voice of authority and shared cultural norms. For example, the discussion in group 1 (18) about responsibility in which the participants expressed their sense of guilt for not doing enough for their health, indicates that this is how the participants saw the situation. However, in reporting her experiences of data collection, Backett (1992) has argued that in spite of her attempts to be non-judgemental, the majority of the respondents ''felt the need to apologise for and justify aspects of their life which they thought might seem unhealthy'' (ibid: 261). This indicates that the subject of health may engender moral talk, irrespective of the conduct of the interviewer. These findings are only logical, given that health is one of the central values in Western societies today and, that people define themselves and others at least in part by their ''healthy'' or ''unhealthy'' behaviour (Crawford 2006: 402). Dissenting voices do not easily surface in a research situation where respondents would have to challenge shared beliefs or values (Billig 1996 [1987]), but as the data showed, qualifying and contrasting views may be voiced. Apparently, the questions (even as strongly formulated as mine) directed but did not determine the content and course of the discussion, and did not prevent the participants from expressing opposing views *in the end*.

Group discussions indeed offered a site where different and contrasting and even conflicting voices could be expressed. The findings here support the idea that focus groups can work as a non-hierarchical method to reduce the researcher's influence and to gain insight into participants' conceptual worlds (Wilkinson 1999: 70). The findings also suggest focus groups can be used to study how people discuss morally laden and potentially sensitive issues of healthy lifestyles and responsibility for one's own health, and also as a site for the participants to ''confess'' and elaborate on what would conventionally be seen as unhealthy lifestyles or inactivity, both of which go against contemporary ideas of ''healthism''

and beneficiary effects of activity evident in public discussion and policy programmes. As Kitzinger and Farquhar (1999) argue, studying sensitive moments and topics in and with focus groups would help to ''map out the boundaries and transitions between public/private, acceptable/unacceptable and routine/non-routine discourses among diverse groups in different situations'' (ibid: 171). On the basis of this and other research (Cunningham-Burley et al. 1999; Waterton & Wynne 1999), I would suggest that focus groups could be even used to inform theorising and policy-making, and to involve lay people into public debates and policy discussions. Also, focus groups and detailed analysis of talk and interaction could be employed to illuminate and deepen the findings of quantitative research, e.g. to construct questionnaires and to develop understanding of key issues or in a latter phase of research to ''tease out the reasons for surprising or anomalous findings'' (Barbour & Kitzinger 1999: 6).

However, the challenge of focus groups is that they can end up bringing forward the voices of the most articulate and dominating participants, or suppressing contrasting and conflicting voices. The moderator's interactional skills are therefore crucial in enabling everyone to have a say without curtailing or forcing the discussion. Also, there may be various barriers to the participants' willingness or ability to acquire information and engage in discussion about health issues in general or their personal issues. Lay views therefore cannot simply be used to replace professional or scientific expertise or focus group data cannot be said to unproblematically represent the views of the whole community (Cunningham-Burley et al. 1999; Waterton & Wynne 1999). The analysis still represents the analyst's interpretation of the discussions, and it is up to researcher to theoretically argue for the transferability of the findings. Focus groups also easily generate large amounts of data, which presents a challenge for the analysis. During the last years qualitative software programmes, such as Atlas.ti used in this study, have entered the field and greatly facilitate organising large volumes of data and for example checking both prominence and rareness of different topics and the broader context of data extracts, thus improving the rigour of the analysis. The challenge of catching the group effect while analysing individual voices within

discussions requires special attention but detailed methods of text analysis such as discourse analysis help to meet this challenge.

On the basis of the findings here it was evident that both activity and decline discourses with their moral implications were part of the participants' thinking. The participants often explained and justified their conduct in response to questions, or they evinced reasons for other people's behaviour. However, these accounts about personal experiences brought abstract discourses of health and old age to the level of everyday life and everyday decision-making. To summarise the content of the discussions in regard to the ideas of influencing and assuming responsibility for health, the participants' talk can be seen as a balancing act between two lines of argument; namely health as ''do-it-yourself'' versus health as a fate or chance. These situated and contrasting arguments themselves embody and draw on broader controversial health and old age discourses and reflect the ambiguous expectations of older people in contemporary societies.

The participants argued that it is possible to influence one's health, which in this context means taking steps to enhance one's well-being or even to prevent illness by means of certain lifestyle choices, that is physical exercise, non-drinking, non-smoking and a healthy diet, actively maintaining social relations, being involved in all sorts of activities, and taking a positive attitude to adversities. Within this line of argument, messages from epidemiological research of ''risky'' behaviour intertwine with recent messages from gerontological studies on the beneficiary effect of ''positive'' thinking and active lifestyle on health in old age (Gilleard & Higgs 2000; Katz 1996). The participants in this study gave accounts of their own attempts to live a healthy life, but also expressed self-judgments of not doing enough for their health. As the findings showed, judgments could also be directed towards other people. Judgment of others and self-blame reflect the general moralisation of health (Crawford 1984: 70), a phenomenon that has been documented repeatedly in earlier studies. The pursuit of health has become not only a moral obligation and a sign of virtuous citizenship but a means to control and discipline individual lives. The findings here and elsewhere indicate that ''healthism'' is part of the older people's own thinking even if contrasting discourses persist too.

"Healthism" (Crawford 1984) can be seen as a cultural discourse that partly overlaps and strengthens the messages of epidemiological and recent gerontological discourses on old age. Thus, if health is one of the "key words" in contemporary western cultures, "activity" is the key word in discussions of old age, describing much of today's public and policy discourses (Katz 2000). As a result, individualistic and activist discourses – with their moralistic repercussions – that emphasize individual choices and activity as solution to the ills of old age are gaining recognition in the thinking of ordinary people themselves. In the talk of these participants, activity was constructed as a strategy with which it is possible to alleviate age-related health complaints, and sometimes binary oppositions were constructed between active and passive people. Metaphoric expressions such as "just lie down", "just stay there" or "slump down in their armchairs", were used to describe the unfortunate state of those people who chose not to fight adversity, but remained inactive and as a result harmed themselves. Even though the activity discourse can be seen as an empowering discourse that allows older people themselves to question ageistic views of their abilities and competency (Jolanki et al. 2000), it does problematise older bodies and lives as dependency prone and "at risk" (Katz 2000: 147). Activity discourse is also essentially individualistic, putting individuals under pressure to lead active self-caring lives (Jolanki 2004), which was visible in this data. The participants put forward the idea that it was possible to influence health in old age in a similar way as health in general. The idea that not only physical but social activities and a positive outlook on life may enhance one's own well-being and even improve health is not new (Herzlich 1973; Williams 1993). More recent and more directly age-related idea is that social participation and different mental activities can assume instrumental meaning as "activities" that can improve cognitive functioning and even postpone or prevent dementia (Gilleard & Higgs 2000; Katz 1996). This theme is currently prominent in the media and various self-help books, and the findings here suggest that older people are now picking up on these ideas. The problem here is obviously not the maintenance of good health, but the tendency to reduce older people's social positions and lives into a health concern, which means that different aspects of older people's everyday lives are seen more and more as part of instrumental techniques to manage health (Katz 1996: 127; Katz 2000: 140–141).

However, the participants also qualified the role of individual action and raised factors that in their mind limit people's chances or even prevent them from influencing their own health, and in this way also detract from individual responsibility. Within fate discourse individual health was constructed as a matter of chance or fate and old age was constructed as a period of inevitable health problems which limit the individual's influence and for which the individual cannot therefore be held responsible. So, the discourse of decline or fate was also present in the participant's talk and it was used to qualify the expectations and demands inherent in activity discourse. Invoking good health in old age as more unlikely than ill-health (''good for my age'') and describing poor health as inevitable in the future served to explain and justify the participants' health complaints. Serious diseases were identified as one of the factors that limit the individual's possibilities to influence their health. Diseases were constructed as external forces that ''come and go'' more or less unpredictably, and therefore they are beyond individual control. Different individual qualities and social resources were also constructed as factors that can either improve or undermine the individual's possibilities and abilities to look after their own health. The participants evoked the idea that people ''are not the same'' or do not have the same resources. This version of the fate discourse draws from and reproduces spiritual and philosophical considerations of human beings at the mercy of destiny (or god in religious discourses). Yet, perhaps paradoxically another underlying stream within the fate discourse comes from the messages of modern epidemiological research. While arguing for various actions the individual can take to improve his or her own health, epidemiological research also points out the areas beyond individual influence such as genetic propensities and probabilities.

Within fate discourse the task of society and more fortunate people was to level the differences and help out less fortunate people. So, even though discussions on responsibility for health revolved mainly around individual responsibility and individual actions, the participants qualified individual influence and also advocated the idea of collective responsibility for health as an alternative for individual responsibility. At the individual level then, the participants' talk touched upon similar issues of collective responsibility, the role of communities in people's lives and the division of obligations and rights which are becoming more and more crucial in

wider debates about the course of development of modern welfare societies (Phillipson 2006: 206). In the participants' talk, the different factors served to legitimise one's own health complaints and evict the moralising view that people in ill-health have brought about their own situation.

Thinking of old age and health furnishes ambiguous elements whose origin lies in wider social and cultural discourses and developments of western, or to be exact, European–American societies. Scientific inquiry and growing gerontological and epidemiological knowledge has helped to question and challenge overly determinist views of health in old age and to argue for more positive views of old age as a matter that can be influenced with one's own choices and actions (Katz 1996). Research results then have served as a tool for empowerment and questioning ageist thinking and practices. Yet, scientific inquiry can be seen as part of an even broader development of modernity and ''consumerist late modern environment'' (Blaikie 2006: 15, see also Gilleard & Higgs 2000: 170) within which individual choice and agency are advocated as a means of well-being and better health. Crawford (2006) sees ''healthism'' in somewhat similar terms as born out of tensions of consumer capitalism.

In addition, according to Blaikie, modernity's devaluation of older people as unproductive has been replaced by older people's potentially productive roles as ''purchasers of goods signifying particular lifestyles'', and the pursuit of health serves as a tool for positive ageing and for preserving youthfulness (Blaikie 2006: 15; see also Featherstone & Hepworth 1995; Katz 2000). Advocating individual activity and choices and individual responsibility for one's own life and health has been further fuelled by alarmist views of population ageing and financial troubles allegedly awaiting advanced economies in response to the ageing of populations (Blaikie 2006: 13–14; Katz 1996: 128; Tulle 2004: 176). As part of the attempt to better manage ageing of populations, neoliberal goverment policies in different countries aim to strengthen the role of individuals as consumers making choices and seek to shift the responsibility for health and social care costs to individual consumers and their choices (Gilleard & Higgs 2005: 57; Phillipson 2006: 203). These trends offer different interpretive possibilities and lifestyle choices for individuals. They can be seen to work to liberate people from overly deterministic thinking of

old age to pursue their individual goals and interests and empower older people to take their lives and well-being and health into their own hands. The other side of the coin is that ''activist'' and ''healthist'' discourses can work as emotional and symbolic ''straitjackets'' compelling people to direct their activities and interests to pursue active and healthy lifestyles in accordance with normative expectations. Furthermore, within these discourses inactivity and ill-health even in old age can be seen in individualistic terms as responsibility and failure of the individual (Featherstone 1991). In this respect, the decline or fate discourse with its appeal to collective human fate offers liberation from individual blame.

The findings here are based on a small-scale study whose participants represent a group of elderly Finns. In view of the size of the population they therefore represent a small group of people. Qualitative studies do not usually aim or claim to provide generalisable knowledge in the same sense as quantitative research; instead we can consider transferability of the findings beyond the study context and whether the findings of qualitative research can feed and give ideas for discussing contemporary development of societies. On the basis of the findings and the references quoted, similar health and old age discourses are in circulation in different societies and have become part of the older people's own thinking. In this regard, the findings here are transferable to a broader context and echo ambiguous cultural discourses of old age and expectations addressed to older people in contemporary western societies. Health programmes, the media and numerous self-help books circulate ideas from scientific inquiry to a wider audience. Yet, these scientific and cultural discourses do not determine people's thinking. In their mundane decision-making people draw from broader discourses, but also from biographical particulars and practices of everyday life. Studies of older people's own meaning-making activities can show whether cultural discourses became lived reality. In summary, the participants constructed health and even health in old age as matters that the individual ''can do something about'', and to a certain extent should act upon. In the end, however, old age, serious diseases, individual differences and social factors represented either the unpredictable or common fate of all people or belonged to realm of collective responsibility, and in any case challenged the belief that the autonomous

individual has the capacity ''to re-make self and world'' (Crawford 2006: 403).

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Appendix 1: Transcription conventions

- overlapping speech starts and ends: //
- particularly quiet speech: * *
- clear pause: ()
- comment, unclear speech or possible interpretation in brackets: (unclear)
- heavy stress underlined: *weak*

International Journal of Ageing and Later Life, 2008 3(1): 77–95. © The Authors

Sailing on seas of uncertainties: late style and Puccini's struggle for self-renewal

By Amir Cohen-Shalev

Abstract

The popularity of Puccini's melodramatic operas, often derided by ''serious'' musicologists, has hindered a more rounded evaluation of his attempt at stylistic change. This paper offers a novel perspective of life-span creative development in order to move the discussion of Puccini beyond the dichotomy of popular versus high-brow culture. Tracing the aspects of gradual stylistic change that began in *The Girl from the Golden West* (1910) through the three operas of *Il Trittico: Il Tabarro, Suor Angelica*, and *Gianni Schicchi* (1918–1919), the paper then focuses on Puccini's last opera, *Turandot* (1926), as exemplifying a potential turn to a reflexive, philosophical style which is very different from the melodramatic, sentimentalist style generally associated with his work. In order to discuss this change as embodying a turn to late style, the paper identifies major stylistic shifts as well as underlying themes in the work of Puccini. The paper concludes by discussing the case of Puccini as a novel contribution to the discussion of lateness in art, until now reserved to a selected few ''old Masters.''

Keywords: Puccini, late style, life-span development, creativity.

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Beloved and popular, the operas of Giacomo Puccini have at the same time been derided by more ''serious'' musicologists as the product of a decadent, bourgeois society (Greenwald 1993). No composer communicated more directly with his audience than Puccini; indeed, for many years he has remained a victim of his own reputation, hence the resistance to his music in academic circles (Kerman 2005). In this paper I offer another perspective in order to move the discussion of Puccini beyond this dichotomy of popular versus high-brow culture. The purpose of this paper is to explore the underlying changes in the operas of Puccini from a life-span perspective. For this purpose I describe Puccini's earlier operas, tracing the aspects of gradual change that began with *The Girl from the Golden West* (1910) and developed through the three one-act operas of *Il Trittico: Il Tabarro, Suor Angelica*, and *Gianni Schicchi* (1918–1919). Following this analysis, the paper focuses on Puccini's last opera, *Turandot* (1926), as exemplifying a potential, if not entirely consummated, turn to a reflexive, philosophical style which is very different from the melodramatic, sentimentalist style generally associated with his work.

Life-Span Perspective and Late Style in the Study of Artistic Creativity

The study of artistic creativity in late maturity is a relatively recent academic enterprise. The terms *altersstill* (old age style) or *spatstill* (late style) appeared in German art history in the first half of the 20th century (Adorno 1949/2002; Brinckmann 1925; Simmel 1922). Nevertheless, until the late 1960's they failed to strike a sympathetic chord with art history in general or with the social sciences (Clark 1972; Rosenthal 1968). These scholars attempted a broad delineation of the art of elderly painters and composers and singled out common stylistic features, such as formal ambiguity, expressive intensity, and lessened attention to detail or to finished surfaces (see Cohen-Shalev 2002). In the US, several behavioral scientists working under the so-called ''productivity paradigm'' applied statistical procedures to questions pertaining to the resilience, or lack thereof, of creativity during the life span (Lehman 1953; Lindauer 2003; Romaniuk & Romaniuk 1981; Simonton 1991). Using expert value judgments, these researchers generally found age-decrements to accompany the

progression of chronological age in the careers of famous artists and literary figures.

These two approaches to life-span creativity – the European approach of ''old age style'' and the North-American ''productivity approach'' – are diametrically opposed in outlook and methodology. ''Old age style'' proponents support a perception of creative ascendance in old age, while the productivity paradigm foresees an age-related decline (see reviews in Cohen-Shalev 2002; Kastenbaum 2000). Evidently, both approaches hinge on opposite and often implicit assumptions concerning human development: the biological model in the case of the productivity approach, and the cultural model of the ''old Masters'' for old age style proponents (Cohen-Shalev 1989).

Recently there has been a resurgence of interest in the artistic products of late maturity, due, in part, to prolonged longevity, as well as to the branching out of gerontology in the form of life-span developmental paradigm (Baltes 1987). This meta-theoretical paradigm offers a more balanced way of looking at human development, where normative age-related factors, socio-historical contextual influences and unique life circumstances interact in numerous ways, resulting in a picture of human development as a compound ''gain-loss'' paradigm. There is a growing number of books and articles concerned with late works of various artists. The most recent additions to the still thin corpus of writing about this issue are the late Edward Said's (2006) *On Late Style*, Russ McDonald's (2006) *Shakespeare's Late Style*, Martin Lindauer's (2003) *Aging, Creativity and Art: A Positive Perspective on late life Development*, Cohen-Shalev's (2002) *Both worlds at once: Art in Old age*, and Thomas Dormandy's (2000) *Old Masters*.

Since there is no accepted Grand Theory of aging it will be futile to insist on a single pattern of creative work in old age. However, a general developmental scheme can be suggested based on the analysis and comparison of many artists. In this scheme, the earlier stage of the artistic career usually focuses on the articulation of a core dilemma whose conflicting elements are made to confront each other within a selected genre. Late style, in contrast, represents a transcendence of basic contradictions and a de-sublimation of the core dilemma. Within the new perspective that comes with age, interpretation is idiosyncratic, individual, and at the same time metaphysical and universal. Aging artists often

refrain from explicating their artistic thinking, showing an antipathy for ordered theory (Cohen-Shalev 2002). There is an ambiguity inherent in the aging situation of simultaneously possessing a sense of self and otherness about oneself. This ambiguity allows for the embracing of literal form and metaphysical content, freedom and discipline, fragments and whole, and – ultimately – life and death. Each and every artist, of course, brings his or her own touch and twists to this very general scheme. It is still a matter of speculation whether this belated honesty and ‘‘stripping down artifice’’ is a result of the imminence of death, the privileged freedom from immediate public constraints, a result of a prolonged developmental process, and/or a growing intolerance for any form of artificiality.

Another question is whether old age style can be achieved only by an artistic genius. Most scholars focused on the greatest figures in Western art, such as Shakespeare and Ibsen, as examples of old age style; this raises the possibility that old age style is the exclusive prerogative of the truly great (Lehman 1953). The concept of ‘‘late style,’’ on the other hand, is more flexible and wide-ranging. Some late work appears when a writer is near death perhaps at a premature age, and it does not take a Shakespeare to re-evaluate a lifetime of creative endeavor. Many late artworks may not be as epoch-making but may still be inherently different in style from the previous works of the artist. This may well be the case of Puccini.

The perspective used to investigate Puccini’s late style can now be more clearly articulated. My point of departure is that the individual versatility of artistic development is underpinned by the unfolding of a life-span developmental process which usually starts with a core dilemma presented in a dramatic and conflictual manner during youth, resolved in maturity, and transcended in old age (Cohen-Shalev 2002). ‘‘Old age style’’ is defined as dealing with unresolved contradictions and offering a distillation of artistic perception and a dispensing with ornament in favor of essentials (Kastenbaum 1992; Said 2006; Woodward 1980, 1991). Because such style is much more difficult to understand and to follow, late works can be subjected to misunderstanding and neglect by the audience and the critics, as is the case with Puccini’s last opera, *Turandot,* which exemplifies the composer’s strife to shift from his earlier melodramatic style, offering a more complex and philosophical treatment of the dilemma that pre-occupied most of his works, which can be generally

defined as the desire for unfulfilled love and its predicaments. In order to show the change in Puccini's style, I describe the beginning of this change in *The Girl from the Golden West* (1910) and how it developed through the three one-act operas of *Il Trittico: Il Tabarro, Suor Angelica*, and *Gianni Schicchi* (1918–1919), until reaching Puccini's last opera, *Turandot* (1926). The paper further focuses on the late work of *Turandot* in order to analyze how it captures both the developmental change that drove Puccini's creativity and his inability to move beyond his artistic conventions. This arrested change will be discussed as exemplifying the difference between a full-fledged ''old age style'' and the more open-ended ''late style'' of *Turandot*. Before proceeding to the operas, the following section provides an overview of Puccini's late artistic period in historical perspective.

Puccini in Historical Context

I focus here on the late period of the famous Italian opera composer Giacomo Puccini (1858–1924), whose achievements – while a sure entry in every important compilation of opera composers – fall short of fellow composers such as Monteverdi, Verdi, Wagner, or Janacek. These four artists earned their right of entry to the pantheon of late stylists owing to works produced at the end of a relatively long life. Wagner produced *Parsifal* at 69, Verdi with *Othello* and *Falstaff* at age 74 and 80 respectively, and Monteverdi with *The Coronation of Poppea*, at 75. Richard Strauss, Puccini's contemporary, also appears in old age style lists, but mainly due to his orchestral works and one song cycle, with only one opera, *Intermezzo*, composed at 75.

Puccini can be placed in a number of significant contexts (Greenwald 1993). He is widely regarded as the inheritor of the mantle of Verdi, the last composer of the so-called ''Great Tradition'' in Italian opera. Furthermore, because Puccini kept abreast of compositional techniques of his time, he may be studied quite validly as a 20thcentury composer. While Puccini died at 66, his late works in general, and particularly *Turandot* – the opera he was busy with for the last four years of his life- merit a serious re-consideration as a particular specimen of lateness. Such an analysis will enrich and open up the discussion of lateness in art, until now reserved to a selected few among the greatest of artists. Creators in

more popular media, such as opera and film, have thus far remained largely outside discussions of old age style. Puccini was a consummate opera composer, but, even to his admirers, he was not regarded as a musical genius.

The opera entered, in the 19th century, the cultural and spiritual vacuum left by the demise of tragedy (Steiner 1961), filling it with middle-class popular entertainment fortified by rising nationalistic sentiments. Opera originated in Italy, at the first half of the 17th century, with the musical and dramatic innovations of Monteverdi. In terms of plots, these early ventures drew most directly from Romano-Greek antiquity, and grew in themes and scope during the next two centuries, partly with the purpose of accommodating themes closer and dearer to the newly formed bourgeois audiences. In the 19th century, first with Rossini and Donizetti and then with Verdi, the opera turned into an artistic form of expression that catered to the growing ranks of the middle-class. Verdi's very own ''tragic melodrama'' which he almost single-handedly developed starting with *Rigoletto* in 1851, proved a perfect vehicle for middle and late 19th century Romantic spirit. Toward the end of the century, perhaps in anticipation of political instability to come, the Great Tradition of Italian opera was coming to an end. For all its universal appeal, Verdi's music was inextricably bound with the Italian political movement toward independence (the *Risorgimento*). While Verdi took a 16-year break from opera, following the success of Aida, a young generation of Italian opera composers was already in pursuit of a new operatic idiom. As Italy was already independent, the flames of nationalistic sentiment went down; these youngsters, among them Mascagni, Leoncavallo, Giordano, Boito and Pizzzeti, readily absorbed cultural influences from the continent, first and foremost the naturalistic drama of the north. Late 19th and early 20th centuries saw the rise to popularity of a new genre, the ''*verismo*'' – the operatic equivalent of the realistic theater: heroes and heroines of the middle and lower ranks of society, stories of earthly passions, and a ''flat'' declamatory musical expressions (often pushed to extreme), which preferred dramatic content to traditional melodic values (Ashbrook & Powers 1991). There was more raw passion than elegant discipline in the *verismo* style, which is perhaps why it was short-lived.

Born in 1858, at the height of Romanticism in musical life, Puccini grew up at a time when Italian opera, dominated by Giuseppe Verdi, was looking for a new dramatic idiom – the *verismo* – resulting in a hybrid of German Wagnerism and Ibsen-like naturalism. Puccini is also an important figure of the *verismo* movement in the Italian opera. For him, melodrama was more than a formal genre, a structural framework or a theatrical device, to be manipulated with flexibility and care. He became identified with a melodramatic approach. When he felt his progressing years demanded something else he was already ''imprisoned'' in the narrative and psychological constraints of a particular musico-dramatic genre that he had shaped for himself and for his audience in almost four decades of his career. Like a mask that has grown too close to the skin, it could probably be removed only at the price of tearing the skin itself.

The Seeds of Transformation: From The Girl of the Golden West (1910) to Il Trittico (1918–19)

One does not choose one's subject, wrote Flaubert; one is chosen by it. This maxim explains why opera composers rely on someone else's story but also spend years looking for a suitable one. Throughout most of his career, Puccini has been looking for stories of a very specific theme – sentimental and melodramatic. This recurring theme is articulated by a marginal figure, a street vendor in *The Cloak*: *''Chi ha vissuto per amore per amore si morri''* (she who lives for love, dies for love.) A Puccini heroine is a character who is feminine, frail, of humble origin and somewhat doubtful in moral virtue, seeking true and unbound love. Her happiness in finding it is short-lived, and she is crushed by cruel fate: torture, broken heart, or suicide. Manon (*Manon Lescaut*), Mimi (*La Boheme*), Tosca, Cio-Cio San (*Madame Butterfly*), Minnie (*The Girl From the Golden West*), Giorgetta (*Il Tabarro*), Angelica (*Suor Angelica*) and Liu (*Turandot*) – all these female characters of Puccini live for love in the first act and die for it in the third. Puccini was so fond of torture scenes that he was accused of misogynic sadism (Carner 1964).

The emotional range of these female characters was therefore rather narrow, a fact Puccini himself was keenly aware of. His letters indicate a constant search for a new class of subjects, that Weaver (1977) calls

''un-Puccinian heroines,'' like the unusual Minnie in the *Girl of the Golden West*, as tender as his previous heroines, but also tough and capable of ''masculine'' feats. At 52, with his three midlife successes behind, *The Girl of the Golden West* (1910) was a first serious attempt to break away from the convenient sentimentalist formula for a different breed of female protagonists. While not always satisfactory in its musical and dramatic treatment (see Carner 1964: 279) this work was a landmark in Puccini's creative evolution, where musical characterization becomes as, if not more, important than the sheer beauty of melody, and musical numbers are integrated into the dramatic texture.

Abandoning lyricism for its own sake and moving away from soppy sentimentalism and coarse *verismo* naturalism proved an awesome task for Puccini. Apparently, *The Girl of the Golden West* was worthy in intention, less so in execution. Eight years later Puccini completed three one-act operas, known as *Il Trittico* (1918). By confining the scope he was able to break the challenge into smaller, more manageable parts, and that seems to have worked. Carner's (1964) description of the score of *Il Tabarro* (The Cloak) takes us into the territory of old age style. In it, Puccini

> achieves a degree of compassion and terseness as well as a close correlation between means and end . . . the structure of melodies is more balanced and symmetrical [. . .] there is an organic coherence and a marked preference for using a few themes in their entirety instead of a multiplicity of brief figures (Carner 1964: 464).

Carner also notes a shift away from complex chord clusters toward simpler harmonies, greater simplicity and directness in the scoring, and orchestral lines drawn with new sharpness, and altogether, a style of chamber music despite the employment of a large orchestra.

That last description brings to mind Puccini's contemporary composer, Richard Strauss, whose last composition, the *Four Last Songs,* does indeed sound strangely chamber-like, even airy, though the score is written for an augmented symphony orchestra. The textures are dense, created by extensive use of instrumental doubling to suggest autumnal glow. While Strauss is a recognized old age stylist, and the piece in question was his last (written at the age of 84), Puccini's affinity with creative lateness had so far gone unnoticed. Still, it was a conversion of considerable importance, as Puccini relied outwardly on the dramatic conventions of

the *verismo* style only to shed them subtly in favor of a diametrically opposite dramatic restraint and emotionally realistic characterization.

Simplicity, economy and profoundness are no doubt the hallmarks of good art in general – but they were not characteristic of Puccini's art until fairly late in life. Because of his temperament and the expectation of opera goers, Puccini did not combine passion and restraint successfully until the end of his life. The nervous, even hysterical fluctuations between extremes of emotional expressions gave way to a dynamic evenness throughout, a quality that obviously contributes to the sense of organic coherence. This unifying influence is felt first and foremost in the orchestral score. *Il Tabarro*'s melodic material consists of two recurrent leitmotifs, the reduction and repetition musically enhance the dramatic unity and at the same time establish suggestive tonal ambiguity. The opening river motive, for example, ''[...] invades the stage like an evil mist through which the characters move'' (Carner 1964: 424).

Il Tabarro presents yet another aspect of Puccini's essential transformation, which concerns rhetorical characterization. In the triangle of Michele, the middle-aged Barger, his younger wife Giorgetta and her lover Luigi, it is the older man who is dramatically the most well-rounded and fully developed. His soliloquy reflecting on his wretched life and contemplating revenge on his younger contender over his wife's heart is ''a piece almost to worth to rank with some of Verdi's baritone or bass arias'' (Carner 1964: 424). It is a musically convincing and psychologically believable portrayal of a desperate, tortured man whose debased existence drives him into paroxysm of murderous jealousy. It is Puccini's first fully fledged, mature male protagonist. The preceding ones were either effeminate, puppet-lovers tenor roles or semi-pathological villainous sadists – Scarpia in *Tosca*, Rance in *The Girl of the Golden West* – or sympathetic but passive observers: the consul in *Madame Butterfly*, and Marcello in *La Boheme*.

Il Tabarro also exemplifies a change that was influenced by Debussy, Puccini's contemporary French composer. On the face of it, the introverted, introspective music of Debussy was the complete opposite of Puccini's melodramatic operas. Nevertheless, while working on *Il Tabarro* Puccini looked to Debussy for inspiration. Unfortunately, Debussy died while Puccini was working on *Il Tabarro*. Puccini's eulogy for Debussy is helpful in understanding his own search:

> Today I hear people speaking as if [his music] were a system to follow or not to follow [. . .] Doubts assailed this great artist in his later years. Even to the composer himself they appeared to represent a restricted field of experiment [. . .] I know how much he attempted in vain to escape from this field. I was anxiously awaiting to see how Debussy himself proposed to revolt against Debussyism (Budden 2002: 327).

In this letter, coinciding with *Il Tabarro*'s premiere, it appears that Puccini identified with his colleague's struggle to free himself from his own stylistic reputation.

One year after *Il Tabarro*, in 1919, was the premiere of Puccini's second one-act opera, *Suor Angelica*: the story of a young woman, noble by birth who retires to a convent after having given birth out of wedlock. This fact is revealed to the audience half way through the story upon an unexpected visit of the woman's haughty aunt, informing her of the death of her child. In her agony the bereaved mother swallows poison. Realizing the terrible sin she has just committed she poignantly prays to the virgin mother for forgiveness. Overcome by delirious ecstasy she sees a vision of the Virgin leading the child into her arms.

While the dramatic content promises a second Butterfly, *Suor Angelica* is Puccini's most un-dramatic, even static work bereft of theatrical fireworks. The insistence on sameness of tone and on thin melodic material seems to suggest an experiment in un-Puccinian musical drama, the making of a genuine dramatic feeling with minimal recourse to action and narrative contrivance. The composer persists honorably, until cracking under duress. The final scene, where the heroine goes through a mystical metamorphosis, is the weakest moment in the drama, since she cannot but pronounce an all-too conventional jarring note. It appears that the relief of a desperate female soul was beyond Puccini's creative powers at that point in his artistic career, and he retreats to the very mechanisms he had desperately tried to avoid. Like his heroine's, Puccini's attempted transformation remains artistically unfulfilled.

Still, *Suor Angelica* continues the path paved by its immediate predecessor: The chamber quality, ensemble rather than an amalgamation of virtuoso soloists, a slim but expressive accompaniment, a focus on a complexity (as opposed to oversimplification) of emotions and a general, inward restraint that sets it apart in the composer's operatic corpus. Further setting it apart is the all-female cast, standing out when compared

to the often abusive treatment of the female character in earlier works, a combination of angelic innocence and seductiveness. The multiplicity of female voices creates an overall feminine presence of unprecedented weight and depth. The juxtaposition of high and low women's voices creates a vertical space, which, musically as well as psychologically, affects a standstill perception of time, which was new to Puccini.

Absolution through Comedy: Gianni Schicchi

The third part of the one-act triptych, *Gianni Schicchi*, was already unique in being Puccini's first comedy. Puccini, who for many years had entertained the idea of writing a comic opera, found the subject in Dante's *Divine Comedy*. Gianni Schicchi, a 13th century Florentine schemer is urged by the Donati family to prevent the execution of the just deceased Buoso Donati's will, bequeathing all his wealth to the Church. Impersonating the dying man, Schicchi dictates a will in which he orders Buoso's property to himself. Having driven the outraged relatives from what is now his lawful property he notices his daughter, obliviously in love with Buoso's nephew. His closing (spoken) monologue is directed from the stage to the audience:

> Tell me ladies and gentlemen, could you imagine a better use for Buoso's money? For this trick I have played, these people have sent my soul to Hades. Well, Amen! With all deference to the great Dante, if you have enjoyed yourselves tonight, I hope you will applaud the verdict – not guilty (gracefully bows). From the libretto.

These closing lines may be interpreted as a clever apology, a camouflaged reflection on a career that, by then, spanned almost 35 years, a career which had often been subjected to ferocious criticism. Puccini pleads guilty to the accusations and at the same time elegantly absolves himself. The lighter vein of comedy enables the replacement of bitter self-depreciation (a response Puccini had been known to indulge in) with self-absolution.

Puccini was extremely fond of the character of Gianni Schicchi. The similarities are suggestive. Both were deeply rooted in their native Tuscany; both were artisans, making use of theatrical devices skillfully for the purpose of making profit; both have been accused of opportunism, and the composer seemed to share Schicchi's delight in sheer wickedness.

Acknowledging his debt to Dante, Puccini feels entitled for a humble claim to fame, added to a sense of irony: the composer who failed to redeem his dolorous heroines through love or faith, is redeeming himself through laughter. Moreover, it appears that the seeds of reflexivity and irony in Schicchi paved the way for Puccini's real confrontation with the stylistic chains of melodrama – *Turandot*.

Turandot: Confronting the chains of melodrama

Turandot is performed regularly, and has been recorded a number of times, but compared to Puccini's earlier operas – *La Boheme*, *Tosca* and *Madame Butterfly* – it is less popular, less recorded and all in all less liked by the audience. Whatever Puccini tried to do differently in *Turandot*, he generally failed with the public. *Turandot* is based on Carlo Gozzi's 18th century parable, a tale of a man-hating Chinese princess, whose hand will be given to the suitor who will crack her three riddles – mythical devices shared by various cultures. The game is played for high stakes, the prize being the princess' hand in matrimony. The stake is the head of the hapless suitor. George Marek (1951), Puccini's biographer, called *Turandot* ''the quiz opera par excellence'' not by virtue of the plot, but because outside the opera itself, in the history of its creation, there was a further enigma: the fact that it took four years to write.

When he started working on *Turandot*, in 1920, Puccini was 62. To attribute the slow progress to age, health or both, is unjustified, considering his overall level of activity at the time. He was, if anything, busier than ever before. Based on the letters sent to his librettist during the four years of *Turandot*'s difficult conception it seems the composer had an intense struggle with his chosen subject, something the prolific musician never encountered in nearly four decades of composing. Always demanding a great deal of his librettists he now turned into a restless despot, regarding every line with hypercritical eye, changing his mind innumerable times, never satisfied with the result.

Two scenes caused special difficulty: the first scene of the second act (the scene of the three courtiers), and the final duet between the princess and prince Calaf. ''It is because of *Turandot* that I feel like a lost soul [. . .] that second act! I cannot find a way out,'' wrote Puccini (Budden 2002: 427).

This scene is sung entirely by three masked figures, in the tradition of the *commedia dell'arte.* The long scene is divided into two parts, sharply contrasting in mood, the first a jovial conversation on the latest suitor, indulging in a rhythmic singsong. The second part is a melancholy rumination on the fate of China under the tyranny of Turandot, where heads fall like apples and worthy men try in vain for the hand of the ice princess. The singers are weary of the horror and dream nostalgically of recapturing lost tranquility.

Another Puccini biographer suspected that the librettists' delay in sending the composer more material had been caused by their lack of faith in his ability to handle it successfully (Greefield 1980.) He had never before handled shifting perspectives and ironic subtleties. To bring off these mercurial and ambivalent characteristics seemed out of character with Puccini's habitual emotional simplicity and melodramatic univalence. Now he had to deal with a divided style – to juggle the comic and the melancholic and still maintain dramatic unity and coherence. As Budden (2002) commented, Puccini failed in crossing the opera's chief hurdle, namely the transformation of its heroine by the power of love. Every decision that he took during the opera's gestation rendered his task more difficult; ''in his hands [Turandot] became progressively more inhuman'' (Budden 2002: 472). She remains iron-clad up to the moment of the kiss, while Calaf's love also amounts to mere physical obsession.

Puccini did eventually solve the difficulty with the above scene, and quite satisfactorily. But then he was faced with a still greater task, the third act duet. This apotheosis duet was meant to be the culmination of a continual struggle between two dominant personalities, Princess Turandot and Prince Calaf, where the icy Princess melts away. ''It must be a grand duet, the two beings, almost not of the world, come amongst humans through love, and in the end this love should pervade the whole stage'' (a letter from Puccini to Adami, November 16, 1924, cited in Ashbrook & Powers 1991: 88). This majestic confrontation proved an insurmountable creative obstacle. Two months before his death, already ill with throat cancer, while Puccini was negotiating a date for its premiere, the scene was still in sketch form, posthumously completed by his pupil, Franco Alfano.

The completed scene has since been a subject for debate, and is unanimously considered less than satisfactory, not just because of Alfano's

rather conscientious effort. Puccini's letters paint a picture of creative impasse. He had been paralyzed by the task facing him: ''I am a little doubtful because it is the type of opera that terrifies me. I should have preferred something of a different kind'' he wrote in December 1921 (cited in Ashbrook & Powers 1991: 76.) Two and a half years later, in May 1924, he was desperate: ''*Turandot* lies here unfinished [...] I have no desire to work.'' Puccini's correspondence during the painfully long gestation of *Turandot* reveals his desperate attempt to move beyond the previous schemes of his art. He instructs Simoni, the librettist, to ''exalt Turandot's amorous passions, which she had smothered for so long beneath the ashes of her great pride.'' (Budden 2002: 426.) In *Turandot*, Puccini must have found a promise and a prospect for reconciling two warring images of the female psyche: the fair sinner consumed by love, and the cruel chimera, motivated by sexual repression. These two contradicting images had already been juxtaposed in *Suor Angelica*, with Angelica and the aunt as their counterparts. In *Turandot*, these two aspects had to be converged in a single role. Apparently there was nothing wrong or regressive in Puccini's artistic powers when he was working on *Turandot*. However, *Turandot* called for a different arrangement of the impulsive (that is, youthful) melodramatic elements, and for a philosophical – perhaps ironic – distance.

Puccini arguably took protective measures in case he did not succeed in confronting the complexities of *Turandot*. The choice of ancient China as a backdrop for the plot provided one safeguard, affording ample opportunity for scenic, luscious, and sensuous musical effects. Another safeguard concerned the puzzling introduction of the faithful slave girl Liu, a character that is entirely Puccini's invention, not present in Gozzi's play. In November 1922, already two years into the work, he decided Liu had to die, the reason being that her death could help soften the heart of the princess. For Liu's death scene he wrote his most inspired music, so much so as to overshadow the following grand duet, where the statement of the triumph of love was to be made. It was eventually Liu – and not Turandot – who captured the audience's fancy, contrary to the conscious intentions of her creator.

My argument concerning the lateness of *Turandot*'s can be complemented by other interpretations. It is widely accepted by Puccini's scholars that

Turandot was not a wholesome attempt on his part to liberate himself from old models. As Wilson (2005: 435) summarizes, ''*Turandot* is an opera that plays out a discursive dialogue with itself, in which Puccini attempts to reassess his artistic oeuvre past and present.'' Some sections of the opera are therefore conventional, while other sections of the score, notably Turandot's music, were characteristic of the more modern style that Puccini had been developing since the 1910s. These disjunctures in the musical score can be seen to represent the underlying conflicts of self-renewal from a perspective of life-span artistic development. However, these differences can also be viewed as stemming from external influences, such as Puccini's response to a shifting artistic climate, which might have pointed the way to even more adventurous experimentation, had death not intervened. Evidently, there is no one parsimonious explanation in this matter. After all, internal artistic development is always intertwined with external influences. I thus concur with Wilson's (2005: 436) interpretation that ''*Turandot*, like Verdi's *Falstaff* before it, illustrates the fact that the new relationship between artist, art work, and audience that modernism demanded was unworkable within the traditional paradigms of Italian opera. The critics' puzzled reaction to both works raised questions about the extent to which artistic renewal was in fact any longer possible within the Italian operatic tradition.'' Nevertheless, it was that very Italian operatic tradition in which Puccini felt at home and which gained him his reputation.

Conclusion

A common pattern of artistic development among dramatists involves a movement in late life away from tragedy, or other forms of tragic drama, to metaphysical fantasy. Shakespeare's four last plays, from *Cymbeline* to *The Tempest*, Ibsen's late quartet, from *Little Eyolf* to *When We Dead Awake,* and Verdi's *Falstaff*, a masterpiece of late maturity – are cases in point (see McDonald 2006). Having cultivated a tragic form of dramatic expression in midlife, these writers and musical dramatists seem to have had a change of creative style, resulting in more open, flexible and less formal expressions in their old age.

For the most part of his career Puccini had been engaged with melodrama. This is not to belittle the power or value of melodrama, an essential component for dramatic expression. Erik Bentley (1967), for example, argued for the indispensable role of melodrama in theater. Still, while for theatrical performance melodrama is a pillar, for Puccini it was the whole edifice. Unlike his predecessor, Verdi, genuine tragic feeling was probably beyond Puccini's personal and artistic sensibilities. As the works analyzed here showed, the late style perspective finds corroboration in the artistic change with which Puccini experimented as he tried to move, in his late period, away from the earlier melodramas that made him famous and popular. With *The Girl from the Golden West* (1910), love is eventually fulfilled (the first time in Puccini's work), yet after a long and winding road. The desire for unfulfilled love and its predicaments continues to occupy Puccini in *Il Tabarro* (1918), where the aging protagonist contemplates revenge on his younger contender over his wife's heart, and then in *Suor Angelica* (1919), where the young protagonist retires to a convent after having given birth out of wedlock. In *Gianni Schicchi* (1919), being a comedy, love wins out more easily and without the melodramatic twists. In *Turandot* (1926), the struggle for the princess' love also drives the plot. However, trying to shift from melodrama to a more philosophical and transcendent mode of contemplation, Puccini was only half successful. The difficulty of fully realizing the shift to late style, as well as the desire to do so, are both exemplified in Puccini's unresolved struggle with the composition of *Turandot.* This late work therefore captures the subtle and complex interplay of an authentic, life-span developmental urge, as well as the pressures for continuity and stagnation.

The dramatic, psychological and musical changes that Puccini experimented with in *Il Trittico* proved unsatisfactory as a preparation for a full transformation to ''old age style.'' Moving directly from *verismo* melodrama to the philosophical fantasy of *Turando*t proved too broad a leap. Perhaps it was his commitment to place and tradition that prevented him from crossing over to the territory of lateness, which – as Said (2006) pointed out – represents a kind of mental exile. Due to Puccini's premature death in the age of 66, we will never know for sure whether he would have been able to complete the change to old age style. In terms of his public relations and the public image of the genre in which he

worked, Puccini's reputation as a popular entertainer certainly stood in the way of his desire to reach the status of a serious *auteur* (Becker 1982; Kapsis 1989). A careful analysis of his late operas and of his correspondence during his work on them shows that Puccini wanted to move away from those old operatic ''war horses'' of melodrama, and to find creative equivalences for his own coming of age. The works of his last years, from *Il Tabaro* in 1918 to *Turandot,* left incomplete upon his death in 1924, are the products of a will to say something different, more worthwhile perhaps, than the earlier hits. As Budden (2002: 477–478) similarly argues,

> From his student days Puccini had determined to cut his own way through the various influences that impinged on Italian opera during its years of uncertainty, forging a language that is instantly recognizable [. . .] permitting the assimilation of contemporary elements into a sturdy, developing organism [. . .] At the same time [the] popular trilogy [. . .] sits comfortably within the tradition of the '*giovane scuola*' which, as he himself pointed out, Puccini had helped to found and which he eventually outgrew.

The late style of Puccini, therefore, opens up a window to the stylistic confrontation of tradition and innovation in late life. Late style is characterized by the desire for self-renewal alongside a commitment to earlier stylistic forms. As Puccini's case demonstrates, this commitment inhibits the developmental push by clinging to midlife conformity, generating a difficult, torturous interplay between advance and regression.

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eISSN 1652-8670