‘*The Ageing Body’*

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Background- the social context and the topicality of body studies

Sociologists working in the area of Health, Illness and Medicine came relatively late to focus their analysis on the sociology of the body although it is argued that it always has had an ‘absent presence’ *(*Williams and Monaghan (2013). This apparent neglect of body studies is surprising as the body has been the centre of people experience of health and illness (Blaxter, 2010) but might be explained, at least in part , by their concern to develop a distinct disciplinary identity away from the reductionist approach of the bio-medical model *(*Williams and Monaghan ,2013).

It has been argued (Nettleton, 2013) that medical sociologists became interested in the ‘body’ for a number of reasons associated with wider and interrelated social changes in the mid-1980s .These included the second wave of feminism and women’s attempts to reclaim control of their bodies from a male dominated medical profession There were the development of technological, biological innovations such as transplantations and cloning which identified the variable nature of the boundaries between the natural and social body(Nettleton, 2013). These developments transformed the notion of what constitutes ‘normal’ bodies and was linked to the rise of the cult of the body in consumer culture exemplified through the increasing popularity of cosmetic surgery and the expansion of the fitness industry. The emergence of the ‘epidemic’ of HIV AIDS leading to deaths of younger people raised doubts about the benefits of medical technology (Nettleton, 2013). Finally, the changes in the demographic profile of the populations e.g.population ageing, also highlighted the changing nature of the ageing experience and of human bodies over the life course. This last societal change will be the primary focus of this paper but before ageing and the body are discussed some of the key concepts and approaches to the sociology of the body will be briefly outlined to provide a broader context.

Key concepts: Embodiment, Health and Illness

Sociological approaches to the body are varied (Fox,2018) but have been simply characterised as the naturalistic and the social constructionist approaches with a third approach, the phenomenological approach, linking the two (Nettleton 2013). The naturalistic perspective assumes that the body is a real biological and universal entity which is not shaped by its social context. It reflects the Cartesian dualistic view of the body where a clear distinction is made between the mind and the body (White, 2017). The social constructionist perspective, on the other hand, argues that the body is socially constructed and is dependent on socio-historical contexts. The phenomenological approach puts more of an emphasis on the lived experience and how people interpret and make sense of their everyday worlds. This third perspective, as will be shown in the following sections, has been particular salient for understanding how people in later life interpret and manage ageing bodies.

Sociologists have also raised the question of whether analysis should focus on the sociology of the body, a sociology of embodiment or an embodied sociology. A sociology of the body would examine the body as an object of the analysis whereas a sociology of embodiment would seriously explore the meanings and experiences of bodies (Williams and Monaghan, 2013). However, the approach that these authors favour is an embodied sociology which would seriously look at the embodiment of its practitioners as well the subjects being studied.

The focus of embodied sociology is not just limited to the corporeal meanings of illness and disability but include experiences of health. The problematic experience of illness is recognised when pain (Fox,2018) and/or other problematic signs or symptoms disrupts normal, taken –for - granted relationships with peoples embodied, identities. An understanding of how an individual defines normality involves an understanding of the relationship between an individual and his or her body (Calnan,1987). Clearly, this notion of normality will be shaped by their social position. not least their socio- economic circumstances in terms of what individuals identify, or feel enabled to identify, as problematic in the light of their everyday activities.

Studies exemplifying embodied sociological approaches to health can be found in the maintenance of healthy bodies eg body building and gym culture (Monaghan. 2001) *To look good is to feel good'* is the mantra although the link between health and appearance is more problematic. The priority of body builders tends to be placed on the healthy look of the outer body rather than the health of the inner body which can involve

reducing body fat to extreme low levels to enhance the look of muscle visibility. This research reflects the body and its appearance is increasingly a signifier of social identity and social inequalities. It is exemplified by the portrayal of obesity as both a social and moral problem and the emphasis in the capitalist social order of the need for individuals to control and discipline the body (Blaxter,2010).

Ageing and the Body

There are a number of sociological theories of ageing which have highlighted both negative and positive characteristics but it is argued that the understanding of ageing has become increasingly problematic due to the increased uncertainty about the nature of bodies coupled with the rise of consumerism and the growing cultural importance of age (Higgs and Rees Jones, 2009).It is argued that ageing has become a much more fluid process and there has been a fragmentation of what once was a highly socialised biological process. These authors in their sociological analysis of bodily ageing identify three categories which are: bodily appearance, bodily functioning and bodily control.

Bodily appearance: this focuses on cultural practices that influence age associated changes in appearance (Higgs and Rees Jones, 2009). There are both pessimistic (old age as hardship) and optimistic theories of ageing but even the optimistic theories which distinguish between the third and fourth age tend to associate the fourth age with physical frailty and cognitive decline. This depiction of the lack of agency and resistance to decline amongst those in the fourth age has been contested through evidence from empirical research but there is some recognition of the limits of the explanatory power of cultural constructions in this context. However, Higgs and Rees Jones (2009) as an example of cultural influences even in the fourth age, point to the rise of anti – ageing medicine including both surgical and non -surgical cosmetic procedures which have become increasingly popular amongst a minority of people who have the material resources required to gain access to them as they are mainly provided in the private sector.

Bodily functioning: The focus here is on changes in the machinery of the body. There are increasing uncertainties as longevity lengthens, at least for some groups, about the limits of human life which clearly has implications for the social and cultural meanings of older age. However, as Higgs and Rees Jones (2009) point out, the main beneficiaries of an extended life span and expanded third age tend to be the wealthy. These social inequalities are even more evident in the more recent stalling in life expectancy in the UK and some other high -income countries.

Bodily control: Socialisation, rationalisation and the individualisation of the body are claimed to be key elements in the civilising process and bringing bodily functions under social control which have implications for personal and social identity (Higgs and Rees Jones, 2009). Cognitive decline and the diagnostic label of dementia reflects a failure, an unintentional failure, of self -control and competence which therefore has implications for identity and social inclusion (Higgs and Rees Jones, 2009).

The threat of loss of self -control exemplify the failings of the uncivilised body. The focus here is on the decline in the body as it is claimed that when the body fails the ageing experience becomes more manifest as caring for oneself becomes problematic.The ambivalences which centre around it ie incontinence and decay, represents, according to some authors (Twigg, 2000) the importance of the social position of age. Managing these intimate activities such as bathing can be awkward, embarrassing, potentially degrading and undignified for the older person and tends to breach the social order because an essentially private and personal activity now occupies the space between the public and the private (Twigg, 1999). Thus, this 'dirty' work tends to become compartmentalised and is managed by a range of strategies aimed at hiding the work which, in more extreme cases, can involve setting the disintegrating body apart from mainstream society (Lawton, 1998).

Dignity under threat and the Ageing Body

Older age is a context or phase of the life course where dignity may be most likely to be challenged or threatened due to vulnerability brought about by the failures in the ageing body, frailty and cognitive decline exacerbated in some circumstances by relatively low levels of resources. This typifies the position of people in later life. The evidence from the empirical research into older people beliefs and experiences suggests that the concept of dignity is both meaningful and salient (Calnan et al,2006) although it is easier to talk about it in its absence or when it's threatened, particularly in the setting of health and social care.
Older people's conceptualisation of dignity were shown to be made up of three different dimensions which were identity, rights and autonomy. Identities were tied up with self-respect and self-worth and rights were associated with quality and the right to choose. Autonomy involved the importance of maintaining independence and not being a burden due to a lack of physical or mental control. Older people wanted support but support for maintaining their autonomy which was crucial to their identity (Calnan et al,2006). Identity is particularly challenged when health is failing and threats to identity are exacerbated when older people experience longer or prolonged dying trajectories:

The evidence about dignity in later life discussed so far has been derived from older people accounts and narratives of their experiences. The evidence from ethnographic studies of how dignified care might be practiced in the everyday world of hospitals in England and Wales suggest that care may not always be provided with dignity for older people (Calnan et al,2013). Key elements of dignified care provided in this setting included respectful communication, ensuring privacy, addressing nutritional needs, elimination and personal hygiene needs, sense of control and adequate information to aid decision-making. In practice, this provision was very variable. Nowhere was it either totally dignified or undignified and it varied from ward to ward sometimes in the same ward with different staff on duty at different times of the day. Despite this variability in the provision of dignified care older people's overall perception of their care was generally favourable. This may have reflected the high-quality care that they received but for many it may also have reflected their low expectations of what the care should be like. For patients passivity, eg *'keeping quiet and keep out of things'* and being seen to be grateful seemed to be the best policy for being treated with respect.(Calnan et al,2013).

This ethnographic study of older people's experiences of admission into acute hospitals (Calnan et al,2013) showed the mantra used by hospital staff about older people, was that: '*it's not just the right place for them'* even though they were more likely to be their commonest type of client, The 'place' that they come to is seen to be inappropriate primarily because the environment is not conducive for the care of older people and because many of the nursing staff appear to lack the core skills to meet their needs. The question was whether to change the patient or change the place. Thus, the hospital system with its pathway or conveyor belt was seen to be more suited for acute patients who are younger and have one condition and can be moved through the system rapidly. The systemic and organisational pressures associated with performance and financial targets tends to mitigate against the providing care for older people. The staffs' interests also tended to clash with patient interests in that the culture of the wards tend to be task focused, and that can result in activities being carried out in the quickest and easiest way that best suit the routines and practices of the ward rather than the needs of the patients.

The hospital ward space seemed to be dominated by the interests of nursing staff and the prevailing emphasis on biomedical specialism seem to be shaped by the interests and career values of the medical profession. Such an approach fits comfortably with the 'bio-medical' philosophy of the acute hospital where the value is placed on speedy and effective treatment of patients with one specific condition. The NHS in England and Wales performance targets, the organisational structure of the hospital, the culture and environment, the work and the skills of the staff might be suitable for speedy and effective treatment of patients with one specific condition who can recover quickly. However, this is inappropriate for the care of the majority group of users which are older people, with more than one health problem, some of whom may have dementia and require a longer recovery time. The evidence suggests that the present system contains an inbuilt discrimination against the provision of high -quality care to older people, suggesting a form of institutional ageism (Calnan et al, 2013). Thus, it is suggested that the adoption of a social as opposed to a biomedical model of disease in health services might be more appropriate for the care of people in later life.

In conclusion this paper began with a brief overview of sociological perspectives on the body and why it has become topical of late. This provided the background context for understanding sociological perspectives about the ageing body and the implications of changes in bodily appearance, bodily functioning and bodily control. The decline in the ageing body has implications for caring practices and why providing dignified care has proven to be particularly problematic in the health service settings.

SEE ALSO: Age Identity; Age prejudice and Discrimination; Aging Sociology of; Body and Society; Elder Care

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