

Defining Aging and The Aged: Cultural and Social Constructions of Elders in the U.S.

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This paper presents a critical analysis of the cultural and social constructions of aging and the aged which pervade public discourse around the growing population of elders in the U.S.. Elders are socially 'othered' through processes of medicalization and categorization as an "at risk" group. Furthermore, elders are culturally constructed as unproductive and overconsumptive collective resources. As elders become increasingly central in social and political discourse surrounding health care and the division of resources, these culturally and socially constructed stereotypes have a real impact on social identity and policy decisions. The paper concludes with a discussion of the role of anthropology in contributing a critical perspective to the study of elders.

Keywords: Elders, cultural and social constructions, medicalization, stigma and identity, public discourse, critical perspectives

The recent surge of gerontological research must be contextualized within the apocalyptic discourse surrounding the growth of the elderly population, a discourse which holds considerable potency in social, cultural, political, and economic contexts of the United States. The growing population of elders nationally and internationally has placed this generally marginalized group in the center of public debate about the allocation of social and economic resources. This discourse may be conceptualized as a locus of power, a site at which the aged body and mind are problematized in the collective social imaginary. The social construction of elders is based on ageist notions of elders as decrepit, dependent and feeble. This construction assumes that the age of 65 marks inevitable bodily and mental decline and a consequent need for health and medical care. The elder body is constructed as a social problem which society can resolve through (bio)medical management.

While the 65+ population is the fastest growing group in the United States, the expected rise in health and medical care is a contested assumption. The generalization underlying this assumption reflects a concept of older persons which posits them as a homogeneous group. The cultural process which places elders in this socially stigmatized category has profound implications for the collective problematization of

elders. The social forces that operate to remove older persons from the rest of society and assign them to a symbolic (and in many cases, physical) enclave is in constant tension with the realization that most of us will eventually occupy that enclave (Hazan 1994). This double bind indicates the contradictory nature of the concept of 'old age' and the construction of elders as 'social others'. In this paper, I explore the social 'othering' of elders, and the cultural constructions of 'old age' which make such a process possible, with special attention to the medical model of aging. In addition, the social implications of these cultural processes are explored.

MEDICALIZATION AND NORMATIVE AGING: SOCIAL CONSTRUCTIONS OF AGE

The growing power of the medical profession to define and construct notions of the body, health, and illness manifests itself in a multitude of processes in everyday life. Cultural constructions of aging are closely entwined with the medical model of aging; they are constitutive of one another. Medicalization means that individuals may view normal aging processes as pathological, giving rise to the need for medication or medical treatment. Indeed, the medicalization of the aging process and the aging population has given rise to a large body of medicine consumers. Estes and Binney (1989) characterize the "biomedicalization of aging" as medicine's power to define what is normal and pathological, and treat the elderly accordingly. They argue that social constructions posit aging as a medical problem, and discuss the ways these constructions are embodied in practice. The medical research establishment sets guidelines for diagnosis, clinicians treat the elderly with medication and technological fixes, and the lay population views the problems of old age as individual and biological in nature, best treated by pharmacology and technology. The production of medical knowledge about aging reflects and is entrenched in cultural assumptions about normative aging and what it means to be "normal". Ageist equations which inevitably couple disease and aging contribute to the treatment of aging as pathological (Estes 1979; Sankar 1984). Although an effort is underway in the field of gerontology to separate normal aging from disease processes, the medicalization of aging continues to reflect the underlying assumption of pathology. In practice, the biomedical model focuses on "therapeutic intervention or prevention [and identification of]... modifiable biological markers" (Adelman 1988). Many practitioners untrained in geriatric medicine attribute symptoms of disorders such as depression, incontinence, and memory loss to normal aging (Adelman et al. 1990; Cohler 1993). Physicians specializing in

geriatric medicine have worked to redefine aging as nonpathological, yet paradoxically the profession's identity is based on the separation and specialization of older persons as a group needing unique specialized care (Cohen 1992). The assumptions inherent in the biomedical paradigm may lead to medicating elders based on ageist notions of normalcy and scientific (and cultural) constructions of the aged body which naturalize ageist ideologies. Not unrelated is the categorization of the elderly as an "at risk" group. Within the discourse of risk, the notion of aging as pathology is essentialized in the image of the frail, incapable elder (Kaufman 1994). The cultural perception of the elderly as vulnerable and nonfunctional has been codified in the medical terminology of elderly as "at risk"; this codification is a reflection of the larger cultural process that Ivan Illich called "the medicalization of everyday life" (1976). The medico-social rhetoric of risk gives discursive and practical power to this cultural paradigm (cf. Douglas and Wildavsky 1982). While I do not wish to minimize real needs for care and help experienced by some older persons, the construction of risk and treatment of elders as an "at risk" group reflects social and cultural interpretations of a statistical concept. The statistical concept of risk refers to probabilities of groups of people; however, the social and cultural concept of risk construes it as "a specific property of an individual", as "a state of being or symptom of future illness" (Kaufman 1994). Thus, the clinical labelling of elders as "at risk" focuses on characteristics attributed to elders as a social group, and treatment centers around medical intervention at the level of the individual.

In addition to being classified as "at risk" physically, the elderly may be the object of the psychologization of social problems (Ingelby 1985). The use of medical and psychological paradigms to treat issues such as loneliness, alcohol abuse, depression, role and identity change, and loss need to be questioned in terms of underlying assumptions about elders' frailty and need for treatment. Especially significant is the prescription of psychotropic drugs to elders. By treating social issues as isolated, individual health problems, or as inevitable adjuncts of a "pathological aging process", the role of social, economic and political structures in creating these situations is ignored. For example, depression related to retirement may be treated with an antidepressant, rather than questioning the structural issue of age-based retirement. Thus, medicine may serve as a means of social control, and perpetuate oppressive structures (Zola 1972; Conrad 1985, 1987). Social issues are treated at the site of the aging body/mind; the individual is rendered responsible, and negative cultural images of the feeble elderly mind are reinforced and embodied.

The medicalization and psychologization of the elderly may result in the social control of elder people through defining and managing them as categorized individuals (Estes et al., 1984). The increased visibility of the elder population has contributed to the public discourse about their health, well-being and social relevance, yet the medicalization of aging promotes the treatment of these issues as problems to be dealt with by biomedicine. The interpretation of public issues as private misfortunes, and these misfortunes as medical problems, fosters dependency, lack of power, and reinforces the elderly's position in the role of social scapegoat. The aged body is blamed for structural ills, and accordingly medicated. Thus, the social body of elders is blamed for overuse of precious health care resources, while the individual elder body becomes the site where medico-social constructions of normal/pathological aging are embodied and/or resisted through practice in clinical settings as well as everyday life and social identity.

THE SOCIAL CONSTRUCTION OF DEPENDENCE

The cultural stereotype of the feeble, unproductive, overconsumptive elder is integrally linked with the social creation of dependence. As the public profile of elders gains visibility in social and political realms, the aging body becomes ever more central in the discourse surrounding health care and the socio-political relevance of elders. These culturally and socially produced archetypes have a real and critical impact in public discourse and policy making (cf. Calasanti and Bonanno 1986). Lawrence Cohen has chronicled the "language of crisis" found in recent gerontological literature, discourse and policy (1992). The dogma of crisis is based on the assumption that the growing population will inevitably become a collective social and economic problem (Cohen 1992). Cohen critiques the use of demographic data "not to supplement but to represent the meaning of old age and the condition of old people" (1992: 133). His critique points out the use of statistical rhetoric to justify and legitimate professional pursuits as well as policy decisions. This "language of crisis" maintains social and political power because of the cultural constructions of elders which posit those over 65 as infirm, unproductive and socially dependent on others. Calasanti and Bonanno (1986) articulate the problematic assumptions underlying the use of statistics such as the 'dependency ratio', a calculation used to measure projected expenses in policy making decisions. The statistic is based on the number of nonworking "dependent" people in society and the number of working people available to support the nonworkers/dependents. This 'objective' statistic makes the assumption of automaticity of movement into a state

of 'dependence' at age 65. The use of such scientifically produced measures naturalizes dependency as a "given" while overlooking the social creation of such needs, which are entrenched in socially structured institutions such as age-based retirement. Furthermore, such 'scientific' measures reinforce the cultural ideology which posits the growing body of elders as an unproductive 'burden', consuming social resources at the expense of the collective body. This ideology is loaded with the negative cultural value placed on social and economic dependence on others. In such a context, it becomes clear that these cultural constructions form the basis for the use of demographic and epidemiologic predictions in policy-making and the "language of crisis" Cohen refers to, which places the aging body at the center of this sociopolitical discourse.

ELDER AS OTHER: SOCIAL IDENTITY AND STIGMA (THE SCALING OF BODIES)

Elders demarcate an ambiguous social realm which lies somewhere between "us" and "them". On the one hand, elders are marginalized and socially invisible as active social agents, and the systematic ageism in the U.S. social context has been well documented (Butler 1975, 1980). On the other hand, as a social 'other' they constantly threaten social borders between old and not-old, as those who are young now expect to become that 'other' one day. In addition, as a group, elders are simultaneously hidden and marked out through social stereotyping. Elders' power to define themselves and actively construct their own identity is tempered by powerful cultural ideologies which deny their social worth. Iris Young discusses the "scaling of bodies" which underpins a cultural aesthetic that constructs the bodies of 'others' as ugly or incompetent bodies (Young 1990). This may manifest in notions of physical health, mental ability, and ideals of beauty. Members of these 'othered' groups may both embody and resist such constructions. The stigma attached to a devalued social identity is profound in its consequences for elders as individuals and as a group, as well as for a social context marked by division and conflict.

CONCLUSIONS: ELDERS IN CONTEXT

The discourse problematizing elders and the accompanying medicalization of the elder body are located in the cultural construction of age as a form of social difference and ideologies which denote aging as social dependence. The social constructions of aging embedded in the public discourse surrounding the elder body are pervasive and powerful. The aging body is a culturally overdetermined one; it has been

problematized as dependent, feeble, overconsumptive and nonproductive. In other words, the elder is constructed as a social 'other' and collective problem. The medicalization and pathologization of elders is intertwined with cultural notions of aging, and the categorization of elders as a permanent "at risk" group. Thus, the elder body has become a politicized site for collective action, as evidenced in public discourse and policy. The creation of specialized social structures such as retirement communities and geriatric medicine as age-segregated formations index ideologies which position elders as an 'other', apart from the collective social body.

EPILOGUE: BRIDGING PERSPECTIVES

Anthropology has much to offer in the study of elders. Scholars in the field have pointed out the need for a critical perspective in anthropological studies of elders, and reflection on the position of the discipline in constructing notions of elders (Luborsky 1995; Luborsky and Sankar 1993). It is crucial to question assumptions underlying research practices, theoretical constructs, and the topics of research. The construction of the elder subject raises the central question of why the aging body has become a politicized site for collective action. This is an important feature in bridging broad concepts of social discourse and power, political economy, social control, and ideology with meaning-centered studies of social relations, identity construction and embodiment. All of these issues are significant to understanding the relationship of elders to health and medical practices, socio-cultural constructions of aging, and the political and economic context of aging.

In the context of this framework, the following research questions come to mind: How are ideologies propagated through medical knowledge and practice, and how are they internalized and practiced on an individual level? How do cultural notions of aging articulate with age-based retirement and the bodily experience of one's own health and aging process? What meaning does the discourse of risk have for policy making, as well as identity and health practices? These are the kinds of critical questions which need to be asked in an anthropology of aging and health. The appeal of critical elder study for anthropology is more than an ephemeral moment in the discipline; the significance of the study of aging represents the opportunity to examine and undermine culturally entrenched biases in our own back yard.

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