

THE UNIVERSITY OF HULL

**“I’d be unhealthy if nobody
wanted me anymore”**

**A sociological analysis of the
relationship between ageing
and health beliefs**

Being a thesis submitted for the Degree of PhD Sociology in the University of Hull

by

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This PhD is dedicated to my wife Angela Burdett-Conway and children Eleanor Jade Conway and Robert Denis Conway, and to the memory of my father Denis Conway.

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Abstract

This thesis is based upon life history and focus group interviews on the health beliefs of 26 older adults from Hull and surrounding areas. The research rationale is twofold. First, the area is relatively neglected. Second, it is posited that, whilst existing research reflects the idea that beliefs are constituted in the context of the relationship between the individual and society, its scope to explore issues of human agency is limited. The analytical framework adopted in this study is presented as a contribution towards redressing this imbalance by adopting a life course approach, thus helping to transcend the notion that agency and structure are separable. Interviewee agency is revealed in the way many draw upon a range of competing texts and narratives, much like books in a library, within biographical context, as competent social actors to create their own explanatory frameworks. The main finding is that imagined community (Anderson 1983) is the most common vocabulary of motive (Mills 1940) in the constitution of beliefs. Motivation, it is argued, is more a product of individuals drawing upon repertoires of explanations in popular values and beliefs, rather than something which is innate and set apart from the social world. The motive of community appears most significant because beliefs tended to reflect a sense of an essential and moral self and a strong orientation towards reciprocal social relationships. The motive of community is, in large part, considered as imagined because it was often not possible to interact with other community members who included dead relatives, friends, famous and powerful people, and fictional characters from literature and TV. It is concluded that as well as reflecting the biographical contexts of interviewees, imagined community is made necessary by a society which subordinates and excludes older adults.

Theorising the relationship between older adults' health beliefs and society: a problem for sociology

Introduction

This PhD examines the social production of beliefs about ageing, illness and death for 26 older adults living in and around the city of Hull in East Yorkshire. It is based upon focus group and life history interviews. This chapter examines the idea that existing research is restricted by the dualist legacy of classical social science analysis which has separated human organisations such as medicine, work and religion from how people actually go about everyday life and how they make sense of the world(s) they inhabit. It is argued therefore that health beliefs can be seen as a problem for sociology, rather than say for political economy or social psychology. The chapter therefore explores the merits of a *life course* approach as a means of transcending the idea that *agency/structure* are separable. Such an approach, examined further below, emphasises the role of time in terms of ageing in society, and the framing of a permeable relationship between body/self/society, in biographical contexts. The main finding is that the interviewee beliefs reflect their agency as competent social actors, drawing upon a range of competing *texts* and *narratives*, much like books in a library, to construct their beliefs. Thus Stainton-Rogers' idea of *explanatory sympatricity* (1991) and a general framework of *narrative analysis* (Mills 1940) are examined and applied in the present study. The central research question asks if beliefs can be understood as a product of a common socially motivating factor. In other words, is there a typical way interviewees use a range of popular narratives and explanations in their beliefs in relation to ageing? In general, an urge towards connectedness or community is reflected in the data. It is argued that this way of thinking is generationally situated and more prevalent amongst older adults. Thus interviewees see health as having an ability to help others and to pursue a way of living and thinking which is based upon community as an ideal. However, given that it was not possible to interact with many other community members such as dead relatives, famous and powerful

people, and fictional characters from TV and literature, it is argued that *imagined community* (Anderson 1983) serves as a self-constructed and social framework to make sense of ageing, illness and death, reflecting a generationally-situated relationship between interviewees and society.

In examining beliefs as a reflection of the link between the individual and society this study asks: is there a central 'vocabulary of motive' which older people draw upon to conceptualise health? The notion of vocabularies of motive is based upon Mills' (1940) supposition that motivation should be seen more as a product of individuals drawing upon repertoires of explanations in popular values and beliefs, than as innate characteristics set apart from the social world. In the interview data the motive of social reciprocity or community appears most significant in the way beliefs are considered. This perspective is reflected in the title of the study which draws on data from an interviewee.

The rationale for such research is twofold. First, with some notable exceptions (Herzlich 1973; Williams 1990), older people's health beliefs have been relatively neglected by empirical sociological research. Consequently, the aim is to contribute towards an understanding of an under-researched area. Second, as the title of this chapter suggests, attempting to theorise in the context of the relationship between individuals and society can be seen to reflect the so called 'problem of sociology' (Lee and Newby 1994); that is, of understanding the relationship between the individual and society. It is argued that, whilst the existing high quality research within the area (Herzlich 1973 and Williams 1990) is based on the idea that beliefs are constituted in the context of the relationship between the individual and society, these studies use conceptual frameworks that are biased towards structuralist frameworks; that is, they emphasise the constraining nature of macro factors such as a blend of economic and religious imperatives under capitalism which Williams typifies as the 'Protestant ethic', or Herzlich's idea that health beliefs reflect broader systems of beliefs and practices or 'social representations'. As a consequence, they are theoretically limited in their ability to explore issues of human agency. This study therefore aims to make a contribution towards redressing the imbalance favouring structural analysis in existing research. This will involve a particular focus on issues of human agency which also recognises the importance of structural issues in

the constitution of beliefs. This chapter introduces the theoretical and analytical position taken in the study by examining sets of ideas and concepts which reflect such a focus. In doing so it is asked, if beliefs are produced within a permeable relationship of body/self/society, does sociological analysis possess the potential to bridge a theoretical gap between the individual and society to understand this relationship?

In terms of the empirical focus of this project, the most similar piece of existing work is Rory Williams' - *A Protestant Legacy: attitudes to death and illness among older Aberdonians* (1990). This is concerned with the dominance, or 'imprint', of the Protestant ethic upon a sample of older people in Aberdeen. As Williams' study examines the same substantive area as this project and it reflects a concern with the problem of sociology, his framework is critically drawn upon and developed. However, the main difference between this study and Williams' work is the way in which older people's repertoires of available resources to construct their beliefs are theorised. It is argued that the analytical framework offered in this chapter, in contrast to that of Williams, offers a way forward, as it is explicitly concerned with drawing upon ways of thinking which transcend the idea that individuals and society should be theorised separately. Williams' approach, it is proposed, implicitly recognises the merits of such thinking as he emphasises factors, such as the influence of the work ethic and religion, in biographical context. Thus he avoids a deterministic portrayal of the shaping of beliefs by using a framework that brings together the individual and society. Having introduced the general position adopted in this study, it will be germane to put this into a theoretical context.

Within social theory traditional attempts to resolve the problem of sociology reflect the predominance of dualisms in the history of sociological thought by the tendency to treat the question of agency and structure as separate issues (Dawe 1970; Giddens 1984; Jenks 1998). This resulted in the emergence of what Dawe (1970) calls 'the two sociologies', wherein one emphasised macro structural issues and neglected the issue of human agency and how this framed and reproduced structure (such as Marxism and functionalism), whilst the other emphasised the issue of agency but tended to neglect the structural context in which this was constituted (such as phenomenology and ethnomethodology). It is argued that Williams' work, whilst explicitly recognising the importance of micro social life in framing the

macro, in that he argues that beliefs reflect the reproduction of religious values and the work ethic in biographical context, does not sufficiently draw upon approaches which can be seen to transcend the macro/micro divide or dualisms inherent in the approaches of the two sociologies. By contrast, the intellectual starting point of this study is based upon the proposition that the constitution of beliefs cannot be reduced solely to the realm of intentionality, nor can beliefs be thought of as exclusive products of society. As a consequence, this study draws upon perspectives which have called into question the notion that agency and structure should be considered as separate issues. As noted, it is posited that beliefs reflect a mutually constitutive relationship between self, body and society. Thus, this chapter outlines and examines some key ideas and approaches, relevant to the empirical focus of the research, which either explicitly draw inspiration from the idea that self/body/society are inseparable in terms of the question of agency and structure, or they may be considered to complement such thinking. Before examining these ideas, it will be useful to consider existing explanations of health beliefs and to examine this body of work in terms of the question of agency and structure.

Health beliefs: existing knowledge

In general, research shows that, as illness is a physical and tangible indication of limitations, it is this rather than health *per se* which is most significant to people. Illness has the potential to disrupt or prevent normal living and spoil identity (Bury 1982; Curren and Stacey 1986a; Radley 1993). As Pollock (1993: 49) has shown, health is usually defined, not as the presence or absence of illness, but in functional terms as something which provides people with the ability to carry out normal day-to-day tasks and activities. Illness, then, can be seen as irrelevant to symptoms and is often defined in terms which highlight the curtailment of activity. Therefore, illness is seen not as the presence of symptoms but as inactivity (Pollock 1993; Williams 1990). Thus being healthy can mean accommodating illness unless this curtails everyday tasks and activities (Pollock 1993; Sidell 1995; Williams 1990).

Another key idea in the literature is that popular beliefs about health and illness reflect moral judgements about a person's competence and integrity. Thus, bringing moral thinking and

practices to bear helps people to both legitimate their position as being sick and to cope with the severe biographical disruption that illness can cause (Gerhardt 1989; Williams, G. 1993). Good health, then, can be seen as a morally worthy state because it shows that a person has the capacity to engage in activities, particularly work. As Cornwell states:

There are obvious reasons why work and health should be connected in people's minds. Illness can incapacitate and prevent people from working. In doing so, it can threaten not only the practical basis of their lives but also their moral reputation. The moral philosophical argument which connects the two is less obvious, but it is none the less fundamental to the recurrent theme in public accounts of health and illness - of 'good health' being a morally worthy state and illness being discreditable. (Cornwell 1984: 127)

Overall, popular beliefs tend to associate health in moral terms with a virtuous and active life, and illness can be seen as a sign of sloth or even sinfulness which serves as a warning to individuals to alter their behaviour (Williams, G. 1993: 92). Popular beliefs therefore reflect a great deal of moralising about a person's sense of self and their place within the social order.

What of the determinants of popular beliefs? What factors can be considered significant in a causal sense? Two levels of analysis have been emphasised in the literature, the cultural and the social. On one level, beliefs are seen to take their meaning from explanatory frameworks which reside at a cultural level. For example, Kleinman (1986) argues that frameworks for the conceptualisation of health and illness reflect an interplay of values and beliefs derived from 'popular', 'folk' and 'professional' domains. The popular consists of social and community networks of friends, family, neighbours, and so on, and the majority of sickness is defined and managed in this domain. The folk consists of non-professional healing specialists such as 'wisewomen' in traditional societies who, in the absence of professional specialists, had a much more significant role in the treatment of illness. The professional, for example, scientific Western medicine, tends to hold the greatest status as an explanatory framework in contemporary society.

On the other hand, explanations of health and illness are also shaped by the social conditions of society. For example, Stacey (1986) argues that everyday concepts reflect the domination of powerful social groups whose interests they serve. Hence the dominance of scientific medical explanations in the West which locates illness within the body obscures or ignores the argument that illness can be seen as a product of inequitable social relations. For Stacey,

beliefs are a reflection of the structure of society, especially the division of labour, the social position of members and their experiences within social class and gender orders. Indeed, many writers have shown how social class and gender help to constitute explanatory frameworks (Blair 1993; Calnan 1987; Cornwell; 1984; Graham and Oakley 1986; Williams 1990).

Bringing together the social and the cultural, Williams (1990) argues that it is economic history under capitalism and religious history under Protestantism which, as cultural resources, serve as explanatory frameworks for older Aberdonians in biographical context. For instance, in emphasising the moral aspects of concepts, Williams highlights the importance of biographical experience in terms of working lives and to a lesser extent social class.

Among the biographical experiences that shaped Aberdonians' ideas about coping, one of the most prominent was the meaning which they had found in their working life. Some aspects of this meaning were class specific . . . much was more generally concerned with work as a moral value and as generational experience. (Williams 1990: 222)

Indeed, a strong strand in the literature argues that individuals, will give privilege to the explanatory frameworks from biographical experience over other grander forms of explanation such as those deriving solely from medicine (Kleinman 1986; Radley 1993; Williams, G. and Popay 1994). However, this is not to say that objective explanations, particularly those of bio-medicine which are grounded in scientific, rational and empirical knowledge, and which are dominant in Western theories of health, are seen to be excluded from the experiential (Curren and Stacey 1986b: 1; Stainton-Rogers 1991: 16). Rather, experience is seen to frame the objective in ways that are meaningful to individuals. This helps people to synthesise macro forms of domination, such as the economic order and bio-medicine which can be regarded as promoting certain forms of conduct and ways of thinking, with the micro context of lived experience. In other words, actors are likely to ground the macro in ways which they see as complementing biographical context, where the latter acts to frame broader forms of knowledge.

In noting that the constitution of beliefs reflects a complicated and diverse interplay between and within cultural, social and biographical contexts, the idea of individuals as 'capable

negotiators of reality' (Stainton-Rogers 1991) is explored in this study. For Stainton-Rogers, the multiple realities reflected in the broad range of explanations for health and illness show that, in bringing together such diversity in explanations which offer coherence and logic, people should be regarded as competent agents engaged in practices of 'explanatory sympatricity'. In Stainton-Rogers words, this helps to see:

people as clever weavers of stories, whose supreme competence is that they can and do create order out of chaos, and moment to moment, make sense of their world amid the cacophony. (Stainton-Rogers 1991: 10)

Thus explanatory sympatricity shows how people draw upon explanations which co-exist and compete with each other to create their own narratives or explanatory frameworks. These narratives are, therefore, not necessarily reducible to a dominant ideology or discourse. For example, as discussed above, Kleinman's (1986) division of cultural explanations, into 'popular', 'folk' and 'professional' domains indicates the diversity of sources that people have at their disposal, as does the influence of gender and social class orders, and the importance of generationally situated narratives in the constitution of beliefs. Indeed, the relevance of ideas which explain diversity are explored throughout this study. Hence the idea that the resources that people draw upon can be regarded as 'texts' is a key idea in the analysis of the data. This reflects Stainton-Rogers' argument that people should be seen as writers of stories 'who weave a narrative in and out of different texts' (1991: 228). Thus, rather like books in a library, the explanatory frameworks derived from biographical experience, medical knowledge, gender and social class orders, and so on, are regarded in this study as texts which are brought together by individuals in the constitution of their own beliefs. Such an approach, it is argued, examines beliefs in the context of issues of agency and structure by recognising the agency of individuals as reflexive social actors.

Health beliefs in later life

Discussion of health beliefs in later life has been largely absent from sociological analysis until very recently (Arber 1994). However, Herzlich (1973) and the previously mentioned Williams (1990) are relevant to the focus of this study since they examine the health beliefs of older adults as a reflection of the relationship between the individual and society. Herzlich's study

was carried out in France and involved middle class people from an urban area (Paris) and a rural area (Normandy). Of those interviewed 50% were over 40. The work of Williams focused on older working class and middle class Aberdonians.

Drawing on the Durkheimian tradition of 'social representation' which, as she states, allows 'us to draw conclusions about the social or cultural variability of the notions of health and illness' (Herzlich 1973: vi), Herzlich argues that the conception of health and illness parallels a distinction between the individual and society. Illness is described as a constraint upon the individual, which is caused by society. By contrast, health is seen as an internal property of the individual - something that was generated from within.

What lessons can be learned from Herzlich in terms of how health beliefs are conceptualised? In general, she emphasises that beliefs reflect the relationship between the individual and society by showing how respondents saw health to be derived from the natural world and illness from the unnatural. For Herzlich, respondents conceptualised health in 'endogenous' or internal terms as something residing within individuals, whereas society and illness were thought of in 'exogenous' or external terms and equated with the unnatural. Thus society makes people ill because it makes them lead an unnatural life. What this also reveals is a sense that when individuals feel they cannot control their everyday lives, when they feel disempowered and at the mercy of forces beyond their control, they are susceptible or vulnerable to illness. Thus Herzlich describes how the spatial and temporal contexts of everyday life could be seen to be 'constraining' and 'unhealthy' (1973: 28). Individuals could feel constrained by a way of life which imprisoned them. As a consequence, they felt powerless to be able to change their lives. Thus factors such as pollution, noise and work were described as unhealthy. However, they could not be avoided. Indeed, the constraints of day-to-day living affected individual conduct in that, 'The rhythm of life and time schedules of everyday life are experienced as constraints which are reflected in the conduct of everyone . . . as externally imposed relation[s]' (1973: 29). Thus when individuals feel that their way of life is not controlled by them, that they are simply passive players in a set of relations from which there is no escape, this leads to 'conflict' and 'antagonism'. This hostile way of life, then, is seen as the determining factor in the constitution of illness.

With Herzlich, then, a particular argument emerges that respondents felt that alienation or insecurity caused illness. Whilst this explanation may be based on her data, it is theoretically generalisable. Here we can draw on Giddens' idea that actors strive to maintain 'ontological security'; that is, the methods available to actors to bring about a feeling of purpose and coherence in human existence by maintaining a constant strand of meaning. However, security can be contested and threatened by bodily crises, which ageing inevitably involves. In the words of Giddens:

The maintenance of a framework of 'ontological security' is, like all other aspects of social life, an ongoing accomplishment of lay actors. Within the production of modes of interaction in which the mutual knowledge required to sustain that interaction is 'unproblematic', and hence can be largely 'taken for granted', ontological security is routinely grounded. 'Critical situations' exist where such routine grounding is radically dislocated, and where consequently the accustomed constituting skills of actors no longer mesh in with the motivational components of their action. (Giddens 1993: 124)

Thus the inevitable demise of the body in later life and the realisation of impending death can bring about a critical situation for older people. However, contemporary discourses which promote individualised reflexivity or tell you to 'look after yourself' are, it is argued, challenged by the interviewees as insufficient strategies to deal with physical decline and the impact this can have upon their sense of self. This is reflected by their emphasis upon collective responsibility and reciprocity as a moral strategy to maintain ontological security through the preservation of a normal way of life and an essential and moral sense of self. The process of individualisation, which forms the social backdrop to look-after-yourself discourses, it is argued, can be considered to be thought of by the interviewees themselves as something that has the potential to turn their worlds upside down. The idea of social reciprocity was particularly prominent in the data as a vocabulary of motive in the social worlds of the interviewees. The contemporary social order was thought to promote forms of conduct and behaviour which emphasised the importance of the individual over the group. Resisting such messages, therefore, indicates a strategy of attempting to maintain ontological security by constructing themselves as actors with morally superior values and beliefs to those of the present world.

Returning to Herzlich, in psychological terms she shows how conceptions of health and illness reflect social representations of health as endogenous and illness as exogenous. But what

about issues of agency and structure? So far all that can be seen is that the conception of health and illness is explained as a function of social representation. For Moscovich, writing in the *Foreword* of Herzlich's book, a social representation is a system of beliefs and practices which both (a) gives a sense of order to individuals and (b) provides a system of meaning through various codifications and classification of 'aspects of the world' for individuals to communicate with one another (Moscovici 1973: ix-xiv). A social representation, then, can be regarded as a vocabulary of motive, in that it provides people with explanations and practices to both live and understand their daily lives. However, what about the pattern of individual interpretations and responses to health and illness as a social representation? Is this uniform or are there differences? Whatever the case, how can this be explained? In these contexts Herzlich is less than definitive. Herzlich implies that the interpretation of health and illness is universal - the metaphors of health as endogenous and illness as exogenous suggest a uniform interpretation. These representations, she argues, symbolise the penetration of ideas that individuals are at fault within a self-conception of illness (1973: 49). An individual feels responsible for 'his' health because 'he has allowed his health to be impaired or undermined, not for having caught an illness but for having lost his health' (1973: 49-50). Yet, at the same time, she implies there are a range of different responses to this interpretation. Thus individuals are described as engaging in a range of different 'hygiene' practices 'for the preservation' of health which include attention to diet, sleeping habits, relaxation and personal hygiene. However, what she neglects is the issue of the variety of hygiene strategies different kinds of people are likely to engage in. Thus, the issue of agency is neglected. Indeed, Herzlich's analysis can be thought of as a form of structural functionalism in that we are left with the answer that hygiene strategies, as forms of agency, are a functional response to health and illness as social representations. However, Herzlich does not sufficiently explain why individuals engage in some or all of the hygiene strategies she outlines. Therefore, the question of how they reflect different takes on health and illness as a social representation is neglected. Other than saying 'hygiene corresponds to the way of life', which Herzlich distinguishes as either urban or rural, and 'hygiene measures also depends upon the individual's state of health' (1973: 100), there is no examination of issues of agency in social context. Thus Herzlich does not explore the constitution of health and illness as a social representation in terms of the influence of biographical and life course factors, such as the

importance of working lives, gender and social class factors, which were discussed above in relation to the general literature on health beliefs. Herzlich's analysis does provide important pointers in terms of structural issues like social representation, however, in terms of issues of agency, her analysis is insufficient or limited. The Scottish study by Williams, however, can be seen to represent a development of Herzlich's analysis that is more sensitive to issues of agency.

The Scottish study

Rory Williams' work in Aberdeen (1990) has many parallels with the Herzlich study. Each author sees the perspectives of their respondents as a reflection of the link between society and the individual. There are also many similarities in their categorisation of the concepts of health and illness. However, Williams' study differs from Herzlich's in six key ways. First, aside from the difference in geography and culture, his sample was exclusively made up of older Aberdonians. Second, and probably as a consequence, much more attention was given to the issues of ageing and death. Third, Williams also looked at concepts related to 'visiting the doctor' or using the health service more generally. Fourth, explicit attention was given to the issue of social class, in that his sample was drawn equally from a middle class and a working class area. Fifth, the issue of constraint was seen as important because he was concerned to describe the influence of dominant values and beliefs drawn upon by Aberdonians. However, unlike the French respondents, the Aberdonians were much less likely to equate the macro social world with the idea of illness. Illness was seen to derive, not from external sources, but largely in moral terms as the result of inactivity. It was also considered to be the inevitable result of decline or 'old age'. Sixth, in terms of their analytical frameworks, both authors stress the importance of seeing beliefs as a reflection of the relationship between the individual and society. However, Herzlich stresses the general psychological content and mechanisms of individual cognition that link the individual with society by emphasising the grounding of beliefs in social representations. Williams' explanation of this link, however, is explicitly sociological. He uses a social resource model to show how individual biography involves the accumulation of 'coping resources' derived from working lives and religious beliefs. One could also argue that Williams' analytical framework

is Weberian, in that he emphasises agency as well as constraint. Thus he adopts what could be described as a *verstehen* methodology to examine subjectivity by considering, at the level of individual biography, the 'moral and economic resources Aberdonians drew on to consider illness, ageing and death' (1990: 1).

In terms of a dominant set of values which governs the Aberdonians' talk and deeds, Williams argues that it is economic history under capitalism and religious history under Protestantism which are most significant. This 'Protestant legacy' is reinterpreted or reconstructed by individuals. Thus ways of thinking and acting in the face of illness, ageing and death, are described as 'coping strategies', which reflect the nature and quantity of 'coping resources' accumulated in biographical context. These resources are summarised under the headings of working experience, material wealth and religion.

For example, he maintains that senses of meaning derived from working lives were very prominent. Work was seen as a moral value and a generational experience, and the influence of the work ethic often shaped Aberdonian coping strategies. Thus in his case study of Mr Esslemont (1990. 232-5), a person who was always devoted to hard work and productive labour throughout his life, Williams shows how such biographical features provide a major coping resource; this allows Mr Esslemont to keep illness out of his mind and take little interest in medical treatment. What was most important to him was simply being able to keep up his activities. He was happiest when he was making things and he considered these products as a source of currency, as he had for all his labour throughout his life. Thus, he told Williams that he saw his state benefits as a hard earned reward for his lifetime of work.

Most prominently, health was thought of in moral terms, not as the presence or absence of symptoms, but as the ability to lead a normal life. Relatedly, illness was thought of as a state of affairs where activity was severely curtailed or prevented altogether. Activity was held to generate health and inactivity caused illness. Thus health and illness were explained in moral and mechanistic terms. On a moral level, protecting or generating health was achieved by various means, including adhering to the normal way of life (including socially sanctioned activities, such as beneficial work in pensioner clubs, masonic meetings and the church) or, on a more everyday level, by maintaining high standards in tasks such as housekeeping and

gardening (1990: 33-34). Williams describes how this highly moral way of life has its roots in the Protestant ethic of hard-work, stoicism, self-control and respect. This is reflected in a willingness to engage in activities which help to preserve and reproduce such values and beliefs. In answering moral questions posed by illness, concerning the meaning of suffering, how to cope and the sources of healing, then, Aberdonians drew upon their Protestant inheritance. Most prominently they had moved away from the Puritan idea of illness as a punishment for sin and looked to Protestantism to give meaning to the process of suffering. In particular, the idea of overcoming suffering was seen as something providential where active struggle would be rewarded and encouraged. As Williams states:

Aberdonians . . . treated suffering . . . as an occasion for learning lessons of faith. They sought, not to explain the cause, but to give meaning to the process of suffering. The faith they learnt was that suffering would pass, that whatever the cause it was a period of trial, and that . . . the 'good things'-divine provisions, consolations, and answers to prayer-could be seen . . . to be occurring in the course of it, so that further explanation was not absolutely required. This was the view which permitted the recognition of miracles in response to prayer, and of something 'fated' or 'meant' in the unexpected resolution of practical difficulties. (Williams 1990: 288)

Thus given the moral backdrop to Aberdonian explanations, it was important for them to view their own ailments as a result of unavoidable mechanical breakdowns in the body. This view was prominent as a means of seeking to avoid the notion that illness or suffering was a consequence of reprehensible conduct and behaviour - a punishment for sinfulness. As Williams elaborates in describing different understandings of illness:

Two concepts of health . . . intertwine in Aberdonian talk, one emphasising moral, and one mechanical, explanations. According to the moral account, the normal way of life in Aberdeen is health giving . . . [Thus] those who saw illness as a test of achievement believed they could maintain their normal way of life against all odds by sheer moral effort; while those who saw illness as exile believed that effort notwithstanding, there were circumstances in which they would not be able to maintain their normal way of life, and that their essential moral self would in that case be lost . . . [Those who saw] illness as legitimate disengagement . . . sometimes pleaded age or the status of being a patient as a justification for their passivity, but some were beyond bothering about normal behaviour and wished merely to give up and rest. (Williams 1990: 52-3)

As noted, other research shows how people often think in moral terms about health and illness. In particular, illness is more significant as a trigger for moral thinking because it can prevent normal living or activity. Thus it can be posited that older adults, who face an increased likelihood of chronic illness, disability and death (Sidell 1995: 131), are much more likely to use moral reasoning in their explanatory frameworks. Williams' research clearly confirms this view in terms of how ageing, illness and death is understood by reference to the

idea of an essential moral self. Other studies also confirm the idea of older adults constructing and maintaining a sense of a moral self. For example, Stephens' study of older adults living in 'single room occupancy' in a hotel in Midwest America shows how they think of dependency with disdain - reflecting an attitude towards it as a 'cardinal sin' (quoted in Hepworth 1995: 179). Stephens shows how the residents were extremely fearful of losing their independence and their way of dealing with it was to engage in strategies which preserved a view of themselves as moral actors. This involved comparing mental and physical capacities with the 'sometimes visible and rapid decline of other aged tenants' (1995: 179) and creating a self-enhancing biography in the presentation of self-identity to others and to themselves. Jerrome's study of relationships between older adults in old people's clubs on the south coast of England also describes how their beliefs about ageing reflect a view of it as a 'moral category' (1995: 181):

Responses to it are a matter of virtue and moral strength or weakness. To be happy and make the most of things in spite of pain and hardship is a moral and social obligation attached to the status of the old or handicapped person. Those who fail are blameworthy and tend to blame themselves. (Jerromecited in Hepworth 1995: 181)

Wenger's study in rural Wales also found that moral themes were prominent in the thinking of older adults. As she argues:

Good health is associated with the right attitudes and moral fibre and complaining or talking about health is seen as self indulgent' (quoted in Sidell 1995: 31).

Moral reasoning, then, is almost unequivocally most prominent in the beliefs and attitudes of older adults.

In summary, six general themes can be discerned in the existing literature. First, the explanatory frameworks of individuals can be considered as socially and culturally constituted in that they may reflect the position of people within gender, class and age-related social orders. They may also be seen as a reflection of dominant vocabularies of motive within cultural meaning systems, such as those deriving from professional, popular and folk domains. Second, explanatory frameworks tend to involve a number of moral themes, especially when illness is more severe and this is particularly prominent amongst older people. Third, illness rather than health is most significant for people because it can curtail or prevent

activity. Illness can therefore be seen, not in a mechanical sense as the presence of symptoms, but in a socially meaningful way as the curtailment or prevention of activity. Thus activity is often seen to generate health and inactivity may be thought to generate illness. Fourth, both where people feel they cannot control their environments and, indeed, where they feel they cannot prevent the mechanical demise of the body which ageing inevitably involves, they may feel disempowered and at the mercy of forces beyond their control. As a consequence, they may feel vulnerable to illness. Fifth, the constitution of beliefs by individuals can be regarded as a creative strategy which brings together a number of diverse, competing and complementary explanations or texts of meaning. Individuals weave together such texts as competent negotiators of multiple realities to make sense of their experience in biographical context. Sixth, individuals can be seen to engage in different kinds of cleansing strategies to maintain health. These can be mechanical, such as paying attention to diet, exercise, sleeping patterns, avoiding potentially harmful environments, and so on. Alternatively, they can be moral. For example, older people may strive to maintain forms of conduct and behaviour and general ways of thinking which they perceive to be part of an essentially worthy sense of social identity. This also provides a way of cleansing the self against the impurities which are associated with physical decline and ailment, as well as a means of coming to terms with the prospect of death. In other words, moral hygiene strategies can be understood as a means by which older adults maintain ontological security in coping with illness and the finitude of their mortal existence.

Indeed, all of the above themes are present in the data and they are examined in the analysis that follows. As noted above, however, it is argued that the analytical framework adopted in this study seeks to move away from the structuralist orientation implicit in much existing research on older adults by recognising the mutually constitutive relationship between agency and structure in the production of beliefs. In doing so, it is argued that beliefs need to be examined as products of a permeable relationship between body, self and society. Ideas and perspectives which complement this way of thinking are drawn upon in the analytical framework of this study and are now examined in the remainder of this chapter. It is argued that, as the beliefs of older people reflect the problem of sociology, since they are produced in the context of the relationship between the individual and society, the theoretical approach

offered here may be considered as a contribution towards answering the questions posed by the complicated and thorny issue of agency and structure.

Key analytical concepts

In analytical terms, ideas that health beliefs are derived from two sets of resources are developed here; that is, the resources offered by the experience of biography and those at a broader cultural level in terms of general beliefs about health. In particular and to borrow from Bourdieu, a number of 'thinking tools' are used to make sense of how such resources are reflected in interviewee health beliefs. Therefore, interviewee resources are theorised as a set of texts which comprise experiential knowledge or biography, vocabularies of motive, narratives, generative discourses, and Bourdieu's notion of the habitus. They are described here in summary form and will be fleshed out in the analysis of the data. It is argued that the use of such thinking tools helps to place the beliefs in the context of the relationship between individuals and society.

The idea of texts is derived from the use of the concept in the work of Derrida (1976), Stainton-Rogers (1991) and Fox (1993). In brief, these writers consider a text as a genre for understanding, containing a range of signs, cues and narratives which can be interpreted differently by different individuals, thereby resulting in a 'slippage of meaning'. Thus, writers of texts, such as books, plays or films, may have intended storylines and narratives, but these may be interpreted quite differently by readers or viewers in ways which contradict the author's original intentions. For example, the early seventies film *A Clockwork Orange*, noted for its violence, was withdrawn from original release by the producer Stanley Kubrick in response to criticisms that it inspired 'copy-cat violence'. Kubrick argued that the film was intended to highlight the futility of violence. However, his withdrawal of his own film indicates that he accepted the view that it was having the reverse effect to that which he originally intended.

This study is premised upon the idea that texts are frames of meaning and understanding that exist both within and in-between the spaces between biography and society. It is posited that the different ways in which texts can be interpreted suggests that interviewee beliefs can

neither be reduced to the social world nor to the consciousness of individuals - rather, they reflect an interplay between the two. Moreover, it is posited that the previously introduced idea of 'explanatory sympatricity' (Stainton-Rogers 1991), which emphasises how individuals, as competent agents, draw upon a range of texts of meaning to create their own narratives, helps to move away from the idea that all meaning is ideologically determined - as does the notions of the 'death of the author' and of 'self-evolving texts'. In terms of the latter two ideas, as Bauman explains:

the beginning of the distinctly postmodern era coincided with the proclamation of the 'death of the author' . . . all the most perceptive observers of the convolutions of contemporary culture and the suppliers of its most influential self-interpretations point to the anonymity of the self-evolving texts, to which the authors lost their cherished privileged access, forfeiting on the way their past monopoly of meaning-making and interpretation. (Bauman 1997: 160)

The notion of texts, therefore, counters theories which depict individuals as vehicles of ideologies or discourses. It also helps to emphasise the fluidity of meaning and interpretation, and older adults' capacities to negotiate, manipulate and resist texts which undermine their social identity - such as ageism - in ways which reflect the privileging of local texts of meaning, sensitive to biographical context. Moreover, the idea of self-evolving texts shows that meaning can be unintended and is, therefore, not reducible solely to the social order or to individual intentionality. In particular, this is because of 'intertextuality' which refers to the slippage and trade-off in meanings created by the impact of different texts upon each other, as no text can be seen to be independent of another (Fox 1993). For example, it is well documented that lay conceptions of health - which can be thought of as texts - contain mechanical explanations of illness derived from the biomedical model (Currer and Stacey 1986a) - which can also be considered as a text. Relatedly, medical practitioners can draw from folk texts (Helman 1986) or gendered texts (Graham and Oakley 1986) in the constitution of their explanatory frameworks. In overall terms, therefore, the notion of texts is used in this study as an analytical metaphor which helps to understand the constitution of beliefs in terms of diversity, and, as noted, especially through the idea of explanatory sympatricity, as a means of foregrounding the agency of individuals who create their own texts of meaning.

Within experience as a textual frame of meaning, it is argued that interviewees draw upon general repertoires of explanations and rationales in constructing their beliefs, in ways which

accord with and reflect their life experiences. It is proposed that this can be understood by using Mills' idea of 'vocabularies of motive' (Mills 1940). For Mills, such vocabularies are generated by popular narratives which provide a means of understanding the social world. As noted, the aim of the study is to establish if a central vocabulary of motive can be identified in the shaping of interviewee beliefs. This idea draws upon Mills' argument that motives should be thought of as 'typical vocabularies' which are put to use in 'delimited societal situations' (Mills 1940: 904). That is to say, individuals are likely to think and act in relation to the dominant narratives available to them in a given situation. Motives, therefore, are not 'inert springs of action', they are products of both structure and agency.

It is argued that interviewees constructed and maintained a sense of connectedness in ways which reflect the constitution of 'imagined community' as a key vocabulary of motive. For the group, this community emphasised beliefs and practices orientated towards connectedness and a sense of belonging. The term 'imagined' is used because it was often not possible to interact in a face to face way with other members of the community who could be dead relatives and friends, the famous and the powerful and fictional characters from literature and TV. To all intents and purposes, members of the community were, then, identikit archetypes who served as role models for the interviewees who also represented themselves as members of the community. The way in which imagined community served as a key vocabulary of motive for the group is fleshed out in the data, but it will be useful to give a brief overview here.

In presenting themselves as connected individuals, it is argued that interviewees are orientating themselves to what they regard as a normal way of life as a means of maintaining an essential and moral sense of self that also reflects a quest for ontological security. A sense of connectedness was maintained in a number of ways by the group. In a most tangible sense this involved engagement in activities which were thought to be beneficial in pensioner clubs, the church and most prominently, by befriending, helping or caring for other older adults who were deemed to be less fortunate than themselves. Such activities were often described in ways which indicated the use of narratives which were held to be generationally situated, stressing values such as reciprocity, benevolence to the less fortunate

and independence. On another level, interviewees could be seen to be applying the work ethic, which many highlighted as being prominent throughout their lives. Thus everyday activities, such as gardening, do-it-yourself and housekeeping, where high standards could be achieved and maintained, were seen to generate health. On a less tangible level (in that the above activities are a summary list of what interviewees actually said they did), the values and beliefs reflected in the way they described how and why they engaged in such activities indicated the use of narratives which were thought to be more common to older people than to the contemporary social world and to younger people. The interviewees, therefore, could be seen to be highlighting an essential and moral self - reflecting a generational compulsion to maintain ontological security. For example, a prominent theme was the desire to feel independent and not to be a burden upon others. Thus helping others, rather than being helped by others in ways which could not be reciprocated, was often highlighted as desirable. In addition, doctors were often portrayed as being more holistic and nicer people in the past. People, more generally, were seen to be more polite and less selfish than they were in the contemporary world. Thus a preference for 'old world' values and conduct or feeling 'too old for the times in which we live' were commented upon.

In both an objective and subjective sense, narratives are seen as forms of explanation which are used in everyday life. For example, they may be associated with a particular generation or, if used by any given actor to imagine or represent health and/or ageing to themselves or to others, they may reflect life experiences. Put simply, a narrative can be thought of as a story which links a series of events in a logical and temporal order. A narrative, therefore, follows a temporal logic and has a beginning, a middle, and an end. Thus, for Denzin:

A story . . . tells a sequence of events that are significant for the narrator [the respondent/social actor] and his or her audience. A narrative as a story has a plot, a beginning, a middle and an end. It has internal logic that makes sense to the narrator. A narrative relates events in a temporal, causal sequence. Every narrative describes a sequence of events that have happened. Hence narratives are temporal productions. (Denzin cited in Coffey and Atkinson 1996: 55)

Telling a story is an obvious way of retelling experiences and events to a stranger. Indeed, lived experience is usually ordered into a narrative form. Thus writers have described how individuals reflect on their lives as a meaningful narrative (Thompson *et al* 1990). As Coffey and Atkinson argue:

Social actors often remember and order their careers or memories as a series of narrative chronicles, that is, as series of stories marked by key happenings. Similarly, stories and legends are often told and retold by members of particular social groups or organisations as a way of passing on a cultural heritage or an organisational culture. Tales of success or tales of key leaders/personalities are familiar genres with which to maintain a collective sense of the culture of an organisation. (Coffey and Atkinson 1996: 56)

Consideration of narratives as resources for the interviewees raises a number of questions: Is it correct to assume that culture simply provides prescriptive narratives on how later life should be acted out? Do older adults simply think and act in particular ways as passive puppets of pre-existing 'cultural scripts' or unfolding plots, with prescribed roles and norms (Blau 1973; Mehta 1997), over which they have little or no control? Alternatively, can narratives be simply considered as stories told by older adults themselves to give a sense of order to events in life which in themselves have no inherent order? Answering these questions is also crucial in addressing questions of agency and structure - a core consideration of this study.

In the doctrine of 'narrative realism' human stories are pre-determined by social structures and individuals simply live out such narratives (Fay 1996:179). For example, Fay points out how in the work of universal historians such as Saint-Simon, Hegel and Marx, history is portrayed as unfolding to a particular plot which follows its structured and pre-determined nature (1996: 180). Thus in this perspective narratives are emphasised as lived in a way which denies their, as it were, 'told' character by actors. By contrast, 'narrative constructivism' argues the reverse; narratives are constructed after the event in the retelling of unordered events which are linked into a logical sequence which reflects the actor's perspective (1996: 190) or agency. Such personally constructed narratives, then, can be considered as relative to individual intentionality and the consequent aims any agent has in mind by constructing the narrative. The problem with such a perspective is that it downplays or discounts the role of cultural narratives by privileging subjective narratives. It thus highlights the telling or constructing of narratives by agents, but denies the idea of narratives as a lived character. What needs to be taken into account is that each approach is too one-sided. In the words of Fay, they:

fail to do justice to the fact that the ongoing activities of agents both individually and collectively already embody narratives. [They] thus fail [in their separate ways] to account for the fact that intentional agents employ narrative forms to display the intelligibility of their actions. (Fay 1996: 194)

To paraphrase Marx, actors create their own narratives but this is achieved by drawing upon existing narratives which are not of their own choosing. Following such an understanding, 'narrativism' as a third approach to narrative analysis merges realism with constructivism (Fay 1996). In invoking moral questions such as, Why am I doing this? or those pertaining to the consequences of What am I doing? which physical decline and ailment in later life and the realisation of impending mortality often invokes (Williams 1990; Sidell 1995), one can argue that the agency of older people is inescapably narrativised in form. For example, religious related narratives (Moberg 1993; Williams 1990: 280-315) and the work ethic (Blaikie 1999: 175; Kohli 1988; Williams 1990: 222-248) have been identified as significant sense-making devices - that is, vocabularies of motive - for older adults.

In short, the use of narratives as resources which are drawn upon to construct beliefs is seen to reflect embedded narrativity, in the sense of a convergence between broader cultural scripts and subjectively constructed narratives, in biographical context. Following the notion that narratives are key resources, the idea that beliefs reflect a narrativised *performance* of later life is also explored. The idea of performance draws upon Goffman's argument that identity is constructed and presented within interactions with others (Goffman 1990). Thus any actor's presentation of identity to another - that is, what Goffman calls 'the presentation of self' (1990) - involves giving off signals about themselves which they regard as appropriate. For Goffman, presenting the self involves 'impression management' which represents a dramatisation at the interface of public image and self-image. In a development of Goffman's ideas, Butler's notion of gender as a performative act 'instituted through the stylisation of the body' (Butler 1990: 270) also finds parallel here. Thus, in thinking of later life as performance, I propose as a starting point that one is not simply an older person in a way which is devoid of cultural meaning. Rather, one becomes an 'old' or 'older' person in the sense of how people, as actors, understand the meaning of 'later life' or 'old age' from cultural scripts and how, as agents, they can reconstruct different meanings in ways which produce a narrative sensitive to their biography. Just as Butler argues that gender should be understood as 'the corporeal locus of cultural meaning both received and innovated' (1987: 128), older bodies can be seen as the point of convergence for the performance of cultural and subjective narratives. To paraphrase (Butler 1993: 2), the notion of the performance of later life refers not to a singular

or deliberate act, but rather, to a reiterative and citational practice by which discourse produces the effect that it names. The citationality of later life related beliefs and practices, as reflected in the beliefs of the group, are explored in the data analysis as something which is grounded in the construction and maintenance of ontological security in later life. In particular, the idea of later life as a performance is explored in a case study analysis of one woman's health beliefs; generally, these are seen as a reflection of her grief and sense of loss over her recently deceased relatives.

Bourdieu's idea of the habitus' is also thought of as a resource which interviewees use to conceptualise their beliefs. In particular, it is seen as something which brings together the subjective and objective. As Bourdieu argues, and as a key principle which informs this study, the subjective (for example, what people think) cannot be separated from the objective (such as general values and beliefs peculiar to a group or society). Bourdieu's concept of the habitus is intended to transcend such a false distinction. For Bourdieu, the habitus is 'an acquired system of generative schemes . . . and dispositions' which inform the practices of agents, that is, what people do in everyday life (Bourdieu in Jenkins 1992: 74). In being derived from a combination of the subjective and objective, the concept offers flexibility in that it moves away from the idea that phenomena like beliefs are determined by rules or that they are simply mirror images of intentionality. As Bourdieu elaborates:

The conditioning associated with a particular class of conditions of existence produce habitus, systems of durable, transposable dispositions, structured structures predisposed to function as structuring structures, that is, as principles which generate and organise practices and representations that can be objectively adapted to their outcomes without presupposing a conscious aiming at ends or an expressed mastery of the operations necessary in order to attain them . . . without being in any way the product of obedience to rules. (Bourdieu 1990: 53)

He also argues that the dispositions and representations that agents are likely to employ are primarily shaped by experience. In addition, and complementing the previously mentioned idea that the body is the key site which links the self and society, the habitus can be seen to be embodied. As Jenkins notes, the habitus resides within the body in three particular ways (1992: 74-5). First, in an obvious sense, the habitus only exists in the thoughts of actors (and thoughts are in the brain, which is in the body). Second, it is only manifested through an actor's practices and in their interactions with others and the rest of their environment. For

example, the habituses of the interviewees are manifested in their representations of ageing and health in an interactional context as between interviewee and interviewer. Third, the habitus is embodied because of what he describes as its 'generative schemes' or 'practical taxonomies' which can be associated with the body. Such practical taxonomies involve sets of distinctions such as hot/cold, up/down, male/female, and so on, which are all primarily embodied as part of an actor's senses.

The notion of generative discourses draws upon the Foucauldian idea that the social world consists of discourses which produce certain forms of knowledge about appropriate kinds of identity, conduct and ways of understanding the social world (Armstrong 1987). For Foucault, a discourse, such as medicine, which is akin to a language, includes regulatory practices to discipline and police members associated with its jurisdiction (Foucault 1977 1979a). Thus, by drawing on a Foucauldian perspective, Katz (1996) argues that many popular values and beliefs about the older body can be associated with medical discourses which link 'old age' with illness and decline. In particular, this study explores the influence of the discourse of conventional medicine within the beliefs of the interviewees. To a lesser extent the influence of work, which may also be considered as a vocabulary of motive, is also considered, since many interviewees drew upon narratives associated with working lives. For the small number of people who expressed religious convictions, the way in which they draw upon the generative discourse of religion is also explored.

As noted, the analytical concepts used in this study can be considered as helpful in addressing the problem of sociology because they help to transcend the idea that agency and structure are separate issues. The following sections therefore examine the merits of drawing upon the life course approach and the sociology of the body as, it is argued, they too share a similar concern.

Key perspectives: the relevance of the life course approach and the sociology of the body

In considering these perspectives it should be noted that in intellectual terms they accord with the insights derived from the previously mentioned debate about the two sociologies. In particular, Giddens' version of 'structuration theory' (Giddens 1984) has been an influential contribution to more recent attempts to tackle the problem of sociology and is a much used resource. It will be useful, therefore, to discuss Giddens' ideas in the context of the focus of this study. The basic starting point of Giddens' structuration theory is a rejection of the dualisms in classical writings. Whilst the full details of Giddens' theory are not of relevance here, I shall concentrate upon two issues which illustrate its potential and limitations. The first concerns his idea of the 'duality of structure'. Instead of a dualism which separates action and structure, he argues that we should think in terms of a duality of structure. This helps us to think of action and structure as two sides of the same coin. For Giddens, the two are united through the social practices of agents. He places great emphasis upon human agency, thus social practices reflect the potential of agents to change or modify the situations in which they find themselves. In other words, he is stressing the connection between agency and structure. Therefore 'structure' is both the medium and outcome of social activity (Giddens 1984). For Giddens, structure (unlike in objectivist writings that discuss it in terms of constraint) contains rules and resources that agents draw upon to produce and reproduce society. What he is arguing, therefore, is that structure is 'internal' to activity, it should not be thought of as having an existence which is independent of human activity. One of the most compelling features of the idea of the duality of structure lies within its concern for the notion of human agency. For Giddens, social actors 'are not puppets of objective structures and they are not dupes of cultural systems' (Turner 1992: 85). For example, older adults can resist the imposition of the category 'old' because it is damaging to individual status (Hockey and James 1993: 172-3; Pilcher 1995:114-5; Thompson *et al* 1990). Moreover, the idea of the duality of structure helps to highlight how older people have the capacity as agents to draw on rules and resources from structures which undermine them in ways which reflect their agency. Thus Hockey and James (1993: 171) argue that older adults draw upon adult and childlike categories they are 'betwixt and between' to subvert social practices and categories which

stigmatise them. Giddens' ideas, then, have some merit in that they parallel research which emphasises the agency of older adults. However, because Giddens refuses to contemplate the idea that structure can exist independently as a constraining feature, this leaves a rather fuzzy set of ideas to understand the origins and existence of 'ageism' as a structural *constraint* upon the activities of older people.

This issue of the neglect of constraint leads into the second aspect of Giddens' theory which is relevant here, namely, his neglect of the body in structuration theory. Whilst the relevance of the 'sociology of the body' to the analysis is discussed later in this chapter, it will be useful to briefly explain the point about Giddens' lack of consideration of the body. As Turner (1992: 87) notes: 'Giddens has yet to address the question of the body of the agent in structuration theory, despite the few hints . . . in *The Constitution of Society*'. Thus he recognises the importance of the body as 'a topic of reflexive inspection', for example, contemporary lifestyle magazines stress that we keep fit and look good. However, as Turner argues: 'such observations have yet to be systematically built into structuration theory' (1992: 87). For Turner, Giddens relegates the body to a 'sub-stratum' of action as a constraining feature because he has a concern to emphasise the knowledgeability of the creative actor. Therefore, 'he has a built in tendency to oppose any and all forms of biologism . . . as versions of a positivistic reductionism' (1992: 87). In Giddens' more recent concept of the 'self as a project' in conditions of detraditionalisation, where the power and influence of traditional authority, such as religion and science has declined, the self becomes a target of regulative practices from different discourses such as psychiatry, psychology, medicine and self-help manuals (Turner 1995a: 255). However, this idea fails to recognise that the body has also become a space for regulative practices such as dietary regimes, keeping fit and 'looking good' which enhance the surface of the body as a system of sexual symbolism to produce pleasure (1995a: 256). For Turner, 'in modern societies, consumer culture has made the project of the body a general activity' (1995a: 256-7). Therefore, the body becomes 'a project alongside, or inextricably bound up with, the self as a project' (1995a: 257).

Returning to the issue of ageism, the idea that the outer body can be interpreted as representative of the self - reflecting the view that the surface of the body represents some

kind of inner condition - will clearly make the physical consequences of ageing more acute for older adults. Giddens' theory stresses the autonomy of the actor as a thinking and choosing agent and so downplays the role of the body. This makes it difficult to feature the role of the ageing body in relation to phenomena such as beliefs. The negative consequences of ageism for people with older bodies lacking symbolic value are, therefore, much more difficult to theorise through recourse to Giddens, given the absence of the body from his structuration theory.

To be sure, then, Giddens offers a way forward in transcending the dualisms of classical social theory. In particular, his theory foregrounds the agency of individuals by arguing that structure is only constituted in the everyday practices of individuals. On the other hand, this neglects the idea that structure can exist independently of individuals and makes it difficult to explore how structures, such as ageism, can constrain and devalue older adults. In addition, the neglect of the body in structuration theory, fails to account for its mediating role in relation to issues of agency and structure. In overall terms, Giddens' ideas offer a necessary way forward in terms of transcending the idea that agency and structure are separate issues. However, they can be called into question in terms of their sufficiency. The same criticism cannot be made of the life course approach and the sociology of the body. Moreover, it is argued they also provide a way of foregrounding agency, without separating it from issues of structure.

The life course approach

The life course approach is a way of exploring relationship between the individual and society in terms of the role of time, relationships and, more recently, the role of the body in shaping 'intentions', identity and the different interpretations of age-related categories within and between societies and cultures. Thus for Harven:

A life course perspective views the interrelationship between individual and collective family behaviour as they constantly change over people's lives and in the context of historical conditions. The life course approach is concerned with the movement of individuals over their own lives and through historical time and with the relationship of family members to each other as they travel through personal and historical time. (Harven, cited in Bryman *et al*: 1987: 2-3)

For Harven, the life course approach examines the role of *personal, family and industrial time*. Personal time refers to the values and beliefs individuals identify with in terms of their own experiences, thus social mobility may mean that individuals adhere to values of thrift and economy if they came from economically deprived backgrounds. Family time refers to the influence of different time periods related to significant others, by, say, adhering to quasi-religious values and practices associated with dead partners such as 'helping the less fortunate', 'giving rather than receiving', charity work, and so on. Harven's notion of industrial time emphasises the role of social change and experience. Thus examples here could include the incidence of rationing, conscription, pre-NHS health care and so on and the mythical idea that society had a greater sense of community in the past. All of these examples are to be found in the data, however the influence of industrial time is most prominent.

The life course approach has been used in the study of families and, in particular, by writers concerned with mid-life and later life (Featherstone and Hepworth 1998, Hockey and James 1993; Williams 1987). The key characteristics of the life course approach can be best further illustrated by reference to the *life cycle* approach, which separated the individual and society and previously dominated the way ageing was conceptualised.

The main premiss of the life cycle approach was based on an 'ages and stages', developmental model of human ageing. In this view people were seen to pass through fixed stages of development. These were characterised by typical physical, psychological and social dimensions. Individuals, therefore, were seen to move in chronological order through different stages of the life cycle, such as infancy, childhood, youth, adulthood and old age. The main criticism of this approach is that it fails to account for variations and continuities in social status experienced by individuals as they mature (Hockey and James 1993: 14). Therefore using a life cycle approach makes it very difficult to account for cross-cultural and historical variation in the way in which ageing is shaped and experienced. It fails to take into account the role of history, then, in the context of social, economic, political, cultural and institutional change in shaping the popular meaning and subjective experience of ageing. It also fails to take into account the role of social factors such as gender, social class and

ethnicity in terms of older adults' state of health (Sidell 1995) and their access to financial, material and domestic/caring resources (Arber and Ginn 1991a).

By contrast, the life course approach emphasises that the social meaning and experience of ageing can only be properly understood by reference to the relationship between individuals and history. In so doing, it makes it possible to show how change in the life course takes place in relation to wider social change (Featherstone and Hepworth 1990a). Moreover, biography and history are not regarded as separate, but as mutually constitutive. For example, societal events such as economic prosperity or recession, can shape biographical events. Conversely, a collection of biographical events can shape societal events. For example, a fall in the birth rate and the ageing of the population will impact upon institutions such as education and work and upon the way retirement is perceived and experienced. In other words, biography and history can be regarded as a collection of collective and individual moments. In the words of Harris:

Biography and history can be seen as mutually constituting and conditioning processes, but are better seen as different movements of a total social process which has both collective and individual moments. (Harris 1987: 22).

The influence of time upon the interviewees becomes apparent in the data presented in later chapters and, in general terms, is significant throughout the study. As noted above, the problem of sociology has largely been unresolved because it has omitted the centrality of the human body to issues of agency and structure. The same cannot be said of the life course approach since it includes a focus upon bodily change. Thus Featherstone and Hepworth (1991) examine the interpretation of bodily condition in assigning social status in the life course. As they argue, with the use of special diets, health foods, keep fit strategies, dieting and other regimens to control the body, older people now have the potential to hold back the physical signs of chronological age (1991: 374). As noted, Hockey and James (1993), who also use a life course approach, describe how older adults can resist the imposition of child-like identities on the basis of their bodily appearance, which, as competent adults, they can resent and therefore may subvert. Subverting representations of old age which are undermining, then, reflects the agency of older adults in a way far removed from the view of them as powerless. Thus the issue of agency is implicated quite strongly by Hockey and

James. For example, they state how resistance represents a 'form of demanding that both the perception and treatment of members of that category [old age] be altered' (1993: 171).

The life course approach, then, parallels the aim of the project of sociology by exploring the relationship between the individual and society. This is achieved by focusing on time, social relationships and bodily change. The life course approach is drawn upon throughout this study and, in detail, this will involve recognition of the way: (1) the idea that beliefs can be shaped by socio-historical context and generationally shared narratives (2) the limitations of theories which imply that people are the puppets of power or social structure, as the life course approach recognises variability amongst older people and the role of the body in mediating their agency; (3) it represents a flexible and accommodating conceptual tool, which is more of an approach than an exacting theory, and so allows the use of other approaches which share the same end of linking the macro and the micro. Indeed, the sociology of the body can be considered to share the same end and is used in this study as part of a life course approach.

Sociological theories of the body and the interpretation of the interviewee data

This study argues that interviewee beliefs can be described as a product of their 'embodiment'. This term is understood to refer to the constant and fluid exchange of meaning between the physical body and the 'social body' (Frank 1990). In sociology there have been three main perspectives on the body, naturalistic, phenomenological and social constructionist. More recently, the idea of the body as an 'unfinished project' has emerged as fourth perspective which tries to synthesise all three approaches (Turner 1992; Shilling 1993).

Naturalistic approaches emphasise a biological explanation of the body as the main cause of social and human activity. Thus the body is thought of as universal in character, with no regard given to its social milieu. This view has been influential within the natural sciences and, in an implicit sense, within many social theories of 'old age'. For example, in 'role theory' (Parsons 1942) and 'disengagement theory' (Cummings and Henry 1961), the 'problem' of ageing was seen to be the problem of older adults. This was seen as a consequence of a decline in physical and mental capacities, irrespective of social and historical contexts. Such

ideas led to the dominance of a depressing, fatalistic and individualising theory. One could argue that such pessimism is in itself ageist and acts to reinforce subordinating narratives and discourses. As Fennell *et al* note:

theory has contributed to the mood of cultural pessimism about the role and status of older people. The elderly are seen as cut-off from their family and trapped in a "roleless role" . . . perceiving society as "distant, alien and oppressive" . (Fennell *et al* 1988: 42).

Indeed, the culture of ageism which is uncaring, stigmatising and disempowering (Bytheway 1995), may also be considered as a reflection of the influence of naturalism. Moreover, such undermining views are reflected in some older people's conceptions of their bodies (Coupland *et al* 1991). This was apparent in the interview data and is explored in the data analysis to follow.

Social constructionism takes the opposite view to naturalism and argues that the body is a socio-historical construct. Thus corporeal-based experience is seen as a reflection of the way the body is conceptualised in social time and space. For example, in a Foucauldian sense, the body is a direct consequence of the 'clinical gaze' (Foucault 1977). Given the hegemony of medical models, the way 'medicine' conceives of the body is also very influential in terms of how it is perceived more generally. Under the clinical gaze, the body as 'flesh' is defined and controlled by 'medicine'. Thus, as argued above, medicine helps to socially construct aged bodies; that is, in influencing or reinforcing cultural stereotypes of old age.

Another way of thinking about socially undermining constructions of aged bodies is by drawing upon Elias' work on the 'civilising process' (1994). Within this work Elias looks at the changing forms of human behaviour and conduct in people's relations with others in the creation of a civilised society (Goudsblom and Mennell 1998: 40 - 45). As Shilling (1993: 150-174) notes, Elias' work includes a particular focus on the 'civilised body'. This shows how the civilising process compels people to hide away natural bodily functions deemed to be uncivilised. Thus, one could argue, because of the natural decline in the control of bodily functions in later life, which may be deemed uncivilised in the presence of others, such as farting, belching and incontinence, old age becomes characterised as having what Elias describes as 'aversive properties' and a 'disgust function'. Older bodies, then, came to be increasingly stigmatised as uncivilised bodies.

In overall terms, social constructionists argue that these interpretations have produced a growth in body taboos. Indeed, as this study shows, it is the interpretation of older bodies as taboo or as other which is crucial in shaping the beliefs of the interviewees. As Goffman's work on stigma - 'the situation of the individual who is disqualified from full social acceptance' (Goffman 1963: 9) - shows, an individual's sense of self-worth is derived from social judgements about the value of their body. Perceptions of what he describes as 'abominations of the body' through 'physical deformities' help to shape the way the 'abnormal' are stigmatised. This idea is significant to the analysis, but what is given most emphasis is the responses of the interviewees to such subordination in terms of their resistance. Nonetheless, in terms of the analysis of the data, the way in which beliefs can be regarded as social constructions is a key consideration.

Phenomenological approaches to the body concentrate on meaning at the level of consciousness and experience in the 'lived body'. In short, the idea that individuals will interpret and construct their own corporeally-based experiences is central to this approach. Thus in Leder's words, 'The body is not simply a thing in the world, but an intentional entity which gives rise to the world' (quoted in Nettleton 1995: 108). As many writers have noted, the phenomenology of the body has been influenced by Merleau-Ponty's argument that perception of everyday life is grounded in a 'lived body' (Merleau-Ponty 1962). In other words, senses shape experience, for example, in terms of how a person enters a crowded room. His research showed how injury to the body - through missing limbs - radically changed perception and reasoning; that is, our intentionality towards the world. As a consequence, he concluded that it was not possible to separate mind and body as separate objects. The mind was never free of embodiment and even 'higher' perception is embodied. In short, all mental activity can be held to be embodied. As Turner notes, quoting Langer:

The body is not an object for itself; it is in fact "a spontaneous synthesis of powers, a bodily spatiality, a bodily unity, a bodily intentionality". (Turner 1992: 43)

Intentionality, then, is embodied. For older people whose bodies have radically declined, their intentionality may be circumscribed by somatic deterioration. Thus as Mathews (1979) argues

in her study of older women, the constraints of limited physical mobility may affect the level of engagement in the social world, but this does not prevent the use of alternative sources of power as creative social actors. Indeed, this idea is applied to the analysis of the data from both female and male interviewees. However, it is important to note that when considering agency, the biological constraints of the body should not be ignored. As Woodward argues, the 'natural' body in later life poses limits to pure social constructionism:

The inevitable and literal association of advanced old age with increasing frailty and ultimately death itself presents a limit beyond which we cannot go. The body in advanced old age not only represents death; it is close to death and will in due time be inhabited by death. The facticity of the mortal vulnerability of the body in old age, and the meanings we attach to it, cannot be explained away by insisting that an ideology of youth, with its corresponding semiotics, is responsible for negative representations of old age. (Woodward cited in Hepworth 1995: 186)

Quite clearly, then, phenomenological approaches help to recognise what Woodward calls the 'facticity' of the body; that is, they recognise the role of the physical body in changing perception and reason. However, the major problem with phenomenological approaches stems from a tendency to neglect the constraints of society upon intentionality. More recently, however, writers have tried to focus on intentionality in an attempt to form a synthesis between naturalism, social constructionism and phenomenology. This study draws on these ideas as outlined below.

The body as an unfinished project

As Shilling (1993) notes, because our knowledge and capacity to alter and control bodies are unprecedented, we are faced with doubt and uncertainty over what bodies actually are and how we should control them.¹ For Shilling, the wide range of body knowledges and choices has stimulated a radical increase in individual reflexivity concerning the body. Moreover, the rise of what Featherstone (1991a) calls the 'performing self', wherein bodily displays of personality, self-realisation and consciousness are used to judge the integrity of character, can also be seen to have stimulated body-based reflexivity. As writers have shown, ageing

¹ Shilling argues that the growing knowledge of, and potential to control, bodies, arises from developments including biological reproduction, genetic engineering, plastic surgery and sports science. This has led to a situation where the body can be regarded as a phenomenon of options and choices, which also involves doubt over what bodies are and how they should be controlled. For example, new reproductive technologies allow reproduction for much older

involves becoming aware of how the body is interpreted as representative of the self (Featherstone 1991a; Hepworth 1995). Thus, if the body shows 'signs of ageing', such as loose flesh, wrinkles or crooked posture, individuals may be blamed for lack of self control in not maintaining dietary and exercise regimes. This can lead to a tension between inner feelings of an ageless self and the bodily signs of ageing. That is to say, the reflexive relationship between the self, the body and society leads to a contradictory relationship between the subjective view of inner youthfulness and the outward signs of biological ageing. This forces reflexivity upon older adults. As Bryan Turner argues:

in a culture in which the surface of the body is seen to be that which carries signs of one's inner moral position, aging is something which has to be denied. With aging the outer body can be interpreted as a betrayal of the youthfulness of the inner body . . . aging intensifies the reflexivity which is forced upon us in a world in which we are all compelled to choose a lifestyle embodying tastes. The aging process is inevitably bound up with reflexivity. (Turner 1995a: 257)

For Shilling, given that the body has become central to individual self-identity, there is now a tendency to see it as an unfinished project which should be worked at as part of an individual's realisation of self-identity. It is unfinished in that individuals are constantly aware of how the body's 'appearance, size, shape and even its contents, are potentially open to reconstruction in line with the designs of its owner' (Shilling 1993: 5). This involves a recognition that the appearance of bodies forms part of a classificatory system of social identity:

Treating the body as a project . . . involves a practical recognition of the significance of bodies; both as personal resources and as social symbols which give off messages about a person's self-identity. In this context, bodies become malleable entities which can be shaped and honed by the vigilance and hard work of their owners. (Shilling 1993: 5)

Indeed, the idea of the body as an unfinished project is evident as a vocabulary of motive in the data analysis.

Regulating Bodies

Turner (1992) argues that bodies are subjected to forms of regulation containing various rules, norms and general guidelines. In what he describes as a reflection of the growth of a 'somatic society', the constitution of the social order is reflected in the way everyday routines and

people than was hitherto possible. Thus, in terms of age-based social identity, this can have the effect of destabilising knowledge of what older bodies are and how they should be controlled.

requirements are 'about the production and reproduction of bodies' (1992: 3). Thus focusing on the body will provide a 'missing link' to the unresolved question of agency and structure. In particular, Turner describes how bodies are regulated by the discourse of medicine, which is in the ascendancy as societies have become more secularised. However, other sources of regulation reflect an interplay between physical necessity, sense of self and discursive constructs of the body. For example, it can be argued that body/self/society are inextricably bound up in the production of emotions, however, their derivation is not solely reducible to one site. As Bendelow and Williams put it, emotions are:

existentially embodied modes of being which involve an active engagement with the world and an intimate connection with both culture and the self . . . From this viewpoint - one which is not merely about bodies but from bodies - embodiment is reducible neither to representations of the body, to the body as an objectification of power, to the body as a physiological entity, nor to the body as the inalienable centre of human consciousness . . . Rather as an "uncontainable" term in any one domain or discourse . . . embodiment instead lies ambiguously across the nature/culture dualism, providing the existential basis of identity, culture and social life. (Bendelow and Williams 1998: xvi)

For example, Hepworth (1998) argues that the constraints of stereotypical emotions associated with later life belies a complex relationship between subjective and cultural imagery which involves conflict, contest and struggle. Drawing on an analysis of literary representations of later life, he argues that the popular view associates physical decline with an accompanying change in emotional state; this falsely attributes the causation of emotions to the biology of individuals alone. For instance, the possibility of sexual activity in later life is well established (Hutchings 1988). Thus, a study of 1844 women and 2402 men aged 50 to 93 shows that:

large proportions of our respondents still report being sexually active and enjoying a wide variety of sexual activities. Indeed, this is true for a number of women and men in their eighties, including some who report continued sex with a partner and orgasm during sex with a partner . . . the majority of our women and men have managed to surmount the rising barriers to sexual fulfilment posed by advancing age and by health impairments, and to maintain and in some cases enhance sexual enjoyment in their later years. (Brecher 1993: 110)

However, as Hepworth notes, the popular conception of old age as sexless requires older adults to engage in emotional labour which separates their inner desires from their body:

the social performance of the respectable emotions of old age requires a self-conscious distancing from subjective feelings . . . in the emotional labour of disembodiment. (Hepworth 1998: 180)

What Hepworth's point highlights is the complex and mutually constitutive relationship between society, the body and the self and as noted above, the notion that older adults act out 'old age' in ways they regard as appropriate. Thus the social performance of 'respectable emotions' may require a performance of old age as sexless which conflicts with inner desires.

Given the primacy of their bodies to many of the interviewees as both enabling and constraining, a key focus throughout this study is the relationship between their beliefs, their bodies and socially prescribed norms of age-based identity. Turner's argument that bodies are regulated by a range of sources is, therefore, a key consideration in the analysis of data.

Summary and conclusion

This chapter has examined the potential of a sociological approach in understanding beliefs. It was asked if such an approach could be used to understand beliefs in the context of the embodied relationship between individual and society. In examining knowledge of the area in terms of existing research, it was noted that this work offers a great deal of empirical insight. Indeed, the main themes in this literature are found in the data. Furthermore, in analytical terms, this work is fruitful in relation to the idea that the relationship between the individual and society is a crucial influence. However, this work was found to be limited; it would be a gross exaggeration to argue that it explicitly draws upon ideas and approaches which help to transcend the idea that agency and structure are separate issues. In drawing upon existing research, therefore, this study will also draw upon the life course approach and the sociology of the body on the role of embodiment in mediating the relationship between biography and society, and agency and structure. Furthermore, the key analytical concepts outlined above were shown, at least in principle, to transcend the idea that agency and structure are separate issues. Thus it is proposed here that, in theory, the approach adopted in this study can make a contribution to the problem of sociology. As the data analysis shows, it can also be considered as an empirical contribution.

The idea that beliefs are reducible solely to the mind, body or society, was rejected as such analysis does not take into account the complexities of human embodiment and the role of

social organisation. It is argued, then, that the production of beliefs takes place not in one site but somehow in the spaces between, or at the boundaries of, mind, body and society.

In general, this study is premised upon two propositions: (1) in light of the link between the self/body/society, the beliefs of older adults have distinctive sets of meanings; (2) older adults orientation towards reciprocity, social exchange and community, which was very prominent in the data, can be seen as an act of resistance towards the process of individualisation and is a key strategy through which beliefs are framed or reinterpreted.

The structure of this study

A great amount of literature exists which illustrates the benefits of qualitative methods for sociological research (for example, Burgess 1984; Coffey and Atkinson 1996; Hammersley and Atkinson 1995; Silverman 1993). However, with some exceptions (for example, Bertaux 1981a; Johnson 1978), very few methodological writings for sociologists are placed in the context of researching older adults. With the intention of combining the insights from both of these literatures, Chapter Two critically outlines the qualitative interviewing method of this study. The chapter also draws upon the previous discussion of the value of the idea of the life course. It is within this approach that the method of the study is contextualised. In doing so, the chapter has three main purposes. First, to introduce the background to this project in terms of previous research and to introduce the interviewees. Second, to explain in more detail how a life course approach was used. Third, to explore in more detail the benefits of narrative analysis in understanding the data.

In the above discussion of Turner's (1992) idea of regulated bodies, it was proposed that this would serve as a useful means of understanding the social constitution of old age, as reflected in interviewee beliefs. With this in mind, and by reference to the Foucauldian idea of the human body as a product of different discourses, the temporal association by medicine of later life with illness and death is shown to be a significant constraint on older adults in terms of how they understand their health. Thus, in discussing macro-level social constraints upon later life, Chapter Three examines the idea that ageing and death are medicalised; that is, the way they are popularly conceived can be framed in terms of the influence and selective

interpretation of medical knowledge. It is argued, therefore, that medicine is a powerful influence over the meaning of ageing and death. However, metanarrative or single explanations such as biomedicine can be called into question on empirical, theoretical and conceptual grounds. It is concluded that the negative view of old age has never been watertight and more positive views influenced by postmodern fragmentation are emerging. This chapter, therefore, explores the argument that stigmatising views of ageing and death are less overwhelming and powerful than many commentators have argued. However, it is recognised that the influence of medicalisation still needs to be seen as a powerful set of ideas and practices which subordinate older adults.

Drawing upon analysis of the body as an unfinished project (Shilling 1993), data presented in Chapters Four, Five, Six and Seven show how the older body becomes a site for the reproduction and reinterpretation of beliefs. Chapter Four presents the ageing body as a project wherein agency is mobilised in ways which run counter to the negative models provided by conventional medicine. Data presented in this chapter shows clear evidence of *agency as a form of self-empowerment* through the questioning of *metanarratives*, and the *intertextual* production of beliefs through postmodern fragmentation and, indeed, their re-interpretation through *narrative reconstruction*. In particular, then, whereas Chapter Three emphasised the social constraint of medical knowledge and its influence, Chapter Four highlights the agency of the interviewees.

Chapter Five examines a case study which shows how the ageing body can represent a site for the expression of imagined community via the formation of beliefs. The term 'imagined' is used since data gives evidence of a strong orientation to close family - all of whom are now deceased - and a collectivist orientation to religion. As the case study data reveal strong feelings of vulnerability, the idea that social performance involves dramaturgical stress when performance resources are cut off or distant, such as the dead family and God, is explored (Goffman 1990; Freund 1998). Above all, this chapter explores both the construction and use of imagined community as a coping resource in the face of bereavement and bodily crisis. In doing so, it is argued that the case study reveals an imaginative interpretation of different texts of knowledge which help to bring a sense of the positive in the face of severe adversity.

Chapters Six and Seven explore the vocabularies of motive through which interviewees construct their beliefs in relation to their attitudes towards illness, ageing and death. As in preceding data chapters, the analysis illustrates fluidity and variation in terms of the relationship between human agency and society. Nonetheless, the constraints imposed by social structure are examined in relation to gender and social class. Whilst not an innovative or original idea, these influences are considered in order not to lose sight of the idea that beliefs are also shaped, or even conditioned, by society. For this reason, the influence of medical knowledge is also considered in the context of illness explanations and coping strategies. These chapters share many parallels with the general literature on health beliefs and, in particular, several comparisons are made with the findings of Williams (1990).

Most prominently, Chapters Six and Seven illustrate the complex and diverse nature of the relationship between human agency and society. Thus a range of influences and ideas are implicated in data demonstrating an interplay between biography, the body and society. Such diversity, it is argued, illustrates the relevance of the previously mentioned idea of 'explanatory sympatricity'; that is, the use of competing and complementary explanations in the constitution of beliefs. A number of factors are shown to be influential: in part they reflect the influence of social class and gender, but, most commonly, they are grounded in biographical context. Such factors include working lives, family and other support networks, religion, medical knowledge and popular attitudes to illness, ageing and death. Above all, then, data show diversity. However, the prominence of the invocation of imagined community by the interviewees, albeit in a variety of ways, suggests a particular relationship between ageing and beliefs, which also show how older adults are inclined to identify with an essential and moral sense of self.

To reiterate, the central aim of the study is to examine whether or not a central 'vocabulary of motive' can be seen as most significant in shaping interviewee beliefs (cf Blaikie 1999: 25). For this reason the concluding chapter elaborates on the functions of imagining community. In also summarising the study, the chapter argues that, whilst imagining community serves a host of useful purposes, it is best considered as a palliative rather than a concrete resource. Thus, postmodern fragmentation may lead older adults to invoke imagined community as a

means of gaining ontological security. This may also reflect the idea that members of particular generations may carry with them shared values, beliefs and experiences (Mannheim 1952) which run counter to the rise of individualism in contemporary society. Moreover, imagining community may also help older adults construct an essential moral self, in biographical context, in the face of negative stereotypes of 'old age'. However, and unfortunately, in the final analysis, it is proposed that imagining community does not eradicate aspects of social organisation such as compulsory retirement which isolate and subordinate older adults.

Method

Introduction

In the previous chapter a case was made for a life course approach which integrated ideas from naturalism, social constructionism and phenomenology. It was also noted that, whilst retaining an appreciation for the phenomenological idea of the lived body, the perspective of social constructionism is emphasised most in the analysis of data. It is with this integration in mind that this chapter critically outlines the method of the study. Using focus group and life history interviews, qualitative interviewing served as the main form of data collection in the study. This chapter describes and evaluates this method, drawing upon debates about the principles, benefits and limitations of qualitative research. In doing so, it is asked if the interviewing methods used in this study can provide data which serve as an empirical contribution to the problem of sociology.

In setting out a case for qualitative research as the most suitable strategy for this study, it is argued that it is based on the principle that data need to be seen as a product of social context, as a product of the social worlds of individuals in relation to matters such as life course events, social class and gender. Thus, given the emphasis upon seeing data in a social context in qualitative research, it will be useful to provide a contextual overview of the background to the current study in terms of previous research.

Background to the current study

The research builds upon an empirical project carried out by myself when employed as a consultant to measure 'health care needs' on a working class estate in Beverley, East Yorkshire (Conway 1993). The area had high levels of deprivation and included large numbers of retired people. The research was commissioned by the local District Health Authority (DHA)

and was controlled by the manager responsible for community services. The objective of the study was to determine the 'health care needs' of the local population in terms of DHA provision. The focus of the research, then, was grounded in the observable and measurable indicators of health care provision rather than the subjective views of the respondents in terms of their own health care need. This, I argue, reflected the link between theory and practice for health care providers. That is to say, the requirements of the DHA simply reflected a narrow focus on dependency needs, which is in keeping with biomedical models.

In reflecting on a similar research experience, Johnson's critique of the influence of objectivist gerontological research offers a way forward (1978). Such research, Johnson argues, denies the subjective constitution of 'needs' from a service user's perspective and implies that needs are *homogeneous* and should be defined by service providers. In his words:

studies which set universal standards on such dimensions as health, income, housing . . . result in bad decisions about need. These decisions are bad in the sense that they are meant to result in an increased life satisfaction for the receiving party and often fail to do so. They are also bad at another level. They take little or no account of the individual's personal assessment and concentrate on decision making, based upon the immediately observable and present features of his or her life. Such an approach denies the historical roots of personal "needs" and implies an unrealistic homogeneity in the face of knowledge that as humans they become more idiosyncratic. (Johnson: 1978: 106)

Similarly, in the DHA study, little interest was shown in how needs were defined by service users. The emphasis was upon matching health care needs to health care provision, rather than the other way around. The project took the form of a questionnaire survey which was used to satisfy the demands of the Health Authority who commissioned the work, and the restraints imposed on the research process by the limited amount of research funding. Data were collected on people under 5 and over 65. The 56 households involved contained at least one member aged 65 years or above. In overall terms, data contained many *implicit* references to health need rather than health care need. For example, most people answered 'don't know' to questions about the provision of health care services. The health visitors' manager had insisted that a question be asked about the frequency of visits. This question was worded along the lines of 'Please tick how many visits you think you would like from a health visitor'. Most people ticked the 'don't know' box. Another question asked people to rate their own health on a 5 point scale with categories ranging from excellent to very poor. A biomedical view of health as something which depends upon the presence or absence of

disease, could not make sense of those who had medically diagnosed conditions like heart disease and mobility problems, yet defined themselves to be in good health. These responses reflected the subjective views of the participants, but the survey did not allow them to explain their reasoning.

As a number of writers have noted, social surveys are an efficient means of gaining an extensive amount of descriptive and factual data (Bell 1987: 8-9; McNeill 1985: 19; de Vauss 1986). They are methods which usually involve collecting statistical data from large numbers of people in a relatively short time-scale (McNeill 1985: 19). Indeed, this sums up the requirements of the DHA almost to the letter. They wanted a standardised and statistical approach. Thus statistical data were gathered by a questionnaire survey on factors such as self-assessment of health, visits to the doctor over the last 12 months, and so on. This involved following an approach with descriptive questions concerned with 'what', 'when', 'where' and 'how many' type issues, as they were much easier to analyse statistically than questions concerned with meaning (Bell 1987: 8-9). The concern was with surface patterns and correlations rather than the contextual production of data (such as the influence of respondent experiences). Therefore, asking respondents to define their health on a numerical scale from 1 for 'excellent' to 5 for 'very poor' was much easier than asking them to explain their meaning or reasoning for such definitions. If the social construction or production of the DHA's specified research problem had been their concern, then a qualitative approach would have been used. As is generally accepted, qualitative research is much more amenable to a focus upon the conceptualisation of meaning in terms of factors such as social context and personal experience (Hammersley and Atkinson 1995; Mason 1996; Strauss and Corbin 1990). Whilst there is no set agreement upon the definition of qualitative research, a number of common principles can be identified. Qualitative research is:

- **interpretivist** in that it emphasises recognition of how the social world is understood or interpreted, experienced or produced. Therefore the social world is seen as multi-layered and complex.
- **flexible and sensitive** because more emphasis is given to 'inductive' rather than 'deductive' analysis. This encourages theory generated from data analysis and makes provision for a change of focus in relation to emergent findings throughout the research. This contrasts sharply with structured approaches such as the survey which usually characterises the social world as unproblematic and amenable to theory testing rather than building. The flexibility of qualitative methods allows a combination of theory testing and building which is very difficult to achieve with standard, quantitative approaches.
- **holistic** as it is based on principles which emphasise complexity, difference and context. Thus there is more emphasis upon gaining a rounded understanding derived from rich, contextualised data, than on charting surface patterns, trends and correlations.

(derived from Mason 1996: 3-4).

While the DHA project indicated there was a wealth of fascinating data to be obtained, the methodological limitations imposed by the survey method made it a very limited resource to work with; this also reflected a dependency-based model of health care provision.²

In terms of the problem of sociology, the DHA study raised the question of why the respondents defined themselves to be in good health when, in fact, they had medically diagnosed illnesses and infirmities. An emergent research area was indicated by questions clustering around the social influences upon people's health beliefs. There appeared to be a clear difference between medical as opposed to everyday explanations. What I wanted to explore was the social construction of such beliefs.

The different ways in which health was conceptualised by the DHA and the people who took part in the study could be described as 'chalk' and 'cheese'. Neither discourse appeared able to make much sense of the other and they seemed to be concerned with vastly different things. The lay view was mostly social, in that health seemed to be something which was subjectively defined, in terms of the ability to lead a normal life (cf. Williams 1990). The frustrating part for me was that this interpretation was just a hunch that needed further confirmation, rather than a statistically demonstrable fact. In contrast, the DHA perspective reflected a technical or rationally based form of theory. Health was defined in terms of the

² See Conway (1995) for a policy orientated discussion of the problems of researching health care need as opposed to health need and Johnson (1978) for a discussion of the same point in the context of gerontological research.

presence or absence of disease. For example, for those with children under 5 years old, the project manager insisted that I try to quantify the incidence of post natal depression (PND). However, not everybody has recourse to medical definitions of PND or to other conditions defined as an illness or disease, particularly if they are from deprived social backgrounds (Pill and Stott 1985). The problem, then, was how somebody could tick the post natal depression box if they didn't know they were depressed! I had argued this point with the health visitors before doing the survey, but they insisted that the PND question be used. One particular reason for their insistence was their belief in the need for more health visitors for single mothers; if this could be demonstrated through my research it would support their case.

To summarise, the main lessons learned from carrying out the DHA study were: (a) the survey method is inflexible and therefore provides very limited access to understanding how beliefs and practices are constructed by individuals themselves, and (b) one can make a clear distinction between medical and lay views of health. This raised the following questions: (a) What were the values and beliefs that people drew upon to make sense of health and illness? and (b) What was actually involved in combining different (or the same) sources of knowledge? In other words, How did people 'do' health beliefs and how could this be explained in terms of the interaction between agency and society?

Data and method

In general, the survey method of the DHA study was limited in terms of the depth of analysis it offered. Therefore, with the intention of exploring the contextual derivation of the health beliefs of older adults, a further study was carried out which used qualitative methods. In particular, this consisted of focus group and life history interviews which allowed me to explore issues as they emerged during the interview process. Qualitative methods also allowed me to follow a lifecourse approach which, like Cornwell's study of the health beliefs of older people (Cornwell and Gearing 1989), seeks to locate beliefs in biographical context. In doing so, one key question was to ask interviewees to describe their state of health throughout their lives. This reflected my supposition that much could be learned about interviewees' values and beliefs by regarding them as an accumulation of experiential knowledge derived from

biography. As data indicate, this indeed proved to be the case. As noted, qualitative methods, whilst emphasising induction or discovery, offer flexibility in mixing emergent findings with existing theories (Mason 1996: 3-4). Therefore, the rationale for focusing on issues covered in interviews was derived from combining key findings and ideas from existing literature discussed in the previous chapter with emergent knowledge gained from fieldwork.

Aside from focus groups and life history interviews, data were also gathered from telephone calls and from conversations with interviewees and gatekeepers prior to, and following tape recorded interviews. These provided an additional source of data which was used to inform the overall process of the research. In general, the emphasis throughout the research process was upon developing knowledge of the interviewees' concepts in a way which was both grounded in, and sensitised to, their experiences and ways of thinking. Access was gained through request letters to people from the previous DHA sample, from a homeopath, Age Concern, a local office of the Council for Voluntary Services and from a snowball technique where I was introduced to friends. In all instances I attempted to gain the fully informed consent of those taking part in the study. The table below provides a classificatory breakdown of the sample and interviewing methods.

Sample breakdown

Key:

ACH = Age Concern Hull; **ACB** = Age Concern Beverley; **CVS** = Council for Voluntary Services; **DHA** = District Health Authority research

Summary:

Age range = 50 - 86; n = 27; mean age = 67.19

pseudonym	access	age	class*	type of interview
Cheryl	ACH	64	working class	focus group
Delia	ACH	66	working class	focus group
Enid	ACH	67	working class	focus group
Harry	ACH	69	working class	focus group
Emma	ACH	69	working class	focus group
Evelyn	ACH	71	working class	focus group/biographical
Vera	ACH	71	working class	focus group
Will	ACH	81	working class	focus group/biographical
Paula	CVS	50	working class	biographical
Fred	CVS	78	working class	biographical
Tim	DHA	71	working class	biographical
Mary	DHA	68	working class	biographical
Joyce	Homeopath	52	upper class	biographical
Ros	Homeopath	69	intermediate class	biographical
Hettie	Homeopath	78	upper class	biographical
Elsbeth	snowballed from Hettie	68	intermediate class	biographical
Dave	snowballed from DHA	50	working class	biographical
Don	snowballed from DHA	50	working class	biographical
Matt	snowballed from Dave	52	working class	biographical
Beverley	ACB	76	intermediate class	focus group
Rose	ACB	72	working class	focus group
Claudia	ACB	73	intermediate class	focus group
Kate	ACB	86	intermediate class	focus group
Brigette	ACB	73	upper class	focus group
Jane	ACB	66	upper class	focus group

pseudonym	access	age	class*	type of interview
Jack	CVS	60	upper class	biographical
Lawrence	CVS	64	intermediate class	biographical

*Key to Social Class**

The unit of analysis is either the individual or the household - whichever is the highest. The class categories are based on a scheme devised by Goldthorpe (see Edgell 1992: 29).

Focus group interviews

Two focus groups took place during fieldwork which used qualitative interviewing. The first took place in an Age Concern Centre in Hull and involved 8 men and women, aged between 64 and 81. The second took place in an Age Concern weekly social meeting in a room in Beverley Westwood Hospital, Beverley and involved 6 women aged between 66 and 86.

As is commonly accepted in the methodology literature, focus group interviewing involves a relatively informal style which reflects the assumption that data are generated via group interactions (Barbour and Kitzinger 1999; Gibbs 1997; Kitzinger 1994). Thus each interview was structured around the themes of ageing and health beliefs which were raised in a way that left them open to interpretation. For example, people were asked questions such as: What's it like to be retired? Do you feel the same or different now compared to when you were younger? Hands up those who would say they are healthy? Hands up those who would say they are not healthy? What does being ill mean to you? Why do you say that? and so on. If responses were not forthcoming, which turned out to be a rare occurrence, prompts were used, beginning with socially neutral questions such as, Do you think the weather has something to do with illness? If necessary, these were followed up by more directive questions such as, What do you think it is that makes you ill? If further prompts were needed, potential 'answers' such as, Pollution and The will of God, were used to stimulate a response. In general, however, the use of prompts was minimal in focus group and biographical interviews.

One particular advantage of focus groups is that they provide interviewees with some control over the questions posed and the structure of the discussion (Burgess 1984). Thus, in the words of Gibbs:

attitudes, feelings and beliefs may be partially independent of a group or its social setting, but are more likely to be revealed via the social gathering and the interaction... (1997: 1)

For example, in a focus group interview, one woman raised the issue of being talked down to or treated like a child by younger adults. Her resentment of this practice was very strong and was shared and elaborated upon by many members of the group. In a phenomenological sense, this raised my awareness of the sense of injustice and hurtfulness brought on by not being treated as equals by younger adults. In addition, compared to the individual interviews, the focus groups provided more data in relation to the time spent interviewing. On the other hand, focus group interviewing usually means that the researcher usually has less control over which issues are discussed. However, this was not seen as a particular disadvantage in the data collection process, given that the focus was on the 'subjective' views of the interviewees. In addition, individual interviews were used. These are described below under the heading of life history interviews.

Life history interviews

These involved 14 people, 8 of whom were interviewed twice. Each interview took place in people's homes and lasted between 45 and 90 minutes. Aside from carrying out the formal interview, I spent time introducing myself and the purpose of the interview. This also provided further information of circumstances and experiences. The most pressing thing I had upon my mind here was to ensure, as far as possible, before formally beginning the interview, that my intended approach would have no harmful affect upon interviewees. It was also important that they were at ease with me and I, therefore, gained their 'informed consent' to take part. On another level, I was deciding how to frame my questions in the context of the interviewee's life course and present circumstances, using an *aide-memoire* of research themes. Indeed, during the course of the interviews I was still conscious that I needed to be sensitive to issues of informed consent and of the sequencing of questions in the context of interviewee

circumstance. In the initial stages of fieldwork, the interviewees were asked to talk about their lives generally in relation to issues of ageing and health. As the data show, death was also a prominent theme in the interviews.

The general format of the interview drew on the core principle of a biographical approach as applied to later life; that is, phenomena like values, beliefs and attitudes needed to be examined in biographical context (Bertaux 1981b; Cornwell and Gearing 1989; Dant and Gearing 1990; Humphreys 1993; Johnson 1978). Thus, since the biographical approach emphasises the importance of personal experience, interviews took the form of a life history. As Cornwell and Gearing argue in the context of a study of the health beliefs of older people:

the beliefs and ideas that people have about health and illness . . . will be connected in some way to their own lived experience and therefore . . . understanding of their views will be improved by knowing something about the contexts from which they have emerged. (1989: 36)

In linking beliefs with experience, the life history method allows three broad objectives to be met, which also reflect the life course approach of this study. First, generalisable elements in interviewee life histories can be examined in relation to existing ideas (Dant and Gearing 1990); that is, they enable theoretical generalisability. Therefore in Chapter One it was proposed that there was a relationship between ageing and beliefs.

Second, life history analysis allows data to be explored in terms of the relationship between the individual and society (Fairhurst 1997). Thus, as noted in Chapter One, it was posited that beliefs are both socially constructed and individually framed, or reconstructed within biographical context. The latter idea reflects the proposition that older adults could be considered as competent agents who demonstrate agency in the construction of their own beliefs. Moreover, following ideas that beliefs can neither be reduced exclusively to the realm of intentionality or to the social order, it was proposed that they would be explored with reference to the idea of embodiment; that is, the interplay between body, self and society.

A third objective is to incorporate a historical perspective and recognise the role of 'temporality' in the constitution of beliefs. Drawing upon the ideas of a number of writers who have pointed to the influence of time in the social world (Adam 1990, 1995; Elias 1992;

Giddens 1987) and with particular reference to Elias (1992), I use the term 'temporality' to refer to the idea of the symbolic structuring of time which makes clearer a sequence of events by reference to another. Thus, many interviewees spoke in terms of temporal displacement through feeling 'out of time' with the present. For example, Hettie a 78 year old retired civil servant, raised the subject of temporal displacement when I was trying to explore her feelings about some youths who had attacked her. In order to understand the extract fully, it will be useful to the reader to consult the transcription codes in the appendix.

SC: You know when you talked, to start off with, about being anxious and [worried

Hettie: [yes

SC: and you mentioned the things that happened, like the bottle through your [window

Hettie: [yes, the times in which we live, ((pause)) I am too old for the times in which we live. I was saying this to a fellow across the way the other day. He said: 'well, I can give you forty years my dear, and I'm too old for the times in which we live'. ((laughs)) No, not nice at all. I mean, you have to lock your doors as if you live in Fort Knox. Well, my next door neighbour [an older person] was burgled.

For Hettie, it was difficult to belong to the present because the past had been so different. She was 'too old for the times in which we live', as was her neighbour and, by implication, other older adults. Another interviewee spoke of men being more polite and 'gallant' in the past. Several also mentioned how doctors were more helpful to them in their younger days. However, they were now considered to be too busy for such conduct. The concept of temporality, therefore, characterises a subjective and socially shaped view of time where clock time is just one example among many others. Time can be social, not simply biological or chronological (Adam 1995). As Glucksman helpfully puts it, the idea of temporality:

is used to denote a distinctive structuring of time, of which chronometric or standard linear time is just one instance among many. Because time can be ordered and regulated and enter social processes, in a myriad of different ways. The possible structuring of time or temporalities, are almost infinite. (Glucksman 1998: 240)

In terms of key concepts, the notion of 'career' has been much used in the life history method. This concept, traditionally used to describe employment patterns of individuals, refers to the idea that individuals will occupy a number of different careers throughout their life biography. In Johnson's words:

Some of them will reach termination at an early age, e.g. the phase of pre-verbal communication, whereas [an] educational career in its formal and informal manifestations might run throughout . . . life. Other careers will begin later (though not necessarily at prescribed points on the temporal scale), like marriage and family or procreation. Some careers may be formally time-limited like an occupational career or a pregnancy whilst others may be of unspecified lengths, like those of particular interests, e.g. collecting, skiing, or even authoring conference papers. (Johnson 1978: 109)

This concept therefore provides a good starting point for thinking about continuity and discontinuity in interviewee beliefs. For example, at one level in the data, the continuity of values and beliefs, perhaps from earlier careers as patients and as church goers, is explored. On another level, the impact of the discontinuity of living alone or having little social contact in everyday experience, which was brought about mainly by major life disruption, such as the death of a partner, family or close friends, or a debilitating illness, is also explored. This often resulted in rethinking, or supplementing previously held values and beliefs. For example, the case study explored in Chapter Five turned to alternative medicine as a result of illness.

In noting that the concept of career is a useful means of situating beliefs in the context of continuity and discontinuity in biographical context, researcher interpretation and understanding of careers can be problematic. Therefore, as is the case in the constitution and therefore interpretation of all analytical concepts, careers may be thought of as a product of 'researcher effect' due more to misplaced interpretation rather than any 'empirical reality'. In an argument which relates to the recognition of researcher effect, a number of writers have put forward a case for a rigorous application of the principles of 'reflexivity' in social research (Clifford and Marcus 1986; James *et al* 1997; Okely 1992); that is, there has been a call for researchers to be more open and willing to be self-critical in research. The merits of adopting a reflexive approach in carrying out this study are examined below.

Taking account of the idea of reflexivity in my research practice

Arguments for the practice of reflexivity in social research can be seen as part of a reaction against the dominance of positivism in the social sciences. Thus, before outlining what reflexivity actually means and how such ideas have been incorporated into the process of carrying out this study, it will be useful to identify the main features of positivist research:

1. Research is concerned with producing factual and objective information rather than value judgements.
2. Knowledge gained from research takes the form of universal laws or essential truth specifying invariant relationships amongst variables.
3. Research should be scientific involving quantitative measurement and the control of variables.

(derived from Hammersley 1993:10)

Positivism, then, emphasises objectivity, the discovery of laws and the use of scientific methods. This position, however, has been subjected to a strong critique based upon the idea that the principles of positivism are not applicable to studying the complexities of the human social world (Bryman 1988; Hammersley and Atkinson 1995). Put simply, the general criticism put forward against positivism is that it fails to take into account the idea that data can be considered to be more of a product of the different social worlds of individuals than of a single objective social reality. Following such a critique, 'interpretivism' has been proposed as a suitable alternative. In this perspective, which is reflected in the research strategy of this study, the emphasis is upon contextualising the data in terms of their social grounding and import. Thus as Geertz proposes, this should involve:

sorting out the structures of signification and sorting out their social ground and import. (Geertz 1975: 9)

Similarly, Mills (1959) argues that sociology should be concerned to look for evidence of the general in the particular. Interpretivism, then, emphasises that data should be seen as the product of the relationship between underlying processes and structures and the idiosyncrasies and differences which lie at the heart of human subjectivity. Thus, as noted, qualitative, rather than quantitative research, has been emphasised in this tradition.

Interpretivism itself, however, may not be regarded as a panacea for the acquisition of truth. Whilst it facilitates an analysis of meaning because of its flexible and sensitive nature, it may be subject to the influence of selective interests, for example, in terms of the actions and roles of the researcher in the research process itself. In this context, researchers are seen as part of the social world they study and, therefore, they cannot claim to be objective and neutral.

Research is seen to reflect the interests of social groups and the biography of the researcher.

According to Hammersley and Atkinson:

Reflexivity . . . implies that the orientations of researchers will be shaped by their socio-historical locations, including the values and interests that these locations confer upon them. What this represents is a rejection of the idea that social research is, or can be, carried out in some autonomous realm that is insulated from the wider society and from the particular biography of the researcher... (Hammersley and Atkinson 1995: 16)

Thus to be reflexive, researchers need to subject their actions and roles in the research process to the same kind of interrogation as their other data (Mason 1996: 5-6). Being reflexive, then, implies that the biography of the researcher and their actions and activities in carrying out research are highly significant. It will be useful to consider these ideas in relation to this study.

In terms of my own generational identity, at the time of writing, I am 42 years old. I belong to a post 60s generation who, many have argued, will carry with them into later life a youthful disposition, involving inquisitiveness, openness, challenging traditional authority, exploration, discovery, or the urge to try new forms of experience, (see for example, the discussion by Mike Hepworth, Andrew Blaikie and Mike Featherstone in the Open University video *Age and Identity* 1991). On the other hand, I am married with two very young children. I am in a routine academic job. I help pay the mortgage and bills and look after the children. I have to hold down my job. I have therefore a number of constraints which prevent an unmitigated celebration of any youthful disposition in the writing of this study. Second, in terms of politics, one could accuse me of trying to rescue old age from the negative, by over-emphasising the positive. In my view, later life has been neglected by mainstream sociology, with some notable exceptions (such as the work of Andrew Blaikie, Mike Hepworth, Mike Featherstone and others). The sociology of 'old age' - largely under the influence of positivism and functionalism - reflects the stereotype of later life as a time of dependency and withdrawal. In response to this bias, this study seeks to emphasise the agency of older adults. Third, in terms of selectivity, my reasons for focusing on illness, ageing and death simply reflected the main themes in the data. Thus they are representative of the interviews and the aim is to generalise beliefs to theory and process.

In the context of actually doing research, reflexivity refers to the idea that research output, such as data and publications, can be regarded as something which is as much a product of the research process itself as it can be thought of as 'truth'. The premiss I wish to pursue here is that there is a link between the autobiography of the researcher and method, theory and problem, which is extremely significant in terms of the production of 'truth'. The notion of reflexivity in research, then, challenges positivist claims towards objectivity, neutrality and truth. In other words, ontological and epistemological views of what the world is 'thought' to consist of and how it functions (or theory) have a profound influence on how a 'problem' is identified and conceptualised and the method of investigation. Put simply, one person's terrorist can be conceived of as another's freedom fighter. For example, the previously mentioned, limitations of gerontological research in the 1960s and 70s on the dependency needs of older people can be seen to represent a positivist orientation. This approach also tended to aggregate 'the elderly' into a homogeneous group, investigated largely by the objectivist method of the social survey. This type of research, therefore, can be regarded as a classic example of the interrelation between method, theory and problem in practice; that is, it follows the positivist tradition of social research, based on the idea that laws can be confirmed and discovered.

In setting out my own position, I follow the main argument against the positivist tradition running through the history of sociological research. Thus, following Geertz (1975), I agree with Weber's idea that 'man' is an animal suspended in webs of significance spun by himself. I take meaning to be a product of this link and the webs to be culture (my focus is the social construction of the webs of significance). I am, therefore, arguing that the analysis used in this thesis does not follow positivist science in search of laws, but it is an interpretive inquiry into the construction of meaning. In saying this, however, it is important to remember that interpretive research is not a panacea for the collection of 'truth'. As noted, interpretive research is not immune to the selective interpretations of researchers. For example, researchers may be criticised for taking particular interpretations of research data based upon selective forms of theorising when, in fact, many other ways of understanding data are possible. As Pawson argues, the:

consequences of theory ladenness of observation have obvious relevance to the phenomenon of 'selective attention to data' in sociological research. It leads to the position where there can always be an interpretive challenge to any datum. (Pawson 1989: 25).

Following such arguments, recent writers have pointed out that, regardless of the method, it is the narrative mode adopted in research publication to express the main themes in the data (such as resistance to authority or individualism) and the style of reporting (typed words on a page, the use of pictures, moving images and sound, hypertext and so on), which crucially influences how research is interpreted (Hammersley 1993: 44-45; Hammersley and Atkinson 1995 218 - 220; Pawson 1989: 25, 109, 255 - 257). Thus, whatever form the dialogue between 'researcher' and 'researched' might take, it is the text which is the final product and this is the responsibility of the writer.

This type of argument is also prominent in a postmodern type critique of social inquiry (Dickins and Fontana 1994) and has influenced anthropological research profoundly (for example, see Clifford and Marcus 1986; Fontana 1994; James *et al* 1997). As yet, the postmodern influence does not seem to be so significant within the writing of leading sociologists of methodology such as Ray Pawson or Martin Hammersley. However, according to Fontana (1994), ethnography has profited from the postmodern critique by becoming much more self critical and reflective, with a good range of styles of doing and reporting research. By way of illustration and in relation to my strategies of reflexivity I have adopted within the research process, it will be useful to mention the postmodernist critique in more detail. Helpfully, Fontana (1994) outlines three types of postmodern critique of social inquiry. First, reporting styles influence interpretation, for example via the persuasiveness of the narrative style adopted and the mode of presentation. This is not a particularly new argument, but nevertheless it is important. Second, the idea that there is no essential truth and the author of the research can no longer claim to be the only voice of authority, but just one among others in the data. For example: (a) those who have taken part in the research are also authors with voices who need to be recognised and (b) there are also the influences of different voices of authority upon authors themselves. Third, and as a consequence of these two criticisms, researchers should seek to deconstruct their own position in order to make them more open to the reader.

Following this critique, my own research may be criticised for adopting a narrative style that claims older adults have agency. Indeed, sociologists interested in later life would probably argue that inequalities in wealth and power affect older adults profoundly and this must be taken into account (Blaikie 1997; Vincent 1995: 15 - 32). However, whilst recognising this point, by denying agency as a meaningful narrative, one is in danger of supporting the stereotype that all older adults are 'frail, decrepit and dependent', physically, mentally and socially, thus making age-related inequality appear legitimate and 'natural'. Second, in an attempt to bring other voices out in the text of this thesis, as much as possible, I have tried to, as it were, let the data do the talking. But for limited space and the purposes of coherence, I would have included more data in the study. Third, as the above shows, I have been open about my starting point, both theoretically and personally. Hopefully, this makes it easier for the reader to deconstruct my interpretation of the data. In addition to these direct responses to the postmodernist critique of social inquiry, during the course of the fieldwork, I wrote myself memos or 'mimeos'. This strategy had three objectives: (1) to avoid any harmful effects upon interviewees by overlooking their sensitivities; (2) make myself aware of how I was focusing on specific things during the research process and could therefore be regarded as a co-producer of the data; and (3) try to learn from my mistakes. Examples of how I attempted to achieve these objectives are given below.

Being sensitive to interviewee sensibilities

The following data illustrate how I attempted to ensure that the research did not have any harmful impact upon interviewees. They also demonstrate strategies employed in conducting interviews and how these were linked with the aim of the research. In so doing, data also reveal ongoing or working conclusions I came to during the process of interviewing.

During fieldwork I took very seriously the view that an interview could be considered as a social event. After my first interview with Fred I wrote a short reflection on how the interview had gone in terms of: (a) the impact of the research upon Fred (b) the overall aim of the research (c) a reflection upon my interviewing strategy in the first interview and (d) how I should proceed in the follow-up interview. This is detailed below:

General impressions

He seemed a little puzzled at the purpose of my research. This was especially so when I told him that I wasn't really interested in doing a satisfaction survey of the NHS. I told him that I was interested in trying to find out why people think what they do about health and illness. His facial expression looked a little alarmed and he said. 'So you want to dig deep then?' Then all seemed fine and he was off like a steam train trying to make as many political points as he could about health and the social causes of illness. For example, Fred's points about the causes of illness included unemployment, poverty, class inequalities and he kept blaming 'the powers that be'. Thus he made vitriolic assertions that pensioners get a raw deal unless they have independent financial means.

As for my effect on the research, I didn't really get much of an opportunity to say anything, let alone bias Fred's responses! Without a doubt, it would be quite reasonable to say that he is an activist. It seems to me that I provided him with an ear to express his firm views to. He also looked a bit puzzled, or even slightly upset when I didn't bombard him with a list of questions. I think he expected me to go along and ask questions about old people generally and his role was to be that of an expert. This was apparent right from the start when we sat down and he was prepared with a small clipboard and paper and a small tape recorder. His statement of 'If I don't know what the answer to the question is, I can find out for you later on', indicates that he wanted to help pass on useful information about older people generally. He was, therefore, rather disappointed and puzzled when I told him that I was interested in lay perspectives of health.

During the interview, therefore, to circumvent this problem, my tactic was to listen to his talk about old people generally and all of the political points he was making. I hope he wasn't disappointed by my research? I will probably try a much more structured approach with him next time.

From this interview, then, I picked up on the following: (a) Fred was very eager to be consulted as an expert on what he thought was some research into the plight of older people; (b) he was disappointed, even alarmed, when I asked questions about himself; and (c) I needed to remind him of my interest in his life history using a more structured approach and, at the same time, try to be sensitive to his disquiet over personal probing! The following is a write-up of my overall view after completing the second interview with Fred.

View

Again Fred seemed very interested and keen to talk. He actually recorded the interview on his own tape recorder! Perhaps he suspects that I am going to distort what he said? In view of this and his general interest in 'pensioners' rights' I promised to send him a copy of the transcripts - which have taken ages to do!

This time I tried to steer Fred more towards health and illness, and to specific questions about his values and beliefs. Fred seemed to react to more direct questions with a contrary answer before returning to a more collectivist view, which is obviously his main discourse.

He does, however, seem to draw things from different sources to explain the world. For example, he is pro-royal family, anti-conservative, pro-philanthropy, pro-trade unions and issue politics, especially 'pensioners' rights'. He is critical of the sort of 'uncaring face of capitalism', where he talks of his objection to health trusts being run like businesses. He calls for more lay people on the management board of trusts. Thus he is against capitalist enterprise, which does not take into account the social costs of its activities.

In addition, Fred's dialogue always seems to drift to the public realm rather than a personal one. For example, this includes: (a) relating his experiences to things that were going on at the time thus he rarely used doctors because he was brought up to believe (he claims) that they should be used sparingly; and (b) talking of health and illness being due to external factors like poverty, inequality, etc.

In terms of aetiology, perhaps he is saying implicitly that the cause of health and illness are due to external factors beyond personal control. However, in keeping with his pragmatism and inconsistencies he says that he believes health and intelligence are largely inherited.

After transcribing and reflecting further on the interviews with Fred, including writing and reading my memos to myself, I came to four conclusions. First, in terms of the resources Fred used to talk about health, he emphasised quite heavily the value of collective, as opposed to individual, responsibility. This seemed in keeping with his background and careers as an active trade unionist and his more recent work for pensioners' rights. However, in keeping with his pragmatism, there were several inconsistencies in what he said. Thus, he was pro-Royal Family, anti-authoritarian, in that he claimed to be very sceptical of expertise generally, but very deferential to expert medical knowledge. He was collectivist in terms of moral responsibility, but selectivist in terms of politics. Social problems, rather than changing the social system which created them, were his concern. I would argue that this, as in the case of most of the other interviewees, demonstrated a strategy whereby Fred drew on a myriad of intertextually produced forms of authority from his life history to engage in a form of narrative reconstruction to construct and present his beliefs and his 'self' to me.

Second, in terms of the impact of the research on Fred, above all, he seemed to have gained a forum to express his convictions in. As far as I could see, the research had no adverse effects upon him. Indeed, this was later confirmed in our correspondence after the interviews.³

At the same time, it is important to note that some writers have pointed to the imbalance in the power relationship between researcher and the researched, particularly in an ethnographic context. However, I did not carry out an ethnography, which is why I refer to the people I spoke to as interviewees rather than 'informants', the latter label being popular amongst anthropologists (Crick 1992). Thus, contrary to the idea that I disempowered interviewees, in many instances, I felt that I was being used as a *confidant*, or someone to talk to, or an

³ After the interviews I sent transcripts of the interviews to Fred and asked him if he thought I had misquoted him. His response was that he couldn't remember exactly what he had said, but he had no problem with what was in the transcripts. I asked him over the phone about the experience of the interview, saying that I was anxious to avoid subjecting people to any stress or harmful effects, and had he suffered in any way from being interviewed. His reply was a very firm no.

intermediary, even a therapist. For example, during an interview with Tim, after his wife had discreetly moved to another room whilst we talked, he told me of his feelings for a French girl he had met during World War Two. He expressed his regret at not maintaining any contact after the war, and this had stayed with him to the present. Aside from fighting abroad in the World War, Tim had been brought up, got married and raised a family in the same area where he had lived all of his life. His children had all left home to raise families of their own and he said he was unhappy with the lack of visits from his children and grandchildren. In addition, many of his friends he had grown up with from school, the war, his working life and as his neighbours had died. For fear of upsetting his wife, Tim did not share these feelings of regret and sadness with her. Tim and his wife lived in a council house where he said he spent a lot of time reading the papers. For me, like many of the other people I spoke to, Tim presented himself as being lonely, except he would not say this outright. Indeed, during the course of many interviews, intimate details were expressed to me. As a consequence, I established a relationship which meant becoming involved as a person in a social encounter rather than as an impersonal interviewee. As noted by Ely (1991: 112 - 113), such involvements can have a wearing effect on a researcher. In my case, I still reflect upon some of the sad stories people told me. On a personal level, this can be very upsetting.

Recognising the co-production of data

Showing how my role as co-producer of data in a research interview was potentially problematic, the following extract reveals my over-prompting a woman on alternative medicine. When asked what she thought of alternative medicine, Evelyn implied that the placebo effect was worthwhile:

If you have faith in something then it will do you some good. Doctors do give people sugar tablets.

However, when I prompted her about the value of using herbs to cure ills she reacted against this quite strongly - 'Oh no I think personally it's a load of rubbish.' I then tried to prompt her on the smell of hospitals, but again didn't get very far with this line. By this stage we had spent about two hours talking, so I asked her as a 'catchall' type question, and as I did everybody else, if there was anything important I had not covered. Evelyn's response was:

If you are ill you should go to a doctor; you should not medically treat yourself because you could do yourself harm.

This could be interpreted as a preference for medicine over self-help. On the other hand, her remarks can also be seen as a reaction to my prompts on using 'alternative' remedies and practitioners - something she seemed sceptical about. Therefore, doctors are really being championed against alternative medicine, not necessarily over personal experience.

There is one thing that I make for myself. It's a turnip. I learnt it from me mother; chop it up, put sugar on it and leave it over night. and it would turn to juice.

I asked if she used herbs:

Evelyn: Oh, I don't no. I think personally it is a load of rubbish. We had one come to a church and gave us a lesson about it. Oh dear I didn't like it. You know, all these little bottles she had. Err, no I don't believe in it. It's a load of rubbish. These little bottles of stuff that cost you the earth . . . even Lavender a simple thing such as lavender is supposed to cure this and cure that. I suppose I am a bit of a traditionalist I am a bit stubborn.

SC: Right well I can't think of anything else to ask you. Were those questions all right?

Evelyn: Yes, they were fine.

SC: Is there anything else I could ask you?

Evelyn: Well, I think if you are ill you should go to a doctor. You should not medically treat yourself because you could do yourself harm. I mean, Aspros can do you harm if you haven't got the right kind of system. If you don't like your doctor then you should see another one...

The premiss I am pursuing here, then, is that I could be considered to be, as it were, forcing Evelyn to consider the merits of alternative medicine, a position she subsequently refuted. Evelyn, then, may have been exaggerating her argument against self-help following my over-zealous prompts on alternative medicine. As Goffman (1990) has noted, in social encounters people perform with role play and manipulation of reality to create an effect which he describes as 'affect management'. What seems to have happened in my interview with Evelyn is that she built up a contrived image of doctor delivered health care as superior to all other forms, including self-help, in a way which seems to have convinced herself. After Evelyn, I tried to make sure that, wherever possible, I did not prompt as much during the course of interviews. I also wrote down my reflections on how each interview had progressed.

Overall lesson learned

Hastrup (1992), goes as far as to suggest that fieldwork can constitute a form of symbolic violence because the 'informant' is hardly given a right to remain silent. However, whilst I agree that this is a dangerous potential, I would not say that this applies to the research drawn upon here. I would agree with her where she remarks that fieldwork should be regarded as a social drama and that the relationship between the 'self' as interviewer and the 'other' as interviewee should be considered as relationship between two categories which involve tensions, rather than discrete entities, as modernist thought would claim. In categorical terms academic researchers could be thought of as belonging to the category of the academic self, the enquiring mind searching for clues to academic problems. In contrast, the interviewee may be thought of as the other, as somebody with knowledge and experience of the research issue, but most usually unfamiliar and unversed in the focus of academic research. There is, therefore, possible tensions which other categories of thinking related to gender, class, age and so on may create between researcher and the researched. However, fieldwork involves an encounter between human social beings who communicate with each other on common ground. In this sense they should not be considered as separate entities.

The condition of fieldwork is fundamentally confrontational and only superficially observational; self and other are inextricably involved in a dialectical process . . . In fact, and quite contrary to positivist wisdom, the main lessons . . . in general is that the absolute distinction between subject and object is a modernist artefact . . . Self and other, subject and object are categories of thought, not discrete entities . . . Fieldwork . . . is a social drama confronting the performers with their unbounded selves. (Hastrup 1992: 117 - 118)

In terms of what I learned about the merits of the interviewing strategy, above all, I regarded this as a cumulative learning process. The more interviews I did, the better I became. As Agar (1980) argues, good fieldwork and analysis should involve achieving a balance between maintaining a 'professional' persona in terms of working through the research process itself and also learning to think and act as the 'stranger' in terms of relationships and communication with those being researched - the strangers. In my research, I would argue that I became the 'professional stranger' (Agar 1980), and, in parallel with Hastrup's ideas expressed above, I did not regard myself and those I was researching as separate entities. I learned to think as the 'other' as opposed to the 'self'. Perhaps, on reflection, I did become the 'stranger' or the 'other' more often than not and this was beneficial. Thus, as my thoughts sometimes drifted towards the talk and feelings of the person I was interviewing, I began to

modify working questions that I was beginning to construct from fieldwork. For example, during one interview with Hettie, a widow living alone, she spent most of the time talking about the health and loss through death of her husband, mother, and close relatives. She spent little time talking about herself. Others too talked mostly of 'significant others' rather than themselves alone and this issue of selflessness or an orientation towards connectedness is addressed in the data chapters.

To summarise, reflexivity can be seen as a useful practice in a threefold sense. First, it helps make explicit the role of the researcher as co-producer of data. Second, it can help to deconstruct the author's interpretation of data by making their existing position explicit. Third, and most importantly, reflexive research practice can help researchers to be sensitive to the interests of interviewees. However, reflexivity, whilst offering an important means of carrying out methodologically rigorous research, cannot alone deal with the problem of generalisability inherent in qualitative research. It is for this reason that the following section outlines the importance of narrative analysis in this study as a means of responding to the problem of generalisability in qualitative research.

The benefits of narrative analysis

As noted in Chapter One, it was proposed that a great deal of diversity and difference underpins the constitution of beliefs. Thus, on one level they can be seen to reflect the idea that older adults are competent agents who weave together a range of diverse, competing and complementary explanations or texts. On a second level, they may reflect the position of people in socio-structural contexts. For example, in relation to generational, social class or gender-based social orders. On a third level, beliefs may be considered as the product of experience or biography. For example, in terms of life course factors such as working lives. It could be argued, therefore, that given such widespread diversity in the constitution of beliefs, claiming validity - that is, being able to generalise from research findings - is, to say the least, somewhat problematic. Indeed, this parallels the previously mentioned 'postmodern' type criticism that the presence of multiple realities in the world calls into question qualitative research findings which claim truth status (Lucas 1997). However, this chapter argues that it

is in response to the instability and lack of shared meaning in contemporary society that the interviewees have imposed their own temporally located orientation and drawn upon the notion of community. Thus the ideas expressed by Bauman below could, arguably, be equally applied to the interviewees:

In the modern world, notoriously unstable and constant solely in its hostility to everything constant, the temptation to arrest the movement, to bring the perpetual change to a halt, to install an order secure against all further challenges, becomes overwhelming and very difficult to resist. (Bauman 1997: 11)

The ideal or vocabulary of motive of community is seen in the data analysis as a reflection of interviewee strategies to build and maintain a sense of ontological security by installing their own sense of order, offering security against what they see as the challenges of instability from the contemporary social world. Therefore, I argue that the findings of this study are theoretically generalisable and comparable with other research which describes how a sense of imagined community amongst older adults acts as a key resource to build and maintain ontological security against both the instability of bodily crises, which becoming older inevitably brings, such as in relation to death and dying (Seale 1998), and the instability or lack of shared meanings which the contemporary world is held to offer amongst older adults themselves (Blaikie 1999).

As noted and following Lucas (1997), the inclusion of narrative analysis in the methodology is a response to the critique that qualitative research ignores multiple meanings in data. Before elaborating upon narrative analysis, it will be useful to outline the origins of the postmodernist type thesis that qualitative research ignores multiple meanings. Much of this criticism can be traced back to the poststructuralist and postmodernist critique of traditional semiotics. Structuralist semiotics is called into question for ignoring the ambiguous nature and different interpretations of signifiers in their relation to whatever they signify (the signified) (Gottendier 1994). For example, an older body as signifier which shows signs of biological decay may be interpreted under ageist narratives as signifying a decayed self. On the other hand, by drawing on alternative 'scripts', the same body may be seen in a positive light. For example, as a product of a self that has worked hard, put others before itself and lived a full life. The signifier can never truly claim 'presence' (unmediated knowledge) because it always stands for something else, for something which it is not. This kind of argument is exemplified in the

work of Derrida on deconstruction and the problem of representation in the contemporary world. In general, both the separation between signifier and signified, and the way they are linked, is seen as the product of different systems of meaning. Thus, what Bakhtin calls 'the multivocal aspects of the sign' has been termed as 'the discovery of polysemy', and this proved to be the undoing of formal structuralist semiotics (Gottendier 1994: 167). Thus, for Derrida and other deconstructionists, polysemy 'undermines all grand systems of meaning and interpretation' (1994: 167).

Recognition of the idea of polysemy, therefore, appears to make it difficult to generalise about subjectivity and experience. In particular, it would seem to make the issue of generalising from the interview data problematic. However, what deconstructionism and postmodernism neglect is that human life has a material basis and that the social world is en-acted or instantiated through interaction with others. Taking the ideas of polysemy and multiple voices to their logical extreme would make it difficult to account for significant differences in the interviewee data which have a socio-economic underpinning, such as social class. Hence, as noted in Chapter One, the recourse to the Bourdieuean idea of the habitus in the analysis of the data. If there are no dominant meanings, strong themes grounded in generational or gendered social orders are also difficult to understand. Indeed, the data analysis which follows presents the central argument that interviewee beliefs are strongly associated with the ageing process.

As noted above, qualitative research is imbued with the idea that the social world is deeply symbolic (Murphy and Longino 1992). I argue, therefore, that in the interview data, it is possible to read the presence of objective worlds in the lives of the interviewees (religiosity, collectivism, individualism, altruism, and so on). My argument, then, is that, whilst the multiple interpretation of the interviewee data is possible and cannot be denied, narrative analysis brings to the fore interviewee methods of bringing symbolic meaning into the generationally situated context of their own life course. Thus, as noted in Chapter One, narratives are seen as key resources for the interviewees to construct their beliefs.

Following writers like Lucas (1997), Coffey and Atkinson (1996), Bertaux (1981a) and Alasuutari (1995), shared narratives can be seen to serve the primary function of bringing meaning to different experiences. Therefore, narratives are inclusive categories, they exist at a general level, but are reinterpreted or 'reconstructed' at an experiential one (Williams G. 1984). As Coffey and Atkinson succinctly note, narratives bring meaning as stories or genres to a myriad of different factors, they 'recount protagonists, events, complications and consequences' (1996: 54). For example, as noted later in the analysis of the data from Fred, a retired shipyard worker and active trade unionist, he talks of having problems with his ear since 'the war', but he only consulted a doctor about it recently. He explains this by reflecting on his ideals that the NHS should only be used sparingly and that he is sceptical about 'expert' opinion. On the one hand this can be seen as a reflection of the 'grand narrative' of medical knowledge where, for example, doctors are seen to be important and they should not be bothered with trifling little matters. Thus he talks of being proud of using the NHS sparingly. On the other hand, his scepticism towards experts can be set in the context of his life course career as a working class, trade union activist and the narratives of resistance to authority he may be drawing upon from this context. To generalise from all of the interviewees as a group, therefore, this study is attempting to ground polysemy in narrative analysis.

It can be argued that the idea of narratives has a number of useful functions, both for the interviewees, and, for the interpretation of the data. These can be summarised as follows:

1. They allow interviewees to bring their past into the present and retell key experiences to strangers like me - thus they aid communication between the interviewees and myself, and they complement the life course orientation of this study.
2. They are culturally prevalent sense-making devices (Silverman 1993) which help people put boundaries around meanings conveyed - for example, moral narratives of Christian virtue are present in interviewee stories of justice and injustice towards themselves and narratives related to the 'work ethic' are also significant in the way they construct their beliefs.
3. They help interviewees to position others in relation to their sense of self - for example, interviewee stories of relationships with significant others are bounded by and constructed in interaction with individuals, organisations, institutions, and so on, throughout their life histories.
4. As well as showing how the interviewees construct reality, they enhance analysis by providing a way of generalising and relating the data to common social knowledge. Narrative analysis, therefore, can facilitate theoretical generalisability for qualitative research.

Summary and conclusion

This chapter has given a critical account of the research methodology used in this study. In doing so, it was argued that the use of qualitative methods offered an improvement on the positivist limitations of the survey method used in the DHA study. In particular, it was proposed that the methods used in this study enable an analysis of beliefs in relation to issues of agency and structure, in biographical context. The concept of reflexivity was examined and it was proposed that the strategies I have employed to maintain this have helped me to examine and reduce my role as a producer of data. In particular, by considering the idea that an interview can be considered as a social event I have shown how I regarded my interviewing strategy as a learning process whereby I learned not to compel or urge responses from interviewees which did not reflect their own views. Finally, I have argued that narrative analysis can be considered as a flexible method, which helps to theoretically generalise the findings of such a small scale, but, nonetheless, in-depth study, to existing ideas in other research and in social theory generally.

In response to the question posed at the beginning of this chapter, it is proposed that the qualitative methods used in this study, by enabling an integration of constructionist, naturalistic and phenomenological analysis, can be considered as a means of providing an empirical contribution to the problem of sociology. This problem, as noted in Chapter One, forms the conceptual and theoretical backdrop to this study.

In overall terms, this chapter has examined the relevance of methodological debates about the principle of quantitative and qualitative research, and about subjectivity, meaning and interpretation. The core argument running through the chapter is that the subjective views of the interviewees are of central concern; this is within the overall context of how they interrelate with broader social knowledge. As noted in the analysis that follows, the generative discourse of medicine is a hugely significant influence and constraint upon the way older adults construct their beliefs. For this reason, the construction of 'old age' through the generative discourse of medicine is examined in the next chapter.

The poverty of medical knowledge as a vocabulary of motive

Introduction: medical knowledge and the conceptualisation of ageing bodies

Before turning to consider the data in the following chapters, this chapter examines arguments that the meaning of ageing bodies has largely been produced through the discourse of medical knowledge; that is, they are held to have become *medicalised* (Armstrong 1981; Katz 1996). In examining such arguments, the chapter takes up the theoretical implications of the Foucauldian view that the human body is produced and understood via a range of discourses (Armstrong 1987; Turner 1992). Thus, as a consequence, it is possible to argue that a number of different interpretations to medicalised constructions or readings of the body are made possible. For example, Hallam *et al* (1999) take up this argument in their analysis of death and social identity. These authors describe a wide range of discourses and interpretations related to dead and ageing bodies.

According to this view, the old, grey body lying undiscovered in the council flat, can be an initiation for a new police constable or trainee funeral director, a stimulus for depression among older neighbours, a source of shame for social workers and a reproach for estranged family members. Even in less extreme circumstances, older bodies can be understood as a locus for tension between discourses - for example, generalised stereotypes of 'the elderly' as opposed to personalised, historicised family identities. (Hallam *et al* 1999: 43)

Different discourses, then, can construct different kinds of what might be termed 'body meanings'. Thus, because of different and competing interpretations and the dynamic and changing nature of cultural and social contexts, the body can take on an ambiguous state. As noted in Chapter One, Shilling (1993) and Turner (1992) argue that the body becomes an 'unfinished project'. Within this argument the body is held to take on an unfinished or ambiguous meaning, whereby a multiplicity of social and cultural constructs of body forms and phenomenological experiences of the self are made possible. The implications of such

arguments are examined in this chapter in relation to the authority of medical knowledge over how the ageing body is understood.

Ageing bodies as the product of different discourses

In theoretical terms, and following the work of Bourdieu (1984), many writers have argued that bodies are used to denote social distinction and that in contemporary life body/self/society form a significant relationship (for example, Scott and Morgan 1993; Shilling 1993; Turner 1992). Indeed, the significance of the tie between self, social identity and the body for older people has become increasingly recognised (Featherstone and Hepworth 1986; 1990a; 1991a; 1998; Hepworth 1998; Turner 1995). What has emerged, therefore, as a strong argument (which can also be traced back to Foucauldian thinking) is that ageing bodies have become a significant target for different discourses of authority.

Within this chapter it is posited that ageing, illness and death have been held to be synonymous by biomedical knowledge. In so doing, it is asked how ageing bodies and death have come to be understood by these discourses. It is argued that different kinds of body/self/society manifestations and experiences amongst older adults call into question objectivist forms of explanation in medical and gerontological knowledge. What this reveals, it is concluded, is a range of different interpretations of later life produced via discourses which show the impact of rapid and accelerating social change.

The following analysis is purposely set out at historical and theoretical levels and is intended to serve as a background introduction to the vocabulary of objectivist medical and gerontological knowledge over later life. In the data, resistance forms a key theme throughout and forms a special emphasis in the analysis. However, medical knowledge still retained considerable authority amongst the interviewees. It is for this reason that this chapter examines the medicalisation thesis in some detail. This, it is argued, shows what older people have to live with, or most accurately, live by, and at times, resist. This chapter, therefore, focuses on what older people are confronted with in terms of the authority of medical knowledge. As Armstrong states:

The body is what it is perceived to be; it could be otherwise if perception were different. The question is not therefore concerned with the nature of the body, but with the perceiving process which allows the body's nature to be apprehended. (Armstrong 1987: 66)

The question is not, therefore, about the nature of older bodies 'per se', but with the underlying role of social and cultural processes in constructing the older body and death.

Given the huge and powerful role of medical discourses within modernity in influencing perceptions of the ageing body, it is suggested here that geriatric medicine and gerontology more generally played a large part in allowing the biomedical conceptualisation of 'illness' and 'old age' to become synonymous. This explanation dominated because of a failure to contest it. In particular, emphasis on variability in the health status of older adults and in the way in which the views of the ageing body have been subject to changing interpretations, both historically and cross culturally, has, it can be argued, not been given sufficient recognition in geriatrics or general gerontology. This is not to say that the negative construction of later life can be thought of as all powerful, encroaching, and watertight. Neither is it to say, that gerontology is solely responsible for the stigmatisation of ageing bodies. As many commentators have noted, negative views of ageing bodies pre-date modernity (Featherstone and Hepworth 1990b; Kirk 1992), although such manifestations have been associated with situations of economic hardship rather than systematic discrimination (Hazan 1994). However, capitalist modernisation and general increases in longevity appear to have intensified the 'dehumanisation' (Hazan 1994: 24) of ageing bodies in four significant ways. First, the stigma of exclusion from the productive process or the 'work society' through enforced retirement can be considered to have led to social exclusion or marginalisation (Phillipson 1982). Secondly, and relatedly, the strong emphasis on identity formation through consumerism in the late twentieth century, which also emphasises youthfulness, similarly excludes a large number of older adults without the 'ability to pay', or to be able to present themselves as 'young'. Thirdly, in traditional societies the ability to transmit 'wisdom' or knowledge from experience to younger generations has been depicted as a key attribute in maintaining authority (Hazan 1994). However, when this usefulness became largely redundant through the rise of the 'information society' and the commodification of knowledge, many older adults lost this form of status. Fourth, the decline in status amongst generational

hierarchies within the family has also meant a further loss in status and power for older adults (Achenbaum cited in Blaikie 1999: 32).

On a more positive note, it can be argued that there is a good deal of ambiguity and debate within discourses which seek to claim expert knowledge over later life. By drawing on alternative explanations, especially those which take into account the impact of rapid and intense social and cultural change in the late twentieth century, a much more positive picture can be put forward. In short, the idea that *postmodern indeterminacy offers new hope for more positive constructions, re-presentations and experiences of later life* into the twenty-first century can be proposed.⁴

The analysis that follows is premised on the idea that the older body has become more and more medicalised. This needs to be seen in the context of increasing marginalisation and modernisation in the last two centuries and as a consequence of the civilising process - the latter idea being introduced in Chapter One. In particular, the chapter examines the merits of the Foucauldian explanation of the rise of 'disciplinary power' as a means of making sense of the 'medicalisation' of 'old age'. As Armstrong notes, for Foucault, disciplinary power is based on an inversion of visibility through the increased intrusiveness of the 'gaze' of discourses of expertise (Armstrong 1987: 67-8). Under this Foucauldian explanation, disciplinary power develops through a system of observations whereby those who know they are under surveillance 'transform their actions and identities' (1987: 68). The disempowering nature of disciplinary power noted by Armstrong, can, it is argued, be equally applied to the association between later life and illness by medicine:

the patient at the end of the stethoscope . . . remain silent as the techniques of surveillance sweep over them. They know they have been monitored but they remain unaware of what has been seen or what has been heard. (Armstrong 1987: 70)

⁴ As well as new hopes for older people there are new fears which shouldn't be ignored. For example, the issue of genetic screening and the use of medical records generally for insurance purposes raises a number of ethical questions - see Balsamo (1995) for a general discussion of technological embodiment.

The medicalisation of ageing bodies

Biomedical discourses claiming scientific foundations of technical rationality have established definitions of 'health' (Turner 1995b) which are used to judge older adults against an arbitrary norm. The power of these definitions reflects the dominance of what Max Weber describes as 'rationalisation'; that is, social organisation largely based on scientifically calculated and predictable ends in the formative period of Western capitalism. However, geriatric medicine has consistently failed to define a 'norm' of 'health' for older adults (Armstrong 1981). Within this context, mutual influences between scientific theories of later life and negative stereotypes of 'old age' have played a key role. Thus, in the absence of definitions from geriatrics or, more fundamentally, by not seeking explanations beyond the realm of biomedical discourses, the idea that later life is a deviation from the norm of 'health' is reinforced.

For Foucault the emergence of the 'clinical gaze' (biomedical definitions of normality and pathology within individual bodies) and the differentiation of 'social bodies' (such as the 'healthy' and the 'ill') were the products of what he describes as the rise of disciplinary power', which operated through new forms of governance (Foucault 1973, 1979b, 1980a). Thus radical social transformation in the movement from sovereign power to disciplinary power involved new governmental strategies such as public health and general welfare policies. The emergence of the 'clinical gaze' was the primary means by which the individual body became an object of scientific medical examination and analysis. The clinical gaze localised health and illness inside the body and developed sophisticated and detailed forms of examination to diagnose it. As many writers have noted, whilst illness does act within bodies, this rather myopic focus deflects away ideas about the political and economic causes of illness (de Swann 1990; Doyal 1979; Turner 1995b). Thus, such naturalistic explanations both detracts from, and side-steps, ideas about the social construction of negative cultural stereotypes of 'old age' and their influence on biomedicine.

Drawing on Foucault, Armstrong (1983) argues that the twentieth century witnessed a profound increase in the control of medicine over social bodies by what he describes as the rise of the 'dispensary'. For Armstrong, the 'new' dispensary enabled an intensified and

developed clinical gaze to expand out into the community. For example, he notes how in 1887 Dr. P. Philip opened a tuberculosis clinic in Edinburgh, which not only functioned as an outpatients clinic, but also involved health workers visiting the homes of existing and possible patients. They reported on patient circumstances and their contacts, and taught them 'healthy' ways of living. This 'dispensary gaze' sought out not only the ill, but the possibly ill and those at risk of being ill in the future. Whereas the clinical gaze located pathology within the confines of the body, the dispensary gaze localised pathology within the social body. This process justified and legitimised the 'spatialisation' of medicine into the community, and increased the opportunity for socially legitimate surveillance of populations. It is argued here that the development of the gaze of medicine, despite its basis in physical science, has played the greatest part in labelling old age as a separate social category in recent history.

Geriatric bodies

For Kirk (1992), the development of medical science in the nineteenth century involved the demarcation and diagnosis of old age as a distinct medical category. Tracing the historical linkage between scientific knowledge and the development of geriatric medicine, Kirk argues that scientific discoveries of physiological decline after 50 signalled the growing medicalisation of old age as a distinct category. Indeed, Kirk convincingly argues that medical theories of ageing have deep historical roots. Whilst noting that attitudes to ageing have always been ambivalent, containing a mixture of the positive and negative, he shows how the prevailing patterns depend on the social, environmental and cultural contexts in changing societies. There is a lack of consensus within popular views of ageing prior to the end of the eighteenth century. However, many writers argue that by the nineteenth century old age was discussed more systematically and in much more negative terms in medical theory (Kirk 1992: 486-494). This negative emphasis has deep historical roots. For example, the maxim of some of the ancient scholars 'Senectus ipsa morbus est' (old age is in itself a disease) was traced by Erasmus back to the ancient Roman play *Phormio* by Terence (161 B.C.) and by Kirk to later scholars such as Montaigne in sixteenth-century France and Holdberg of eighteenth-century Denmark (Kirk 1992: 486). The maxim took on almost axiomatic status in European medical

textbooks in the nineteenth century and, from that period, had a profound influence in popular health literature and upon welfare legislation (Kirk 1992: 486-494).

It is clear, however, that medicine was not solely responsible for the negative differentiation of old age. Age-based classifications were also established by political and economic means (Harper and Thane 1992; Houtepen 1995: 221; Macnicol & Blaikie 1989; Phillipson 1982). Nonetheless, it is important not to overlook the power of medically and statistically defined age limits in associating old age with illness, and their influence on social policy legislation in the late nineteenth and early twentieth-century.

For Armstrong (1983), the birth of geriatric medicine as a clinical discipline with a special identity was precipitated by a sample survey of the medical condition of older people carried out in 1948 by Sheldon, a hospital physician. This was the first record of the health of a 'normal' community sample of 'the elderly'. Sheldon not only found more medically defined illness amongst 'the elderly', but, more specifically, many older adults knew they were ill but had no intention of seeking medical assistance. This finding legitimised the need for geriatric medicine and its spatialisation into the older social body.

The results of numerous subsequent surveys which reflected Sheldon's findings highlighted a major problem for geriatric medicine: whereas clinical medicine assessed illness as opposed to the 'norm', the problem for geriatrics was how to establish a 'norm' amongst 'the elderly'. How was it to distinguish between pathology and the normal ageing process? In order to address this problem and to establish geriatrics as a separate speciality within clinical medicine, geriatrics turned to gerontological research for support. However, at that time, gerontology asserted various theories of ageing in which physiological processes of decline were said to result in dependency and passivity in later life. Even though, then, geriatrics supports the gerontological view of later life as involution which is separate from pathology, rather than clinical medicine's central proposition of later life as pathology (Armstrong 1981), the influence of negative theorising in post-war gerontology and the need to gain recognition from clinical medicine meant that geriatrics largely characterised later life as decay and retrogression - the same signs by which pathology was identified. Geriatrics was, therefore,

influenced by negative gerontological theories which located the problem of ageing at an individual rather than a social or cultural level. As Fennell *et al* argue:

role theorists saw loss of work as producing demoralisation and reduced self esteem - especially as there were no substitutes with the same cultural value in American society . . . one of the results of this approach was a considerable amount of data produced by researchers on the activities pursued by older people. Much of this data was purely descriptive, with often only tenuous linkages to any explanatory theory or set of hypotheses. . . [Therefore, one can] cast some doubt on the extent to which disengagement can be regarded as a unitary and universal phenomenon (Fennell *et al* 1988: 44-5, 49)

In geriatrics the need to establish 'norms' of ageing was emphasised by medical practitioners (Armstrong 1981 and 1983). However, given the huge variation in the physiology of older people and in the historical, social and cultural construction of health and social experience in later life, geriatric medicine has been unable, not surprisingly, to come up with a clear set of criteria to define a norm of 'health'.

In a Foucauldian study of the creation of gerontological knowledge Katz argues that the association between death and ageing is a discourse derived from an ongoing series of power struggles between different interest groups (cited in Featherstone and Hepworth 1998: 153). For Katz, this is not to deny the finiteness of human existence, but merely to emphasise the social construction of old age by medicine. Under the huge influence of clinical medicine as a source of power and knowledge, gerontology has played a large part in the pathological production of the aged body which is largely defined by chronological age.

Medicine decontextualised the body and situated it biologically in terms of time and space. In time the body was given a relatively fixed lifespan, one that was indifferent to a person's moral, social or environmental contexts. In space the body became a fixed network integrating the cells, tissues, organs, and systems of circulation, respiration and digestion . . . On a second plane, medicine invested the body with the meaning of old age through a set of perceptual techniques that equated pathological disease, decline, incapacity with the normality of the aged body. The attributes of old age and the aged body became entrenched indicators of each other's supposedly normal/pathological states. (Katz cited in Featherstone and Hepworth 1998: 153)

There is no doubt that modernist inspired discourses are clearly implicated in the negative social construction of aged bodies. These can be broken down into two dimensions. First, many commentators have argued that later life related discourses, particularly geriatric medicine, have classified physical decline and decay as illnesses which may be avoided or cured, thus stigmatising later life and locating its causes within individual bodies. Second, the

association between old age and death has intensified the stigma of being in an ageing body because of the growth of taboos about death.

Philosophical and political challenges to the medicalisation of ageing and death

As argued above, modernist theory has never been able to demonstrate a watertight world view, there have always been some leakages. For example, despite the undoubted dominance of negative views of aged bodies in the last two centuries, positive representations have persisted throughout modernity (Kirk 1992), and more recently postmodern fragmentation can be seen to have led to increased diversity amongst older people. Thus, Featherstone and Hepworth (1990a) argue that widespread social and cultural change has meant that in the 'postmodern life course' younger people now look older and many older people now look younger and that they are taking up lifestyles which were previously associated with younger people. Relatedly, research evidence suggests that older women would prefer to dress in clothing fashions which are associated with younger people (Fairhurst 1998). However, Fairhurst also notes that they may also feel they would be morally condemned or seen as 'mutton dressed as lamb' for not wearing conservative clothing more appropriate to their generation.

Some examples of social change which illustrate the variability thesis used by Featherstone and Hepworth will be useful here. First, the rise of 'body consciousness' and the increased availability of body maintenance techniques and technologies has allowed many people, particularly the materially advantaged, to mask or disguise the physical signs of ageing, for example, through the use of clothing, cosmetics, and plastic surgery. Second, the increased life span of individuals has meant that intergenerational relations have become fragmented and heterogeneous. For instance, childbearing can be experienced from ages ranging from, say, 13 to 63, and grand-parenthood can also be experienced by a wide range of ages ranging from, say, the late 20s or early 30s to people in their 80s and above. Third, longer life spans have meant that many more people are experiencing later life. As a consequence, new

categories have been used by sociologists and gerontologists alike, as a way of trying to understand the social experience of later life within contemporary society. These include categories such as 'young old age', 'middle old age' and 'deep old age', and the distinction between the 'third age' and the 'fourth age'. For Laslett (1989), the life course can be divided into the 'first age' of childhood, the 'second age' of adulthood and working lives, the 'third age' which lies between retirement and the 'fourth age' of rapid decline, dependency and which ultimately leads to death. This is a much shorter and compressed period compared to the other ages of life. For Laslett, by contrast compared to the other ages, the third age is rapidly expanding, involving activity, new challenges and relatively good health.

Indeed, in the last 15 years or so growing older is increasingly being constructed as a time for individual choices and different lifestyles. This can be seen to reflect a growing recognition of variability within the category 'elderly'. In the words of Phillipson this 'new social ageing' - that is, the way it is produced, shaped, categorised and acted out - can be thought of as postmodern:

we are more likely to relate ageing as having all the complexities and hallmarks of a 'postmodern society': the range of lifestyles; the focus on individual choice; the more detached role of the state . . . there appears to be a richer variety of possibilities for constructing old age and for being an older person. But the contrast is somewhat misleading. Labelling the new social ageing as 'postmodern' in fact raises complex questions about where old age has come from, and where precisely it is heading. (Phillipson 1998: 11)

Though Phillipson queries the label, one can argue that many aspects of the new social ageing are indeed postmodern. Diversity and difference amongst older adults calls into question the stereotyping of them as a homogeneous social category. As Conrad observes:

The socio-economic discrepancies inside this population are no less formidable than in the younger age groups: between the 55-year-old steel worker who is half unemployed and half retired and the 70-year-old policy consultant on a second career, between 'new old' middle-class wives and widows on culture trips and the permanent hotel dwellers, between senior golf champs and the victims of work disability, chronic diseases, and dementia there are probably immense and probably increasing inequalities. These contrasts make it doubtful whether the term 'old age' can still serve as a conceptual roof for all these situations. (quoted in Phillipson 1998: 123)

What can be argued, then, is that modernist goals of universal explanation and generalisation are not applicable in the late twentieth century when the world is increasingly characterised by disorder, dysequilibrium and dysintegration, driven by constant and rapid social

transformation (Bauman 1992a; Lash and Urry 1994). Indeed, arguments about the demise of structures of authority over ageing and death are addressed throughout this study.

The postmodern urge to move on, to transcend, to achieve progress that knows no boundaries, coupled with achievements and discoveries in science and technology, has brought about rapid social and cultural change (Bauman 1992a). This has led to a 'runaway world' or what Anthony Giddens describes as the 'juggernaut of modernity' (1990: 139). This disembedding from traditional sources of authority brings a proliferation of different discourses positing a myriad of lifestyle choices, social classifications, and biological and phenomenological variations in the experience of the body and self. Thus, as discussed previously, the familiar social category of age no longer has such solidity in recent decades (Featherstone 1991b, 1995). It should be noted, therefore, that the modernist inspired futures outlined above offer bleak and inappropriate forms of understanding of ageing and death into the next century. For this reason, philosophical and political critiques of modernist inspired negative stereotyping of later life and death are examined below.

As much recent feminist work drawing on the sociology of the body has shown, the binary categories of modernist bodies are dissolved by the ambiguous nature of the body itself. For many feminists writers, then, the body is ambiguous and the binary categories of modernism are contestable (Greer 1991; Komessaroff *et al* 1997; Stacey 1997). In addition, as Shilling (1993) argues, the body is both socially constructed and physically real. Older bodies, then, are both texts of meaning systems and 'lived' in as vessels of biological experience and necessity. The body as a text, reflects the instability and shifting nature of meaning systems by which it is inscribed.

The body has been read by historians and cultural theorists as a text of political, moral, sexual, religious and aesthetic values and meanings in a multitude of fashions which cross-cut science and art, public and private. Histories of the body invariably represent histories of meaning systems in which the body is positioned through a shifting set of relationships, be it the mind, the spirit, the soul, the personality, the psyche or the emotions. (Stacey 1997: 122-3)

As Grosz (1992: 199) succinctly notes, 'bodies speak'; they become 'coded with and as signs'; they are 'intertextuated, narrativised; simultaneously, social codes, laws, norms and ideals become incarnated'. Following this position, as well as accepting that the symbolic meaning

of ageing bodies inspired by modernist thinking is largely negative, the following sections examine the idea that arguments against such thinking offer a way forward. Ageing is examined in terms of feminist philosophical critiques and death is explored in relation to Derrida's ideas about it being a 'mystery' rather than meaningless or a void as modernism would imply.

Reconstructing ageing bodies

Amongst feminist writers there is a growing tendency to contest and challenge stigmatising and stereotypical social attitudes and practices towards older women - particularly in the critical literature on the menopause (Greer 1991; Komessaroff *et al* 1997). Indeed, this literature provides a useful intellectual base for alternative conceptions of later life. As Harper suggests:

Feminist theories of control and the body may help in forming new concepts of later life which fully accepts loss of bodily control, rejects the stigmatisation of the declining body, and acknowledges the possibility of peace between meaning and control, symbol and experience, thus allowing the frailty of extreme later life to be fully integrated into mainstream social experience. (Harper 1997: 170)

As many writers have argued, the western symbolic order has produced the social meaning of menopausal women. Women are predominantly depicted as sexed objects. The move from 'wandering wombs to hormonal lack is still charged with definitions of normality' (Campioni 1997). Emily Martin convincingly argues that the body has come to be regarded as an information processing system which has replaced the machine metaphor of biomedicine (Martin 1997). In order to advance the interests of women, Martin argues that metaphors deriving from chaos theory, which are 'currently exercising a significant amount of influence in some medical specialities' (Martin 1997: 248), should replace those of the body as a machine and information system. Therefore, in what could be regarded as a call to women she writes:

For these shifts in imagery to occur, women would have to be open to more active, positive self-images at the same time as medical practitioners would have to be willing to help women construct them. Menstrual "irregularity" or menopausal "symptoms" might still be treated medically in some cases to alleviate intractable discomfort or other serious problems. But if women themselves saw the phase changes of menstruation and menopause as a result of their bodies' remarkable adaptability, then perhaps women would experience them as less problematic. This in turn might allow doctors, in a synergistic way, to rely less on hormonal treatments to create a mechanical regularity to either menstruation or to menopause. (Martin 1997: 251-252)

Kwok Wei-Long (1997) proposes an alternative model of menopausal women which draws upon Donna Haraway's cyborg myth, 'a myth for our times, a myth that eschews universals and true experience in favour of partiality, irony, and perversity' (1997: 257). Thus Wei-Long proposes 'a new kind of politics of menopause that is also powerfully heretical of the western logos and its dominations' (1997: 257). Wei-Long argues that feminist critiques which draw upon an essentialist model of the natural, in opposition to a biomedical model which is unnatural, can be criticised for claiming an essentialist version of truth. Therefore, what is needed is a reconstruction of feminist politics which recognises that nature is seen through culture. As she puts it, 'all that can be said of nature is cultural' (1997: 266). Feminism needs to take into account that 'The postmodern omnipresence of the cyborg spells the death of any politics built upon "nature", as the classical feminist politics of menopause most often is' (1997: 267). For Wei-Long, 'the idea of the cyborg captures not only a new ontology but also a new political imagination for the hybridized realities of contemporary times as well' (1997: 267). The old politics of essential truth no longer have such solidity - they 'no longer hold up'. The 'cyborg model of menopause most importantly allows what there can be of nature to enter the discussion closed off by the social constructionist response to the classical feminist mode. *For the very blurring of nature and culture enters the field of menopause politics to reconfigure its terrain and the ontology that grounds it'* (original emphasis retained 1997: 269).

Unfortunately, nothing of similar quantity to the feminist literature, can be said to exist to support the interests of ageing men. However, in terms of death it can be argued that Jacques Derrida's ideas in *The Gift of Death* (1995) offer a philosophical way forward for men and women. Derrida argues that we should regard death as 'a gift' rather than as something that we think will bring about a closure upon meaning. As Small explains:

Derrida seeks to show how the event of death always exceeds our attempts to master its meaning . . . to seek to establish some linear connection, such as that we die as a necessary step into eternal life, is

to enact the death of mystery in the very endeavour of seeking to engage with the mystery of death. The gift of death contains both promise and danger. It is always excessive and undecideable. It does not place a closure on the meaning of what is given to human thought and experience; rather it remains a secret and a mystery. (Small 1997: 211)

Staying with the philosophy of Jacques Derrida and the feminist philosophical critiques outlined above, we can note ideas about undecideability and instability filtering through to gerontology in its critique of essentialist discourses. For Derrida, cultural life involves intertextuality; that is, the production and reproduction of texts which intersect with other texts. As a consequence, authority and meaning cannot be reduced to monolithic structures or single explanations. 'Neither our own or others' texts are settled or stable' (Small 1997, citing Lyon). In discourses related to later life there is some indication that such insights are beginning to have an influence.

Gerontology is increasingly recognising that social difference and diversity amongst older adults can be addressed without taking on board the whole *oeuvre* of excessively post, postmodern social theory. For example, in a positive, but rather polemic commentary by Jefferys (1996 10-11) in the British Society of Gerontology publication, *Generations Review*, 'postmodernist theories' are applauded for 'explaining' the variation in older people's 'lifestyles' and 'meanings'. In the same issue Wilson criticises modernism as 'bad science and perverse ideology' (1996: 8-9) and as a way of justifying 'a redistribution of income and resources away from those who are disadvantaged towards the better off'. Indeed, within medical discourse there is some evidence of an intellectual movement away from biomedical myopia through recognition of the idea, not necessarily exclusive to postmodern social theory, but certainly championed by it, that there is no such thing as an essential truth (Hodgkin 1996).

Summary and conclusion: reconstructing ageing bodies and death

In focusing on the interpretation and production of the ageing body by objectivist discourses, this chapter has explored the issue of social identity when the body becomes physically frail or when it reaches a certain chronological age. The chapter has shown, with reference to medical and gerontological discourse, the stigmatising ways in which old age is associated with illness and death. Critiques of the temporal categorisation of later life and its sequencing

with illness and death were also reviewed. In addition, philosophical and political arguments that challenge ageing and death-related taboos were introduced. In overall terms, medicalisation was questioned as means of categorising the social status of older adults. The tenuous grounds of biological explanation neglects social and phenomenological factors and, has been the subject of much critique from writers in medicine and gerontology. Therefore the older body can be seen to be occupying an increasingly ambiguous or contested space within academic, medical and gerontological discourses. By contrast, a strong lobby, involving organisations such as *Help the Aged* and *Age Concern* seeks to expose the inequality and 'plight' of older people. This reflects a long-standing tradition which, however well intentioned, has depicted older people as marginalised, frail and dependent. For example, in an exploration of images of ageing in the twentieth century Blaikie notes:

In 1948, the Liberal Party recycled one of Van Gogh's most profoundly depressing drawings (a sketch entitled 'Despair', showing an old man holding his bowed head between his hands) as a cover for their pamphlet *The Aged and the Nation*, and Peter Townsend's study of warehoused elderly in old workhouses (*The Last Refuge*, 1962) continued the trend begun by pre-war pensioners campaigners of representing age as dire impoverishment. (Blaikie 1999:120)

However, while still prevalent, this approach is increasingly supplemented by theories which highlight difference and diversity amongst older people (Jefferys 1996; Wilson 1996). These latter arguments have been examined here.

As argued, the medicalisation of older bodies can mean that the relationship between older bodies, self-identity and society involves subordination and homogenisation rather than resistance and difference. In the chapters that follow, data reveal the resources through which beliefs about health are developed. In particular, the text of experience is highlighted as the main resource. The generative discourse of medicine, whilst influential, is seen to be interpreted and framed through the experiential texts of the interviewees. This framing is seen to reflect a biographically situated re-interpretation of medical knowledge. Indeed, this can also be seen as representation of outright hostility and resistance to the generative discourse of biomedicine.

Agency, illness and ageing

Introduction

As noted in Chapter One, the growing literature on lay health perspectives indicates both resistance and synthesis from lay concepts in relation to the generative discourse of medical knowledge (Calnan 1987; Curren & Stacey 1986b; Helman 1986 1990; Gabe *et al* 1994). This chapter argues that interviewees demonstrate both of these tendencies, particularly resistance towards medical knowledge. This latter trend, it is argued, has not been picked up in the research literature on health beliefs in later life. The area is under-researched for two main reasons. As Sidell (1995) argues, later life and health are more likely to come together either in the 'humanitarian' literature which concerns itself with the 'plight' of sick elderly individuals or in the policy-oriented literature which represents older adults as a burden for health and welfare services. Following modernist explanations, the meaning and experience of 'health', 'illness' and 'health care' is therefore assumed to have an unproblematic, universal and often medicalised nature. This chapter questions these ideas and demonstrates the production of distinctive sets of beliefs which reflect older adults' resistance to negative stereotypes of 'old age' as a social category and the relationship between ageing and beliefs.

This chapter's focus on health is echoed in analyses of people's survival strategies in later life (Bury and Holme, 1990; Cornwell 1984). As pointed out in the previous chapter, it is possible to identify a 'medical myth' which makes ageing synonymous with illness and disease. This myth draws upon the implicit ambiguity of the term 'old age', in that it refers to both a stigmatised bodily condition and social identity, and simply as a temporal period within the life course. As the last chapter argued, old age can be cast as both the *cause* as well as the *time* of ill health. As a result, throughout the period of 'old age', individuals with health problems are less likely to have specific causes attributed to their illnesses; they are more likely to be

told that such conditions are 'due to your age'. What is argued here, then, and in the following data chapters, is that if 'health' and 'age' tend to be seen as synonymous, one needs to recognise older people's health beliefs and practices as representations of something more far-reaching than just a bout of flu or an attack of rheumatism. For 'health' and 'illness', read 'age', 'time of life' and 'embodiment' when these terms manifest themselves in the interview data presented in this chapter.

This chapter explores the view that interviewee beliefs related to health can be seen to represent a form of resistance, not just to discriminatory medical frameworks, but also to the wider ideology of ageism generally through which the category 'old age' has largely been produced (Bytheway, 1995). Thus, 'illness' stands as a cultural icon for the all-encompassing conditions of old age itself. This may help explain the paradox that while older people experience higher levels of morbidity than people in mid-life, research consistently shows that they perceive themselves to be in good health (Blaxter 1990; Sidell, 1995). One explanation posited is that such individuals are drawing upon an alternative notion of health, perhaps one which is more holistic or social in nature. However, it could also be suggested that when older people lay claim to 'good health' during a research interview they may be engaging in an act of resistance to a stigmatising social identity. Thus, if ageing and illness are indistinct, denial of the evidence of illness also represents resistance towards being thought of as 'old'. In the data which follow, the beliefs of the interviewees can be understood as texts which encompass interviewees' broader strategies of self-empowerment and experiences of powerlessness, and as a key site within which agency is mobilised.

A correlation between older people's health beliefs and the general growth this century in the questioning of traditional sources of authority (or what Lyotard (1984) refers to as 'metanarratives' such as biomedicine) has not become a focus in the limited, though valuable work which exists in this area (Williams; 1983 1990), although this point has been made in more general research in this area (Williams, G. and Popay 1994: 134-135). While a Parsonian model of the 'sick role' (Parsons 1951) usefully takes account of the interaction and indeed bargaining which goes on between patient and doctor, it assumes, ultimately, the compliance of the patient to the doctor's authority. Similarly, Zola (1975) and Illich (1976)

highlight the place of negotiation within the medical encounter, but give insufficient attention to resistance to medical power. To all intents and purposes, medical knowledge is held to be all encompassing and there is little scope for theorising resistance in traditional structuralist sociology. Existing work on health beliefs in later life, if anything, flies in the face of contemporary social theory, instead emphasising the way metanarratives such as the Weberian 'Protestant ethic' can shape, or even constitute, the perceptions of older people themselves (Williams 1983 1990). Furthermore, no analysis has as yet been placed within the political context of the so called 'grey power' or agency of older people. Thus, the twin aims of the chapter are to ask (1) whether the interview material represents a questioning of the authority of metanarratives such as biomedicine and (2) whether interviewees' accounts constitute aspects of *broader* strategies of self-empowerment or forms of agency within an ageist society?

As well as demonstrating resistance, the data also show evidence of the influence of the discourses of medical and indeed religious 'experts'. The purpose of this chapter, however, is to highlight resistance. It therefore, investigates the workings of power in the empirical area of interviewee beliefs and highlights their agency. In theoretical terms, both the tension between resistance and acceptance, as well as the sheer heterogeneity of lay knowledge, make it difficult to understand this material using traditional structuralist sociology such as that deriving from Durkheim, Marx or Parsons.

The following sections discuss the interview data. At first glance the data show how medicine holds sway over interviewee beliefs. However, further examination indicates that they also resist this powerful discourse. Viewed as a whole, the content of this material constitutes a set of statements about something which both interviewee and interviewer recognise as 'health'. It would seem at first reading, therefore, that they share a common understanding of this concept. However, this material also reveals that, for the interviewees, the notion of 'health' stands, more broadly, for the conditions of later life itself. In this respect they are illustrative of Armstrong's analysis of the processes involved in the rise of the 'geriatric gaze' (1983); that is, where the chronologically determined category of 'old age' came to be scientifically defined as an illness. The next section shows how, in broader terms, 'old age'

takes on a negative, illness-based aspect which is often internalised by older people. Like biomedical knowledge, they too understand their age - the temporal period they reached within the life course - as the cause of their poor health. As a result, their age-based social identity, in being meshed with the expectation of deterioration and death, takes on increasingly negative qualities.

Ageism, the body and dependency in later life

The idea that later life is a stage in the life course when dependency and social inequality are to be anticipated has been shown to rest upon sets of social, economic and political constructions (Bond and Coleman 1990; Phillipson 1982; Phillipson *et al* 1986). This chapter argues that dominant conceptions of health and illness in old age are cornerstones within this particular set of beliefs and practices. They contribute to a negative representation which can be internalised by older people themselves. As Coupland *et al* (1991) point out, age is recognised by both children and older people as a marker of social identity, and this is evident in the sometimes ageist language they use themselves. Interestingly, the work of these authors shows that when older people were asked about their health they gave their age as a sign of being above average. In other words, they too understood poor health to be synonymous with later life, a belief which distinguishes their own well-being from that of younger people:

SM: as well as I can be . . . I'll tell you first I'm going on ninety

CH: oh no, very good. . . well, I'm almost eighty and I can't expect as much

MM: not on top of the world but . . . when you come to eighty three years of age you can't expect to be like a spring chicken can you?

GT: I haven't been too well . . . because . . . of course I'm getting on now I'll be eighty next year.

(Coupland *et al* 1991: 138).

The material, therefore, shows how a broadly negative cultural representation of later life can be reflected in the specific notion that good health is inevitably a scarce resource for 80 and 90 year old people. In a circular fashion, this then feeds back into a more general perception

of later life as a period of disadvantage and dependency. Illness, then, as an objective category, can be both expected and accepted after a certain age. Just as medicalised old age has been, so older people can regard ill health as something which stands for old age. Material similar to that presented by Coupland *et al* (1991) was evident in the data. For example, during a focus group interview, I provoked lively discussion by asking if the health of a person was due to divine intervention or the 'will of God':

Several
people

together: ((turning to the speaker, some shaking their heads, smiling, frowning, arms being crossed))
No; naa; course not.

Delia: I just think it's old age.

Emma: I think it's age.

SC: ((surprised)) Age . . . Now you are the ones who are calling yourselves old.

Emma: ((calmly)) Well, we are old.

Here age is being cited as the cause of illness and, as such, is helping to make sense of poor health in a way which relieves the individual of any sense of blame or responsibility - though it does require people to take on the social identity 'old'. At the same time, the generative discourse of religion is being rejected or resisted. Other interviewees, however, resisted age as a marker of social identity and, interestingly, both Delia and Winifred also refused the notion of old age as an inferior social category. Their focus was not just the health of the body but, more broadly, what could be called the body's condition or appearance being the site within which social identity comes into being. This reflects a core idea within the sociology of the body - that the human body is a crucial intersection which links the self and society (Shilling, 1993). Thus, the identity which individuals felt would be read off from their bodies was not always one which matched their sense of self. For example, in the account of a 71 year-old retired storeman he describes not 'feeling' his 'age' and also the way this has been undermined by a heart attack:

SC: When you said that you were now feeling your age, can you remember how long you have been feeling like that?

Tim: ((matter of factly)) Just this last year . . . eighteen months, possibly.

SC: Why do you think that has happened?

Tim: Well, I felt too young before. I should have felt like this previously. Talking to one of the few chaps who is still alive . . . they have felt like this for years - and it's just come on for me. As I say, I am 71. ((frowns)) How are you expected to feel when you are 71?

What is being expressed, therefore, is a feeling of tension or difference between a set of external bodily symbols which indicate decline - such as wrinkles, grey hair and slack flesh - and the subjective sense of an ageless self, located within the body. Following Merleau-Ponty's explanation of the role of the body in determining consciousness which was introduced in Chapter One, one can suggest that Tim's sense of self changed radically after his heart attack: rather than feeling 'too young' he now felt his age. There was a conflict between his sense of self and what Featherstone and Hepworth (1990a) describe as the 'mask of old age'; that is, the negatively perceived external appearance of the ageing body. While the positive re-presentation of the body, via the 'mask' of cosmetics and clothing, is a possibility for some older people, this was not the case among the individuals interviewed here. For example, a retired businesswoman also described feeling a sense of disjunction between her body and mind.

Ros: As you get older, your body gets older, and you look older. But, if you had no mirrors and no clocks you would never know that you are getting older, because the inside of your brain is still exactly the same. It doesn't get any less. You think exactly as you thought . . . fifty years ago.

SC: And do you feel like that?

Ros: ((sighs)) Oh yes. The only trouble is that you can't do what you could do fifty years ago; and that is the frustrating part about it.

SC: So do you feel young inside?

Ros: ((sighs)) Oh yes. You do. You do. ((pause)) But you get a shock when you look in the mirror...and you expect to see - well I expect to see - a dark vivacious face looking at me...and I get a grey wrinkled face looking back and I think, 'Well, oh God' . . . and there's not much you can do about it . . . everybody is getting younger and you are getting older.

Indeed, despite her statement of resignation: 'there's not much you can do about it', her words can also be interpreted as a statement of resistance to the mask of old age. Much like Kaufman's depiction of the 'ageless self' (1986), Ros presents herself as not getting older in that she thinks in the same way she did when younger; she thinks: 'exactly as' she 'thought . . . 50 years ago.'

Hettie, the 78 year old woman introduced in Chapter Two, echoes this sense of a divergence between self and body, using the metaphor of letter as essence, and envelope as appearance:

Hettie: The thing is that bits of your body wear out, but inside, the essential me is still the same. The physical me is the envelope in which the letter is, and the envelope gets worn out.

The mask of ageing, then, can be seen by older people themselves as an externally imposed masking of their sense of self, a cultural strategy which is accomplished via a prioritising of the body and its appearance over the person in the body. In this way the body is made to stand for and indeed becomes the self. Normative ideas of beauty, health and participation or interaction in the everyday world are drawn upon in such a way that the older person feels excluded or marginalised in relation to younger people. As a woman who had worked for most of her life as a mother, wife and part-time shop assistant said:

((sighs)) and everybody is younger . . . the policeman, the bus conductor, the people in the shops . . . they are all younger . . . it makes you feel strange.

In this way the difference between that which is internally located - emotions and the mind - and the outward signs of bodily decline and their association with culturally constructed dependency, produces an experience of tension or difference, even anomie. J.B. Priestley describes the experience in the following way:

It is as though walking down Shaftesbury Avenue as a fairly young man, I was suddenly kidnapped, rushed into a theatre and made to don the grey hair, the wrinkles and the other attributes of old age, then wheeled on stage. Behind the appearance of age I am the same person, with the same thoughts as when I was younger (quoted in Featherstone & Hepworth 1990a:148).

In some ways this experience parallels Goffman's dramaturgical model which makes a clear distinction between self and role (Goffman 1990). However, both Goffman's dramaturgical model and also the notion that older people can be marginalised via particularly negative readings of their bodies risks obscuring these individuals' alternative representations; that is, their agency. The next section examines data which demonstrate the interviewees' resistance to sets of generalised assumptions about their incompetence and lack of social value. Significantly, as already argued, medical beliefs and practices play a key role - as a metanarrative which reflects the primacy of the body as a signifier of social identity. It is,

therefore, the body in health and illness which becomes a key site for resisting dependency and marginalisation in later life.

Resisting the mask of old age

The following extract comes from a focus group interview in an Age Concern Centre

SC: Just to talk about things that you think could affect your state of [health

Cheryl: [Oh, I know, when people treat you as if you are daft because you are old. I know because I am in Pensioners' Rights and we get MPs talk down to us as if we are [daft.

2 voices: [Umm, daft. Yes.

Cheryl: [and we get them saying, ((sarcastically)) 'oh we will take you into the restaurant for a cup of tea and a [sticky bun'

2 voices: (((in chorus)) Yes.

Cheryl: (((getting angrier)) and we say, 'we do not want a cup of tea and a sticky bun our brains are the same as what yours are'. We go to talk about pensioners' rights and they talk to you as though you are a [baby

Other voices: [They do. It's not right.

Cheryl: (((very angry)) and you're not. Mind you, it doesn't just happen there, it happens all over the place . . . they think pensioners and they think you are stupid. They do.

Emma: ((sharply)) They do.

Delia: ((defiantly)) They think we are up agin wall and that we are on way out . . . well, I can tell them that we are not going ((laughs)).

Being talked down to in a child-like way or being subjected to processes of 'infantilisation' (Hockey & James, 1993), as well as perpetuating powerful negative stereotypes, clearly annoys older people themselves. Resentment and hostility towards marginalisation is evident in the following extract from Fred's interview.

Fred: ((angry)) when you get old, they push you to one side . . . the people ruling us have no respect for us. I fought the war for this country . . . and what do I get back in return now? Nothing! I think it is a disgrace that old people have to buy second hand clothes in charity shops. We deserve better after all we have done for this country ... I ... I ... ((shaking his head, sighing and then eventually goes quiet)).

In addition to health, old age is also discriminated against in terms of body image, participation in production and consumption and thus in collective social life. As previously

argued 'consumer society' and the 'work society' both reinforce and create negative language and images of later life. In turn, this can produce a slide into symbolic or social death (Baudrillard 1993). Generally speaking, there is an inverse relationship between growing old and participating in social life, or as Turner (1989) argues, between personal 'maturation' and 'reciprocity' with the wider society. It is via these process that old age comes to be marginalised and stigmatised. Hence, the negative 'downhill all the way' or 'time's up' narrative which underpins the dominant conception of old age and helps to reproduce the way health care services are provided for 'the elderly'. The threat of health-based forms of discrimination is evidenced in a recent report by the Royal College of Physicians which highlights age bars for certain treatments by some units, and to an implicit view that younger people should be given priority (Mihill 1994). Age is therefore not only the cause of illness but a constraint on its treatment or cure. Some writers argue that, not only increased dependency (Phillipson 1982) but also unnecessary death (Mihill 1994) are its outcome.

The prospect of increased dependency is also evidenced in recent proposals from 'Britain's most powerful pensions body' (Jones 1999) to raise the retirement age for men from 65 to 70. If such a proposal was implemented, older people on lower incomes would be penalised because they would not be able to take early retirement and would be forced to undertake an extra five years of work. Poverty is a fact of life for many older adults. For example, from a sample of 1, 317 people from the readership of *Yours*, a magazine for older people, aged 55 to over 90, a quarter find it difficult to pay for household repairs, heating and clothing (Hall 1999).

In the face of marginalisation, however, as the data show, the interviewees are challenging ageism. Indeed, age-based politicisation is taking place in an international, as well as British context; for example, organisations like the Grey Panthers, the American Association of Retired People, European pensioners' political parties and the UK Pensioners' Rights Campaign, the National Pensioners Convention, Age Concern, Help the Aged, the University of the Third Age and so on have sought to combat age discrimination in labour markets, education and compulsory retirement. As yet, however, most commentators seem to agree that the tide hasn't completely turned (Blaikie 1997), although it is clear that the 'time's up'

narrative is being resisted, and that this is growing (Tulle-Winton 1999; Blaikie 1999: 66, 185-188).

Given the social inequalities which divide older people from one another, such as income, gender, ethnicity and health, and the stigma often attached to the label 'old age', their resistance to exclusion is limited by their fragmentation and liminality. Yet a growing body of research evidence shows older people actively seeking a multiplicity of ways of resisting authorities which undermine them and assert their own identity in ways which call into question the association between old age and senescence (Bury and Holme 1991; Dittmann-Kohli 1990: 291; Mathews 1979; Thompson *et al* 1990; Williams 1990). This research has shown that, despite poor health and standards of living, and as a result of accepting adversity and readjusting expectations of what constitutes normal living, older adults remain optimistic. Thus, while vulnerable to the power inscribed in the members of dominant social categories, such as doctors, social workers, younger family members, and so on, older people also appear to have access to alternative sources of power. What follows below is an examination of how 'health' and 'illness' are key sites for resistance amongst the interviewees.

Resisting Medicine

Working within the framework outlined in Chapter One, I examine the ways in which the interviewees have drawn upon a range of discontinuous and interrelated narratives and texts. Following the life course approach, the importance of historical continuity in the way traditions from the past are called upon to make sense of the present is acknowledged. It is, however, also important to note that their role is not always deterministic. Therefore, emphasis must also be given to discontinuity, rupture and *break* with the past. Two important theoretical perspectives are worth noting here. Lyotard has argued that this century has seen the demise of 'metanarratives' (Lyotard 1984). This has confronted medicine with increasing challenges. In the context of the meaning of 'health' for older people, which, to all intents and purposes, may constitute not just a bodily condition, but an entire social identity, their agency, vis-à-vis medicine under threat, needs to be recognised. Second, the notion that the social world is fabricated via intertextuality explains why the 'ideologies' of the powerful continually break down. Their hegemony is inherently unstable. Thus, medicine as an ideology can never

achieve absolute power but instead is subject to a continuous process of re-constitution via the play of intertextuality from different genres of meaning.

The interviewees challenged medicine as a metanarrative on a wide range of grounds. There were also apparent contradictions, in that respect and criticisms were simultaneously present as explanatory orientations, a reflection of the experiences and perceptions of those concerned. To make sense of diversity as is evident in this data, ways of understanding contradiction and ambiguity need to be drawn upon. Concepts such as the death of the author, intertextuality and narrative reconstruction are therefore crucial here. For example, in relation to ill-health one person was critical of:

Ros: greedy doctors at the top.

However, she goes on to absolve the government and to include the 'undeserving poor' as the other guilty party:

Ros: Oh no, it's not the government's fault . . . It's those doctors at the top . . . [and those] seamy people [who] must have their pint of beer . . . no matter how little they have got.

Three narratives are evident here. The first is that greed is wrong and that 'greedy doctors at the top' are to blame. The second is more pragmatic, health care is not made the government's responsibility. The third, perhaps as an indicator of political beliefs, draws on the notion of the 'undeserving poor'.

By contrast, another person said he felt that 'the powers that be' were responsible for inequalities in health. The implication here was that health care providers were having to respond to social causes which they were powerless to do anything about:

Fred: ...it's unemployment and poverty what causes ill-health.

This view, then, was being put into the context of a more far reaching criticism of social inequality, a slippage of meaning whereby 'health' becomes a concept which extends beyond a narrow medicalised focus on the body. By recognising the 'undecideability' present in the

reading and writing of texts and in language itself, it is possible to access the social meaning of the interviewee's lay health beliefs (see Fox 1993). As Roland Barthes has argued, the text frees people from the tyranny of structurally determined, ideological meaning - all meaning is intertextual (Eagleton 1983: 141). Thus, ideas about intertextuality and narrative reconstruction allow one to address the presence of vastly different explanations of the same thing. In each interviewee's account, a number of different texts and narratives are being traded off, with each other, to intertextually reconstruct another narrative.

For the group as a whole, medicine was resisted in terms of its knowledge and practices. In detail, this involved overt practices, such as using alternative medicine, and conceptual challenges which consisted of strong criticisms of the knowledge base and ethos of medicine. In general, interviewees combined such challenges with other texts and narratives via the processes of intertextuality and narrative reconstruction.

Using alternative medicine as a practical challenge to medicine

Four people used homeopathy. Interestingly, all were women and all were in high income brackets. They all expressed incredulity and disdain towards the metanarrative of biomedicine. For example, Joyce aged 52, from a very prosperous social background, turned to homeopathy for an allergy problem because of the perceived failure and unsympathetic attitude of the GP.

Joyce: ...this is why I have got into homeopathy . . . ((sharply)) he [the GP] never seemed to be all that sympathetic. He would never listen, because I kept saying to him, whilst Malcolm [her son] was still young, what terrible problems we were having. He seemed to think that I was exaggerating, I used to say, ((pleading voice)) 'can't we just find out if he is allergic to anything?' I thought something was upsetting his brain [her son's] and ((sharply)) he [the GP] wouldn't hear anything of it; and blow me, it did turn out years later, we found out that Malcolm was very, very, allergic to milk. He has been addicted to milk. He used to drink it by the gallon. So, whilst clearly he did have emotional problems, I think the whole thing was being made worse than it need have been. I think a lot of it came from him drinking milk . . . so that made me seek advice from alternative practitioners, because, when I started irritable bowel syndrome, and I had years suffering from that . . . and again I was under the impression that there was an allergy involved in it, but I didn't know where to begin to find out what I was allergic to.

This can also be interpreted as a reconstruction of narratives, as feelings of responsibility towards her son from her career as 'mother' were played off against ideas and narratives

implying that 'doctor knows best'. Eventually feelings for her son lead her to question the credibility of the GP's expertise and to seek help from an alternative practitioner.

Right at the beginning of the interview without any prompt from me, Joyce emphatically rejects medical knowledge and power:

((very calmly)) I hate to feel that I am totally in somebody else's hands. That is why I hate going into hospitals . . . when you are in hospital you are supposed to lie in bed and let them make all the decisions, and they don't even explain what they are doing. You don't know if they are making mistakes or what . . . I do not like that. I would like to know what is wrong with me, what the treatment they are giving me is and how it is going to work, what might go wrong, what is the cause of what is wrong with me . . . ((sternly)) I just don't like to be in anybody else's power ((laughs)) . . . I don't know how else to put it . . . I just don't like to feel helpless and being dominated by someone else, and my life in their hands completely.

This forceful statement clearly questions the power of medicine, particularly when she states, 'I just don't like to be in somebody else's power . . . and my life in their hands completely'. Also, the disempowering experience of becoming a 'patient' is firmly rejected.

There were also clear misgivings about impersonal biomedical treatment regimes from this group. This included general criticisms of the over-prescription of drugs and of the lack of time and explanation given by medical practitioners. One person with ME said of GPs:

Elsabeth: ((getting angry)) This is how they are, if they can't do anything they just won't bother to explain to you . . . they don't explain anything really; they just put satisfactory . . . and, really, it's all over in a flash.

Here, the impersonal and the almost automated or production-line nature of health care is rejected. The logos or the heart of the matter seems to be a call for approaches which involve giving more explanation and more time to patients.

Alternative medicine also seemed to offer empowerment. As one woman, who said that she read about and practised homeopathy, stated: '...so I do think you can help yourself'. In all cases, the use of homeopathy was an obvious resistance practice, but this was clearly related to an ability to pay, in that those using alternative practitioners were in high income groups.

Conceptual challenges to medicine

Whilst those who used alternative medicine were vociferous in terms of their critique of medicine, most other interviewees were also highly critical.

One person when talking about the health care received after a heart attack remarked:

Ros: Well you don't know what you feel. But I felt frightened, ((pause)) frightened . . . I think they try and frighten you to take the pills. I told them that they did not agree with me whatsoever - but I felt if I didn't take them, ((sighs)) I would probably die. I took the pills and they didn't agree with me. I think they caused me the second illness, which was double pneumonia, which nearly lost me my life. I was in a coma for four days.

Clearly this account refers to disempowerment and the fear that was induced by the perceived consequences of not adhering to medical discipline. There is also an expression of dissatisfaction, in that the cause of the 'second illness' is attributed to the medical treatment received for the first. Many of the group regarded expert knowledge with scepticism. For example, one person, who was mostly deferential to biomedicine, also questioned the authority of experts:

Tim: you can't take any notice of the experts because they all contradict each other. One says do this, that and the other and the other one says don't do that, do this.

In theoretical terms, this common-sense explanation parallels the Foucauldian idea that the body is a contested space for the imposition of different authorities. The expertise of one source of knowledge can therefore call into question the logic of another. Furthermore, it reflects the idea of free floating anonymous texts or the death of the author in that a multiplicity of contradictory voices are discerned within experts' opinions.

In the area of drug prescription, many people were critical. For example, the first thing said in one interview, without any prompt from the researcher, was:

Evelyn: I think that when you go to see a doctor they are writing a prescription before you know it.
Another person states:

Emma: I think people take too many tablets. I stay up in bed till three o'clock in morning and I read. If you take too many tablets, it's no good. You just have to do it yourself and not rely on tablets.

One woman, when describing how going through a divorce had affected her health, found herself on the receiving end of gender as well as age-based discrimination when consulting her GP:

Paula: My new doctor is very good, he will sit there and listen to me. Whereas the one I had in Hull he was awful...he said...((blasé voice)) 'all you women who get divorced, you get all these problems. You will just have to learn to live with them'. I said, ((adopts hurt voice)) 'well, I didn't plan it, I didn't set about to get divorced, it wasn't my fault'. All he said was, 'you will just have to learn to live with it'...I don't know why he treated me like that, I was so upset...it made things worse. I just couldn't seem to communicate with him.

There was also a clear reference to an unequal relationship. Here, feeling a lack of power at that particular time, resistance could only take place later in a safer setting:

Joyce: Although I was very annoyed with him, I couldn't do anything at the time. You don't want to get on the wrong side of them, do you.

A number of people seemed to resent the ethos of the NHS as expressed in the organisation and delivery of health services. Many also felt that, other than as a source of symptoms, they were not being listened to and that this was wrong. Doctors were seen to engage in language games to gain the authority of expertise in relation to the physical body:

Joyce: All it is, is that quite often you know what it is, but you do not know what the medical term for it is; and the doctor would say, you don't know what you are talking about, I am the expert. They oppose it; and really, I do not think they should. I think they should listen to you more.

In other words, doctors draw on scientific texts using 'medical terms', to gain the logos, or truth claim, of expertise. An epistemological challenge to the Cartesian duality of mind and body was also evident:

Joyce: I do think instinct plays a part in illness. It's probably because it is your body, not the doctor's, and you know instinctively what it is and what the cause of it is; because your body is connected to your brain, isn't it.

This can also be read as an example of how lay knowledge is rooted in the text of experience, whereas medical knowledge is derived from the concept of disease. There can be an interchange between the two, but the narratives of most of those interviewed were rooted primarily within their own experience. Thus, biomedical practices such as taking drugs, and explanatory frameworks which separate mind and body are called into question.

There was also evidence of a firm criticism of the ethics of technical rationality, or what Weber calls *zweckrationalitat*, where action is guided by considerations of ends, means and secondary consequences which can be subjected to calculation rather than by any absolute moral or ethical values (Runciman 1978: 28-30). For example, everybody was opposed to age bars in health care on moral grounds and some were critical of NHS medical consultants for working part-time, and of modern day doctors for 'empire building'.

Ros: The doctors I think they are empire building . . . the doctors at the top they don't do enough work . . . every time the government step in to do something they can't put it right because of those at the top. You see our old fashioned doctors... You see, like when we were kids. The doctors were very kind. When somebody didn't have enough money to pay the doctor would let them off . . . people were different then. I think people nowadays are more interested in money and things like that.

Others were critical of NHS organisation in terms of the abuse of power by medical elites, and as a critique of new managerialism:

Fred: It is just not right that consultants can work part-time, ((frowns)) I mean, it's not on is it? You wouldn't get it anywhere else...you wouldn't get somebody coming in to a firm to do their job part time and then going off somewhere to run their own business . . . that is what they are doing . . . it is not fair on the doctors and nurses who know about health and how to care for somebody properly to be told that they have to work on business lines and make a profit. I don't like all these managers who are running the health service like a business; you can't do that. It's just not right. I don't agree with those Trusts. They should get rid of them straight away . . . the problem with the Trusts is that you have all these business people talking about cash going in and cash going out. You have got no lay people on there who are actually going to have the treatment in hospital.

Deprivation and power are key themes in the next extract where Fred is very critical of the individualising discourse of 'looking after yourself':

Fred: It's all right them in health service going on about looking after yourself. What I think what causes ill health today is unemployment and poverty. The thing is that it is the powers that be that will not recognise it. If they did they would have to say it was their fault. Then they would be in a right state . . . because they would have to do something about it . . . when I hear that Virginia Bottomley going on about looking after yourself, I think what a load of rubbish. It's unemployment and poverty what causes it.

The main narrative here is that looking after yourself is only part of the story. For Fred, 'health' includes more than just the maintenance of bodily well-being, instead encompassing the entire socio-economic positioning of older people within society. The political discourse of individual responsibility is seen to be faulted because it side-steps social causes: like 'unemployment and poverty'. This seems to suit the needs of more powerful groups because they can

disclaim responsibility: 'the powers that be will not recognise it [because] they would have to do something about it'.

In general, therefore, beliefs contained an epistemological critique of the objectivism of scientific medicine. This was also seen as a sign or icon for contemporary society, a reflection of rationalisation. The latter view, therefore, linked in to the narrative that we live in mechanistic or uncaring times. In challenging this objective body of knowledge many interviewees pointed to exogenous causes of ill-health, such as poverty, pollution, unemployment, iatrogenic health care, and so on.

To summarise, four areas of conceptual challenges seem to be important. The first concerns expertise, the second relates to drugs, the third to gender, and the fourth to medical power generally. In relation to personal health care, there was a challenge to the authority of biomedicine in the form of a general scepticism towards expert knowledge: 'experts . . . contradict each other'. Drugs were seen to be harmful, 'I took the pills and they caused me the second illness'. They were an easy option for doctors: 'they are writing a prescription before you know it'; and for patients: 'If you take too many tablets, it's no good. You just have to do it yourself'. Gender was being used to sustain power inequalities, 'all you women . . . get all these problems. You will just have to learn to live with them'. Finally, even though 'very annoyed' with a medical practitioner, his power was recognised: 'You don't want to get on the wrong side of them'. The text of personal experience was also drawn upon to express a challenge towards health service practices and organisation more generally, one which constitutes an important aspect of older people's agency.

Resistance through intertextuality and narrative reconstruction

Overall, then, the interviewees' health-related criticisms could be seen to reflect the intertextual reproduction of meaning in the social world through the demise of the authority of the metanarrative of biomedicine. Thus interviewees drew on a wide range of narratives and texts within the interview. This included: (a) 'greedy doctors at the top' (b) the government was not responsible (c) the 'undeserving poor' would not change their lifestyles (c) 'poverty and unemployment' caused ill health and responsibility for this lay with the 'powers that be' (d)

medicine could affiliate itself with more powerful interests, such as the state, by obscuring inequalities in health and individualising health care (e) expert knowledge was challenged from the basis of experience; for example, the experiential text of responsibility towards other family members could overrule biomedical discourse (f) those with higher incomes used texts from alternative medicine and they also consulted alternative practitioners (g) logos of equity were asserted; for example, some saw it as wrong for medical practitioners to not explain 'what they are doing' and to purposefully disempower patients by claiming the authority of expertise over the physical body; many rejected ageist health care firmly (h) it was seen as wrong for doctors to exploit gender inequalities to maintain power and control (i) the cultural construction of later life through the mask of old age was experienced by many, and this was also perceived to be a false construction (j) over-prescription of drugs was firmly rejected (k) scientific approaches within zweckrational health care were rejected.

Following this it could be argued that the ways in which medicine was challenged represent different forms of resistance to a negative, age-based, social identity in that interviewees were claiming other identities which were not totally controlled by medical discourse or, in large part and other than their own experience, by any other single source of power and knowledge.

Summary and conclusion

In this chapter it has been argued that interviewees re-construct narratives via forms of understanding made possible by intertextuality to explain health and illness. The friction between texts of experience and the negative 'mask of old age' alerts one to issues of self-identity and, as argued, is closely connected with resistance to the objectivist or scientific approach of medicine. Interviewees' reactions, therefore, can be seen as a reflexive challenge to the stereotyping of the social category 'elderly' as an embodiment of the 'time's up' narrative. When addressing the issue of 'health' in later life one can usefully note Foucault's contention that there has been a growth in locations of power and knowledge that seek to inscribe physical and social bodies or communities with discourses of normality and self-government (Foucault 1979a). In the data presented here, self-identity, in terms of the privileging of experience, can be seen as a form of reflexive empowerment which conflicts

with inscriptions of power and expertise that shape and target 'the elderly' as a social body. A range of inscriptions ran through the interview data, some of which were deferential to sources of power and knowledge such as medicine, religion and science, whilst others were not. On balance they give clear evidence of the questioning of authority, or the rejection of totalising theory (Lyotard 1984).

The chapter has presented data which highlight the agency or 'spirit' of the interviewees. This is not to deny that the interviewees' talk shows evidence of vulnerability to inscriptions of domination, but instead to highlight in theoretical terms how their agency is made possible through intertextuality and narrative reconstruction. Indeed, resistance was asserted most vehemently in response to objectivist discourses, particularly medicine. This was often represented as stigmatising, reductionist and conceptually flawed. However, it is not the intention to obscure arguments that agency can be considered to be socially produced (Bourdieu 1984; Conway 1997; Mills 1940). This argument is explored in some detail in the following data chapters, which analyse how vocabularies of motive that are framed largely by the text of experience in biographical context are drawn upon within the data.

As medical power is threatened by marketisation and de-professionalisation, contemporary health care has become even more of a battleground for status and control. As many have noted, Western medical power has drawn its knowledge base from the scientific tradition (Doyal 1979; Turner 1995b). A 'relapse' into the knowledge and practice of objectivist science must, then, seem attractive to medicine. Yet, in the interviews, it was the scientific approach which was almost universally criticised.

A view of 'the elderly' as a residual group, coupled with cuts in real terms to NHS resources, reinforces ageism in health care. However, the possible synergy between this and the epistemological and political challenges from older people merits closer examination. As de-Swaan points out:

medical intervention has expanded greatly over the last half century, including areas where medical expertise can offer no conclusive answers and where other approaches are conceivable. (de-Swaan 1990: 58)

As for any age group, the interviews show heterogeneity. Nonetheless, there was also a clear theme of resistance to negative notions of dependency and towards bio-medicine. All of the people interviewed were unhappy with the imposition of child-like identities or the practice of infantilisation to varying degrees, and all were unhappy with zweckrational health care. Significantly, two interviewees were involved in political lobby organisations.

Finally, to return to this chapter's twin aims. In gathering material about the health beliefs of older people, emphasis was given to the local significance of more generalised terms such as 'health', 'illness' and 'healthcare'. This challenges the narrow assumption that older people inevitably have (a) different kinds of health problems by virtue of their age and (b) homogeneous responses to them by virtue of the explanatory frameworks of their generation. Instead, the concept of 'health' itself may take on quite particular sets of meanings for an age-group whose subjective interpretation of health conflicts with the objective biomedical definition. In terms of the latter, the explanatory frameworks derived from biomedical discourse help to reinforce the stereotype that ill health in later life is synonymous with and, indeed, caused by, being old in a sense which is largely interpreted in a more singular and negative way rather than being seen as older in a pluralist and therefore less restrictive sense.

While it would be deterministic to forecast that as more people live longer and as the NHS continues to discriminate against older people, we can anticipate major conflict, it should be noted that these accounts show considerable resentment and hostility towards negative representations of ageing and towards bio-medicine. While the findings from this chapter cannot be considered as empirically generalisable, the theoretical approach followed is one which can be utilised in a range of similar research settings. The key concepts used here have helped to recognise and theorise agency. This chapter shows that the narrative reconstruction strategies adopted by the interviewees reflect the plurality of forms of knowledge open to them (Foucault 1973). Following Derrida, the methodological practice of 'deconstruction' has been used to make sense of the workings of power in the intertextual construction of the social world. As Fox (1998: 8-9) explains, for Derrida deconstruction is an approach which allows one to explore the underlying assumptions underpinning claims to truth. It works by showing how alternative views are possible as opposed to privileged

readings. It is, therefore, an anti-authoritarian practice, a tool for resistance. The chapter also follows Foucault's genealogical approach (1980b), which calls for a methodology that will bring out narratives that have been previously hidden by totalising theory. What I have attempted here is to bring to the fore some of the multiplicity of texts and narratives drawn on by the people interviewed. It is this material which provides insights into these individuals' agency. For many powerful interests, oppressed groups are not seen to have agency; they are thought of as 'not worth it'. Not only health care providers but also sociologists need to listen carefully to the accounts of their clients and their interviewees. If their agency is denied, dependency will continue to be fostered, both on conceptual as well as practical levels.

The following chapters examine the data as a whole in terms of the vocabularies of motive through which the interviewees cope with the present. These 'beliefs', as was argued in this chapter, reflect the socially embodied experience of the group in the present, including the deaths of significant others, the loss of work, and bodily crisis. In other words, their beliefs can be seen to represent a permeable relationship between body/self/society. Whilst this chapter has focused on agency through narrative reconstruction and intertextuality, the next chapter explores the invocation of imagined community in terms of the interaction between human agency and society.

Imagined community and dramaturgical stress in the social performance of ageing, illness and bereavement: a case study

Introduction: the social function of imagining community

'Stage fright' is a potential occupational hazard for an actor in the theatre or for a social actor arriving for a job interview. Performing and monitoring one's own performance and those of others thus can be stressful whether on stage or in the theatre of life. (Freund 1998: 268)

The above quotation is taken from Freund's article which describes how people can be considered as actors, playing out different performances or roles which are publicly expected. Drawing upon Goffman's 'dramaturgical' model which was outlined in Chapter One, Freund argues that, in constantly reviewing and acting out different performances, individuals may experience 'dramaturgical stress'. He also adds that there are a number of reasons for dramaturgical stress, all of which are influenced by changes in the relationship between individuals' bodies, sense of self and social worlds within which they are embedded. These ideas are explored in this chapter. It is argued that imagining community is a necessary, but insufficient strategy to prevent dramaturgical stress.

Reference to the idea that social performance is stereotyped for older adults can be used to illustrate Freund's idea that dramaturgical stress is produced by changes in the relationship between, self, body and society. For example, it may be caused through a clash between a subjective sense of self and the stereotypical narrative that older people should act and feel 'old'. This argument is evidenced in the extract taken from David Guterson's murder novel *Snow Falling on Cedars* (Hepworth 1998: 178-180) where the defending counsel, Nels Gudmondsson, aged 79, reveals the incongruence between his sexual feelings and what is seen as creditable and appropriate in a public sense. When questioning the wife of the victim

he becomes very aware of how somebody of his age is not supposed to have feelings of sexuality.

Nels Gudmondsson stood at a distance from the witness stand when it was his turn to question Susan Marie Heine: he did not want to appear lecherous by placing himself in close proximity to a woman of such tragic, sensual beauty. He was self-conscious about his age and felt that the jurors would see him as disgusting if he did not distance himself from Susan Marie Heine and appear in general detached from the life of his body altogether . . . The bad part was . . . that a woman like Susan Marie Heine inspired a deep frustration in him. He felt defeated as he appraised her on the witness stand. It was no longer possible for him to communicate to any woman - even those his own age he knew in town - his merit and value as a lover, for he no longer had this sort of worth and had to admit as much to himself - as a lover he was entirely through. (Guterson cited in Hepworth 1998: 179-180)

Social performance, then, can be extremely stressful for individuals, especially if the coping resources they draw upon as embodied social actors have become eroded. In the example of sexual feelings, discussed above, it was the chronological age, and, by implication, the physical appearance of Gudmondsson as an older man which undermined a performance of himself as a sexual being in a publicly credible sense. Thus, his body constituted a mask which hid his inner feelings and could not be drawn upon as a socially legitimate sign of his sexuality.

Via the analysis of a case study of one older woman, this chapter argues that the stress she expresses is not due to a loss in the sense of bodily decline, despite her physical pain. Rather it is the loss of significant others, her close family who were previously a constant source of support to her. In the present they are, for her, still a boundary or reference point which provides her with a sense of connectedness, involving feelings of belonging and affinity; that is, ontological security. However, as she now finds herself alone, without the physical presence of her family as a source of support, and as a tangible representation of her ideal community, she is having to use her imagination to draw on coping resources which the community offered in the past. Moreover, as she is alone in the present, she is particularly vulnerable to dramaturgical stress because of the very fact that her coping resources are imagined. Imagined community, then, helps her to deal with stress because, as mentioned in Chapter One, it provides a sense of ontological security. However, because of its very elusiveness, namely, the fact that it is imagined rather than real, it also makes her vulnerable.

The idea of imagined community, mentioned in Chapter One, is derived from Anderson's (1983) study of nationalism and is seen in the study as the main vocabulary of motive which is used to frame the beliefs of the interviewees. For Anderson, nation building involves the fictional abolition of internal diversity, in that it is present but simply ignored. For example, rather than recognising that there may be inequalities between the citizens of a nation, say on the basis of social class, differences are emphasised between one nation and another. Such an emphasis upon allegiance and homogeneity within the 'community' of the nation is also imagined because most of its members will never know each other. In Anderson's words:

It is imagined because the members of even the smallest nation will never know most of their fellow members, meet them, or even hear of them, yet in the minds of each lives the images of their communion. (Anderson 1983: 15)

Imagined community becomes so deeply embedded in the public imagination that people are prepared to kill or die for its preservation. The concept has also been used recently in the sociological study of ageing and death, and it will be relevant to expand upon its use in these contexts to illustrate its potential. For Blaikie (1999: 151-2), nostalgic representations of communities in Britain's seaside towns are more the product of commercial interests and the myth-making reminisces of older people themselves, than historical reality. Such imagery presents seaside towns as 'safe havens' with 'crime free boulevards' and 'peer group sociability'. This is partly founded upon a Victorian association of strong fishing communities with close knit families and coincides with an influx of retired people. Given the reduction in the numbers of people taking seaside holidays in Britain, negative images, such as those found in saucy postcards that mock unhealthy looking bodies and old fashioned styles of dress and behaviour - many of which are deleterious towards older adults - have declined. The new emphasis is upon 'heritage' and this is a strong orientation among older adults themselves. In Blaikie's words:

Heritage has a habit of creating symbols that render otherwise disparate phenomena self-evidently related. Indeed, some would aver that this is precisely its function: to invent a strong, shared sense of 'imagined community' where history reveals little concrete evidence. (Blaikie 1999: 151)

The production and maintenance of imagined community in British coastal resorts, then, can be seen as a product of commercial interests targeting the 'grey market' and older people themselves seeking utopian escape.

Seale (1998) employs the concept in his analysis of death. Imagined community, he argues, offers a defence mechanism against death by providing a means of maintaining individual meaning for dying and bereaved people. Thus individuals can feel that their own life or those of significant others are part of a greater whole which will continue after their deaths. Modern societies offer a range of small nationalistic communities which people can affiliate themselves to:

it is possible to understand modern society as comprising a series of small nationalistic communities. Organisations, institutions, schools, firms, factories, businesses, are all microcosmic nations, competing with each other, demanding allegiance and a degree of self-sacrifice, and offering, in a small way, the promise of ordinary heroism, and a fictive immortality in their continuation beyond the limits of individual biography. (Seale 1998: 56-7)

Indeed, Bauman (1992b: 105-117, 125) draws upon ideas about nationalism to describe how death is given meaning in modern societies. As he argues, nationalism provides a feeling of affinity, a sense of belonging and of hope, it also makes individuals feel they are never more important than the nation or the group. Through this referent modern societies offer prospects of immortality and of cheating decay which are not possible for mortal persons. Thus through individuals affiliating themselves to the group ideal of the reproduction of its principles, sustained by the idea that these are superior to those of other groups, immortality can be seen as the 'project' of modernity.

History itself is given the unity of an eternal, uninterrupted continuum by the perpetual, indeed non-temporal presence of one's own group or of principles of which that group claims to be the last and final, the most fulsome incarnation. The permanence of one's own group, and the transience of all the rest, condition and legitimate each other. No wonder the advent of historical thinking, the 'historicity' of the world view, coincided with the advent of modernity, which posited immortality as a project, a human task... (Bauman 1992b: 119)

A civilisation, then, which claims superiority over all others, brings about a perpetual call for the welfare of the group to be considered as more important than the individual. For Bauman, contributing to the perpetuation of the group, such as through procreation, is seen as the primary means of achieving immortality for less powerful groups. By contrast, other more powerful groups are able to engage in additional survival strategies, helping them to transcend their own existence. Thus they may leave behind 'great' works of art and architecture, contributions to knowledge, works of fiction, music and so on. Modernity's emphasis upon

immortality, then, is described by Bauman as a key strategy to give death meaning, and, at the same time, also encourages the denial of death.

In addition, with a slightly different emphasis from Seale and Bauman, Becker (1973) applies ideas about nationalism to the study of the phenomenon of death in the way it gives impetus to a culture of heroism. For Becker, the emphasis upon being heroic, involving sacrifice and forfeiture for the group, in the knowledge that it will survive, serves as a meaning system for individuals to cope with death.

As the case study and the following chapters reveal, feelings of belonging or seeking to feel connected to a moral community were a strong theme in the way health beliefs were discussed. It is claimed that imagining this community involved interpreting and reinterpreting narratives of order and conduct and the construction and maintenance of boundaries between the community and other groups.

It is further proposed that imagining community also involved conceptualising purity and impurity or danger. Moreover, community and purity were seen as mutually constitutive. Indeed, constituting what is pure and impure can also be seen to reflect the idea discussed in Chapter One that older adults' health beliefs are grounded in moral cleansing strategies that proffer correct ways of thinking and acting. Thus, it is proposed that invoking signs of the pure helped interviewees to identify themselves with the community, whereas signs of impurity, that is, of incorrect ways of thinking and acting, were deemed to be morally reprehensible and potentially disruptive to the community. As (Bauman 1997: 11) has argued, dirt or the 'impure' can be seen as 'a threat to a way of life'. Indeed, for Douglas' (1995), notions of what constitutes dirt reflect beliefs about potential pollutants and dangers to order.

In her words:

Hygiene . . . turns out to be an excellent route, so long as we can follow it with some self-knowledge. As we know it, dirt is essentially disorder. There is no such thing as absolute dirt: it exists in the eye of the beholder. If we shun dirt, it is not because of craven fear, still less dread of holy terror. Nor do our ideas about disease account for the range of our behaviour in cleaning or avoiding dirt. Dirt offends against order. Eliminating it is not a negative movement but a positive effort to organise the environment. (Douglas 1995: 2)

For Douglas, given that there is no 'absolute dirt', our models of what constitutes dirt and the rules of hygiene change with cultural ideas about what constitutes knowledge. Similarly, Bauman (1997) argues that, given rapid social change, the models of what constitutes purity and what are the best hygiene strategies are ever-changing and have become almost fluid. Following this idea, it can be argued that defining a way of life involves a forthright and imaginative reinterpretation of meaning in such a position of instability and bodily crisis which becoming older can involve. For those experiencing the crises of 'old age', then, the invocation of an imagined community can be imperative.

The case study

The analysis is based upon two 90 minute interviews with Hettie, aged 78. She lived in an expensive new home which she, her aunt and mother had built for them as their ideal retirement home. However, within two years both her aunt and mother had died. Hettie stayed on in the house alone. Prior to these deaths she had also lost the brother she had left work to look after, as well as her husband. Hettie came from a middle class background and she married within her social class - her husband was a self-employed accountant. As for Hettie's formal occupation, she had been employed as a professional civil servant throughout most of her working life. During her childhood she had a private education which included some secondary education in a religious school in France. I gained access to her from a homeopath she had used, and she had given her consent to be interviewed before her contact details were passed on.

In terms of her own health, Hettie constantly emphasised her 'nervous breakdown' and 'depression'. Thus, like the interviewees discussed in the previous chapter, illness rather than health was most significant to her. In one sense, she related her mental health concerns to problems with her physical health. For example, she said that a viral infection and a whiplash she had suffered in a minor driving accident made her depressed. In this instance, therefore, she saw her mind and body as having a common boundary. Physical infirmity was psychologised; it had mental health consequences. However, and most significantly, she conceptualised her health, or lack of it, in a social sense. It was something which was directly

attributable to her feelings of vulnerability to attack on her mind/body from 'impure' forces in the outside world. Thus, when I asked her about her own health she talked at length about her bereavements and of feeling vulnerable. Throughout the interviews she gave an impression of wanting to be connected, sometimes in terms of her religion, but most often in relation to how lonely and traumatised she was because of her bereavements. The deaths of her close family had left her, as she put it, feeling like a 'lonely ship', cast off from the support network of her family. Thus her rationale for wanting to be safely connected seemed to be based upon the idea that without the protection of something collective she was open to attack. Quite literally, she had suffered a number of traumatic incidents which made her feel vulnerable and had resulted in her 'nervous breakdown' and 'depression'. In describing them to me she gave an impression of being very emotionally disturbed. Her voice trembled, and there were long, dramatic pauses. She used her body to gesture that she was in pain, for example, by holding her hand to her head and looking as if she was going to cry at any moment.

Anyhow, to cut a long story short, about September time in 1992 I had the two dogs out and came through the car park in Safeways and three lads on bikes threatened me with a knife. It frightened me terrifically. The dogs scared them off. About three months later I was awakened - about a quarter to five on a Sunday morning - by the sound of a stolen car being rammed into the house opposite. It went off like a bomb. It was shocking. It frightened me to death. A month after that I had a beer bottle through the window (). Then I had the two dogs out and we were going down Woolworth's passage and there were two lads on bikes and we made ourselves scarce, hunched up against the wall. And the first one was alright, but the second one spat in my face as he went past. ((trembling voice)) I have had so much trauma. ((puts her hand to her head and her voice is shaking, she is upset)) Then I lost my best friend. So I ended up with a sort of . . . nervous breakdown.

She felt as though she had little defence against such attacks because she was marginalised:

and it is a hell of a thing to come to terms with, it really is. ((pause)) I am very lonely for a start. And ((pause)) you miss the warmth, you miss the companionship. ((pause)) You see, mother and Aunt Mary used to live their life through me. They used to say: ((excited voice)) 'Now then love, what have you got to tell us?' I'd say: 'I've seen Mrs So and So' and she said: ((quizzical voice)) 'So and So'. OH, we were all so very close. My mother, my husband, Aunt Mary and I. ((pause)) We were a little world on our own,((pause)) and when you lose the lot it's... ((pause)) Well I hope it doesn't come to you, but it's not very nice . . . and this wind it plays bloody havoc with me.

Her sense of self, therefore, is collective, being constituted within the context of her immediate family: 'We were a little world on our own'. She had a pivotal role in this world as a carer and represents her mother and aunt as living their lives through her. Hers was, therefore, very much a sense of self which reflected her membership of the 'little world', that is, of the imagined community. However, after her relatives died she was unable to reconstruct herself

in protective social relations of the kind her close family offered her. Thus, accounts of violent atrocities on television - which can also be conceived of as being thought of by her as signs of impurity - made her 'depressed'.

SC: Do you use the TV?

Hettie: Oh, yes.

SC: Do you use it a lot?

Hettie: No, not now.

SC: Did you use to?

Hettie: Yes. But. As everybody is today, the bestiality of nature. And this, not so much now. But I got heartily tired of weeping at Bosnia. I mean, what GOOD does it do me. ERRM, I can't right the wrongs, I think the way they have... Mind you, I think ITV spent a lot of money and a lot of equipment, sending men and equipment out there. So they wanted to get their money back. But, you know, there is such a thing as over exposing people. OOOOO, and they never... Was it Martin Lewis who said, and he got scorned for it, 'Lets have a bit of good news instead of all this bad news'. I mean, WHY NOT? There is some good news, there must be. BUT we get... And it makes me so depressed. Not when I live on my own. When you have got somebody to talk to and you thresh it out. Well, THAT'S THAT. But, I mean, when you live on your own, it really affects you.

Thus, Hettie aligns herself with TV presenters who promote a 'little world' view of good rather than bad news. Nice people on TV, then, also belonged to her imagined community. Reading literature sustained her well-being, something which none of the working class interviewees mentioned. For example, Will thought reading medical textbooks would cause him anxiety. As he put it, 'The more you know, the more you think you have got.' By contrast, Hettie found that books gave her 'a lift', she needed something that was 'a bit uplifting'.

I like reading biographies and autobiographies. I used to love murders, but just recently I have gone off them. I have just been rereading, because I think she is marvellous, Dorothy Sayers (). They are very good at the library. I also like that Dick Francis, Queen Mother's jockey. I really read books that give me a lift. You want something a bit uplifting, not like the news on TV.

Dead relatives, Martin Lewis and his 'good news' and writers of uplifting books are all, therefore, part of Hettie's imagined community. Most especially they are imagined because it is not possible for her to have face-to-face contact with them. As, to all intents and purposes, her feeling of 'communion' with them is in her mind rather than in day-to-day contact.

The term illness, aside from being used to refer to bodily incapacity, which she mentions almost incidentally, was used most often by Hettie as a metaphor for evil such as 'scroungers', or the 'pro's' (prostitutes) and the 'scum of the earth' - all of whom she had encountered as welfare claimants when she worked for the civil service. Those who exploit others and criminals generally were seen as representative of 'sickness' and 'disease'. Just as she perceived the atrocities in Bosnia as a generalised representation of an all-pervading, and inescapable 'bestiality of nature', my suggestion that she might consider moving because of the frightening incidents she had experienced was something she refused to contemplate. For Hettie, there would be no point since, as she thought, all of society was suffering from an 'all embracing' 'disease' and nowhere was safe.

Hettie: Well, tell me anywhere where you can go where there isn't similar? ((pause)) I was talking to a friend who lives in Wood Lane ((pause)) very nice and quiet, but she was burgled, just before Christmas. ((pause)) I mean, it is the society in which we live. ((pause)) I don't think it is where you live. And I think that one of the reasons that there is so much depression and so much ((pause)) FEAR, is that... ((pause)) It is all embracing, is this disease. ((pause))

Hettie's feelings of vulnerability, therefore, stemmed from the loss of her strong sense of identity as a carer for significant others throughout her life - all of whom were deceased. She had lived her life, including a professional career, in a conventional family where her leisure and day to day activities had nearly always involved close family - particularly her mother, aunt and husband. Her family were the most important people in her life and she had resigned from her job to look after her sick brother because 'there was nobody to look after him'. As noted above, the 'impure' forces which threatened her were pathologised as representative of something 'sick' or 'this disease'. Illness, therefore was being talked about in terms which were social rather than biological. For Hettie, health was a metaphor for social relations rather than something confined within individual bodies

What is argued below, therefore, is that Hettie's vulnerability derives from a lack of clear boundaries for her sense of self. This was not confined to an individual self, but had been lived out in a relational sense as a carer for her close family. However, given the death of significant others whom she had cared for and, at the same time, had provided her with a sense of ontological security, she was now open to external attack in a negative sense. Her

resources which had previously encompassed self, body and close family had now declined considerably. This was causing her extreme dramaturgical stress and feelings of vulnerability.

The importance of a moral sense of self

When asked to talk about herself in relation to health and illness, Hettie highlighted the importance of her role as carer for her own sense of well-being.

Hettie: Well, what actually do you want to know? I mean, do you want to know what I have just been saying?

SC: Well, I just want you to tell me about your life in your own terms [really

Hettie: [yes

SC: [and in relation to health and illness.

Hettie: Well, the thing was, emmm, lets think, ((pause)) I'll say it all. ((pause)) In 1971 I lost my only brother, I nursed him ((pause)) he died. 1975 ((pause)) Err, my Husband died . . . And my Mother was very ill, and so was my Aunt . . . In 1982 I found my Aunt dead in bed when I went to take her a cup of tea. Nine days later my Mother died. My Mother was 95 and my Aunt was 90. I felt then ((pause)) ((quiet voice)) like a lonely ship. I had looked after people for so long. I'd done a lot of caring for other people. Anyhow, I do a lot of charity work. I help people and I do charity work. I help people and I go to hospital [to befriend patients and families]...

She therefore highlights how helping others provided her with self esteem and a positive sense of self; that is, others who could be described as deserving, 'people in need' and worthy charitable causes such as the 'Yorkshire Cancer Campaign.' Also, her sense of being a carer was clearly disrupted by the deaths of family members. Losing them through death made her feel vulnerable.

I wondered if leaving a professional career in the civil service to look after her sick brother had contributed to her sense of vulnerability. Had she 'lost any confidence' after she left work to look after her brother? Her response to my question here indicates that she prioritised relationships with close family members and the charity events they shared. The idea of belonging to a moral community was prominent in her reply.

No, my mother used to run lots of charity events for people in need, and we used to have garden parties . . . We used to do all sorts of things. We used to have whist drives, bridge drives [sounded

like] . . . You name it, we did it. As mother got older I took more and more control . . . fashion shows . . . Oh, we had wonderful things as a family. We raised about £15,000 [in 1943].

'Health' is therefore conceived in moral as well as social terms in these data, something which, as noted, has also been highlighted by many writers as a strong theme amongst older adults (Cole 1986; Hepworth 1995; Williams 1990). As Turner notes, in historical terms 'illness was, within a Christian framework, often seen as a punishment by God or a form of instruction to the soul' (1995b: 20). Thus, reflecting the idea that religious rather than scientific explanations were dominant, writers such as Bynum and Gottfried depict how the 'Black Death' (Bubonic Plague), having depopulated Europe in the 14th century by 75 per cent, was seen as a punishment from God for immoral behaviour (Cited in Kleinman 1988: 18). However, following the rise of scientific knowledge and the demise of religion, the latter is less likely to be invoked to give meaning to illness. This process has been identified in Parsons' concept of the 'sick role' (1951). Thus individuals can be exempted from responsibility for illness as long as it is held that they can be re-integrated back into society after seeking socially sanctioned diagnosis and curative treatment from medicine. However, the sick role concept cannot be applied to people with long-term or chronic illness - something prevalent among many older adults (Sidell 1995). Failure to comply with the requirements of the sick role, coupled with attitudes which preceded the provision of health care, free at the point of delivery, are likely to compel older adults to regard illness as a breach of moral standards, whereas the young are more likely to see it as being due to external agents (Stacey 1988). In the case of Hettie, a Christian rather than scientific framework was used to explain health and illness. The accumulation of scientific knowledge, therefore, is made possible by God parting 'the veil':

I believe God parts the veil for doctors as they will be able to heal something or other. In the past it was tuberculosis, and they found a cure for it. This is why cancer is incurable at the moment, but I believe that God will part the veil and then we will be able to cure cancer. Then, of course, we have got AIDS to deal with. ((pause))

The authority of doctors, therefore, is being legitimised in terms of their divine knowledge. There is a 'veiled' boundary between human knowledge and that which is sacred. When the veil parts, doctors can see *the truth*. This will help them to 'heal something or other'. Major illnesses such as tuberculosis have been cured by God imparting divine knowledge. Her

implication was that a cure for AIDS will be found from the same source. Science, in the form of medicine, is seen, not in contest or conflict, but as subordinate to the divinity of what she regards as sacred. Her own 'moral' charity work is linked with the unseen hand of God, both of which are health generating. For Hettie, therefore, order and purpose are important prerequisites for health. Reflecting her ideas about purity, is her concern with domestic order and cleanliness:

SC: Do you ever let things go in the house?

Hettie: Oh no.

SC: Never?

Hettie: NNNo, Never. I don't like housework, but I never. You hear some folks: 'I don't know what to do with myself, so I cleaned the room out'.

SC: Yea.

Hettie: I won't do that. But I wouldn't like to see it get dirty.

SC: Would you say that you are a, sort of, tidy person?

Hettie: I am ((pause)) very tidy It annoys me intensely to see things untidy.

Above all, order and purpose are seen as part of her idea of community. We are not individuals we are all part of God's whole:

Hettie: I think there is a purpose to everything or there wouldn't be much point in coming here. There is something to do. Something to learn. If we won't do the task and we won't learn from it. ((pause)) Then, ((pause)) we shall be incomplete, shan't we . . . I think there is a job for us all to do . . . You see, a lot of people would say there that: 'How do you know we have got a job to do'? Well, I don't know. But, you see, nothing that God creates is a throwaway thing. There is always a purpose to it.

In the following extract Hettie uses the metaphor of the tapestry to continue linking her ideas about order and purpose with her religious faith. It also provides further illustration of her view of a general community. Individuals are seen as part of a whole and in this instance, she uses the metaphor of the parable of the tapestry.

Hettie: Have you ever heard of the parable of the tapestry? . . . That each one of us, in our life, make stitch or two. And when we look at it it's all ends... And it doesn't seem to fit in anywhere. But eventually, when we do go home. Turn it over and we will see how our little bit fitted in with every thing else. ((pause)) And nothing that happens to you ((pause)) is ((pause)) haphazard.

This theme of moral beliefs also came out strongly when she described the frightening incidents she had been subjected to as dangerous forces in society, or 'this disease'. Thus the absence of moral work produces a kind of metaphoric sickness: 'It is all embracing is this disease'. By implication these 'sick', immoral forces are something she is vulnerable to following the erosion of her embodied sense of self within the boundaries of her close family.

The sense of threat to social boundaries finds expression at the bodily level too. After her 'nervous breakdown' she consulted the doctor, but the prescribed drugs were a problematic threat.

Well I have the sort of system that just can't take drugs. They do not do me any good.

Thus the chemical incursion of drugs upon her 'system' affected her badly. Her earlier family-based sense of self was now vulnerable to fracture and rupture since her local 'collectivity' was lost to her. Her boundaries could be penetrated because she was now exposed as an individual with vulnerable surfaces. Solace was sought in other resources such as religion. However, such was the frailty of her collective sense of self, that this was not always enough.

So, ((pause)) I started to get a little bit better. It's a very long uphill struggle. I had a very good counsellor in the Vicar from the Minster ((pause)) he was marvellous. And all the people at the Minster have been very ((repeats)) very supportive. And they have helped. But the fear, the apprehension. It can be too much. I can be perfectly all right one day, but the next day can be awful.

Indeed, even during her working life, which involved more contact with the outside world, the signs of danger and sickness, nonetheless traumatised her. To gain promotion she had taken a transfer to social services in Hull. This involved direct contact with claimants. She was, 'shocked' by some of the clients, and 'had no idea that there was this side to life.' Even their 'smell' was a sign of what she called a 'disease', as was their bad language. Other signs included neglecting children.

Hettie: I got a promotion, but couldn't have it in situ, and I did a very foolish thing, I went to social services in Hull in 1965. Well, that PLACE. In those days: it was 1965 when I went. Err, mm, the trawlers from the sea were still very much to the fore in Hull. And it was appalling. I was shocked. My goodness. You know errm, the 'News of the World' (). I had no idea that there was this side to life. 'Well', he said, 'You have worked in a Civil Service office before'. 'Well', I said, 'yes, but the nastiest smell we ever had was a farmer coming in with manure on his boots'. I had *no idea*. We used to have a very seamy lot. Well, one of the girls. OH ((pause))

SC: Do you mean the clients?

Hettie: The clients, yes. ((very long pause))

SC: Did you have contact with them?

Hettie: Yes, I was the supervisor, and I had to go and supervise these folk. A fellow came to see me one day and he said: 'Hettie, would you mind coming with me, because . . . I have a client in Hessle Road, and she is a PRO, and she is trying to twist my arm for some underclothing'. You see. 'I can't say yay or nay, so, he said: 'will you come?'. And I said: 'Yes'. Soon as I rang the bell and she opened the door ((pause)). HER LANGUAGE. It was... My colleague said: 'I have brought a lady to check what you really need'. OH, *it was* SHOCKING . . . I went on a training course in Leeds and I was sat next to a lady who was really lovely, working with the sick and elderly. I said: '*I beg your pardon*'. She said: 'Don't you work with the sick and elderly?' I said: 'For every sick person or elderly person we have 99 of the scroungers and the scum of the earth'. She said: 'Where do you ((aristocratic type pronunciation)) *come* from?' 'Hull', I said. 'Where do you come from?' ((aristocratic type pronunciation)) '*Oh, Harrogate*'. But it has been noted as the worst, this side of Liverpool. They were nearly all seafaring persons, you see. And every Friday, on the *counter* somebody would be refused money because they had already had it on the Monday. They would say: 'well, you can take the kids'. Then they would leave them on the counter and the child fellow ((pause)) well, he would take them into custody. It was... I didn't last very long. I went to the other side. To the, err, insurance side.

The 'other side', then, by implication was regarded as a place of normality, away from all the signs of impurity or evil she describes in her experiences in social services. An earlier encounter with otherness was also recounted with disdain when she talked of a school trip to Lourdes in France. On this visit Hettie had been 'shocked' by the commercialism which she said she saw. She constructed herself as a normal, a 'nine to fiver', who had been put into an 'abnormal world'. Her sense of other which is outside of this spatial metaphor is implicated by her language and intonation: 'TRASH', 'INJURED', 'ILLNESS', 'SICK PEOPLE' - which she uses in stark contrast to the health generating properties of her own good work and the actions of God who 'parts the veil'.

Hettie: Err, and you see, they couldn't understand why I was getting so upset at all of these things

SC: Well, I guess if you had been in a [convent

Hettie: [but you see, I had never ((pause))

SC: Never seen much of the outside world?

Hettie: Yes, that's right.

SC: Is that right?

Hettie: No, not really that ((pause)) You see I was a nine to fiver ((pause))

SC: Uh hu.

Hettie: ...but you see this was beyond my ken, you see. That they could have TRASH ((pause)) sell trash for a very, very special reason.

SC: MM.

Hettie: Can you understand that?

SC: Yes. ((lying)) Do you mean sort of cashing in on people's beliefs and [faith

Hettie: [that's right and not only
that on the terrible people. On the awful injured, illness, sick people, playing on them.

As noted, a moral sense of self is often very important to older adults in the way they think about health and illness. For Hettie, this manifests itself in the way she positions herself in an imagined community. Members of the community are held to be morally superior to those on the outside of it. However, the problem for Hettie was that, whilst belonging to the community gave her ontological security, its very lack of material presence (namely, the fact that it was not possible to interact on a face-to-face level with many other members of it), made her feel vulnerable and suffer from dramaturgical stress.

Following the life course approach of this study, it is also possible to see the role of time in the shaping of Hettie's beliefs and her dramaturgical stress. Thus, it is argued below that Hettie's beliefs reflect a very strong sense of temporal displacement in the way her imagined community was associated by her with the past rather than the present.

Concepts of personal and social time

Hettie saw herself as living outside of her own social time and, as a result, she felt displaced. Indeed, looking back on her memories was a great comfort to her.

SC: Do you spend much time looking through... [Remembering

Hettie: [yes, a lot. I look at photographs now and then.
And I have most of the birthday cards, anniversary cards and Christmas cards that my husband sent to me. ((pause)) I have got them all in a box. ((pause)) And every now and then I get them out and have a really good weep. I tell myself that I am a fool. And that's it. ((looks as if she is about to start crying))

Nonetheless, she stresses her current charitable activities, implying that this is a natural continuity of the good work she had engaged in with her family. For example, she makes this explicit when she highlights how her husband - 'a wonderful fellow' - would be 'very pleased' with her current involvement with the Boy Scouts.

Hettie: He [her husband] always used to say his second home was scouting. He was a district commissioner of () . . . and he had 60 years in the Scouts . . . OH, He was a wonderful fellow ((pause)) and he died in 75.

SC: Were you involved in anything like that, [the Brownies

Hettie: [NO, NO ((laughs)). No, I was never involved in that, but now I am chairman of the executive committee on the Scouts in Beverley. And I do feel that he would be very pleased.

Hettie's perception of social change as a threat meant that she paid a lot of attention to physical boundaries to spatially protect herself. Thus she locked herself in at night as if she lived in 'Fort KNOX'.

Yes, the times in which we live ((pause)) I am too old for the times in which we live. I was saying this to a fellow across the way the other day. He said: 'Well I can give you forty years my dear and I'm too old for the times in which we live'. ((laughs)) No, not nice at all. I mean, you have to lock your doors as if you live in Fort Knox.

Extending her metaphoric use of 'health' to describe social relations, she refers to crime as a disease of the present. It was 'symptomatic of the times in which we live'.

It is all embracing, is this disease. ((pause)) I mean, they can't keep their hands off anything. I mean, did I tell you - the other day somebody pinched a bottle a pint of milk off me. Not that this has anything to do with... But it is symptomatic of the times in which we live. I mean, there's a milk bottle there. Once upon a time you would never have pinched somebody's bottle of milk.

In Hettie's view people in the past engaged in good work. Thus 'old family doctors' belonged to her imagined community. By contrast, present day doctors were now mechanistic and dehumanising in the way they treated people as a bag of symptoms; another 'sign of the times' in which she felt she had no place.

Well, before I lived here . . . he [her doctor] was very good, very good. ((pause)) Err, I don't know if you are old enough to remember but, ((pause)) we used to have ((pause)) doctors. ((pause)) And we lost our two main ones, they retired and they both died. Now doctors ((pause)) treat the symptoms. ((pause)) They don't treat the patient. ((pause)) You go and they ask you what you are complaining about... You see, when you had the other fellows they would say: 'that's because you tend to get a little bit too het up a little too quickly'. These folks say: 'oh I will give you a tranquilliser' ((pause)) You see they haven't time. But, you see ((pause)) the old family doctors, they had surgery in the morning, visiting in the afternoon. They say they haven't time. But the old family doctors would have a surgery in the morning, they would have visiting in the afternoon and have a surgery in the evening, they did

midwifery during the night. ((pause)) These don't. They do surgery in the morning, a bit of surgery in the afternoon and the evening and then, ((pause)) Bob's your Uncle. ((pause)) If they are not on duty at that time then . . . No . . . ((sighs)) It is a sign of the times, I suppose.

Hettie now found it difficult to maintain and defend boundaries around her self/body, feeling displaced by social change and exposed to 'attack'. Using a bodily metaphor, she describes herself in spatial terms as: 'too much out on a limb . . . It was horrible . . . that was the reason for the vulnerability'. On one level, therefore, ageing to Hettie was a negative experience which left her feeling displaced and 'out of time'.

However, on another level, and on a more positive note, she also associated ageing with maturing into wisdom. Thus as she grew older, she got more insight into what she sees as the workings of God because 'the veil', the boundary between this world and the next, gradually opens. As she puts it: 'As we get more mature, the veil parts a little bit'. Thus, for example, after describing her late husband's spiritual maturity, she talks more personally:

Hettie: He had a kind of. ((pause)) I don't know what it was. ((pause)) A sort of spiritual ((pause)) aura. ((pause)) The only way I can describe it. ((pause)) An affinity with ((pause)) goodness. The words in English... Well all words are ((pause)) peculiar, when you try to express something that you have to feel. Have you never met anybody, that you feel... 'There is a something about you that ((pause)) I sort of grasp, but it's very elusive'.

SC: Mmm.

Hettie: It's nothing to do with ((pause)) () or anything like that. It's a spiritual thing. It's your spirit calling to another spirit. Once I had the most enormous experience. I mean, it was there and it was gone. The veil moved aside for a split second. I was in an office. I was at work at the time. It was one Thursday afternoon, I think it was. It was a lovely summer's afternoon. () And I just looked up and it was a wonderful experience.

SC: So what was a wonderful experience, then?

Hettie: The feeling that I had seen a little bit behind the veil.

Two narratives, then, seem to be important to Hettie. First, ageing is seen to result in feelings of displacement. The values and beliefs that older people feel an affinity with are held to belong to the past and are out of date in the present. This leads one open to attack from illness which is seen to stand for the other. By contrast, ageing is seen to involve gaining spiritual maturity, helping her to maintain and build a moral sense of self which helps her cope with illness. Hettie's use of these contradictory narratives, one negative and the other positive,

illustrate explanatory sympatricity, in that she is drawing upon competing sets of ideas in the way she conceptualises her beliefs. The fluid and contradictory way she both draws upon and perceives different resources is given further illustration when her religious beliefs, something which is largely represented by her as a bedrock to her sense of ontological security, are depicted as something frightening. As described above, Hettie depicts how the parting of the veil aids medical progress, the conversation continues:

SC: So what happened to you when the veil parted?

Hettie: I just saw ((pause)) I just saw... Oh, I don't know. I don't know. It was enough for me.

SC: Was it like really nice and [beautiful

Hettie: [no, but it was only just for a split second. ((pause)) And I have got... And I know, I said out loud. OH NO, NO. ((very long pause and she seems slightly traumatised))

Despite the fact that religion seemed to have been used as a key pillar in building her sense of connectedness, then, because of her vulnerability and the loss of her 'little world' she indicates that she is traumatised when seeing behind the veil.

Her acceptance of 'illness', without taking it on as part of her self-identity, can be linked with her conception of her self and body as separate, her body being somewhat machine like.

SC: Is it... Do you feel that you are [unhealthy...

Hettie: [oh, it isn't unhealthy. Unhealthy, I think, is when you are full of... ((pause)) Well, the old idea of ill-health. The old idea of ill-health ((pause)) was when all the parts were not working properly. ((pause)) Unhealthy was when you had ((pause)) some sort of communicable disease. I mean, if we are going to define words. ((pause)) I mean, lack of, ((repeats)) lack of symptoms ((pause)) is good health. ((pause)) But, you see too... ((pause)) When you are getting old parts of you are beginning to, are wearing out, ((pause)) like cars and bikes and other mechanical things. They won't last forever.

As argued, for Hettie, health was the product of social relations. Even when she talks about her body, she contests the idea that she can be thought of as unhealthy:

SC: Well, perhaps we have exhausted everything. I have run out of questions. ((pause)) Do you think there are any other questions I could ask you about your health?

Hettie: Oh, no. ((pause)) You see, ((pause)) I haven't had any... I am not boasting, ((pause)) but I have had a wonderful illness free life...

Perhaps this is not surprising as ill-health is her metaphor for evil rather than a description of bodily disorder. As noted, this was a persistent theme in Hettie's account. Indeed, since good health is associated with the right attitude and moral fibre by many older people, there can be great pressure upon them to deny feeling unwell. As Sidell puts it.

Denying ill-health is to deny the negative stereotype of old age. Older people are thus under great pressure to cope stoically with ill-health, not to complain and to suffer in silence. (Sidell 1995: 32).

In resisting the idea that she is unwell, Hettie represents herself as merely wearing out naturally, a process which is taking place in parallel with her accumulation of knowledge and spiritual wisdom. As she says, when one gets older, the veil - which shrouds religious truth - parts a little more and allows her to have more of an insight into what lies beyond it. This was how she separated her self or, more accurately, her spirit, from her body. Her spirit is, therefore, spatially located within a body which eventually will wear out.

SC: You know we touched on this before: you said that bits of your body wear out, but inside you are still the [same

Hettie: [the essential me. The spiritual me is ((pause)) always young. ((pause)) The physical me, ((pause)) the envelope in which the letter is, ((pause)) the envelope gets worn out.

Concepts of health

For Hettie, four main concepts of health were evident. First, in very mechanistic terms, health was the *absence of 'disease' and 'lack of symptoms'*. It was 'when all your body parts are working properly'. This, however, was mentioned only in passing by Hettie and seemed unimportant to her. Second, however, and more insistently, health was *social*. It resulted from her 'normal life' within an imagined community. This protected her from external threats, yet being restrictive paradoxically increased her feelings of vulnerability to illness. Third, health was *moral virtuousness*. References to religion and God in her explanations of what is 'good' and 'bad' were given throughout her talk on health and illness, indicating a view of health as a kind of high moral ground. For example, she not only talks of crime as 'this disease' or 'this sickness', but suggests that 'for every sick person we have the scum of the earth' and makes a train of association with bad 'smells' and 'language', prostitution, neglecting children and so on. Finally, health was represented as multidimensional, in that it transcended the boundaries

which divide body, self and society. Health, therefore, was *psycho-socio-biological*, encompassing factors such as her bereavements, being spat and sworn at by youths, having to lock herself up at night as if she lived in 'FORT KNOX', her 'awful neck-ache' from a minor driving accident, and her 'nervous breakdown'. All of these she describes as 'the sum total of my health.' A layered or incremental, rather than one dimensional view of health and illness was, therefore, prominent in Hettie's beliefs.

Though representing herself as being alone, Hettie retained a sense of personal agency which was closely tied in with the 'little world' of her immediate, imagined community. She accessed resources for well-being from within the social, economic and cultural capital available to her (Bourdieu 1984). Books on health, biographies, fiction, TV, friends and in particular religion, all gave her 'a lift'. Indeed, the fact that she challenged the doctor about the effects of the medication upon her and went to an alternative practitioner, shows Hettie's capacity to use economic resources to play the game of consuming health, and use cultural capital via her knowledge of other courses of health giving action. Removing the initiative and responsibility for health from bio-medicine, she shows her willingness to act on her own behalf and 'shop around'.

Concepts of illness

Though Hettie describes illness as *when all of the 'body parts are not working properly'*, it was not merely the inverse of the mechanistic view of health. More emphatically, illness was destructive. It prevented her from living a normal life. It was her metaphor for forms of *evil*, such as 'the bestiality of nature' and the 'all pervasive disease' of crime in society. As a result, she had to lock herself up in her home as if she lived in 'FORT KNOX'. Thus illness was very much a *social crisis* for Hettie. Her body was hardly mentioned at all.

Following her associated view of illness as evil or 'other', she represented it as something destructive *to be fought* or contested. Hence her use of military metaphors. For example, when she 'started to get a little better' it was 'a very long uphill struggle.' However, 'the fear, the apprehension. It can be too much. I can be perfectly alright one day, but the next day can

be awful.' In a related vein, *illness has agency*, in that it could be thought of as something along the lines of an occupier, such as the cold which 'settled on' her 'chest'.

Death

Death was a recurrent theme in Hettie's interview. Still coming to terms with her grief for her family, she gave her own death much less significance, merely stating that she hoped to avoid a painful death. Despite her use of Christianity as a coping resource, she believed in re-incarnation. Indeed, other research has shown that in a British context, despite claiming to be Christian, many people believe in re-incarnation as a reflection of a personalised interpretation of Christianity (Gorer 1965; Seale and Cartwright 1994). In Hettie's case, her close family are the source of her belief in re-incarnation, an idea she links with the collectivity of lives, referred to in the following data as the 'common good'.

SC: What about... I don't quite know how to ask this? It's about dying. Do you think about dying at all?

Hettie: Well, yes. ((pause)) It isn't the... I am not afraid of dying. What I am always wondering about is how I go through that door. ((pause)) The method of. If I could push off like Aunty Mary did. She always used to say: 'well I say when I die, I go to sleep and when I wake up I shall wake up in heaven. And that's just what she did. She went to bed at night and I found her next morning.

SC: What [about

Hettie: [I want to be cremated

SC: Do you want to have your ashes scattered or anything like that?

Hettie: No, I couldn't care less.

SC: What about... Would you like to think that you have left something behind in the world? Some sort of good?

Hettie: I hope that people would remember me ((pause)) as somebody who has tried to help them. That's what I have tried to do all my life. And you know, I don't know if you have ever heard this before, but ((pause)) and I don't know whether it will tally with your ideas () We are sent on this earth ((pause)) with a talent, however small or however great. And we are to use that talent to the common good, cos God has neither hands nor feet nor anything else, because we have got to be his instruments; and each one of us has to use what we have got for the common good. Now, if we refuse to, ((pause)) ((repeats)) if we refuse to learn the lesson that we are offered ((pause)) and when we go through that door - because I always liken it to a schoolroom - and we go on to somewhere else; ((pause)) because I am convinced that some people come back here to learn the lesson that they never learned in the first place.

SC: What, you mean re-incarnation?

Hettie: Yes.

SC: Do you believe in all that?

Hettie: Well, I can never believe that a miraculous ((pause)) world that we live in ((pause)) is only to be for eighty, ninety a hundred years ((pause)) for each one of us. ((pause)) If we don't learn the lesson that we are supposed to and can only learn here then we shall come back again; not necessarily and immediately afterwards. ((pause)) But sometimes to fit in the pattern. Because I believe, because still like at school, we have lessons to learn. ((pause)) Each one of us is born with a spark of divinity, I believe. ((pause)) And that spark has to grow ((pause)) And only by living different lives will that be big enough. ((pause)) So that we then become more Christ-like. ((pause)) I have met people who it isn't their first time.

SC: Have you?

Hettie: My husband was one of them.

She then goes on to talk of her husband's 'spiritual aura', as referred to earlier. As Bauman (1992b) argues, religion has been a central aspect of the 'survival strategies' which Western culture has used to offset the thought of death or the end of existence. Through the strategy of transcendence, religious knowledge (particularly the Christian religion) allows individuals to deny mortality through the idea of the immortal soul which transcends human mortality, and allows the soul to live on forever. This view pervades Hettie's account. However, in her present world, religious beliefs were insufficient protection. Her vulnerability was too great, particularly now that she had lost the protection and security of close family.

Agency

Hettie's social and cultural capital provided her with key resources to 'fight' illness. For example, after the failure of conventional medicine to help her she decided to look elsewhere, rather than accept there was no alternative. In a blasé voice she said:

So ((pause)) I decided I should go and see what the homeopathic man would say.

She was wary of the objectivist models which underpin medical science.

You see I don't like these general notices, we're all different. And we are all made differently. OH sort of alike, two eyes, a nose, a mouth and that sort of thing. Errm, our needs are different...

Food provides one example of Hettie's distrust of bio-medicine; if she did not enjoy it, it would not do her any good. Emphasising the importance of family, she highlights her dietary practices within the context of mother/daughter relations.

NO, nOw my diet. ((pause)) I was the bane of my mother's life. I would eat cream cakes ((pause). I won't eat vegetables, I won't eat fruit, I like bananas . . . You know, sometimes when I see all these general notices: don't eat sugar, it's bad for you . . . And my mother; I nearly drove her mad when I was about fifteen. I used to come home at night and she would say: 'now I have got a LOVEly meal for you tonight. It's your favourite.' ((drooling childish voice)) 'Oh what is it?'. It would be Lamb chop, peas and new potatoes. 'OH no'. ((mother's voice)) 'So what would you like?'. 'I would like a cream drop'. ((laughs)) In the end my mother took me to the doctor and she said: 'Will you tell this child that she must eat vegetables and fruit and proper food. ... ((laughs)) And I never put on weight or lots of weight, I have always been about the same.

However, she does make some concessions. Therefore, even though she doesn't like sprouts she eats them:

But I do try to have a meal everyday. Last night I had some chicken. ((pause)) I can't bear sprouts. But I had some sprouts, some carrots and some peas ((pause))...

However, her relationship with medicine remains ambivalent. For example, after the doctor had told her that she should continue taking tablets which, she said, made her feel ill, she took him on as an equal, saying she would 'fight' on her own.

'Well', he said: 'I don't know what else I can give you'. 'Well', I said: 'don't bother. I will just have to fight this in my own way. It will probably take me a hell of a lot longer, but', I said: 'I can't do with being perpetually like a zombie', I said: 'I have got to be master of me own fate. I just can't do it.' He said: 'Alright, come back if you need to'.

Even though she feels vulnerable and alone, she refuses to think of herself as being old in terms of the negative sense of being dependent. As she puts it, 'I don't need anybody else'.

Her friends, the clergy and the imagined community are all she needs

Oh, no thank you, I have got friends who I can talk to. And, as I told you, the clergy have been excellent. No, I don't not need anybody else, thank you very much. There must be... Well I know there are thousands like me. ((pause)) I have got a wonderful book by Dr Clare Weeks on ((pause)) self-help for your nerves she was on TV. After her first talk on TV she received 1200 letters from sufferers. ((pause)) Wonderful books, filled with such confidence and encouragement.

The wider dualistic relationship between adult as giver and provider and old person as receiver and dependant is being implicitly drawn upon to metaphorically relocate herself both temporally and inter-generationally. Hettie therefore retains a sense of personal agency. Given her emphasis upon self-reliance, health is seen as her responsibility. As noted above, in her reported conversation with the doctor she says: 'I have got to be master of my own fate'. With the loss of her close family to consult about her health, she has been reduced to individuated, self-care and because of this she is vulnerable; she had tried almost everything she could think of to maintain her health, and is now reconciled to acceptance.

Ee Gods, you name it and I have tried it. ((pause)) The only thing I haven't tried is acupuncture. ((pause)) . . . But, quite honestly, I think it is throwing good money down the drain. I have been to physiotherapy. I have been to almathery [sounded like]. I have been to reflexology, I have been to crystals, I have been to chiropractic lady. ((pause)) And you see they ALL say: ((pause)) 'I am afraid there is nothing we can DO'. If somebody could invent a miracle cure for arthritis and rheumatism, ((pause)) then I would go for that.

Like the interviewees in the last chapter, she emphasises her agency throughout her account. Thus, she presents her life as a meaning-making narrative, in that she highlights how she has constructed its narrative. For example, she highlights key decisions made by her which have had a deleterious effect. Hence she states that moving into the bungalow, 'it was the worst possible thing I could have done', and on her promotion choice, 'I did a very foolish thing, I went to social services in Hull'. Her agency is, therefore, being emphasised, for better or for worse. She is identifying herself and her decision-making as a source of problems and, albeit negatively, is creating a way of accounting for what has happened to her. Thus, as Coleman *et al* (1998) point out, later life may often be thought about by older people - as it is by Hettie - as a narrative or story where past and present are connected. Because ageing is often characterised by a search to find meaning, the typical strategy is to link past and present to provide a sense of coherence. The story of a person's life is one in which the older person is both, the key actor within, and the writer of, the narrative. Following this, discontinuity, through making the wrong decisions, which could even be catastrophic, is explained as part of the narrative. For Hettie, even though some of her decisions have, in her view, bordered on the disastrous, she is the key person who has given her life meaning. This also links in with her own social practices. She acts on her own account by ways which include challenging the doctor, seeking out alternative practitioners and being the lifeline for her mother and Aunt. Therefore, she represents herself as an actor and expresses an internal locus of control.

Two interesting pieces of work come to mind in discussing the agency of Hettie. Each of which document and theorise the way in which older people can contest or challenge the representation and conception of themselves as 'old', as a finished and negative stereotype, rather than as older, and as an unfinished but not necessarily sub-standard or flawed social category. First, Biggs (1997) discusses the way in which older people can develop a 'persona' to accommodate themselves to the social world and the social mask to which it refers is a 'means of acceptable self-presentation in interpersonal contexts' (1997: 559). Much like

Goffman's dramaturgical model and the way Mathews (1979) depicts how older women resist negative stereotypes of old age, the persona can be thought of as 'a device through which an active agent looks out and negotiates with the world to protect and deceive' (Biggs 1997: 559). *Personae*, therefore, are coping strategies which take into account social and bodily contexts. The idea, therefore, illustrates the interaction between human agency and society - a key consideration of this study. In later life individuals become increasingly aware of different aspects of the self through experience and they reflexively influence their relative emphasis in any given context. Similarly, Hallam *et al* (1999: 54) contest the idea that old age can be thought of as representing a social death. This idea is also challenged by older adults themselves who draw on alternative sources of power, including the symbolic, to express their agency. Thus, older adults can subvert symbols of meaning of 'old age' as a representation of decline, passivity and social death with sets of meanings of their own. For example, we live in a youth-orientated society where negative and stigmatising images of later life proliferate. However, testimonies to a strong sense of self in later life belie such representations (Dittman-Kohli 1990; Thompson *et al* 1990). Social death is therefore imposed or socially constructed. The agency reflected in the expression of resentment and hostility to such a representation were discussed in the previous chapter.

Returning to Hettie's representation of herself, the playing of the persona and the subversion of symbolic meaning are devices she uses to present her account. She talks in stereotypes, clichés and prejudices which are animated and personalised through her forceful speech, and by her different emphases and exaggerated pauses and her deliberate change of voices. She is, in effect, adopting the different persona she sees as being attached to the actors' social roles she has interacted with as an actor herself throughout her life course. In doing so, she is subverting and ridiculing their symbolic meaning. She is aware of different aspects of people's selves as they are performed in social relationships.

Summary and conclusion

Hettie conceptualises health in social terms. In keeping with the broader health beliefs literature, there is a 'privileging of experience' in her account over the medical model

(Williams, G. 1984 1993; Williams, G. and Popay 1994). Her explanations are logically consistent with her own biographical experience and this is drawn upon to make sense of cause and course of illness. In its own right, her body is hardly mentioned (except the drugs which overpowered her system and her needs for different kinds of food). Her main emphasis is upon the social body. She highlights her experiences in a way which indicates that she sees health and illness as both the concern of, and directly attributable to, social relations. Social relationships and the moral or religious systems through which social relationships are performed provides her with a sense of understanding. Her imagined community can be regarded as a microcosm of what she regards as an ideal imagined community. She still works at maintaining this to provide her with security. It can be seen as Hettie's 'body project', which was mentioned at the beginning of this chapter.

Social relationships are in crisis for Hettie and this crisis provides the site within which the notions of health and illness are framed. Her urge towards being connected provides her with the resources to cope. Being connected to a moral and imagined community is her way of coping and of cleansing herself of the impurities she associates with illness. Thus, religion and the memories of her family provide her with a moral framework to answer questions about the nature of illness, ageing and death. The idea that she suffers from illness is resisted. She is not unwell. Her ageing is held as the natural wearing away of the body, but at the same time, she is achieving spiritual maturity and becoming closer to God. Her spirituality also helps her to cope with the prospect of death because she feels her spirit will live on. It transcends body-self and society. In addition, her social class habitus provides her with the economic, cultural and social resources to consume health care discerningly. Thus, she has tried a good range of health providers both public and private, conventional and alternative.

Given her orientation towards embedding her body-self in a shared set of beliefs and practices, the loss of her close family has exposed her vulnerability (which she has always felt in the past). Her body-self is permeable and remains open, as it was when her close family were alive. Thus, she constantly sees her body-self boundaries as being infringed by her sense of the other, or, as she puts it, 'this all pervasive disease' of society. She is, therefore, experiencing dramaturgical stress. In the past she orientated her body-self within boundaries

that had a clear division between normality and the other. Religion and her close family were within these boundaries. Throughout her account, she is constantly trying to assert boundaries, but the loss of her family makes it difficult for her to continue doing this.

Even in the face of all of these crises, Hettie highlights the positive. As much as it can be held that illness can help a person clarify their sense of identity (Kleinman 1988: 137-45), Hettie's pain and suffering has meant that she works constantly at her idea of an imagined community as a means of coping. In highlighting her Christianity, therefore, the idea that her spirit is going to a better place where once again she will be connected in a relational context with others with whom she has something in common - particularly her family - is emphasised. Thus she will be connected again within a community. Indeed, reference to the idea of community can explain her constant assertion of boundaries throughout her account. Therefore as Cohen (1985: 12- 15) notes, symbolic boundaries mark 'the beginning and end of community'. In other words, they mark off the symbolic meaning of community to individuals. The consciousness of the boundaries of the community Hettie feels she belongs to are largely constructed in interactions between herself and family members. Even though her family are dead, she keeps her sense of community alive through a manipulation and embellishment of symbols and metaphors such as being 'a lonely ship', 'the veil' and 'the parable of the tapestry'.

In general, this chapter's analysis highlights the merits of the sociology of the body in that it has explored the data by drawing upon a synthesis of phenomenological, social constructionist and biological perspectives. For instance, **phenomenological** exploration of Hettie's re-interpretation of narratives associated with the discourses of religion and medicine show how she has engaged in narrative reconstruction which takes into account her biographical experience. In addition, attention to the less observable side of social interaction, such as those with her dead family and with God, has also highlighted the shadowed resources and coping strategies she uses.

In terms of **social constructionism**, and following Mannheim (1952), Hettie's positioning of herself within a moral community is generationally situated. The past is highlighted as a better

time than the present. She feels out of time or temporally displaced by the present. She 'is too old for the times in which we live' as, by implication, are other older adults, but her memories of the past are a great comfort. She looks at old photographs and birthday cards, anniversary cards and Christmas cards from her dead husband which she keeps in a box. Looking through such representations of her memories serves as a release from the stresses of the present: when she looks at them she has a 'really good weep'. The past may be gone in that her family are dead and the good 'old family doctors' she had when she was younger have been replaced by doctors who simply 'treat the symptoms', they do not 'treat the patient'; however, she maintains a sense of continuity with her memories by positioning herself in the moral community which she associates with the past and by an adherence to its principles. Thus her dead husband would be 'very pleased' with the good work she does for the Boy Scouts in the present. In addition, she highlights how she was brought up to believe in God and to do good work through charitable activities and this she continues to adhere to in the present.

In many ways, Hettie draws upon different sets of knowledge, which are from a multiplicity of different sources. This has allowed Hettie to bring together more than one kind of explanation to form her own logically consistent explanation. The process which Hettie has engaged in is akin to Stainton-Rogers' (1991) idea of 'explanatory sympatricity' which was introduced in Chapter One. For Stainton-Rogers, explanatory sympatricity is premised upon the idea that:

people have access to and utilise a range of alternative accounts of health and illness . . . this . . . [is] a more plausible understanding of what they do than claiming that there are specific, enduring personality traits, psychological mechanisms that constrain people to think in particular ways. (Stainton-Rogers 1991: 226)

The coping resources Hettie has drawn upon - religion, 'good work', medicine, the collective self, her social class habitus, family and friends - can be seen as texts which she has cited and manipulated to produce her own idiosyncratic vocabulary of motive. She is not the passive puppet of social process and domination; she is a conscious agent constructing her own knowledge.

This chapter has also attempted not to neglect the **biological** constraints which being in an older body has meant to Hettie. Thus the organic process of ageing has meant that despite her wish to be considered as independent and as a carer and giver, rather than as somebody who is dependent upon others, she has had to seek help from conventional and alternative medicine. It was also argued that the biological cannot be separated from the phenomenological and social contexts in which Hettie's explanations are constructed. As noted, then, Hettie emphasises how her close family had provided her with a sense of ontological security. However, following their deaths, she experienced acute dramaturgical stress in maintaining a performance of later life where the key resource for achieving her sense of ontological security is something she has to imagine. They, as were some of the other members of the community, such as the famous people she finds inspirational and the writers of 'uplifting' books, are people she cannot have face-to-face contact with. Her ageing and her loss of significant others, plus the impact of social organisation upon her has almost forced her to imagine community in the face of adversity. This is not to deny her agency in the face of crises, but rather to show how she still constructs a sense of being connected as a survival strategy in later life. Being connected in this way links her mind and body in a relational sense with the imagined community. In this sense, her body can be seen as a project for the expression and construction of her imagined community. The community she imagines is her key source of coping. However, because the community can at times be distant and elusive, it is also something which does not always protect her from dramaturgical stress.

Having set the data in the context of existing knowledge about health beliefs, and by emphasising that interviewees draw upon competing views from different domains in the construction of their beliefs, it has been argued that this can be seen as a reflection of their embodied relationship with society. It has also been emphasised that the way they construct their beliefs represents their agency as competent social actors rather than seeing them as being determined by oppressive social forces. In theoretical terms, it has been argued that the 'thinking tools' outlined in Chapter One help to make explicit the idea that phenomena such as beliefs should not be theorised in a way which separates the individual from society. Having also introduced the general health beliefs literature and the work of Williams and

Herzlich, the following two chapters draw upon this body of work in order to explore the vocabularies of motive which shape the nature and form of interviewee beliefs.

Beliefs about the doctor and illness

Introduction

This chapter is premised on the idea that illness rather than ageing or the approach of death gives people the first signs of the physical limitations of their bodies. When illness becomes significantly debilitating it may no longer assume temporary status and, like ageing and death, can bear a sense of finality and inevitability. In the words of Williams, illness becomes:

more encompassing, as the first step in a downward path, as in some respects an end, and a renunciation. And in this way it is like ageing and the approach of death... (1990: 27)

It is for this reason that this chapter examines beliefs about illness before considering ageing and death in the following chapter. Given the importance of medicine as a cultural meaning system, attitudes to doctors are also examined in the context of illness explanations. Reflecting the concern with the problem of sociology, the social meaning of illness beliefs, then, is the key focus of this chapter. Indeed, for Williams, illness 'plays continuously on a few basic assumptions' (1990: 27) and, as noted in Chapter One, illness experiences can be episodes of moral enquiry (Kleinman 1988; Becker 1995:116). Thus, despite the rise in influence of biomedical knowledge, which locates the causes of illness in the body, individuals still continue to ask moral questions such as why me, or why now, which go beyond the realms of biological or medical explanations (Herzlich and Pierret 1986). Following such ideas, it can be argued that illness represents a synthesis of knowledge which brings together the body, the self and society. For example, as noted previously, in Herzlich's study, people were portrayed as seeing illness as an invasion of inner reserves of strength. In an implicitly economic metaphor, health was seen as an inner reserve of capital. Illness was thought to be caused by society. In Williams' study, the different perspectives on health and illness were held to reflect different socio-historical and cultural contexts. Thus influences which included

working lives and religion were held to bring about a strong sense of stoicism amongst the Scots and the desire to carry on in the face of adversity. Illness was not emphasised as an invasion of inner reserves of health. What emerged was the way the Scots drew upon the resources of work and religion in biographical contexts to find ways of accommodating or living with illness.

The main premiss which links the French and Scottish studies together with recent research is the idea that beliefs, as products of creative processes, mirror an interplay between personal experience and macro social contexts. In the British context, the research tends to follow a blend of structuralist and resource-based analysis, highlighting the importance of social factors such as class and gender (Calnan 1987; Cornwell 1984; Graham and Oakley 1986), and the status of medical knowledge as a reflection of the division of labour (Stacey 1986). For example, Calnan (1987) argues that working class people are more likely to characterise health in mechanistic, biomedical terms as the absence of illness or disease. By contrast, middle class people are held to be more holistic, therefore, psychological and social dimensions of illness experience could also be portrayed.

For Cornwell (1984), social and economic hardship or the 'hard-earned lives' of her working class interviewees shaped their beliefs. She also argues that general social values and beliefs, and medical knowledge are significant. However, these are not passively received. Most significantly, people draw upon their own knowledge and experience to relate such knowledge to personal biography and circumstances. Thus, in the first instance, Cornwell held that her interviewees were likely to give 'public accounts' which drew upon general social and medical knowledge - reflecting what they felt to be socially expected norms and conventions. However, after gaining rapport with her interviewees (for example, in follow-up interviews), she argues they were much more likely to give 'private accounts', reflecting personal experience and knowledge. Thus older working class men were initially inclined to stress that retirement involved choice and self-determination. However, in 'private accounts' they were likely, as a result of socio-economic hardship, to see retirement as a time when choice was beyond their control. Men were held to usually draw upon working experiences in their concepts. For women, either the domestic labour involved in childrearing and running a

home on a low income, or a combination of this with part-time, low skilled formal employment were seen as key points of reference in constructing their knowledge. Thus Cornwell maintains that socio-structural position can be crucial in influencing how beliefs are constructed.

Whilst social class and gender are considered important in the present study, the idea that data reflect multi-dimensional influences is also explored. For example, as noted, religion once provided an important framework for understanding due to its dominance in traditional societies. In contemporary society, however, medical knowledge has largely replaced religion as the dominant cultural meaning system to understand illness (Helman 1986). However, as shown in Chapter Four, the sufficiency of medical explanations is called into question by the interviewees to a considerable degree - reflecting the relationship between ageing and beliefs. Indeed, the demise in the status and authority of contemporary medicine (Gabe *et al* 1994) also seems to have been reflected in interviewee beliefs. Thus, whilst medicine maintains considerable authority at a cultural level, in terms of individual understanding, we may find diverse knowledges of illness owing to differing experiential or biographical factors. Thus, as previously argued, the analysis shows that individual experience is crucial in shaping how medical knowledge is drawn upon. Furthermore and relatedly, it can also be argued the experience of time influences beliefs.

Time has been described as highly significant in constituting generational identity (Mannheim 1952) and the social world generally (Adam 1990 1995; Elias 1992; Giddens 1987). Indeed, Blaxter (1992) argues that the role of time is crucial in the context of the relationship between the individual and society. For Blaxter, the intertwining or the 'unique flow and sedimentation of experience' (1992: 21) with calendar, social and personal time plays a part in shaping concepts of health and illness. Thus, narratives related to calendar time represent the increasing experience of illness in late middle age and beyond. Therefore, as Bury (1982) notes, chronic illness in youth, because of its relative scarcity, is likely to be seen in terms of 'biographical disruption'. Following this idea, and by recognising the increased incidence of illness in later life, the fact that older adults are more likely to see it as part of everyday

experience (Sidell 1995) can be more readily understood. Older adults may deny its existence altogether or, more usually, accommodate it into normal living (Williams 1990).

Blaxter (1992) describes how social time shows the impact of historical change over generations to differing degrees. Thus, relatively rapid social change is likely to bring about radical differences between age generations. If a society is relatively stable, age cohorts may not differ from each other to any marked degree. However, the rapid social change which the interviewees have lived through has, it is argued, produced a range of textual resources through which illness can be understood. As noted, illness often signifies or enshrouds more than one meaning (Kleinman 1988: 8), it can become multiple or 'multivocal' and 'polysemic'. Thus, for Kleinman, individuals produce 'illness narratives' which bring coherence to physical suffering. This study explores the idea that imagined community serves as the key vocabulary of motive in the narratives reflected in the beliefs of the interviewees. Thus, the idea that the assertion of community membership reflects a key way of maintaining ontological security is explored in this study. In a world characterised by a range of competing discourses such as science, religion, medicine or lay knowledge, individuals are, therefore, forced into a kind of 'do-it yourself' construction of meaning in the face of illness. As Kleinman notes:

In the fragmented, pluralistic modern world, anxiety is increasingly free-floating and requires personal processes of creating idiosyncratic meaning to supplant the shared moral and religious significance that guided our ancestors on how to suffer. (1988: 28)

In the absence, then, of shared moral and religious texts in the contemporary social world, it is suggested that imagining community has the primary function of providing the guidelines that Helman suggests people need in the face of illness. Thus, as noted, research shows that older adults are much more likely to bring moral themes into their beliefs (Sidell 1995). The notion that we live in a fragmented and postmodern world where individuals are held to make sense of their experience from a number of co-existing, complementary and contradictory explanations at any particular point in time also finds parallel here. As noted in Chapter One, people create order out of chaos, that is, people engage in 'explanatory sympatricity' (Stainton-Rogers 1991). This reflects a situation where all forms of knowledge are highly contestable. Thus, explanatory sympatricity derives from a situation where:

theories operate in parallel, at one and the same time competing and co-existing, (Stainton-Rogers 1991: 7)

For Blaxter, the idea of personal time shows that social processes do not have an *homogeneous* impact upon individuals but, rather, reflect the influence of factors such as social class and gender in the context of biography. Indeed, as noted in Chapter One, the life course approach takes this into account by exploring beliefs in terms of differing careers such as childhood, childrearing, work and retirement. Similarly, Blaxter argues that personal time can significantly influence how people think and act. Thus 'temporal profiles' of infancy, schooldays and childrearing are:

crucial to our perceptions and expectations . . . and against which all social situations are judged.' (Blaxter 1992: 20)

To reiterate, existing research into illness beliefs emphasises the importance of class and gender, the status of medical knowledge as a cultural meaning system, and the way illness tends to compel people to think about it in moral terms. Research on older adults has shown how moral themes tend to predominate, and how working lives and religion can be very important. Moreover, the experience of time - that is, the biographical context of lived experience - plays a central role in shaping beliefs. Thus, in the analysis which follows, it is argued that all of the above examples help to make sense of interviewee beliefs about illness. In particular, distinctive sets of ideas which bring together mind, body and society can be discerned in the data that follows.

Given the similarities between illness in later life, ageing and the approach of death mentioned at the beginning of this chapter (that is, all are physical indications to people of the limitations of the body), the above ideas are also drawn upon in the following chapter on ageing and death. For the purpose of clarity, instead of dividing interviewees into categories of working class and middle class, they are referred to by their geographical locations. All Hull interviewees can, therefore, be considered as working class. All others, who were from surrounding villages and the town of Beverley, are almost exclusively middle class and are referred to as villagers. Where social stratification is used in presenting data, the small

minority from this latter group who are working class are referred to as working class rather than as villagers.

Illness and the doctor

Especially for people from Hull, medicine remained a powerful and influential discourse to make sense of incapacity and ailment. In addition, as discussed in Chapter Four, nearly all of the interviewees were critical of many aspects of bio-medicine, such as the prescription of drugs and what was held to be an emphasis upon the biological aspects of illness rather than its social and psychological dimensions. These views reflected an ambivalent orientation towards doctors: those from Hull tended to be more deferential, whereas those from the villages were more critical. However, medical knowledge was often called upon to make sense of illness by the majority.

The first set of data shows the importance of doctors to the interviewees. In particular, the more severe the illness, the more likely it was that people said they would put themselves under a doctor. In addition, when talking of illness, doctors tended to be mentioned more by those from Hull.

Working class attitudes to doctors

Will from Hull, one of the frailest interviewees, said it was very important that he saw a doctor. Pausing frequently for breath he spoke very slowly. Indeed, many other interviewees also had a lot of pauses in their talk. In addition, those from Hull appeared to pause more generally than those from the villages. During the interviews it seemed obvious that this group paused more because they experienced difficulty in articulating themselves clearly. They seemed to be searching for the right words to say from their available vocabularies - this trend was also present in Will's talk. Amongst everybody Will showed the most deference to medical power:

Will: the point is that when you are ill, you can't do a thing about it, you have to rely on medical attention.

SC: Do you think so?

Will: I am certain you have.

SC: Do you always go to a doctor when you are ill?

Will: I have got to attend a doctor because I am ill. I am seeing a doctor.

Thus, his explanation of illness behaviour mirrored the idea of 'public accounts', which, Cornwell argues, are derived from publicly shared assumptions of order and knowledge (Cornwell 1984). It also reflects the idea that medicine presents a dominant cultural meaning system to understand illness (Helman 1986). Will's opinion of medicine can also be understood by reference to the idea that individuals construct their beliefs as reflexive social actors (Calnan 1987). Thus, when Will moved from the subject of his own body to health care for older people generally, he could be very critical of medicine. He was in the hands of medicine because of his very poor health and, under the circumstances, therefore, this was seen by him as most appropriate. However, discrimination against older adults through the rationing of health care was an abhorrent idea to Will.

SC: Have you seen that stuff in the news recently about people who have been refused hospital treatment because they are old?

Will: Rrr, yes, I ave seen that.

SC: Do you think that is right or wrong?

Will: I think it is wrong, absolutely wrong. ((pause))

SC: Why?

Will: Because ((pause)) in a lot of instances ((pause)) that person ((pause)) smokes. ((pause)) not ((pause)) for any wrong purposes at all. But they ave smoked that long and they really enjoyed a smoke that much, that no matter how ard they try, it is a second nature to em. ((pause)) It is same as me. I mean, I don't inhale, but I love a smoke . . . personally, it's an opinion I ave ad for a long, long time. I don't like voicing it, but seeing as you are interested enough, I will tell you. I think meself, when a person gets beyond a certain age ((pause)) the elth authorities and the doctors think: 'Right, you've ad your life, we concentrate on the younger end. You've ad your time, let us deal with somebody now that's got their time to come.' ((pause)) . . . The principles of our physicians is to ((pause)) prolong life. ((pause)) And to save life. It is not to decide which ones they are going to look after and which ones they are going to let go. ((pause)) They should have an equality among all types of patients and among all ((pause)) age patients.

Implicitly, then, Will can also be seen to be asserting his membership of a moral community. As he states in unequivocal terms: 'The principles of our physicians is to prolong life'. These principles he feels are being broken and he is condemning it unequivocally. Perhaps reflecting a desire to be connected to the status quo, most interviewees said they would consult a doctor about illness. However, significant others such as family and - particularly for

women - friends were usually consulted first. If the problem could not be resolved by themselves, interviewees would connect and consult with members of their communities with whom they had most contact. When this was not possible, as in the case of Hettie, the imagined community served as the key vocabulary of motive.

Delia: I go to doctor. Since I had the stroke I have had high blood pressure, so I go to the doctor every fortnight. I don't tell him all the little things, you know I work it out and try and sort it out myself?

Evelyn: If I am not [in control] I will go to the doctors, I will not mess about . . . I mean, now I know when I have had enough. I can tell . . . the only person I would go to would be a doctor. Although, I would ring or go to my son's for advice sometimes.

Resonating with the idea that working class people are more likely to resort to mechanical biomedical explanations (Calnan 1987), those from Hull placed most stress upon seeing a doctor:

Evelyn: if you are ill you should go to a doctor. You should not medically treat yourself because you could do yourself harm. I mean, Aspros can do you harm.

The youngest woman amongst working class interviewees, Paula, who was 50 years old, did not explicitly come out and state that doctors were the first people she consulted. However, when she talks about her own health problems, she explains and defines them in terms of doctors' diagnoses, rather than her own. Also, when I asked her to talk about her life in terms of her health she, like the other interviewees, talked in terms which were social as well as biological. Paula talked of being very upset by her recent divorce.

Paula: Two years ago I fell down and the doctor said it was arthritis . . . Last year I was going through stressful times and it did affect me health. I am still getting over it now . . . The doctor said I had to change my lifestyle . . . I told my own GP that I got divorced. I got very bad shakes, and my head - oh, it was like pins and needles in my head . . . The doctor in Beverley, he said: 'Well, a lot has happened to you . . . and it is starting to take its toll.

Being upset had, she said, led her to not 'eat properly' which in turn made her lose her hair and develop a skin disorder. She had problems finding suitable living accommodation after her divorce, finding only an 'awful place' which was 'full of damp and mould'. This, she said, was 'not very good for my health'. Paula had arthritis and a recent 'bad fall' had damaged her knee. Therefore, for Paula, her state of health was due largely to her divorce. Being

disconnected, then, was seen as a key cause of illness. In addition, she legitimates this view by highlighting how her doctor had confirmed this to her.

As noted, many writers have shown how older adults are likely to employ moral reasoning in their explanations (for example, Stacey 1988: 151; Williams 1994: 79). Indeed, this tendency was very strong in the data. The values and beliefs most interviewees associated themselves with, most often reflecting their membership of imagined community, were highly moral in their nature. In the next extract from Fred, one of the oldest people from Hull, the theme of morality is very strong in his talk about consulting doctors. Thus, even though he had a problem ear for most of his life he had only consulted a doctor about it recently. He took pride in saying this was his way of not wasting NHS resources. He was not like other people who 'flocked' in for free health care in the early days of the NHS. He believes that 'most things you can treat yourself' unless you 'need an expert'.

Fred: Me hearing int perfect . . . I did go to the doctor's about me ear.

SC: When did you first go to the doctor's about your ear?

Fred: Oh, about a couple of years ago.

SC: How long had you been having problems with your ear?

Fred: Every time I got a cold. ((laughs))

SC: So how long was that?

Fred: Oh, early days. After the war mainly.

SC: Why didn't you go to the doctors about it?

Fred: Well, I just thought that this was a cold and all I could do was just to try to get rid of the cold. ((pause)) That's what people do. I mean, I hope so. ((laughs)) I have never been one to dash off to doctor's, if I have got anything wrong. Unless I have had accident and, err, need an expert, ((pause)) I believe most things you can treat yourself. In the old NHS, in the early days, ((pause)) everybody flocked ((pause)) for Aspros, bandages. I never did. Our doctor said to me if there was more people like our family then the health service would be able to concentrate on people who really needed it.

In parallel with traditional working class culture, and like the majority from Hull, Fred was reluctant to consult books about illness. If he had to consult anybody, it would be somebody who represented 'expert' medical opinion.

SC: You said you like to read, do you ever read anything about health?

Fred: No. ((pause))

SC: Do you ever try and look something up? You know, like your ear, did you ever try and look something up about that?

Fred: ((pause)) No, I don't think there is any point. I mean, your ear, it's so complex, you cannot understand. It's not like your eye, because you can see into it with the other one. You can't do that with your ear. I mean, something like my ear it is very difficult to know what's a matter with me. So, therefore, you have got to go and see an expert, ((pause)) and then they will decide.

Another example of a reluctance to consult books about health and illness amongst working class people came from Tim.

SC: Would you look in a book about an illness?

Tim: No, if you read a medical book you've got to have an illness in there ((points to his head)), haven't you.

Tim and Mary, a working class couple from Beverley, show considerable deference to medical knowledge - for these two, health and illness is defined by a doctor. Like the working class women who Cornwell spoke to (Cornwell 1984), Mary was reluctant to give much detail in the presence of her husband. Her account was very much in the 'public' as opposed to the 'private' or personal domain.

Tim: The doctor's assessment for both of us is that if he is as fit as we are when he gets to our age, then he will be delighted.

SC: Do you agree with his assessment?

Mary: Yes.

SC: Do you always agree with his assessment?

Mary: Yes.

SC: Do you ever see anybody else about your health, apart from your doctor?

Mary: No.

SC: How do you feel about using somebody else instead of a doctor?

Mary: No, I wouldn't. I would only see a doctor.

There was a slight concession to the idea of self-help.

SC: Do you think people are responsible for looking after their own health?

Mary: If you can, you do. You can get tablets and whatnot from the chemists. Anadins, Paracetemols.

Like most of the working class interviewees, when talking about personal health problems, Tim usually mentioned doctors in the same breath. Thus, doctors had told him that he had recovered from his heart attack and he did not have a 'heart condition' and he was not an 'invalid'.

SC: You said that you had a heart condition?

Tim: No, I said that I had had a heart attack and I have recovered . . . The doctor emphasised that. That you have not got heart condition and you aren't an invalid...

Virtually every explanation of serious illness by Tim would contain a deferential mention of a doctor's diagnosis.

Tim: I have got a very small trace of diabetes - which the doctor says is...

At the same time - like Fred above - his account is underpinned by a moral theme. Thus he would not consult a doctor about minor ailments. Tim and his wife Mary are not frequent visitors to the doctor's surgery.

SC: Is there anything that you would do yourself rather than going to see a doctor about it?

Tim: Well, only normal things. Headache or something like that.

SC: Anything else?

Tim: No, that doesn't mean to say that we are always in the doctor's surgery, because we aren't.

SC: So, you do not mind using the doctor.

Tim: When it's necessary. It has to be absolutely necessary.

SC: What do you mean by absolutely necessary?

Tim: Well, if it's something that I can't put my finger on...

Like many of the other men, Tim would not consult anyone other than his spouse or a doctor about illness.

SC: You know when something is wrong - do you talk to your wife about it?

Tim: Oh, yes.

SC: Do you talk to anybody else?

Tim: No.

SC: So what do you do - if you talk to your wife and you could not sort it out, then you would go to the doctor?

Tim: That's right, yes.

SC: Would you not ask anybody else?

Tim: No.

As noted, Paula said that going through a divorce had made her ill. Following this kind of narrative - that expressing feelings of connectedness helps one stop or deal with illness - Tim says that his wife will consult more widely than him.

SC: Does your wife consult you when she is ill?

Tim: Yes.

SC: Do you think she talks to anybody else?

Tim: Well, she might comment on it to friends. When she goes into the neighbours she'll say: 'How's your leg?'

SC: Do you not comment on your health to people that you meet?

Tim: No, not especially.

SC: If somebody was to say to you: 'How are you?' Do you not say: 'Oh well, I have got a bit of a tummy ache', or something like that?

Tim: No.

SC: Not even to a really good friend?

Tim: No, I don't think I've got any good friends. We've millions ((pause)), hundreds of acquaintances, but we don't go visiting and we aren't visited.

When he was much younger, prior to the inception of the NHS, he didn't always go to the doctor about illness. The reason Tim gives for this is expressed in terms of social class differences. The doctors in those days were implicated as being very middle class and he highlights a large social divide between doctors and working class patients.

Tim: The calibre of doctor then was different to what they are now. You can talk to a doctor nowadays almost as an equal, whereas pre-war you had to stand to attention to em.

Two of the youngest working class males, Dave and Matt from Hull, were very reluctant to use a doctor. Both of them, like the older men, Fred and Tim, found it very difficult to talk in any detail about their own illness or health. Doctors were mentioned very rarely. At the same time, Dave shows his deference to medical knowledge when asked to explain health and illness to an eight year old child. In such circumstances, Dave would explain being healthy as when the child did not have to go to the 'doctors'. By contrast, he would explain illness as consisting of circumstances which involved a doctor. Interestingly, Matt explains his reluctance to use doctors and the way he copes with his arthritis, as products of learning to 'stand' on his 'own two feet' in his working life and as part of masculine culture - because 'men don't cry'. In addition, both are critical of the idea of patients being refused NHS treatment for smoking. Dave, like many others, felt that doctors dispensed too many drugs - they 'shove you off with prescriptions'.

SC: What does the term healthy mean to you?

Dave: ((pause))

SC: How would you explain the term healthy to an eight year old child?

Dave: Err, I think being elthy is nothing wrong with yer, you don't go to *doctors*. ((pause)) You wake up in the morning and you are fine. ((pause))

SC: So, what about illness. How would you explain illness to an eight year old?

Dave: Err... ((pause))

SC: How would you explain illness to the child?

Dave: ((pause)) When you are not feeling very well ((pause)) and the doctor's come. Or if you ave got to go to doctors. ((pause))

SC: So how will they know that they are not feeling very well?

Dave: ((very long pause))

SC: So what would you say to explain to them?

Dave: ((pause)) Err... ((pause))

SC: What about the care of medical professionals, does that help you to stay healthy?

Dave: ((pause))

SC: Seeing medical professionals, does that help you?

Dave: ((pause))

SC: Does seeing medical professionals help you to stay healthy?

Dave: Do you mean doctors?

SC: Doctors when you were in hospital, say?

Dave: *Oh yea.* ((pause)) I very rarely use doctors.

SC: When was the last time you used a doctor?

Dave: ((pause)) Err, I dunno, a long time ago.

SC: Can you remember what it was for?

Dave: Cold ((pause))

SC: Cold ?

Dave: And then won't have even gone, the wife would have sent uz.

SC: Yea.

Dave: ((pause))

SC: So your wife would have sent you?

Dave: My wife sent me. ((pause))

SC: So why wouldn't you go?

Dave: Well, doctors just shove you off with prescriptions. ((pause))

Matt: The arthritis is... I have had it so long that you learn to cope with it. Because there isn't a lot a doctor can give you for it anyway. And you learn to cope with it . . . and I don't take anything for it anyway unless it is really bad. ((pause)) Err, I just put up with it. And you learn to do that... And ((pause)) you, sort of, put the pain at the back of your mind. ((pause)) And, err, you just carry on . . . Ever since I was 16... I left home and I went to sea ((pause)) and ((pause)) you ad to stand on your own two feet, and you ad . . . to sort your own problems out . . . You got to remember, as well, that it was a total male environment. I was brought up in the era when ((pause)) men don't cry, or become emotional - well, or whatever, and you don't cry, cos that's a sign of weakness. Women cry, men don't cry. And, err, you stand on your own two feet and you sort your own problems out. That was the era that I was brought up in.

SC: Say you were ill, and I was a doctor, and I said: 'Right, you have got to stop smoking'. Would you do it?

Dave: If it meant that I would carry on living, yes.

SC: What if it wasn't a do or die thing?

Dave: ((pause)) Then I would probably carry on.

SC: What, carry on smoking?

Dave: Yea.

SC: What do you think about doctors who refuse people treatment because they smoke?

Dave: ((pause)) Err, no, I don't agree. ((pause)) Cos doctors don't run your life. The life is your own. ((pause)) You do what you want. They can't dictate to you. Do doctors do that?

SC: You obviously disagree with that?

Dave: I disagree.

SC: So, how would you disagree with them?

Dave: Well, what I have just said. ((pause)) It's your life. It int the law. ((pause)) There's people like who inject drugs, that's a different thing. ((pause))

After the tape was switched off during the interview with Matt he talked critically of the power of the medical profession. He described how he would only go to a doctor for a sick note or if he was ill because he didn't find them 'much help'. He would not go for preventative reasons. He also talked of people being frightened of doctors and insisted that they shouldn't be. Giving the example of his doctor wanting to prescribe drugs during a consultation about him being depressed, he said he insisted on being given counselling and, after a struggle, this was agreed by his doctor. He would not agree that the doctor was wrong. He simply said: 'That is the way they are'. Indeed, this paralleled the views expressed by most of the other interviewees, where they expressed resignation rather than outright hostility towards the beliefs and practices of doctors. He also mentioned how he had been refused a chest X Ray by a consultant about ten years ago when he had a 'wheezy chest'. This was on the grounds that he was a smoker. He said he gave the consultant a 'piece of my mind' and told him he had no right to refuse him as a taxpayer. However, he was still refused an X Ray and he did not pursue the matter because 'it wasn't worth it'.

The views of Dave and Matt, then, can be seen to be grounded in a sense of community. For Dave, his beliefs seem to reflect the idea that medical knowledge should be respected because of its advantageous position within the status quo. This narrative here seems to be that it is the 'done thing' to give responsibility and authority to medicine. Therefore, Dave is

simply acceding to this line. In addition, he can also be considered to be asserting his membership of a more humanitarian community, as he dislikes doctors because they 'shove you off with prescriptions'. For Matt, whilst sharing a dislike of doctors for similar reasons, his beliefs reflect a sense of connectedness with working class, masculine culture which stresses independence and autonomy. Thus one reason for his reluctance to use doctors is that he was brought up to believe that 'men don't cry'.

By contrast, the remaining younger working class man, Don, tended to follow a more conventional route in the way he coped with illness. This involved consulting a doctor. He first made sense of his particular illness through the media when he heard about it on TV. Following this he consulted a doctor. Anything he thought of as serious he would be 'off to the doctors'.

Don: And this chappy on the television was saying the same. So I said: 'Well, that's what I suffer . . . I'll go the doctor's . . . it explained . . . you could have this operation . . . or you could be fitted with these machines. And when I went to the doctor's I told him that... No, I ave got it wrong. No... Previous to that, I was suffering water on ma legs. Not so much now, but it. . . So I thought . . . I've gotta go to doctor's about this . . . and before I went . . . this programme come on. And when I got to the doctor's, I told him about this programme, about the snoring, and I also told him about me ankles as well, which was holding water . . . If I thought for an instance that there was something serious, I would be off and get it sorted. I would not let it linger on. . . . Errm, but if I thought that there was something seriously amiss, I would be off to the doctor's. There are no two ways about that. ((pause))

Middle class attitudes to doctors

Those from the villages, regardless of age, also expressed deference to medical power. However, they were less likely to mention doctors as readily as people from Hull. For example, during the course of a focus group in Age Concern in Beverley with six older women, doctors were hardly mentioned at all. Only a very fleeting reference to doctors was made by one of the women when I asked them to explain what the term 'illness meant' to them.

SC: What does the term illness mean?

Brigette: Well, errm, the doctor said I had got ((pause)) something.

The villagers were more likely to talk of doctors during individual interviews when they delved deeper into their own experiences. They were also likely to be more vociferous and articulate in their criticisms of medical power and knowledge than people from Hull.

Aside from expressing feelings of subordination to doctors before the NHS, most of the oldest people from working class backgrounds did not actually use doctors during that period because they simply could not afford them. As a consequence, self-management of illness or simply ignoring it - like Fred above - was a preferred strategy.

Ros' family could not afford to pay for health care when she was younger. They relied upon self-help, including home spun remedies and 'wearing it off'. Thus, she implicitly highlights her family's strong moral fibre when she links their illness management strategies with stoic family values of having to 'wear it off'.

SC: What about your upbringing . . . Did that affect the way you thought about health and illness in anyway?

Ros: Well Mum . . . would say: 'Well Ros, you will wear it off', . . . ((pause)) Because . . . in those days... ((pause)) I wasn't born into the landed rich or something like that . . . money was very tight in our house. . . . ((pause)) to pay for a doctor was something we couldn't do . . . if you could possibly manage, or if Mother could manage, they did.

Ros' deference to medicine materialises when she is explaining what illness means to her. Thus having a heart attack was 'a blow to the ego' because her doctor says it is.

Ros: Dr Pink, who again is a specialist, said, 'It's a blow to the ego'.

When hospitalised after the heart attack she maintains that she was coerced into following a medical regime. Ros said that she had been worried by horrifying tales about the consequences of not taking her medication and this had frightened her. The extract below shows her deference to medical knowledge. She describes taking medication, even though she was very much against taking drugs. This reinforced her scepticism of medical power, in that the drugs 'nearly lost me my life, I was in a coma for four days'. Indeed, like many of the other villagers, her disdain towards medicine led to action rather than an attitude of simple resignation. Mechanistic health care, in the form of drugs, as it was for many from Hull, did not belong in the imagined community.

SC: So what were your feelings about what was happening to you at that time?

Ros: Well, you don't know what you feel. ((pause)) But I felt frightened. Frightened. ((pause)) And when I came out of hospital, after having stayed in, erm, ((pause)) I do think they try and frighten you to take the pills. You must take the pills . . . they did not agree with me whatsoever . . . I felt if I didn't take them, I would probably die. ((pause)) I took the pills and they didn't agree with me, they spaced me out . . . I think they caused me the second illness which was double pneumonia - which nearly lost me my life, I was in a coma for four days . . . after that that I decided that I was going to see X [Homeopath] . . . they told me that every time I had a cold I had to take antibiotics . . . I thought, well, this is no way to live. ((pause)) So I went to see X . . . I must confess. ((pause)) He certainly did me good.

Much like Hettie's talk of, 'feeling too old for the times in which we live', cited in the previous chapter, Ros felt that in her younger days people were more courteous to each other in everyday life and this included doctors. This view was reflected in other data and is discussed in more depth in the following chapter. However, the extract is shown below since it reveals her attitude to contemporary medicine. In the past doctors were seen as 'very kind' and 'humane people' - but, in her view, these values are very rare today. Thus, like Hettie, doctors of the past belonged to the imagined community. In an implicit reference to social change and the growth of individualism, she says that now 'people are more interested in money'.

Ros: Our old fashioned doctors ((pause)) . . . they were very kind . . . In instances where people needed their service, and they didn't have any money, they would ((pause)) override it and go and look at them . . . they were humane people. ((pause)) You very seldom get that today [nowadays] I think that people are more interested in money and things like that . . . I think they saw all the abject poverty that was going on around them and they saw all of the - you know.

Ros also explained that she had tried homeopathy after the near disastrous consequences of taking drugs because it was 'good enough' for the Queen Mother. If it was good enough for her, it was good enough for Ros. Thus, the Queen Mother and homeopathy were also positioned in the imagined community.

The next extract from Ros' interviews contains many of the themes discussed above in relation to the other interviewees. Doctors are talked of critically since they prescribe too many drugs and lack the time to talk to patients properly. As a result, and like some of the others on higher incomes, Ros uses a homeopath. However, her criticisms are more wide ranging than most from Hull. Thus, in what can be described as a critique of individualism and technical rationality, she describes those at the top of the medical hierarchy as 'empire building' within an organisation which she sees as inefficient. In her view, doctors 'have too many patients'. A preventative approach is better than a curative approach because it will

save money - yet money is wasted in the NHS system just to use up budgets. It needs 'sorting out'. However, doctors are also referred to with respect - 'you can't run doctor's down' because it is the system they work under. This is why they haven't got enough time to talk to patients at any length. There are also moral undertones in the way she describes people abusing the NHS in its early days, thus wasting taxpayers' money, an echo of Fred's talk of people who 'flocked in for free Aspros'

Ros: You can't run doctors down . . . they have got so many patients they can't treat. ((pause)) . . . [the homeopath] will sit and talk to you. Maybe an hour. . . Doctors couldn't do that. ((pause)) They just couldn't . . . if you go and you say: 'I've got a sore throat'. They will say: 'Oh, I will give you some antibiotics'. . . . [and] that's not always the right thing. . . . When you think of some of the prices that are there for pills and potions and whatever, I think it would be very cheap on the NHS . . . this homeopathic medicine . . . is not ((pause)) specifically to clear your sore throat. It is to build up your body's resistance . . . hasn't that got to be cheaper?

SC: But they keep going on about money now in the health service, don't they? They say it is costing too much.

Ros: Yes, well, it's their own silly fault. . . . I had a woman who worked for me, and she said: 'Oh I'm going to the doctor's.' And I said: 'Oh, what for?' It was near Christmas time. She said: 'To be honest: I need some cotton wool to stick it on the tree.' AND THAT'S the sort of thing that you get. ((pause)) Well, I think that people ABUSE IT. . . . now the surgeries are practically empty because it costs too much to go and have the prescriptions made up. . . . in the olden days, when everything was given free, they'd go for silly little things. . . . And I tell you something else, ((pause)) there's no wonder that they want to sort this health system out. I have heard of two instances: one where [a hospital] had too much money left at the end of the year. And what did they do with it? They ripped up a perfectly good carpet and put down a new carpet. ((pause)) There was somebody on the radio the other day quoting another instance of an authority that had too much money left. And they did likewise. Don't you think that they ought to buy a blanket or two? . . . But the doctors... I don't know what their game is really. I think they are empire building, a lot of them. I do really. ((pause)) And it's not the young doctors because they work far too hard. . . . Well, I don't think that you get at the top that they work very hard. I don't think that they take their share. I'm quite sure that they don't. They are the ones that reap the money in. But they are not the ones that do the work.

Another villager, Elsepeth, who also used homeopathy, showed a similarly ambivalent attitude to doctors. Although she continually sought help from them, she was also resigned to the idea that they would not recognise her ME.

Elsepeth: A couple of years ago I had one viral infection after another ((pause)) and after the third one, which was an ear infection, which was very, very severe. I was very, very down, it was awful. I just couldn't pick up at all. Errm, I kept going to the doctor again and again. And eventually I had just ((pause)) no energy and no will to live. It was just too much. I had ended up with ME. He wouldn't confirm it, **of course.** (my emphasis in bold)

Thus, although Elsepeth's faith in doctors was evidenced in her repeated visits, her critique of medicine is also manifested in her practices - in that she uses homeopathy as an alternative to conventional medicine. Like many villagers, her critique of medicine is wide ranging She describes the doctor confirming the incidence of ME to her, but in rather vague terms and

saying that he could not help. This diagnosis was obtained by telephone because it took too long to get an appointment. This supports her view of GPs as unhelpful - they will not keep people informed if they can't help them - 'if there is nothing they can do'. Indeed, 'they don't explain anything'. On one level, therefore, and like many other interviewees, mechanistic health care is positioned by Elsepeth outside of the imagined community.

Elsepeth: The doctor said ((pause)) - well, he didn't even tell me what it was - he just said: 'It sounds like ME, but I can't do anything about it'. This was over the phone - I rang him up.

SC: So, why did you ring him up? Why didn't you go to see him?

Elsepeth: Well, you can't make an appointment to see him in less than two weeks ((sighs))...

SC: So, what did he say?

Elsepeth: Well, nothing. He said it's important to try and rest and not try to fight it. ((pause)) So, I did that, I did nothing. I just rested. I couldn't do anything else. If I was sitting up in bed I would be exhausted and I had to lie down again. Just from talking, you know, visitors and friends. It was a most extraordinary feeling. ((pause)) It just went on and on. My chest got worse and I grew hyper. My friend, erm, she did ring up and got the doctor to visit me. ((pause)) But that didn't do anything. () So then . . . I got the homeopath.

SC: Weren't you annoyed that the GP didn't help you?

Elsepeth: No, because this is how they are . . . If there is nothing they can do, they just don't bother to explain to you. ((pause)) They don't explain, ((pause)) anything really. ((pause)) I knew this was so, ((repeats)) so I wasn't upset about it. They don't explain anything really. They just put satisfactory. ((pause))

The youngest interviewee from the villages, Joyce, was the most critical of doctors and conventional medicine. She took issue with the prescription of drugs. Aspects of conventional health care were described as dehumanising and disempowering. Thus she says: 'I hate to feel that I am totally in somebody else's hands [in] hospitals . . . you are supposed to lie in bed and let them make all the decisions . . . I would like to know what is wrong with me' (Joyce's comments were given in more detail in Chapter Four). Like Elsepeth she too visited the doctor on numerous occasions, seeking a remedy for her son's allergy problem with no satisfactory results. Although she challenged medicine in her critical comments, she would not challenge her GP directly because of his power. As she puts it: 'You don't want to get on the wrong side of them'. She only changed her doctor when she was unsatisfied with the treatment she had received from a nurse in the same clinic. Thus, the authority of medicine, which she challenged, was still something that she was reluctant to

tackle head on. The 'final straw' in making her change doctor was the shortcomings of the treatment she received in a visit to the GP's Well Woman Clinic.

Joyce: And the nurses there . . . I was in bed five minutes only. I couldn't believe it. She . . . said: ((indifferent voice)) 'Oh you have had a smear a few years ago, you don't need that. So that's alright. Do you examine your breasts?' she said. 'Well no', I said, 'I'm so skinny and bony that I can feel lumps everywhere anyway'. ((laughs)) So she said: ((serious voice)) 'Oh, you should. ((pause)) You will in future, won't you' I said: 'Well, no, I won't, because I will only give myself a scare, if I think I have found a lump and, honestly, I will feel lumps all over the place. You see, I don't know what I am feeling for.' ((pause)) She said: ((disappointed voice)) 'Oh, well they like you to. So I will put yes'. She ticked yes. . . . So, ((pause)) apart from taking my blood pressure, she hadn't done anything and I hadn't achieved anything. And I was cross about her ticking yes, when the answer was no . . . How stupid . . . So, with that I rang up . . . [to] complain . . . and I said: 'By the way, I am not very happy with my doctor' . . . and she said: . . . 'I'll send you a list' . . . and I asked friends - did they know that doctor and this doctor. So that is how I found [a new doctor].

In addition to consulting friends about doctors (something nobody from Hull mentioned), she, like most of the villagers, placed great emphasis upon consulting books upon health and illness before, or in addition to, consulting the doctor.

The two men from the villages did not say much about doctors at all. Jack, a 60 year old retired Chief Nursing Officer, was more likely to draw upon his own professional knowledge than to leave illness to the domain of doctors. His only comment referred to the idea that doctors were obsessed with the idea of preserving life - this is discussed in the later section on death. The other, Lawrence, in common with most of the men, was very reluctant to talk about his beliefs at all. Doctors were not mentioned by him. As noted in the following section, he was much more talkative when describing his work, just like all of the working class men.

References to doctors, then, echoed the examples found in the literature on health beliefs. In particular, deference to medical knowledge was unanimous - especially when illness was severe. However, almost everyone disliked the use of drugs and what they felt to be the impersonal approach of doctors. The villagers tended to be most critical, and some had sought help from alternative medicine. In order to highlight both the coherent and the contradictory themes in the data, the material is now aggregated into typical descriptions which can be autobiographically located. Therefore, the following comments represent typifications or 'ideal type' beliefs. This is based on the strategy adopted by Williams (1990: 43). Typical autobiographically located descriptions are also used in the summary analysis of

illness, and in the following chapter on ageing and death. In terms of references to medicine, which I have termed *Illness and the doctor*, there were four broad themes. These are as follows:

Illness and the doctor

1. *Doctor as the main authority over illness*

- a) I must be ill because the doctor says I am and/or
- b) If I am ill, I have to see a doctor.

2. *Doctor definition of illness as something to be questioned*

- a) I do not believe doctors when they say I am ill and/or
- b) When I am ill, I don't follow the doctor's orders.

3. *The influence of the biomedical model leads doctors to prescribe drugs for illness*

- a) When I was ill, doctors just shoved me off with prescriptions and/or
- b) Doctors following the logic of the biomedical model made me ill with drugs.

4. *Lay culture as an important alternative to medical knowledge*

- a) Before I see the doctor, I consult family, friends and/or or lay culture generally about illness and/or
- b) I consult books before or as well as seeing the doctor and/or
- c) I don't tell the doctor everything and/or
- d) I consult friends about the doctor.

As noted above, medical authority has a significant influence upon popular concepts of illness. Above all, this was the main pattern running through the data. Doctors were most commonly seen as *figures of authority*, combining some or all of the aspects of premisses 1 and 4. The Aberdonians commonly regarded the *doctor as collaborator*, which often included a desire to control decisions and an expectation of disagreement. Williams, however, does not note any significant difference in these patterns in relation to class or gender, which are noted in this study. For the interviewees in this study, the doctor was regarded as an authoritative figure, but by and large, they were excluded from membership of the imagined community for practising mechanistic health care. Thus, for most from the villages, if the doctor did not help them, an alternative was sought - hence the use of homeopathy. Compared to those from Hull, the villagers drew upon much greater reserves of social and cultural capital in the face of illness. They had the ability to pay for alternatives to state-provided health care and they showed much greater knowledge and interest in their own biology. Many from Hull expressed an aversion to reading books about health as an alternative to seeing a doctor. In terms of gender, all women tended to seek advice from friends as a common practice. At the same time, it is important to note that, like the Aberdonians, what tended to draw the group to medicine was their actual level of physical incapacity - the greater this was, the more likely people would be to consult a doctor.

Calling into question medical authority was not exclusively middle class; everybody, to varying degrees, engaged in some form of critique. Thus, and unlike Williams' doctor as enemy, which he found to be uncommon, the *doctor as disputable*, whilst not such an extreme label as Williams', was very common in the data. This combined some or all of premisses 2, 3 and 4. However, the levels of critique and non-adherence were significantly related to social class. Thus an almost universal criticism of the use of drugs emerged. This was as far as the critique of medicine tended to go for about half of the people from Hull. The remaining half went further and stressed that illness should be self-managed. Those from the villages tended to be much more explicit and articulate: drugs were blamed for causing new illnesses and alternatives to medicine were sought through private health care schemes and in the use of homeopathy. Also the curative approach, consistent with the logic of the biomedical model, was explicitly criticised by many villagers.

Following the influence of lay culture, which was discussed above, everybody consulted someone or something else before seeing a doctor. Thus sources of knowledge about illness came from books, magazines, friends, family and lay culture generally. However, gender and class were related to the patterns of action here. Regardless of class, women tended to consult more widely than men. Many talked with friends and family members. Most of the men, on the other hand, would only consult a female partner and usually very briefly. As noted by Arber and Ginn (1991a; 1991b), gendered social relations involve women in greater responsibilities as carers for illness than men. This is reflected by the female interviewees' accounts; they said they consulted friends as well as partners. A particular version of masculinity whereby men either ignore or keep thoughts and concerns about illness to themselves seems to have been influential. Indeed, one man expresses this explicitly where he talks of not speaking to anybody apart from his wife about illness because that was the way he had been brought up; in his words: 'Big boys don't cry'. In terms of class, some of the villagers, as well as consulting others about illness also talked to each other about doctors - something which was not mentioned by any of the women from Hull. Generally, the villagers had a more selective approach to using medicine. Thus, they would try different solutions for illness, consulting widely, including books, discussing the merits of different doctors and trying alternative healers when they perceived that medicine had failed them.

Above all, however, there was a tension or an ambivalence in the way the interviewees regarded medicine. Yet, it still had considerable authority amongst all of the interviewees. Aside from social class and gender differences, two factors may be responsible for this. First, given the influence of medical knowledge in society, it is not surprising that the interviewees consulted a doctor. Second, in terms of interviewee experience of social time, many had memories of health care prior to the NHS. This, arguably, led them to regard the NHS with a considerable degree of respect. On the other hand, as noted above, there was considerable disdain or disregard towards medical authority, and the reasons for this, alongside the reasons for the continued respect towards medicine, are explored in the concluding section of this chapter.

Illness

Like the French and the Aberdonians, illness was normally thought of as something which could be accommodated into normal living or, on the other hand, it could simply be ignored. Thus, despite the presence of what could be thought of as significant ailments, including arthritis, limited vision, hernias, poor circulation, cancer, angina, osteoporosis, emphysema, disability, and others, most interviewees did not think of themselves as being ill. Like the Aberdonians, illness was held to be something which curtailed activity. However, only when activity was restricted in almost absolute terms, could one be considered as ill. Underpinning the idea that illness could be accommodated into normal activity (even if this involved activities such as use of alcohol and smoking from the working class men), was the moral view, expressed by some, that one needed to be able to rely on inner strength to cope with illness. This inner strength, however, was not something which was innate, it came from biographical experience. Thus Fred and Tim, who had experienced pre-NHS health care, implied that they did not like to use doctors frequently because they did not want to waste resources. For Matt, his reluctance to use doctors was explained as a product of his working life where he learned to 'stand' on his 'own two feet' and because of the masculine culture he was brought up in where 'men don't cry'. The generative discourse of hard work or endurance was drawn upon by Ros when she talked of illness management strategies. Her mother used to say: 'Ros, you will wear it off' because they were not part of 'the landed rich', she came from a working class background where they had to 'manage' themselves. In particular, therefore, the interviewees drew upon and combined sets of resources from their habitus to both conceptualise and cope with illness. Therefore the sources of 'inner strength' can be interpreted as social rather than individual. These strategies are evident in the extracts below.

Illness definitions and coping strategies

Despite the general deference to doctors amongst the working class interviewees, the extracts below also show their disregard for medical knowledge in terms of: not following doctors' orders; challenging the diagnosis of being labelled ill; claiming good health despite the presence of significant ailments; highlighting the importance of religious faith for a sense of well-being; continuing to drink and smoke even though there was a general recognition that

these were detrimental to health; learning to cope with chronic illness because medicine was seen as not being able to help; and a moral narrative that, as independence is highly valued, coping with illness or accommodating it is the done thing. The extracts also show the main definition of health - being able to engage in normal activities which, in itself, is seen to be health generating.

Cheryl: I had a stroke 6 and a half weeks ago, just a mild one, a slight one, but it didn't stop me doing the Jarrow March. It's mind over matter. If I had of taken notice of the doctor I would have had to be sat there with my feet up, taking tablets until I was barmy . . . We walked . . . I had a drink. It did me more good than all of the medicine.

SC: So what exactly does being healthy mean?

Cheryl: It's mind over matter, int it. It's like doctoring, int it, It's nine tenths psychology.

Delia: Telling yourself you are not ill

Enid: Getting out. If you can get out, that is the thing.

Delia: Don't believe em when they say you are ill.

Unidentified

voice: I had cancer of the breast and I got over that.

Cheryl: It's your own outlook . . . I think that's very important to keep your mind going. I do it myself. I just cut myself off completely and relax.

Harry: Well, I sup beer and I smoke and I've been like that since I was 21.

SC: How would you describe your state of health?

Evelyn: Health, ((pause)) I don't know. Oh dear, this is like moaning. I have angina for a start, ((pause)) I have a hiatus hernia, I did have blood clots, ((pause)) three operations. Three years ago I had cancer of the bowel and they operated . . . I feel alright . . . I go to church. It is very important for me, I do a lot of things for the church. It gives me a great amount of strength.

SC: But what does healthy mean to you?

Fred: Well, I mean, it means that, err, you don't have any complaints ((pause)) about err sickness . . . you can do any activity that you want to do . . . I can go in the garden and spend all day in the garden. . . . I can do any activity that I want to do; As long as I am physically active.

SC: Is there anybody that helps you with your bad knee?

Mary: There's nothing they can do about it . . . so, I might as well keep it . . . I can get by . . . You get bad days and good days, it's like everything else

Matt: I have had it [arthritis] so long that you learn to cope with it. Because there isn't a lot a doctor can give you for it anyway . . . I don't take anything for it . . . unless it is really bad. ((pause)) Err, I just put up with it . . . you just carry on.

Elsebeth: I'm convinced that if you can sort it out yourself it's much better for you.

Jane: I enjoy life. ((pause)) I keep fit, ((pause)) I hope. I do keep fit classes, been doing those for twenty six years. I do walking regularly. Try and keep as active as I possibly can. I enjoy doing this voluntary work because they are a nice set of ladies, you know. it's nice to be with them especially with retiring . . . I have a husband, who is equally fit ((pause)) because he keeps active all of the time . . . We put it all down to trying to keep active. Err, continue our pursuits that we have done all our lives . . . we both have bicycles and we both cycle. ((pause)) So, we do our best. ((pause))

SC: What . . . does the term healthy mean to you? .

Claudia: Well, to me it would be to be healthy and fit. But you have just got to do your best and to keep going.

SC: So what does healthy mean?

Claudia: To be really fit. Fit to get out and be free. Free of everybody and free to do what you want to do and not have to ((pause)) wait for somebody else to take you everywhere. ((pause)) Not have to rely on people so much. That's what I would call being healthy. Things you can do... ((pause)) BE [FREE.

Another voice: [be independent

SC: It's interesting that you all [6 women, one working class and the others middle class] mentioned going out and doing things. Does that make you feel better?

Different voices: Yes, hmm, yes ((all agree))

Kate: It costs me a fortune in taxi fares.

Emma: I have had polio and, err, I had a muscle taken out of me bottom here and put in me ankle so I could walk, and that was in 1924. And, err, although I have got a slight limp I don't let it stop me from doing what I want to do. I keep giving myself a push.

However, despite the wish to keep going, 'just carry on', 'be independent' and 'sort it out yourself', illness (particularly for those with severe threats to their health) was held to have agency: it could be a violent disruption to normal activity which could not be avoided. Spatially, therefore, illness could traverse boundaries. As noted by Sontag (1978), a strong cultural meaning of illness associates it metaphorically with otherness and evil. However,

given the inevitability of physical decline to the interviewees, especially the older ones, this narrative could be reinterpreted. Thus a certain degree of acceptance was therefore required. It can 'just come on'. However, one can still be mentally active. Illness involves pain and this can be fought. Thus, as noted in the case study, Hettie asserted her agency by highlighting how she was not ill. She was simply wearing out biologically which was a natural part of the ageing process. When she talked of illness she described it in terms of otherness - for example, she describes a chest infection as 'this chest'. Many other interviewees also described ailments in terms which implied that they saw them as an invasion of personal territory, as something which was alien to them. Hence it was often referred to in the third person, such as 'this asthma', 'this chest', 'the arthritis', 'the hepatitis' and so on. The following extracts show a good degree of acceptance in attitudes towards incapacity.

Will: Up to 79 I was fit and active. I could get about. I prided myself on being active . . . but no matter how hard I have tried, since this illness I just can't follow this line that we seem to be arguing of mind over matter. Matter is taking its full course now and I just can't do anything about it. I have had a good life, I have had an active life, I shall be 81 next month. Outwardly people say: 'Oh, you look well for your age'. But I know that inside things aren't the same. But . . . my illness has not deterred one little bit from activity of the mind. I am still mentally active.

Emma: I think these things just come on.

SC: Would you like to have a holiday?

Mary: No, I'm alright.

Tim: I had a heart attack four years ago, and I haven't had the confidence to travel. It's inexplicable really. I was in the army during the war and went all over the world. And, you know, it makes you strong.

At the same time, the merits of being strong-willed tended to be emphasised. Thus, like Will's comments that illness does not deter him from keeping his mind active, the much younger Paula insists that she is going to use her willpower to fight illness.

Paula: I have got willpower and I wasn't going to let it beat me. Illness could also be considered to have agency because it may be invisible.

SC: How do you know when somebody is healthy?

Don: You don't. I can't possibly tell that becoz there could be somebody who looks ideally healthy to me . . . but who as some sort of awful disease...

Demonstrating how illness and pain are much more prevalent experiences amongst older adults (Sidell 1995), many interviewees stressed how it was destructive to normal activity and involved pain. For many interviewees, illness constituted a violent and major disruption to everyday life.

Elsepeth: A couple of years ago I had *one* viral infection after another ((pause)) and after the third one, which was an ear infection, which was *very, very* severe, I was very, very down. It was awful. *I just couldn't pick up at all . . . and eventually* I had just ((pause)) *no energy* and no will to live. It was just too much.

Beverley: And then all of a sudden I just stopped dead, and that was it.

Ros: Then of course it smacks you one. And it *really* is *very*, ((repeats)) *very* difficult for you . . . when you have not been ill. . . . it's a *blow* to the ego . . . I felt ((pause)) *as if the world had gone from underneath my feet . . . everything in one fell swoop, GONE.*

In its most severe form, then, illness was regarded as a major threat to a sense of self and ontological security. The issue of pain was highly significant. If the pain was severe, one could feel overpowered.

SC: So what does healthy mean?

Unidentified
voice: Free of pain

Another
voice: Free of pain, yes.

SC: Being free of pain.

Unidentified
voice: Yes.

Kate: That's a big one.

SC: Is pain significant?

Claudia: *Very, very* significant.

Beverley: *Very, very* significant. Especially day in and day out.

Claudia: Everyday is practically the same. You don't get much relief.

Beverley: You wake up in the morning and you think: 'There must be more to life than this' . . . I just go to bed and think ((laughs)): 'Let me die' and draw the curtains.

If one is in pain, one is constantly aware of issues of health and illness.

SC: So, ((pause)) how important is health to [you

Beverley: *[very important.*

Lots of
voices
together: Yes, It is. It is very important ((some nodding))

SC: Do you think about it a lot?

Rose: Yes.

Claudia: You can't help but think about it when you are in pain, and you just wish it would go away.

In the previous chapter Hettie associated illness with impurity such as in her term 'the scum of the earth' to describe people she thought were morally reprehensible. In the extracts below a similar association with otherness is made by identifying illness with dirt and disorder as exemplified in untidy 'minds', bodies and 'houses', and choosing voluntarily to be dependent.

Ros: I like reading.

SC: Do you use the library?

Ros: ((laughs)) I did but... But one day I went in ((pause)) and I saw this filthy woman bringing a load of books back. And really... She had got the kids with her, drooling and that. And I thought, oh heck. I mean, you take the books to bed, don't you. I thought, no way, that's me finished. So I don't go, I don't go to the library.

Emma: You can pick up a virus on the buses. . . . they really are a disgrace, they are filthy. . . . my husband he got shingles. We had always driven a car, but when we had to get rid of it we started getting the buses; and he seemed to have lots of little things wrong with him all of the time. And he got shingles and he nearly lost his eyesight.

Ros: I'd like to think that there is no muck underneath my bed lurking . . . I don't like dirt. ((pause)) It's one thing I do not like, is dirt.

SC: Why?

Ros: I don't know, I never could bear it as a child.

SC: Was your house dirty then?

Ros: NO. No, you never did find the dirt when we were younger like you do today.

SC: Even when there was six of you?

Ros: Oh, no. . . . But it was clean. Mum was clean, very clean. ((pause))

As noted in Chapter One, the sociology of the body emphasises the mutually constitutive and interrelational character of body/self/society. This idea was demonstrated as a relevant way of exploring the data in the previous chapter. The following extracts makes explicit a permeable relationship between mind, body and social context.

Ros: You, getting back to some of these university students. I have been in some of these rooms. And they are absolutely appalling. There is no need for it. There is no need for it. . . . They think that because they are at school and learning, they know everything. . . . and they don't have any manners... And they eventually end up with that mentality, because that is the type that they are. But if they would keep their minds ((pause)) tidy. And if you have got a tidy mind, ((pause)) you keep a tidy house and a tidy body, don't you. But they do, don't they... They seem to delight in running around with, erm, scruffy shirts on and scruffy hair dos. And there's no need for that in my opinion . . . I am not being nasty about this . . . these people, I have seen them on estates, ((pause)) and they are the first people to whinge and moan because they are not getting any money from the government for this, for that, for the other . . . basically . . . they are never doing a thing to help themselves. . . . you get the man who says: 'Oo, I have to have my pint every night', and that sort of thing . . . then, quite suddenly, one day they pop off; ((pause)) because they really don't understand how unhealthy they are making themselves with all this, err ((pause)) boozing, and the way they eat and no exercise...

The narrative of cleanliness, highlighting moral cleansing strategies to avoid illness, implicates order and being clean and tidy as important in generating health. Thus, as Ros says, 'if you got a tidy mind, you keep a tidy house and a tidy body'. Those who do not follow these principles will fall by the wayside. Much like Hettie's metaphorical debarring of people she regarded as unclean from her imagined community, Ros excludes people whom she also regards as unclean. Examples of such people are students with 'scruffy shirts' and 'hair dos' and, by implication, the undeserving poor consisting of 'those people' from 'estates . . . who must have their pint of beer every night' and also demonstrate their uncleanness through poor diet and lack of exercise. Thus 'those people . . . quite suddenly, one day they will pop off'.

Given the way illness was seen to be destructive, and often associated with impurity, one common way of conceptualising it was to turn to the familiar domains of family/social contact, working lives and religion for comfort, advice and security. As noted, religion was by no means important to all of the interviewees. However, for those who said they were religious, these values and beliefs pervaded their accounts. Close family/social contact was

represented as a major source of support by the majority. The way this was expressed often reflected the influence of gendered social relations. Women, regardless of age and social class, talked freely and emphatically of the value of family and social relationships. The men, even though they implicitly recognised the value of family, were much more reticent about this. Thus, whilst Harry simply said: 'Sometimes it's your family that keep you going', most men tended to be more oblique. For example, Tim said he would consult his wife when I asked him if he would consult anybody apart from the doctor. During the interview it was obvious his family were important to him: he kept bringing out photographs of his children and grandchildren - if only as a way of deflecting personal questions about his own experiences of health and illness! Above all, most men did not want to appear as a burden on family and friends. This is illustrated in the extract from Lawrence where he expresses an aversion to talking about issues of health and illness.

SC: Are your children concerned about your health?

Lawrence: I don't bother them with that. ((pause))

SC: She [his daughter] doesn't ask you about your health?

Lawrence: Well, she asks me, but I just say I'm fine.

SC: What about talking to people about your health?

Lawrence: Sorry?

SC: Do you talk to people about your health?

Lawrence: ((pause)) I think its, errm... ((pause)) You know, I can say to you, 'Are you alright?' You know, but that's it. I didn't think the people around here would be interested really. With regard to when I go down to the Age Concern pop in thing, ((pause)) some of the blokes there ((pause)) they tend to talk very much about their heart operation. ((puts on a grimaced expression))

SC: Well, I suppose it's significant if you had gone [through

Lawrence: [yes, yes, yes

SC: something like that, it's pretty major.

Lawrence: Yes, I'm sure it is. I'm sure it is.

SC: But you don't want to hear it?

Lawrence: They do like to tell, you know, to go into great detail about their operation.

There is a great deal of evidence which shows that girls develop a greater sense of connectedness to others. For example, Gilligan (1982) found that girls are much more likely to be concerned about the impact of their actions upon others, whereas abstract concepts of justice are more important to boys. In general, women are better at integration with others and can gain a great deal from a variety of relationships. Walter's (1999: 174) finding that the impact of losing a connection through death is influenced by gender illustrates this. Thus, loss is likely to hit a woman harder, conversely she is likely to be supported by a wider network of people. For Walter, women are much more likely to express their emotions, thus enabling them to cope better with loss. Men find it harder to cope, as they tend to contain their emotions. Women's more expressive style of highlighting the importance of family or friendship in relation to illness management strategies is evidenced below (my emphases in bold).

Claudia: Life is still worth living . . . it is, ((pause)) if only to be with my daughter. **We get on so well and we love each other . . . I have got a wonderful relationship with my daughter . . . I consider myself to be one of the luckiest persons in the world.** ((pause))

Beverley: **Yes, I do too.**

Claudia: **She's absolutely wonderful.**

SC: Have you got somebody to share confidences with, to make you feel better?

Beverley: I have only got to pick the phone up, and if I am feeling off the family will be down . . . I **have got two wonderful daughter in laws.** ((pause)) Oh, marvellous.

Jane: **That's a big thing to offload yourself, isn't it?**

Unidentified voice: **Yes.**

Another voice: **Hmm.**

Jane: To be able to have someone [to

Beverley: [to moan about.

SC: Can you do that in here? Can you complain to each other in here?

Claudia: I don't see why not.

SC: Do you know each other well enough [to

Jane: [I would think so

Beverley: Oh yes, I've rang Madeline up and Madge, ((pause)) you know, I feel as though

Claudia: [well, I've only been
coming for three weeks, but I feel as though

Jane: yes, it's a good group, isn't it? We all relate very well together

Two voices: [Yes

Claudia: [and I've been about three or four
[times

Jane: [sometimes Rose can be feeling a bit low, don't you?

Kate: Rose, have you got a headache or are you just holding your head?

Rose: Yes.

SC: SO you said, going out, or doing things, can make you feel better [or

Kate: [being among company.

SC: Claudia said that your daughter was [important

Claudia: [very, she's the most important thing in my life.

Being connected in the context of family relationships and friendship was very important. As shown, the depth and range of attachments are influenced by gender. Nonetheless, regardless of age, social class or gender, fraught or disharmonious social relationships were seen as a disruption to community, and, therefore, as sources of illness.

Paula: When I got divorced . . . I think it . . . made me ill . . . I could have been really ill with it.

This also included the extremely reticent Lawrence.

Lawrence: I got married at twenty seven. We had two children. ((pause)) We were together for twenty years. It was a very unhappy marriage. Then I met the wife and we are very happy.

SC: So was health significant to you in all of that?

Lawrence: Health, yes, well. ((pause)) My first marriage resulted in me having high blood pressure. ((pause))

SC: Was that because there was some [stress

Lawrence: [stress, yes. Stress and tension.

In the next extract Joyce talks of how problem relationships with family members made her ill. Indeed, when I first asked her about her health she talked at considerable length about the problem's with her son's health. Eventually, she began to talk about her own health, which she saw as a product of her relationships with close family. If these were at all problematic, this could make her ill.

SC: You seem to be saying that a lot of things related to your health were related to looking after Malcolm. The [worry

Joyce: [mmm, yea, that's right, yea. Well, I think if you are all in a family, if there is one person tense ((pause)) it rubs off on everybody . . . it's had us worried out of our ((pause)) WITS really. And it's affected my daughter's health as well, all that stomach trouble ((Joyce's)) . . . it was due to the tension that was caused by Malcolm...

Participation in reciprocal social relationships was seen by many as something which helped them to stay illness free. In addition, peace of mind and the idea of being content was associated with being healthy.

SC: What's your secret, then, for staying healthy?

Lawrence: ((pause)) I suppose being contented, peace of mind. ((pause))

The data from Hull interviewees indicated how their habitus had been shaped within the context of living on low incomes and enduring general hardship. Thus, the idea of frugality or living within one's means as a key source of contentment and avoiding illness came into play.

SC: What about your state of mind, your emotional state, does that help you?

Dave: Yea, I think that elps. ((pause)) . . . me wife elps in that department. She brings in the money. ((pause)) I'm the breadwinner. She manages it. She pays all the bills. ((pause)) So, there's nobody knocking at the door.

Fred: That is the reason why people find themselves in a state, because they have not budgeted properly.

Most of the men, regardless of age or social class, were quite prepared to talk at length about work - but nothing more intimate than that. Indeed, for many, reference to work was used to make sense of health and illness. At the same time, this did not mean that the women did not make a reference to work. The next two extracts contain the theme of fraught social relations as a cause of illness, but they also bring in the theme of work. The following extracts go on to

make generic references to work as both a cause of illness and a strategy for maintaining or gaining health.

SC: You said you had a heart attack.

Ros: Yes.

SC: Was that as a result of working too hard?

Ros: Well, I think it was stress *really*. Because err... The work you can take in your hands, you know, as you go along... Very busy and very hectic...

SC: What does the term illness mean to you?

Lawrence: Not being well. Errm... ((pause)) In nineteen seventy four I tore my Achilles tendon, I was off work for six months. Lots of matrimonial problems. That was being ill to me. ((pause))

Cheryl: If you had a job where you had to do a lot of kneeling like cleaning or nursing or something like that you get it in your knees don't you.

SC: What do you think caused that [a problem with her knee]?

Mary: A long time ago when I was working - nine or ten years ago. It was with kneeling on the floor. I worked in a supermarket. You sometimes had to kneel for shelves and that.

Claudia: What I have got comes on with *wear and tear*. ((pause)) Osteoporosis comes on with wear and tear . . . Myalgia attacks the muscles. But, when I was 26 I had nervous exhaustion. Every nerve in my body broke down. And I was in bed... I had to come off work. And I was off work *twenty six weeks*. ((pause)) And I was in bed... ((pause)) . . . And I was *completely*... My face was *twisted* and every nerve in my body *just gave*. And that was work. Working.

SC: Couldn't somebody say that you caused the wear and tear?

Claudia: I worked. *I worked hard*.

Ros: I never had a day off work or anything . . . I was just like a human dynamo . . . I never really appreciated people being ill. ((pause)) . . . I used to think they were a bit maungy. ((pause))

SC: Were you sort of busy, energetic?

Ros: I was *extremely* energetic . . . If I decided to spring clean a room one day... ((pause)) If I set off on that room at one o'clock in the afternoon. If it wasn't finished at twelve o'clock that night it was finished before I went to bed, from top to bottom, even if I started after lunch it was finished before I went to bed, even if that meant staying up until twelve o'clock

to finish it off. *Well Mum was the type*, that erm, you know, she would say: 'Well Ros, you will wear it off', you know.

SC: So, you know when you are ill, do you try and look after [yourself

Joyce: Yes. . . . [but] I would rather be up and about.

The worlds of work and unemployment were drawn upon most often by working class men and one middle class man from a working class background (Jack) in conceptualising illness. Possibly as a reflection of the greater importance of abstract concepts of justice to men (Gilligan 1982), this narrative implied that social inequality was a root cause of illness.

Fred: A lot of people nowadays don't get enough exercise this is why they are ill . . . people don't get enough exercise because they are unemployed . . . What I think that causes ill health today is unemployment. The thing is that it is the powers that be that will not recognise it. If they did they would have to say it was their fault and then they would be in a right state wouldn't they; because they would have to do something about it wouldn't they. When I hear that Virginia Bottomley going on about Looking after yourself, I think, what a load of rubbish. I mean, how can you look after yourself when you don't have a job?

Don: ...ah just think that society as gone down the tubes that much that ((pause)) you don't feel safe anymore. ((pause)) I think English society for the lower classes, and that's working classes, because there is lower classes below that now, ((pause)) erm, I think as gone down the path. ((pause)) . . . I think the quality of life for the working classes as gone down. We are now paying a lot more... ((pause)) My contribution to society tax-wise, ((pause)) buying-wise ((pause)) and everything else, is far greater now than it ever was. I am now paying more tax, directly or indirectly. ((pause)) My buying power as gone down, ((pause)) even though prices ave gone through the roof, even though, erm, there is a massive, err, ((pause)) fight to keep prices down ere there and everywhere. The prices what I can't get away with like gas, electricity, water, gas, err, ((pause)) all the rest of it ave shot through the roof.

SC: Does that have any bearing on people's health?

Don: Yea, course . . . IE, winter time, erm, ((pause)) you ave got the fire blasting away at winter time. You keep it nice and warm ((pause)) and I would think that would contribute to, err, ((pause))

SC: Has it had any bearing upon your health?

Don: ((long pause))

SC: [Have you ever

Don: [YEA I would think it... ((pause))

SC: been unemployed, for example?

Don: Yea, I was unemployed eight years ago for . . . eighteen months. Err, ((pause))

SC: Did that affect your health?

Don: ((pause)) ((sighs)) Well, it certainly affected me diet.

SC: Why's that?

Don: Well, becos ma wife was working part-time, err ((pause))

SC: Moneywise you couldn't afford it?

Don: Yea.

The nearest any of the middle classes came to talking of underlying social factors came from Jack, a retired nursing officer. Jack presented himself as being 'brought up' on 'Christian socialism'. This, he explained, meant that more was gained from giving to people rather than from receiving. Two themes run through his extract below: (1) health-related beliefs and practices are learned through culture; that is, smoking and drinking is a big part of Scottish working class culture, and he had learned to smoke as a young nurse because many of his colleagues smoked. He stopped when he was told he couldn't smoke in his brother-in-law's home in America (2) the demise of community through the erosion of the extended family was seen as leading to an increase in illness.

Jack: Yes, our lifestyle is *bad* ((in Scotland)) . . . They have an idea that, you know, bacon and eggs and things like that. We were well off. Cos ma father never drank . . . and, therefore, you saw the opposite. You saw that people had to live on bread and jam, ((pause)) *grease*, dripping, bread and that. I mean, some of us still live on that. ((pause)) And that was the diet. So the whole ethos of drinking and smoking ((pause))

SC: Did they do a lot of it?

Jack: Well, they did. You couldn't go anywhere ((pause)) without it being in your eyes . . . If you went to a *social gathering*, and *drunkenness*, err, alcoholism was a big problem in the village. . . There's a lot of abuse of alcohol. ((pause)) IN FACT there's a whole social thing around it . . . In my view, the majority of illness is to do with life upsets, or sadness, or low spirits, or dissatisfied, jealousy, or whatever.

SC: So, in those terms, would you say there is more or less illness?

Jack: Yes there is. I see more. I see the nuclear family [he means the extended family] disappearing before our eyes . . . (a) they are all over the place and (b) they are often twice removed from them, twice married, or not married, you know. The whole scene has *changed*. ((pause))

SC: You said you used to smoke...

Jack: I did

SC: Did your father smoke?

Jack: No.

SC: What did your father think about that? Did he lecture you?

Jack: No, no, no, no, no. He just said it was bad for me. I should know better because I was a nurse. ((laughs))

SC: Is that when you started, when you started nursing?

Jack: Yes, err, err, aye. That's where I learned it, they all smoked like chimneys. Boredom in a psychiatric ward on a Sunday afternoon. Bugger all to do but smoke.

SC: How long did you smoke for?

Jack: Off and on for about twenty odd years.

SC: Do you feel guilty about that?

Jack: Not *particularly*. ((laughs)) Funnily enough, I don't even feel one bit guilty about it. It doesn't bother me. ((pause)) I stopped . . . because I went on a plane, playing golf in America . . . and on the plane I couldn't smoke. Then we got there. Then the bloke I went to... my wife's brother - well off like. Anyway, we went across to see him. ((pause)) 'Welcome, the only thing I've got to say to you is that you can't smoke in the house' . . . to cut a long story short, that's why I stopped.

Generally speaking, most people emphasised mechanical cleansing strategies such as diet and exercise - although definitions of what constituted a 'good diet' varied by social class. As noted, however, many men, whilst mentioning lifestyle factors very briefly, were much more reticent about articulating explanations and definitions of illness, including its causes.

SC: What do you think are the most important things that cause people to become unhealthy?

Lawrence: ((pause)) I dunno. ((pause))

SC: So you can't really identify a particular cause for the heart attack. If I was to ask you what caused it, you could not really pin it down to anything.

Tim: No, because I was retired when it happened and I had no tension or owt like that.

SC: So when did you start thinking about your health, was it when the breathing problem started?

Don: No, err, I couldn't really tell you when I started thinking about ((pause)) elth. I think it's just, err, I think it's just... ((pause)) ((sighs)) ((pause))

SC: Did you just carry on until you realised that you couldn't do all the things that you wanted to do?

Don: Na, I think it's just, sort of like, erm... ((very long pause))

In particular, moral cleansing strategies that offered biographical coherence were used to explain illness. Thus, the importance of family and friends, staying active and work lives were mentioned above. Religion was another source of cleanliness, used by some.

SC: What do you think about people who say that it is all [illness] the will of God really?

Paula: I think life is mapped out for you really. I thought me mam is having a word with him up there and she is telling him...

SC: Your wife said that she says prayers. Was she joking?

Tim: No.

SC: Do you say prayers?

Tim: Yes, yes, when I get to bed at night. Whether its genuine or whether it's superstition if you don't say em tonight - then something is going to happen to you - I don't know . . . There's a lot of inexplicable things happen isn't there. I mean, these kids with leukaemia and that . . . you read about these things - miraculous happenings...

Elsebeth: Well, what I think I am trying to say is that I don't understand. But really, there aren't many people who really do understand these things . . . This is what I meant when I said that we are made beyond the comprehension of which any of us can understand. The complexity of any system of the body... They are all incredibly complicated. It's miraculous really. And I think we can't understand because it's God's work.

Joyce: I prayed and prayed for that boy [her son].

The idea of a Christian God was all important, then, to Paula, Tim and Elsebeth, and 'he' was seen to be health generating. For Jack, religious values involving staying active and serving others generates health. This he defines as the 'Protestant work ethic'.

SC: So, are you healthy?

Jack: For the lifestyle I live in, yea, . . . I would say I'm healthy.

SC: What kind of lifestyle do you live in?

Jack: Well, I do, err... I play golf, bowls, run Age Concern, ((laughs)) err, help with the pipe band, ((laughs)) err, take Gaelic classes, and err, have a wide circle of friends, Irish, Scottish and English. And I've not got enough time to maself sometimes. If you were to ask me what I do during the day, I have no idea. ((laughs)) So, it's the old Protestant work ethic, if you like. ((pause)) So, you put yourself in a situation where you are doing things. Where people need you.

SC: So does that make you healthy?

Jack: Yea.

SC: Doing things for other people?

Jack: Yea, I think I would say to myself: 'I'd be unhealthy if people didn't want me anymore'. ((laughs)) I know that sounds stupid, but that's how I see health. ((laughs)) . . . Yea, I think it is a fundamental belief that's, err, if you did more for other people than you did for yourself... It's the old Scottish Christian Socialism.

Being connected in a way which is morally useful, then, is what being healthy means to Jack. This is highlighted by the importance he gives to the abstract principles of what he refers to as 'Scottish Christian Socialism'. When he feels he can no longer live up to these ideals, then he will be unhealthy. Morally, and in metaphorical terms, being useful to others is how he cleanses himself against illness.

On the other hand, whilst highlighting the importance of feeling that they belonged to a community with shared sets of beliefs and values, many would implicate magic or luck as important. Indeed, this mirrors a very traditional view, prominent in pre-modern Europe, of illness as random, feckless and capricious (Sontag 1978). Thus, despite the use of science to expel mystery and metaphysics from illness beliefs, detailed so imaginatively by Foucault (1977), what some writers now typify as a postmodern world (Bauman 1991; Lyotard 1984), has led to a re-enchantment with the everyday world. This view is illustrated in the data.

Fred: As I say, I have been very lucky.

Elsebeth: I have had a charmed life. I had never had any major illnesses.

Ros: I just kept going on and going on [when she was younger]. I never knew what time it was and I never ever knew how very, very lucky I was either.

Illness themes

As in the case of medicine, data revealed many contradictory ideas about illness. **First**, illness concepts amongst the interviewees contained multiple meanings. For example, illness was regarded as an external agent caused by society, similar to the findings in the French study. On the other hand, illness could be seen as an individual responsibility whereby inactivity or, to a lesser extent, factors such as diet and lifestyle generally had led to illness. **Secondly**, as noted above, many perspectives could be regarded as medicalised. **Thirdly**,

the influence of social and personal time seems to have had a significant influence in the way interviewees conceptualised and managed illness. For example, in terms of social time, a strong belief was presented that when the interviewees were younger, society was characterised by much more communitarian or reciprocal social arrangements and this was perceived as a significant source of health. In this type of society people were said to be polite and courteous to each other, and doctors had much less impersonal relationships with patients. Working class communities as well as geographical communities were thought of as supportive of each other, and crime was said to be much less prevalent. In short, the world was considered a much nicer place and, as a consequence, illness was much less prevalent. Relatedly, many interviewees maintained that they adhered to values and beliefs which reflected the social arrangements of society in their formative years. In particular, the idea of community was very influential amongst the interviewees. A strong belief was represented by most of the interviewees that reciprocal social arrangements, helping others and engaging in activities which involved shared values and beliefs such as the work ethic, collectivism generally, or those deriving from Christianity were held to be ways of combating illness.

Fourthly, similar to the findings in the French and Scottish studies, illness was regarded as destructive, as something which involved continuous struggle. Therefore, maintaining activity, which for most involved engaging in pursuits which involved social contact, and for many, benevolent and altruistic social exchange, were seen as key ways of combating illness. Indeed, many maintained that they stayed active, despite what could be thought of as extremely debilitating threats to their health. Ageing was largely represented as involving an increasing incidence of illness. Therefore, similar to the Scottish study, many of the oldest people accepted illness as a natural phenomenon with which they had to live. Similar to Williams' explanation of illness as a 'loss to be endured', many thought of it as something they could do little about and that they had to accept. In many ways, therefore, illness concepts merged into the way ageing was regarded. Each was thought of as a sign of physical decline and mortality. In detail, the way in which illness was represented by the interviewees can be summarised into five main themes, which are shown below:

1. *Illness as controlled by social reciprocity*

- a) If I engage in activities which involve helping others, I can resist or accommodate my own health concerns, and/or
- b) If I engage in activities which reflect the values and beliefs important to me throughout my life, I can prevent or cope with illness and/or
- c) If I am involved in hostile social relations, they can make me ill, and/or
- d) If I have an untidy mind and untidy social relationships I will have an untidy body, and this will make my condition worse, and/or
- e) If I am on a low income, then I am most likely to become ill.

2. *Illness as the 'other' which needs to be fought*

- a) I must keep up my defences, because illness has the agency to cross my boundaries, and/or
- b) I need to be on my guard because illness is invisible, and/or
- c) Illness is evil and/or
- d) I need to be careful about diet and exercise to prevent illness and/or
- e) If I am ill, it limits or prevents my social activities and relationships.

}

3. *Illness as the presence of symptoms*

- a) I know that I am ill when I have certain biological symptoms and/or
- b) I know that I am ill when I don't feel well.

4. *Illness as part of the ageing process*

- a) As my body wears out I cannot avoid experiencing more illnesses.

5. *Illness as a mystery*

- a) I don't know why I have this illness, it is inexplicable , and/or

- b) Illness is the will of God and/or
- c) I have been lucky, I have had few illnesses.

In these typical autobiographical statements some consistent patterns are present. The first and strongest involved a combination of controlling illness through 'worthwhile' activities associated with the imagined community (1a and 1b) and acceptance that ageing involves more frequent illnesses (4a). This pattern resembled Williams' explanations of illness as 'controlled by normal living' and 'as a loss to be endured'. Many felt that, if possible, illness should not be allowed to curtail normal activity. Indeed, the latter, in itself, was seen as a source of health. These feelings were often combined with the view of resignation or acceptance that illness could cross boundaries (2a) and bring about a sense of loss of self and capacity. Further examples of the way the body/self and social relationships was seen as interrelated came from those who had experienced fraught relationships with significant others. Thus, one woman talked of how a divorce had affected her health, as did one of the men. In addition, many of the women regarded normal activity as something which brought together mind/body and the social. For example, stress was placed upon keeping homes clean and tidy and in maintaining physical appearance. As one of the women put it: 'If you keep a tidy mind and a tidy house' then you will have a tidy body. In other words, illness is controlled by setting up boundaries of order which bring together self/body and the social world as a means of keeping out impurities. In addition, several of the men made an explicit link between the body and society where they talked of social inequality as a root cause of illness.

In general, normal activity involved helping others via activities such as voluntary work, caring for significant others and generally acting as a source of emotional and physical support for other older people. Thus a strong moral dimension underpinned what many regarded as normal activity, encompassing the resources of working lives, religiosity, friendship and family bonds. Therefore, keeping active was held to be the right thing to do because it was influenced by sets of moral values and beliefs which acted as prescriptive strategies for living. Given the moral certitude attached to these values and beliefs, they were held to be natural strategies which would combat illness.

The second consistent pattern was to combine aspects of illness as controlled by social reciprocity with some or all of the aspects of the view of illness as the 'other' which needs to be fought (2a, 2b, 2c, 2d and 2e). The latter premisses are similar to Herzlich's 'illness as destructive' and Williams' illness as a continuous struggle.' Bringing together mind, body and social context, the idea of keeping up one's defences was important. In terms of its negative consequences, illness was regarded with some hostility as a destructive force (2b, 2c and 2e). In response, interviewees not only looked for help and support at the level of social activity and relationships, but monitoring diet and exercise was generally mentioned. However, versions, of what constituted a good diet could vary by social class. The oldest from Hull emphasised the importance of meat in their diet - 'sausages and bacon', as one put it - whereas others tended to stress the importance of combining different foods in the diet such as meat, fish, pulses, vegetables and fruit.

Thirdly, illness was partially regarded in a mechanistic way as involving the presence of symptoms (3a and 3b). In a sense this reflects Herzlich's health 'as mechanical' and Williams' health as being 'free from illness and disease'. However, this was the rarest way illness was regarded in this study. Above all, illness was something which curtailed activity. Thus, despite the presence of severe symptoms such as cancer, osteoporosis, poor mobility and heart conditions, if some kind of activity could be maintained, most did not regard themselves as being ill. Thus, whilst ageing was acknowledged as a natural wearing away of capacity and increased vulnerability to ailment, the label 'ill' was associated with being old and a sense of finality or death; its connotation as an immutable category, then, was rejected by almost all of the interviewees.

Fourthly, the rejection of the label 'ill', was not unequivocal. For example, after explaining how her bowel cancer and other ailments had not stopped her helping others, Evelyn seems to have a sense of uncertainty about the merits of a medical definition of illness as the presence of symptoms. Thus she then goes on to state: 'I don't know if I am healthy or ill'. In this fourth pattern, then, the ambiguity of illness as both a metaphor for old age as well as a biological category seems to have caused some confusion amongst interviewees who had accommodated illness.

Fifth, illness was conceived as something which was not always understandable. I have, therefore, termed this pattern 'illness as a mystery'. This ranged from a view of illness as too complicated for lay or expert understanding, to something which was due to the 'workings' of God. Within this continuum, the theme of illness as a consequence of bad luck can be located.

In general, and in keeping with the literature mentioned above, medical knowledge, folk or lay culture and general values and beliefs, dependent on biographical context, were very prominent. They were resources to be drawn upon and reconstructed into meaningful narratives to conceptualise illness. Concepts of illness, therefore, showed 'multiple meanings' (Kleinman 1988; Stainton-Rogers 1991). However, these were the illness concepts of older adults. Thus they drew upon values and beliefs that had sustained them throughout their lives - for example, work and social reciprocity. In addition, later life was seen as a time when the importance of close family, social contact and/or religion were appreciated more. When making sense of illness, these factors played a part in 'narrative reconstruction' and 'explanatory sympathy' as coping strategies amongst the interviewees. What the data also reveal is that the invocation of imagined community was imperative in the way interviewees regarded doctors and illness, and in related interactions, coping and management strategies. The following chapter examines the invocation of vocabularies of motive in beliefs about ageing and death.

Beliefs about ageing and death

Introduction

Like the other analysis in this study, this final data chapter explores the idea that beliefs take on distinctive meanings which reflect interviewee embodiment; that is, there is a key relationship between ageing and beliefs. In addition, the idea that beliefs reflect different vocabularies of motive is explored. In doing so, it is asked if imagined community can be regarded as the dominant vocabulary of motive in the data. Moreover, on empirical and conceptual grounds, it is argued that beliefs do not always parallel popular stereotypes.

First, however, it will be useful to expand upon previously introduced arguments on how 'old age' has been popularly understood in different historical periods. As writers like Philippe Aries have pointed out, prior to the twentieth century, the average life span was relatively short and most people, apart from elite social groups, did not live beyond middle age (Aries 1965; 1974). With a relatively small number of people who were considered to be 'old' prior to the 19th century, little research focused on social aspects of ageing before World War 2 (its medical dimensions were the exception here). However, this does not mean that historically, popular concepts of 'old age' did not exist. Moreover, as noted in Chapter Three, it is not possible to state categorically that, in the past, older people were regarded in a more positive light than they are today.

Post-war theories of 'structured dependency' emphasised how older adults became increasingly stigmatised in association with their withdrawal and disengagement from the social world (Townsend 1957; Phillipson 1982). Without question, particularly with the onset of compulsory retirement in the early part of the twentieth century, the economic dependency of older people contributed to negative stereotyping and increased stigmatisation of the term 'old'. In addition, older adults were stigmatised through political and cultural means (Turner

1989). For example, in times of economic recession, older adults, who have been forced out of the labour market by compulsory retirement - where the evidence suggests they are still capable of productive work (Phillipson 1998) - can be subject to a 'politics of resentment' from the general population (Turner 1989: 591). Culturally, as noted, Western society has idealised youth and this has further stigmatised 'the old'. This 'culture of narcissism':

defines [older adults] as useless, forces them to retire before they have exhausted their capacity for work, and reinforces their sense of superfluity at every opportunity. (Turner 1989: 596)

Confronted with such powerful negative stereotypes, some older people respond passively, accepting a disengaged or dependent role. Others may refuse the imposition of such negative stereotypes and show themselves as active and alert (Thompson *et al* 1990 1992; Williams 1990). As a consequence, older adults may associate the label 'old' with others who possess the stereotypical attributes, preferring to describe themselves as 'older' (Sidell 1995). Indeed, most of the interviewees refused to represent themselves as old. However, ageing continues to be thought about within the context of these stereotypes. They serve as a source or a springboard for both active and passive attitudes to later life.

More recently it has been argued that, whilst negative stereotypes dominate in Western society, rapid social change has produced a more diversified 'later life' (Blaikie 1999; Featherstone 1995; Featherstone and Hepworth 1986). More people living longer and healthier lives is an important reason for this development. In addition, those with the ability to pay are becoming increasingly targeted by merchandisers selling goods and services associated with lifestyle choices far removed from negative stereotypes of 'old age'.

Contemporary ideas about ageing, then, encompass both positive and negative imagery. While ageing continues to be stigmatised, there is growing evidence of more positive and less ageist ideas and representations - particularly with the growing integration of older adults into consumer society. Both positive and negative ideas about later life are evident in the interviewee data discussed below.

Beliefs about ageing

When talking about 'old age', the interviewees, like the Scots (Williams 1990), offered prescriptive explanations and strategies which made sense only when the meaning of the term 'old' was clarified. What follows, therefore, is a typology of what 'old' and other associated terms meant for the interviewees. In addition, the constitution of such meanings is explored in relation to the way they can be understood to reflect a playing out of different vocabularies of motive.

Most commonly, later life was regarded as a continuing process which encompassed early old age and deep old age. The way these two phases were regarded were very similar to the Scots views, although the main difference was that the interviewees did not regard them as mutually exclusive categories. The former involved activity and relatively high levels of physical and mental capacity. The latter involved increasing illness, dependency, pain and withdrawal. It was a clear indication of the proximity of death. Most of the interviewees saw in themselves attributes from both ends of the spectrum. Nonetheless, very few would, classify themselves as being old. Rather, they were 'getting old' or 'older'. For the interviewees, ageing was seen as a time of gradual decline, slowing down and as something involving a process of acceptance.

SC: What about when your physical appearance started to change? ((pause)) I mean, dare I say, grey hairs [and

Beverley: [well, no it never bothered me because... I was salt and pepper in my thirties.

Kate: I was grey when I was nineteen.

Unidentified
voice: It's inevitable.

SC: Don't you ever think: 'Well, it's the will of God'... [which can be used to explain illness].

Delia: I just think its old age.

Enid: I think its age.

Cheryl: Well . . . you alter as you get old.

Emma: I think when you get older things do come.

SC: You have all said ageing [causes illness].

Emma: Yes, it's nature.

SC: Well, can you fight nature?

Will: How do you fight fire and water? It is something that is inevitable and you can't stop it.

SC: Do you think that your health is different now to when you were in your fifties?

Tim: Oh, yes.

SC: How?

Tim: ((sighs)) Well, it's the age business that's all. I'm unable to do at seventy what I could do at fifty.

The acceptance of gradual decline was also associated with impending mortality.

Fred: You see, I think that when your time comes, it's your body; it cannot take anymore of life's strains.

Demonstrating a conception of possessing the attributes of early and deep old age, Beverley will not go to 'old people's meetings' even though she recognises that she could be considered as being old.

Beverley: It's [ageing] not a disease as such () . . . I don't go to any of the ((pause)) old people's meetings, because I don't consider myself to be old, although I am, ((pause)) err, old.

The following extract brings together the idea that mind, body and social identity are deeply intertwined with each other. In this case the body is held to have affected personal feelings about age-based identity.

SC: When you said you were feeling your age, can you remember how long you have been feeling like that?

Tim: Just this last year, 18 months possibly.

SC: Why do you think that has happened?

Tim: Well, I felt too young before. I should have felt like this previously. Talking to one of the few chaps who are still alive, they have felt like this for years - and it's just come on for me. As I say, how are you expected to feel when you are 71?

Unlike stereotypical representations of the body emphasising health and youthfulness, and, conversely, that physical decline and illness are abhorrent (Bytheway 1995; Featherstone and Wernick 1995), the 'aversive properties' of old age were seen as unavoidable. What this reveals, then, is that physical experience can be considered as a vocabulary of motive. Thus when 'your time comes' there would be a gradual slowing down in the day-to-day pace of life and in bodily capacity.

Lawrence: I think your whole life changes. It's much *slower*. After retirement.

The pace of life slows down as does the physical capacity of the body. The latter was referred to most commonly.

Emma: You start to slow down. You know that you are getting old when you run for a bus and you can't get on it. It's after about 65 you start to slow down.

Edith: I can't walk far. Yes, that's when you know you are getting old.

However, many found alternative activities which they offered as prescriptions to accommodate ageing. For example, instead of going out at night because of tiredness, one could go out during the day.

Jane: I think [you do not want] to go out in the evening because you start getting rather tired by then.

2 or 3
voices: Yes, Mmm.

Joyce: You haven't got the motivation to [get

Claudia: [to get ready to go out.

Joyce: If you have been out during the day, you are quite happy to stay in your home.

Claudia: To go for a meal now. I used to love going out for a meal in the evening. ((pause)) But now, eight times out of ten we go out for lunch. Rather than an evening meal because I get [so tired

Joyce: so tired. [you get

There were lots of things which could not be achieved, but despite this, and in Emily's case, also having to care for a dependent partner, she could still find things to do.

SC: Do you think there are differences in health between somebody of your age [70] and somebody who is in their fifties?

Emily: Mmm. They can do a lot of things that I can't. They can do gardening and everything. . . . But, you see, my husband had a heart attack four years ago. I look after him and I still find a lot of things to do.

As well as a general acceptance of ageing as decline, frustration was also expressed. Thus, as noted in Chapter Four, a minority of women felt dismayed by the appearance of grey hair and wrinkles. Frustration also clustered around the view that a decline in constitutional strength had to be endured. These feelings are evident in the following data, even though the notion that this loss has to be faced and accepted is also expressed (my emphases in bold).

Emma: **You can't fight things like you did when you were younger.** I think: . . . 'Oh, don't be stupid, you can do this, you could do it before.' And I can't. It's just getting old.

Evelyn: I think **now that I am older all of these things that have happened to me annoy me** because I can't do the things that I could do when I was younger. I think having a heart attack when I was younger. I mean, now I know when I have had enough, I can tell.

SC: When you said you were feeling your age . . . what did you do before you felt like that.

Tim: Well, I walked a lot further.

SC: Are you seeing anybody about your health at the moment?

Tim: Well, I go to diabetic clinic . . . which the doctor says is age more than anything else.

SC: So, does this coincide with you feeling your age?

Tim: ((pause))

SC: Has it depressed you at all?

Tim: Oh, it **made me feel miserable**, being ill at all. Having gone so long. The first time I was ill I was 63.

SC: Do you ever feel that you are being patronised by younger people because of your age?

Claudia: No, not me.

SC: Say, in the shops?

Beverley: No, not really [because

Claudia: [No, not really.

((a number of them start talking at the same time again))

Brigette: I was in the dentists.

Beverley: My () would say to me 'Don't go to the bingo.'

SC: You were patronised at the dentist?

Brigette: I was ((pause)) helped up the stairs and helped down. ((laughs))

((chorus of laughter))

Brigette: I felt terrible.

SC: But did you need help?

Brigette: Yes, I do. I can't do a whole flight of stairs. ((pause))

SC: But you still resented it?

Brigette: I did, I did. I was annoyed that age had come on so quickly. ((laughs))

((chorus of laughter))

Brigette: But, erm, he said, err: 'Don't stop coming because we have got a surgery downstairs.' I wished I'd known that before. ((pause))

Claudia: Stress is an illness. To be depressed or anything like that is an illness.

SC: So what sort of things cause stress?

Beverley: Well, not being able to do what you could forty years ago. ((pause))

SC: Does that cause stress?

Beverley: Yes, ((pause)) well to me it is. I get frustrated if I can't do [it

Joyce: [yes

Beverley: and I will do it if it kills me.

Jane: I think you are less [tolerant

Beverley: [I mean, I was nursing and I always used to say: 'If you can accept your illness, you are 90%...' ((pause))

Claudia: [Cured

Beverley: [Cured

Claudia: Yes.

Beverley: But I can't do... I can't accept what I [can't do.

Claudia: [no, I won't accept what I can't do and I will go to the very, very limits of everything ((pause))

Beverley: Yes, I do.

Claudia: But then, two or three days I have just go to lay down [and

Beverley: [you've got to

SC: So how does that make you feel, frustrated, annoyed or ((pause))

Claudia: No, just helpless. You can't do anything.

Catherine: **I am frustrated about what I can't do meself.** ((pause))

Beverley: And the family sort of say: 'And you don't want to do it on your own. You've got help. But you are too independent to ((pause)) ask for help. ((pause)) So I think: 'Oh well, if I die swimming, then I will die happy.

Claudia: Yes

The two ends of the ageing spectrum: early old age and deep old age

Paralleling Laslett's theory of the 'third age' as a time of personal fulfilment (Laslett 1987 1989), early old age, was often seen as a release from the drudgery of working lives, a time for leisure, choices and new challenges. On the other hand, many found the early period difficult and said that they missed work. Thus, Lawrence found retirement a release, but the first year was difficult.

Lawrence: I think your whole life changes, it's much slower after retirement. ((pause))

SC: So why did you retire?

Lawrence: Well, I'd just had enough. I'd been there forty years. ((pause))

SC: It wasn't through your health?

Lawrence: No, no. ((pause))

SC: Did you miss work?

Lawrence: The first year I did, yes. The first year I found difficult. The transition period. But I wanted to get away from the pressures of work. The only thing I had in mind when I retired was to take it easy.

The villagers were most likely to talk of relaxation and holidays. Ros and her husband can afford to go when and where it pleases them.

Ros: We can afford it, we can go when we like, and where we like and really that's what it is all about, isn't it.

Tim had highlighted how illness and his low income had restricted his ability to travel. Yet when I asked him and his wife about having holidays he said:

Tim: Well, every day is a holiday, is it not?

Like many others who felt that retirement was a release, Tim had been glad to get away from the pressures of work.

SC: Was it a big shock when you stopped work?

Tim: No, it was a delight. I retired early . . . those idiots they were bringing more and more in who were telling me how to do a job that I had started 30 years earlier. I had the prospects of having a major barny by 8.30 every morning. So I said I was taking early retirement and on the Friday I left.

In other words, he had retired because of conflicts with younger people. He disputed their views, feeling he was correct because he had much more working experience. For Tim, the increasing employment of younger workers was also responsible for the demise of industry.

Tim: They were as glad to get shot of me, as I was to leave.

SC: How old were you?

Tim: 63.

SC: So, it wasn't that early really was it?

Tim: No, 16 months.

SC: So, this was because of the younger people that they had brought in?

Tim: Yes, yeah, nnn.

SC: Was the firm expanding?

Tim: Not really.

SC: Then how come they brought in so many younger people?

Tim: Oh, I don't know. This is industry isn't it. This is why things are in such a state.

SC: Are you saying that decisions and responsibilities should be left to people with more experience?

Tim: Without any doubt.

What we see in Tim's talk could be interpreted in the sense of Mannheim's (1952) explanation as a feeling of cohort or generational identity. Thus, members of Tim's imagined community are older adults who have the experience to do a job properly. In addition, Lawrence's account of finding the initial period of retirement difficult after a working life of 40 years, indicates the habitual influence of the work ethic. Indeed, the work ethic has been described as something which is very influential in society (Grint 1991; 17-32; Rose 1985). This influence appeared prominent in the data and, it is proposed, served as a key vocabulary of motive which acted as a spur to engage in an active retirement.

It was very common for interviewees to emphasise how they stayed active; this could be mentally through 'activities of the mind', or in social and physical pursuits involving leisure activities, and helping or befriending others less fortunate than themselves, or everyday activities like gardening and do-it-yourself. Even doing formal work in a garage on an unpaid basis was mentioned, as was maintaining regular exercise regimes to 'keep young'. Activity, was often explained in moral and, more rarely, religious terms as something which was 'the right thing to do'. The activity itself was sufficient reward. Indeed, this moral gospel of activity can be seen to reflect Samuel Smiles' often quoted religious maxim that: 'Heaven helps those who help themselves' (Grint 1991: 18). Activity, therefore, became a moral or religious duty, which also represented the continuity of working lives. In addition, Ekerdt's notion of the 'busy ethic' finds parallel here; that is, the idea that people carry the work ethic with them into retirement. For Ekerdt, the busy ethic counters the view of later life as degeneration as it:

legitimises the leisure of retirement, [since] it defends retired people against judgements of senescence, and it gives definition to the retirement role. (Ekerdt 1986: 243, used in Blaikie 1999: 175)

As Grint (1991: 26) argues, work has considerable status in popular values and beliefs. Moreover, it can be added, this is usually more marked for older adults. In this context, Williams (1990) usefully depicts a number of values of work. These, it is argued, can be applied to the data. They involve:

a value on work as some kind of self-discipline, as the ability to defer gratification, to pursue duty as opposed to pleasure, to follow a punctual and orderly routine; second, there may be a notion of work as effort, diligence, skill, or high standards; and third, there is usually some concept of work as a source of basic personal worth in the eyes not so much of others at work as of others anywhere in the web of common relationships . . . [fourth,] A commitment to work in terms such as these may be quite distinct

from a commitment to employment; and with the retired . . . there is an opportunity to explore what range of activities this notion of work and its equivalents can cover. (Williams 1990: 223)

In particular, the data reveal the merits of Williams' explanation of the values of work in terms of (a) pursuing duty and (b), whilst not as prominent, as a personal source of worth in the web of common relationships. As a key vocabulary of motive, the work ethic was most commonly played out along altruistic or communitarian lines.

Although not an exclusively male preserve, men gave formal work most prominence. Some of the more educated women stressed the value of their previous paid employment.

Ros: I had a mixed business which was very, very hard work. . . . and it was very good to me. . . . I loved work it gave me satisfaction.

Women from Hull described working lives very much in a domestic context, accounts which reflected Cornwell's (1984) data. Fred who had been an industrial worker throughout his life still engaged in productive labour.

SC: But what does healthy mean to you?

Fred: I . . . do a bit of woodwork. You know, I can spend all day doing that.

SC: You do woodwork? Do you do DIY and things?

Fred: Yea. ((pause))

SC: Do you sort of make things and stuff like that?

Fred: Well, I have done for me son in law, I made him two stands for his, err, his store for his honey. I made him a bee hive. It started off making things anybody wants, ((pause)) I go. And I do things in the house. I go and do it. I still have my woodwork tools from being a shipwright. . . . Oh, I made a bookcase, err... And a table with folding legs ((pause)) that you can fold up. I got two cabinets and made them into big carcass [he made a large cabinet out of two smaller ones]. I can do anything, you know. ((pause))

As a custodian of the work ethic, then, Fred can be considered to have transformed this into the busy ethic in his retirement. He is also active in an equal rights organisation for pensioners and a trade union. He has been a member of the latter since the early period of his working life. His membership of these organisations could be regarded as reflecting a sense of duty. Relatedly, in the extract he takes great pride in his woodwork.

Given the importance of the work ethic, retirement could bring a sense of loss. The following extract shows Will's strategy to recover the rewards of work. Between the ages of 65 and 78, he did unpaid work in a garage. Will 'didn't want paying', it was 'something to do', as he was 'mekin meself useful', and it 'got me out of the house'. Indeed, work itself seems to have been his major form of currency in retirement. He only stopped when he became physically incapacitated after a heart attack, when he became 'poorly'. However, 'Ernest' from the garage still takes him out for a lunchtime meal every Friday.

Will: And if I ad been allowed to I would have still kept on ((in the last job before retirement)) because . . . I enjoyed the job.

SC: Did you retire because you had to?

Will: Yea, I had to retire at 65?

SC: Was that a shock to you then, retirement?

Will: No, it wasn't a shock, I was BORED. . . . ERRR, I accepted it. ((pause))

SC: Where did you live, for example?

Will: Well, They found me this flat. ((The one he is in now)) You see, I had me name down. I lived in at Isaac Robinson House. It was residential, you see.

SC: So what sort of things did you do to fill in your days when you were retired?

Will: I put ((pause)) some enquiries out about ((pause)) err, just some general work, helping out ((pause)) on the wards in the err, ((pause)) ospital. ((pause)) I was told that IF ((pause)) I did get a position, even though it was voluntary, ((pause)) it would mean that I was doing the work of a union man. So that was ruled out.

Will's sense of ontological security includes the narrative that trade unions exist to protect jobs. For Will, unionised workers are part of his imagined community. Thus, he will not consider the voluntary work for fear that 'I was doing the work of a union man'. After this experience, he found work in a local garage.

Will: Every afternoon . . . I was up at the garage. ((pause)) Well, you were meeting different people, ((pause)) coming up for M.O.T.s and... ((pause))

SC: So, what did you do at the garage, then?

Will: Well, I just used to () see if the lights were alright and, err, braking lights, you know? Generally ((pause)) messing about. Cleaning garage up, sweeping up and all that kind of thing. Anything to fill me time in. ((pause)) And I really enjoyed it. An I was there for nearly 13 years.

SC: 13 years?

Will: Oh aye. ((pause))

SC: Did you get paid for that, then?

Will: NO, NO, NO, NO. ((pause))

SC: Did you not want anything for it?

Will: NO. ((pause))

SC: Did they not offer?

Will: He offered, but it was... ((pause)) He was just something that I... It was just something to do. ((pause)) I, err, mm, I mean, I **was meeting different people, meking meself useful to someone.** ((pause)) And, err, ((pause)) payment didn't enter into it. (my emphasis in bold)

SC: So why did you stop doing that?

Will: That was with that... I haven't been up there since I was poorly. ((pause))

SC: Since you collapsed?

Will: Since I clapsed. ((pause)) And I was going up there right till the day before I clapsed. ((pause)) . . . The thing was, it got me out of the flat, were I would have been just sitting on me own, ((pause)) just feeling sorry for meself and vegetating, ((pause)) probably.

Will: Now, every Friday dinnertime, Ernest, who was at the garage that I used to go to... Every Friday he will come down ere ((pause)) and he will pick me up ((pause)) and we will go out ((pause)) during his dinnerbreak and that. ((pause)) Now then. It is usually ((pause)) somewhere ((pause)) where they serve bar meals and that. You see? . . . So, we ave a meal. ((pause)) Then ((pause)) we will ave a drink. ((pause)) . . . and we sit there and we ave a right good ((pause)) natter and that, you know? . . . and then he brings me straight back to door again, which is great for me.

The main narrative in Will's talk could be summarised as follows. Work offers the prospect of doing something useful. Therefore he is following a duty and asserting his membership of a moral community (he does not want financial payment): this and the fact that he meets other people, as opposed to 'vegetating' alone in his flat, is reward enough to him. The narrative also has a happy ending. Despite his heart attack, which made him stop working, 'Ernest', the garage manager, now takes him out for a weekly lunch and drink. Will has also been invited to Ernest's for Christmas, but does not want to go because he thinks he will be a burden. In showing that he has gained a personal sense of worth in his relationship with Ernest, he is, therefore, giving further evidence of the belief that being rewarded for work by payment is unimportant. What is being highlighted is that work has given him lasting friendship and companionship.

The sense of duty in maintaining useful activity also illustrated a feeling of wanting to connect with people in need and 'putting things back into the community'. The views represented in the following extracts reflect a consensus that helping others or doing something useful is the most important attribute of successful ageing. For example Jack's idea that he would be unhealthy if nobody wanted him sums up this view and is therefore quoted in the title of the study. Similar feelings are expressed in the extracts below (my emphases in bold).

Beverley: Well, I'm Beverley Slough and I'm aged seventy six. **I'm a voluntary helper.** ((pause)) I had fall four years ago ((she talks of four fractured vertebrae)). But, errm, I don't consider myself *ill*. It's not a disease as such () And, err, I feel as though **I must get out and help.** I don't go to any of the ((pause)) old people's meetings, because I don't consider myself to be old, although I *am*, ((pause)) err, old. But, err, **as long as I can get out and help other people, I'm happy.** I can't walk very far, but I won't give up and, err, I am quite happy to come and do voluntary work. ((pause)) And I live on my own, my husband died twenty years ago. So, ((pause)) I have had to go into a flat from a house, err, so, err, ((pause)) **I do me best.**

Claudia: I get out as much as I can . . . And I think it's a good thing to be able to get out and there are such things for people who will ((pause)) **do voluntary work.**

Ros: Well, I went with my friend to do the flowers and I thought: 'This is lovely. I think I will come here. ((pause)) I also think by **getting involved in the activities that the church does you are putting things back into the community,** ((pause)) which is well worthwhile. Because, you see, we are having a fair on Saturday. Well, we all do baking and things like that, things for the Tombola and we go and serve... And **it all helps,** doesn't it.

Edith: I been with Age Concern for three years, I work in the charity shop for Age Concern and I am a chaperone on the bus for Age Concern. ((pause)) I was bored, type of thing so I went to work in the shop. I like working with the old people and I am getting on a bit too. ((laughs)) **I feel I should be getting out and doing something,** I'm not tied to the house. ((pause)) I was hovering up for something to do.

Despite the fact that social differences were held to remain in later life, older people were said to be able to 'bond together'. Jack was active in his local Age Concern and I asked him about social mixing.

SC: Lionel ((contact person for Age Concern in the village who referred me to Jack)) said they don't mix ((in Age Concern)).

Jack: ...some are from the housing estate. Some are from the bowling club. Some are the middle class, well off. **The men all sit together. ...they do bond in the sense that if they are ill they will visit each other. And they bond on bus trips and things like that.** But the normal gossip, errm, they don't bond. They sit in their own groups. ((pause)) That's understandable, because they have more to say about the housing estate. I mean, they are

not interested in what people's shares are doing. You see, if you go around the tables and keep your ears open there are different discussions. The housing estates talk about who gets benefit, why does she get that, all that sort of thing.

Tim maintains that it is being friendly and sociable which helps his wife feel young.

SC: Do you think your health is different from your wife's?

Tim: Well, I should say that my wife is much younger in years than I am. Not in age, but in general attitude. You know, **she is much healthier than me. You know, friendly more sociable, etc. She's a much nicer person than me.**

Those still in work (3 working class men) looked forward to retirement as a release from the day-to-day drudgery of work and as an opportunity to be spending more time with partners. In particular, Dave was looking forward to retirement to allow him more time with his wife and for increased leisure activities.

SC: What about retirement, do you ever think about that?

Dave: Oh yea. . . . I have made plans to do things. . . . I think I'll get out more with the wife. ((pause)) Cos at the moment my work, . . . takes up a lot of time. ((pause)) Go fishing.. ((pause)) Cos my work takes up a lot of time.

SC: So, you are looking forward to it in terms of having more time with your wife and to go fishing?

Dave: Yea.

For Matt and Don, retirement was thought of as a time for new challenges which were underpinned by the morality of public service in voluntary work and politics.

Matt: To be able to become more *involved* in the voluntary work that I do. And to be given time to do that . . . to spend time doing voluntary work. I mean, because if I could afford it, I would retire tomorrow and do the voluntary work. ((pause))

SC: What about retirement, have you thought about that?

Don: It looks at the moment that I will probably be going towards politics. I would like to be in politics, I would like to be counsellor, if I had the chance. Of course working full-time, I know legislation allows you to be a counsellor and all the rest of it, although, at the moment, I can't dedicate my time to get as active in the system as I would like to be.

In general, deep old age was associated with being older than others and severe physical incapacity. Thus for Will, it was difficult to accept that somebody who was much younger than him in chronological years could know what it is like to feel old.

SC: Remember when that lady at Age Concern, that one who was talking about mind over matter, she was saying that: 'We get treated like children. We get people talking down to us just because we are old.' Do [you

Will: [I can hardly ((pause))

SC: Do you ever get that?

Will: No, I couldn't credit it.

SC: People never talk down to you?

Will: NO, no. And I couldn't accept it from that person really because ((pause)) she isn't old. ((pause)) ((she is 64 years old))

Deep old age was also held to involve a certain amount of exclusion.

SC: Do you feel, kind of, displaced from society?

Will: OH NO. I aren't displaced from... ((pause)) There are certain areas where you can still go.

SC: But do you feel excluded from a lot of it [because

Will: [well, you do. You do. I mean age, well, let's face it, you can't go dancing. ((pause))

Being old was seen as the final stage of life, a recognition that interviewees found painful. Feelings of dependence and of being a burden to others were also associated with deep old age. Asserting his membership of a moral community, where independence is valued, Will plans to refuse an invitation to spend Christmas at Ernest's.

Will: ...I have an opportunity to go out to ((pause)) Ernest's at Christmas time and to see their relatives and I can spend either Christmas day or Boxing day with them. But no, they are a young family, they want Christmas as we used to have it. ((pause)) Christmas is a family affair, ((pause)) they don't want to be bothered with ((pause)) visitors and that when they... You know what I mean? While I can manage, I am quite content to do what I can. I want to be independent because once you lose your independence, or if anybody takes your independence away from you, ((pause)) what else have you got left? ((pause)) What have you got left?

SC: Is that a particular source of pride to you, your independence?

Will: *Absolutely.*

SC: Does it keep you going, then?

Will: Yes, ((pause)) it most certainly does.

Will, like many of the other interviewees, wanted to maintain his independence because it was a source of pride to him - it was a vocabulary of motive that shaped interviewee beliefs.

Whilst not based exclusively in the motive of reciprocity, this way of thinking was not distinct from it. It implies the narrative that if one is dependent upon others, this will involve an imbalanced form of social exchange. One cannot give back in return the amount one is given. Given the strong moral reasoning of the interviewees, losing their independence could be held to be aversive. As Will says: if you lose your independence, 'what else have you got left'.

Ageing and temporality

As noted, temporal or social change influenced beliefs, and many felt displaced or excluded by it. Yet social change was also seen positively. Of all of the interviewees, Ros was one of the most critical about the negative consequences of social change. Even for her, however, it had good points: older adults had been more dependent in the past.

Ros: When you think of old people ((pause)) when I was a kid. When they were old they were very old. I mean, they were relying on people... Like my mother used to say... She'd make a pan of soup and she'd say, 'take this to Mrs So and So', you see. Take her a bowl of soup. Because that was how they lived. They didn't have anything else to live on, you see. I don't think I would want that kind of carry on for me.

In addition, the repressive parental authority of former years was mentioned by several people. Thus Ros 'was made to go to Sunday School' when she was a child.

Ros: I was made to go to Sunday School. ((pause)) I wasn't asked to go.

As noted above, some interviewees felt that doctors had been socially distant and aloof prior to the NHS. Tim said that he could regard them as 'equals now'. When he was younger he 'had to stand to attention to em'.

On balance, however, more positive comments about social change came from younger interviewees. Joyce's comments are typical. Here she is emphasising how oppressed she was by the disciplinary regimes of her parents and school when she was younger.

Joyce: It [school] was . . . very strict. They didn't have the cane for girls, but there was plenty of detention. . . . I didn't like the uniform. It was a horrible bowler hat. . . . Out of school you had to stay in your uniform, so that included with your hat on. So that meant all the way home. I used to get in ((laughs)) and stamp on it ((laughs)). I used to hate it. So I often didn't wear it. I would just ride boldly out of school without the hat on. And be immediately put in detention. And that would happen several nights a week. You know, and they were ((pause)) very strict

about things like that. . . . When I went out with my first boyfriend . . . my parents had never had a relationship with anybody else, apart from each other. They were very serious. And they knew each other from being very, very young. They knew each other for years and years. They were courting for years and years. Then they were engaged for years and years. Then they got married. So, they assumed that the first boyfriend would be the one. ((pause)) This lad of about seventeen, asked me to go to the pictures with him one night. And I said to them. And I was only a girl of about fifteen then. And I told them. And they thought, OOH, so soon, you know. ((laughs)) When he brought me home... He got me back at the appointed time. My father was there to meet him. And he said: 'YOU will come to tea tomorrow'. ((laughs)) I was surprised he turned up. They grilled him. What were his prospects and all the rest. . . . my parents just assumed that this was going to be marriage. ((laughs)) It was just going to the pictures. ((laughs))

SC: Did your parents want you to go to university?

Joyce: ((pause)) My mother would especially would have, but... ((pause))

SC: Your father didn't?

Joyce: My father was more...((pause)) . . . he . . . took the view . . . it didn't matter for a girl ((pause)) to have a career. ((pause)) . . . In fact, ((laughs)) he didn't want my mother to know, he said: 'Well, it's going to cost me... I have been talking to my friend who has a daughter at university' . . . He said: 'Well, I'll do it, *if* you really want to go, I'll pay for you. But', he said: 'I have to be honest, well, you don't look like the back of a bus, so you could...' You know... ((laughs)) It was the way he worded it. He said: 'She doesn't look like the back of a bus, she will get married and it will all be wasted. 'So', he said: it's up to you, think about it, but your mother has really got her heart set on it'. Which is a very ambivalent way of saying it: 'I am not that bothered, but your mother is'. He left it up to me. Well, I thought . . . why should I do it.

In the last extract she is also representing herself as being discriminated against unfairly on the basis of her gender. Thus her father 'took the view . . . it didn't matter for a girl . . . to have a career'. However, Joyce did not bring her children up in the same way. Children, as for most interviewees, were seen as having more freedom in contemporary society.

Joyce: They [her parents] certainly believed in children being seen and not heard. ((pause) We weren't allowed to talk at meal times and things like that, you know. The children are much freer nowadays. Well, my children are much freer. ((pause)) I certainly wouldn't bring my children up like I was.

Similarly, Matt described his traditional working class upbringing where he was not encouraged to show his emotions. He emphasised that this had had a negative effect on him throughout his life. He had not brought his son up in this way: he had encouraged him to show his emotions. Thus, as noted above, Matt would tend to keep concerns about his health to himself. However:

Matt: The way I ave been bringing my son up is totally different to that. And I, I mean, he as ad to go to a couple of funerals, and I ave encouraged him to cry. ((pause)) And to cry in public. And I told im that it's nothing to be ashamed of. ((pause)) Errm.

Most fundamentally, as noted in Chapter Four, bodily change was significant. For example, the distinctive ways others respond to the bodily signs of ageing in the charitable act of giving up a seat can have a deleterious impact upon self-esteem.

SC: Do people treat you differently as you grow older?

Ros: Some do and some don't.

SC: When did you notice that they were treating you differently?

Ros: Well, how shall I put it then? ((pause)) When somebody offers you a seat. You know. And you think, ooo heck, that is it.

Returning to the idea of imagined community, for the majority, social change was negatively perceived because it involved too many impurities, which were viewed as threats to the perceived value of the morally virtuous values of the members of the community. Thus, young people were seen to have little or no respect for authority and to have no sense of value.

Elsebeth: I got teased a lot when I was at school because I was shy. However, this was in a nice way, not like what you get from young people today. In my day young people had respect for authority, they knew how to behave. This is something they are lacking in today.

Ros: She [her niece] does a lot of things that I don't approve of. But, mainly she is... More or less she has got more our ideas than a lot of the others.

SC: What sort of things does she do that you don't approve of?

Ros: She spends money like water. And I don't approve of that. I have never approved of that. But she does. She buys, buys, buys. She doesn't think twice, when she wants something she will go and get it. She is irresponsible. Well, you see, I don't know... When we were kids. Matt and I knew we had to work ((pause)) and save; and if we didn't there was nobody going to give us anything. . . . She tends to keep up with the Jones's a little bit I think, ((pause)) and I don't approve of that.

Linked with the lack of respect, relationships between people are more casual today because they do not share the values of older people.

Elsebeth: I have two friends in Yorkshire ((pause)) who come over () And one of them said: 'do you realise it is fifty years to the day since we started nursing.' Yes, we still have great friendship and camaraderie and I would rather see some of that going on now. There is too much of this casual attitude now, nothing seems to mean anything anymore. So, yes we did have a lot of fun really, because you have got a ready made community.

Tellingly, Elsebeth ends her comments with an explicit reference to 'community'.

More active sexual relations amongst young people and the demise of chivalry from men towards women were also represented as signs of impurity.

Ros: I had a lot of boyfriends, but no hanky panky. That was the difference between us lot and you lot. There was never any hanky panky with any of us. And that to me is where today's people slip up. I liked to be asked to dance properly and I liked to be taken back to my seat . . . They don't do that nowadays, do they.

SC: Well, I think it's straight down the pictures, or whatever, and [then

Ros: [Bob's your uncle, it's straight into bed. Well, I think that is terrible.

Ros: ...men are not very gallant now are they, men.

When talking of a girl he had met during the war.

SC: Was she your girlfriend, or just a friend?

Tim: She was much younger and the chaperoning business was very strict then. I would have liked her to have been me girlfriend. But, of course, girlfriend in those days didn't mean sex. You know, it's a different thing now with the kids. It would just have been a case of holding hands.

As noted previously, many located meaning in their reminiscences of values of the past. Thus, for example, disdainful remarks were made about people being too selfish today. Many interviewees felt temporally displaced. Thus Ros, when talking of holidays, thought Austrians and Germans were 'old world . . . they had a sense of value . . . which we haven't got in this world today'.

Tim also conjures up an old world which he sees as virtuous when talking of his 'good Victorian upbringing'.

SC: What do you think makes you the way that you are?

Tim: ((sigh)) Well, I had a good Victorian upbringing . . . which meant that when you saw a lady in the street, you tipped your hat . . . I still tip me hat to a lady. I get a riding now from certain people, but it doesn't bother me one haporth because me mother taught me to do that, and please and thank you, and you know. She taught me to do all those sorts of things.

SC: And you [always

Tim: [I am still living under the good influence of my mother.

Significantly, he adds that he is 'still living under this good influence'.

Perhaps as a reflection of social and age differences, Joyce, who was much younger and middle class, talks of the repressive authority of her father as Victorian, in stark contrast to Tim.

Things were quite Victorian in those days. I mean, MY Father was very strict. There were girls at school whose fathers were even stricter.

Other signs of a sense of community under threat reflected Giddens' notion of a 'juggernaut of modernity' (Giddens 1991) or runaway world which excluded older people.

SC: Do you think society is changing with less respect for older people?

Will: ((pause)) Well, I don't know. ((sighs)) ((pause))

SC: I mean, people say to me that they used to say: 'Have respect for your elders. Take their advice. They have a lot more knowledge and experience than you do.' Do you think that people don't say that anymore?

Will: Oh, they don't say it anymore, because whatever advice you give them, you think they are going to tek it in, but teking notice is another matter altogether. ((pause)) I mean, the attitude seems to be, with the younger end, ((pause)) 'It's alright, but you are living in a different world, a different age. ((pause)) Things weren't as they were then as they are now. Everything is speeded up. Living is faster ((pause)) today.' ((pause)) And I feel meself ((pause)) that ((pause)) the majority verdict is: 'If you can't live with the speed of today, ((pause)) then be content with ((sad voice)) the speed of yesterday. You know what I mean? I probably aren't mekin meself clear.

Given Fred's stated orientation towards helping others (as quoted in Chapter Four), it is not surprising that he talked quite angrily about the poverty of older people after 'all they have done for this country'. At the same time, however, he would not accept that all older people were treated badly by younger people. If you don't give people respect, they will not respect you. One could not expect 'community' in social relations if one did not respect others.

SC: Some of the people that I spoke to at Age Concern said that they were patronised on the basis of their age. Do you ever find you are not getting the respect you deserve because you are old?

Fred: No. It's what they call age gap, int it? In fact, err, when we are down at the bus stop down there ((pause)) the young people there are fine to us. When the bus comes they say: 'Go on, after you.' ((pause)) I mean that is respectful, that is the way we were brought up?

SC: Some people say that some of the kids nowadays they get out of hand . . . they don't have any respect for authority. You don't agree with that?

Fred: No . . . I think you only get respect, if you give respect. Even young people need respect. You have to admit that they are people with their own idea of what they want. Err, ((pause)) and err, ((pause)) that err... ((pause)) I think you have to be experienced in the way that... ((pause)) Yes, they would like to do that, but you can't because. That's what you have to say. ((pause)) So, you are respecting them to use their mind, ((pause)) to think of what you said to them, what you can have or can't have. Err, and then, if you do that, you will get respect from them, because they will think that they must know a bit more than what they do. You see, I find, I think it's quite true, that a lot of old people, err, denigrate the young people, err, you know, they are playing outside their and they shout at them because they are playing outside the front door. ((pause)) That's not anything new, it's age old, is that. I mean, I knew an old fella who used to live near us, that, err, there was no park where we lived, you go and play football there and, err, he objected to it. He would come out and pinch your ball.

Ageing and continuity

Above all, most interviewees represented their lives as a meaningful narrative. This involved drawing upon the imagined community which as a group they saw as an important influence upon their lives. The importance of continuity in the lives of older people emerges in other research (Coleman *et al* 1998; Dittman-Kohli 1990; Humphreys 1993; Thompson *et al* 1990 1992). Indeed, it is abundantly evident in the data in the present study. Jack, the retired nurse manager, stressed that he had been brought up to believe that helping others was the most important thing in life. Thus, he would think of himself as being unhealthy if he wasn't able to do this anymore. Ros had retained the values of hard work which she said she had been brought up on during her working life which 'had been good to' her. She also liked the values of the 'old world'. Fred had always been active throughout his life and work was very important to him. These two things stopped him feeling old. In Tim's house they always had a 'good table' and they were frugal with money. This reflected how he was brought up by his mother because as a child he never 'had his arse hanging out'. Indeed, being frugal and making ends meet was mentioned as a value that had been maintained throughout life by most of the Hull interviewees.

Continuity, however, was not always a good thing. If you were unhappy in your younger life you could take this with you into retirement (Coleman *et al* 1998). Elsepeth, who revealed to me that she had always been very shy and withdrawn illustrates this view:

Elsepeth: Take retirement. Everybody says: 'Well, that will be wonderful.' It's not wonderful at all, because you take yourself with you...

As Coleman *et al* note, linking the past with the present is a strong theme amongst older people, even though the past is not universally relished:

ageing is characterised by a search to find a personally meaningful way of life which connects the past with the present. But it is important to note that not all older people have a past with which they wish to connect. (Coleman *et al* 1998: 415)

Inner youthfulness and maturity as coping premisses in the imagined community

Many interviewees were open about a decline in their physical capacities and they accepted this. However, as noted, many represented themselves as feeling young inside and highlighted the development of an inner spirit or maturity. This helped them realise the importance of the collectivity of their lives. These representations seemed to provide a great source of security which helped people cope with the perceived instability of the social world. It also seemed to re-assure them that the outward signs of ageing were, ultimately, unimportant.

Ros: I think she thinks we are a little bit decrepit [her niece] . . . because all she thinks about is age. Well, age isn't very relevant. You can be old at fifty. You are as young as you feel.

If you felt young on the inside, you were not old. As noted, Hettie represented herself as someone with growing spiritual maturity, the following extracts highlight the idea that ageing brings wisdom.

SC: Do you not think you have changed at all?

Ros: In what way?

SC: I don't know. That's what I am asking.

Ros: In what way do you mean changed?

SC: Well you have got more knowledge and experience haven't you. So you might be a bit more, you know, worldly wise.

Ros: I think you are more, more... ((pause)).

SC: Cynical?

Ros: More sensible. ((pause))

SC: Are you more trusting or less trusting?

Ros: Well, shall I put it this way, I think that when you are younger, ((pause)) they are very impressionable days. Everything you do, you try to impress. I used to give dinner parties and they had to be better than anybody else's. You know, everything. You know, when you buy a dress, its got to be... As you are going out, it has got to be outstanding. But when you get older you don't have to impress. You need not impress. And I look at people who I see who really cannot afford to do what they are doing. And I think you silly people. It does not matter. Does it? But I think that when you are young it does matter. But when you get older you know darn well that it doesn't.

SC: Do you think you have changed, then?

Matt: No, I hant changed, cos when I was younger, I suppose the way they put it, I mean, the way, I suppose that () bolshy or red, because I was ... I never conformed. I found it very, very difficult to conform. ((pause)) I was at odds with authority ((pause)) when I was younger. Errm, this was in my teens. I was forever in trouble for it, and it took me until I reached my twenties until I realised that I was being an idiot. ((pause)) And that's when things started to change. ((pause)) But, erm, up until then I was at loggerheads with everybody, ((pause)) even the union... ((laughs)) This was when I was in merchant navy, you know. I was always right and everybody was always wrong. And I found that ((pause)) ((quiet voice)) I was being a fool.

SC: So would you say you have matured?

Matt: I ave matured, yea, I mean, I still am maturing, life's a learning process. It don't matter how old you are, you are still learning.

SC: So are you more tolerant now?

Matt: I think so, yea? I am more tolerant becos; becos, emm... I think what's made me...

For Ros, therefore, her ageing has brought a sense of maturity - there are more important things than trying to impress others on the basis of appearances. Similarly for Matt, even though he is much younger, his ageing has brought maturity - this means 'not being at loggerheads with everybody anymore'.

Ageing themes

1. Ageing defined

- a) Later life involves pain and/or dependency and/or
- b) Ageing is a process not an illness and/or
- c) I accept it, but sometimes it can be frustrating and/or
- d) You realise you are in later life when others treat you differently and/or
- e) The speed of life can be disconcerting.

2. Retirement

- a) Retirement was a shock and I miss work and/or
- b) Retirement is a release and/or
- c) Not having enough money in retirement is a concern and/or
- d) You take yourself with you into retirement.

3. Temporality, coping strategies and coping resources

- a) Ageing doesn't bother me because it involves maturing and/or
- b) I don't feel old and/or
- c) Being friendly and sociable helps you avoid feeling old and/or
- d) Being useful to others and/or productive helps you avoid feeling old and/or
- e) Society has changed for the better during my life and/or
- f) Society has changed for the worse during my life and/or
- g) I resent being treated as if I am old and/or
- h) God and/or my family have been a great source of comfort to me throughout my life.

As noted in the introduction, the meaning of ageing is seen as variable in different societies and in different historical periods. Both positive and negative images have been shown to persist throughout history and this mixture or variability is said to be present in recent popular understanding (Featherstone and Hepworth 1986; Kirk 1992). Such variability was evident in the views of the group. For instance, many held that, for themselves, later life involved pain and dependency (1a), and at the same time they talked of being active and doing something worthwhile. Above all, people held a combination of these views about themselves. Thus, similar to the Aberdonians, when faced with severe illness and pain, these issues were given more emphasis. Bodily states, therefore, significantly influenced beliefs about ageing. However, unlike the Aberdonians, the strongest theme contained a combination of 1a and 1b. For example, Will, who appeared to be the most physically incapacitated of the group, emphasised how he kept his mind active, even though bodily pain was significant to him. Ageing was regarded as a process (1b) and was most definitely not regarded as an illness.

Accepting physical impairment could be frustrating (1c), but ageing was regarded in a much more holistic sense than biomedical metanarratives would imply.

In general, the physical body had a significant influence upon beliefs related to age-based identity. Others acted towards the interviewees as if they were 'old' (for example, by giving up a seat on a bus), therefore, brought confirmation that their bodies displayed the physical signs of ageing (1d). However, the wish to stay active through, for example, carrying the 'work ethic' into later life, or what Ekerdt (1986) calls the 'busy ethic', helped the group cope with the negative aspects of an aged appearance and physical realities such as pain. The work ethic was therefore a common vocabulary of motive, something which also featured strongly within the Aberdonians beliefs and in other research (Thompson *et al* 1990 1992).

In temporal terms, social change was regarded with a mixture of feelings. Most strongly, people felt temporally displaced or 'out on a limb', they were 'too old for the times in which we live' (1e). For the group as a whole, the past was embraced so firmly that a golden age almost emerged in their talk. The values and beliefs of the past were held to be much more reciprocal and communally shared than those of the present. Therefore, in terms of 'personal time' the group felt at odds with, or somehow that they were set apart from, social time.

In terms of retirement, for those who emphasised the importance of working lives, leaving work could be difficult. Perhaps reflecting the argument, that, within a modernist orientation, social identity is largely built upon what one does in a formal occupation (Miller and Rose 1997; Featherstone 1991b), the initial period of retirement could be problematic (2a). On balance, however, most women in the group did not describe leaving work as a source of problems. For example, although Hettie had a formal 'career' as a professional, she accepted her 'natural role' or biographical career as a carer for her family. Undoubtedly, this reflects a gendered construction of the caring dispositions of women (Chodorow 1978). The majority of carers for older adults are older women (Arber and Ginn 1991a 1991b).

For Hull interviewees, retirement tended to be experienced as a release (2b), a response to what Cornwell called the 'hard earned lives' of the working class. Younger working class

people were concerned about having enough money to live on in retirement (2c). This was something which was not mentioned by any of the villagers. In overall terms, 2b and 2c tended to be combined by younger working class people.

In terms of temporality, as noted, the group emphasised how they carried values with them into later life. Their lives were represented as meaningful narratives which involved beginnings, middles, plots, characters and endings. Thus personal time emerged as much more stable than social time which, as noted, was felt to be unstable and chaotic. Self and society were, then, often seen in opposition. However, for Elsepeth, continuity in personal time was not always seen as a good thing. If you had problems during your life you could take them with you into retirement (2d). As she states: 'you take yourself with you into retirement'. Personal time, including a strong orientation to the ideals of community, nonetheless served as the major resource when coping with crises in social and chronological time. This also helped people to cope with bodily crisis and the loss of significant others

Ideas about community also provided resources and strategies to cope with ageing. Thus in highlighting maturity as an important and worthwhile attribute which came with ageing (3a), it was noted, for example, that conflict with others was much less desirable than cooperation. Assertions of being old were rare as this was associated with decline, decrepitude and dependency. Therefore a younger sense of self was presented by the group. However, many did say that in biological terms the aches and pains of later life could be a burden, and a constant reminder of the price they paid for their maturity. Thus 1a, 3a and 3b were usually combined.

Being friendly and sociable tended to be stressed more by women (3c) possibly reflecting gendered socialisation (Chodorow 1978) and a gendered interpretation of the work ethic, which Matthews (1979) describes as a propensity to use the relational aspects of the construction of gender as a strategy for identity management in later life. Feeling useful and productive was emphasised by both sexes. However, women tended to stress this in much more emotional terms ('I love my daughter', and so on), whereas men turned to the vocabulary of motive of working lives. For example, in his garage job after retirement, Will reinterpreted the narrative that work should involve financial payment. Social contact and

feeling he was doing something useful were payment enough for him. Thus 3c and 3d tended to be combined by women, whereas men emphasised 3d. Indeed, the importance of the work ethic by the males has many parallels with the work-related beliefs of the Aberdonian men. As noted, many look to their past as a positive period, making personal time and social time 'out of kilter' with one another (3f). On the other hand, many from Hull presented themselves as experiencing poverty or 'hard times' when they were younger. Thus 3e and 3f were most commonly combined by this group.

Other data indicate that those with more of the characteristics associated with deep old age gave most stress to the past as a time involving a greater sense of community. Such an invocation of imagined community could be interpreted as a function of having limited support networks in the present. Therefore, community was imagined in the absence of other feasible coping strategies. Overall, then, it can be argued that self/body/society are linked in personal time through an orientation to community. Later life was held to involve incapacity and frustration, yet the bias towards shared ideals and values helped the group to, as it were, bear the pain. Thus, unlike the general disdain towards mechanistic health care, which was interpreted in Chapter Four as a resentment towards ageing being treated as an illness and to a wider ideology of ageism, the invocation of imagined community seems to have helped interviewees cope with being treated in everyday life as if they were 'old'. Whilst this was not acceptable, it could be endured. Resentment towards being treated as if they were 'old', then, was a minority view (3g). Also, for some, religion was highlighted as a key resource (3h). However, for most, and possibly illustrating the urge to feel connected, support from close family was highlighted as most important (3h).

Death

Like ageing and illness, death can be regarded as a social phenomenon (Bauman 1992b 1998; Clark 1993; Hockey 1990; Seale 1998; Walter 1994). Emphasising the negative, writers like Aries (1974, 1983) and Gorer (1965) are associated with the thesis that we live in a 'death denying society'. Others modifying this view, describe how, largely under medical control, death is hidden away or 'sequestered' as a strategy for avoiding a fear of the unknown

(Bauman 1992b; Mellor and Shilling 1993). In a more positive and upbeat tone Walter (1994) challenges the death denial thesis, arguing that a 'revival' is taking place. This involves the growth of death-related values and practices which are meaningful to individuals. For Walter, the revival is, in large part, influenced by the rise of individualism; it also reflects individual agency as a form of empowerment against the declining authority of medical and religious knowledge. In general, popular understandings combine positive and negative dimensions. Indeed, all of these views are reflected in the data, and it is to a consideration of death-related beliefs that I now turn.

As noted previously, death and dying, while not originally considered as something which was part of health beliefs, emerged as a very important topic to the group. Indeed, this can be seen to reflect the unique relationship between ageing, illness and mortality which constitutes the terrain of later life. Thus, as noted at the beginning of the previous chapter, ageing, illness and death all share in common the fact that they serve as reminders of the limits of the human body.

Death and religion

For those who expressed religious beliefs throughout their interviews, religion was a major resource which was drawn upon to understand death and dying. Although religion was not as important to Matt as some of the other interviewees, he nevertheless believed in the Christian religion. Therefore, his life span was held by him to last for the biblical three score years and ten. Matt saw this as a very short space of time and therefore life had to be enjoyed.

Matt: My philosophy is life is very short. To me, err, a life span of seventy years is a very short space of time. ((pause)) . . . So why not enjoy it and do what you want to do ((pause)) while you can, because one day the day is going to come and you are not going to be able to do it. ((pause))

He implicitly draws upon religion in the following extract where he talks of not being afraid of death because he knows he has been 'given a number, and when that number is up, *that's it*'. In other words, he is not afraid of death because he knows it is pre-ordained by God. Since he can do little to avoid it - it '*doesn't bother*' him.

SC: You are not worried about getting old yourself?

Matt: That doesn't bother me. Old age doesn't bother me. ((pause)) That is something that has never bothered me. ((pause)) Errm, it happens to us all. It bothers a lot of people but it doesn't bother me. . . . But death doesn't bother me. It is something that is gonna appen. ((pause)) It could be tomorrow, it could be in ten years time, it could be in twenty years, or whatever. It doesn't bother me.

SC: You don't think that: 'I have got another twenty years, or whatever?'

Matt: It doesn't bother me. It doesn't bother me in the least. ((pause)) Err, ((pause)) I ave spoke about this before, and a lot of people, err, ((sighs))... I ave found that a lot of people find it very ard to believe. Errm, I am not bothered. I really am ((pause)) not bothered. ((pause)) Because it has got to appen and... ((pause)) I look at it this way, ((pause)) one thing that is certain from the day you are born, is that you are going to die. That's a process that starts from the day you are born. The other thing that I sort of believe... The way I look at it... When you are born you are given a number, and when that number is up, that's it. . . . Now, for some people, it can be after a few months or a few years, for other people it can be hundred years. It depends what number you ave got. That's the way I look at it. That's the way I view it. What my number is, I don't know. But when it is up, it is up.

Lawrence who was older and middle class also referred to the biblical three score years and ten in a quite literal sense. He was happy to live to this age because his parents had died much younger.

Lawrence: My father died when he was 40, my mother died when I was young, and if I live three score years and ten I will be happy with that.

Joyce who was younger also drew upon religion to talk of death. Thus death was welcomed because it meant going on to a 'better' place. However, she would regret leaving loved ones behind. Death also needed to be prepared for in terms of the needs of those left behind - thus she had made a will.

SC: Just a question about dying, if you don't mind.

Joyce: ((laughs)) Well, we have all got to do it.

SC: How do you feel about dying? Have you ever thought about it?

Joyce: Oh yes. Errm. ((pause)) Errrrr, ((pause)) What do you mean? What would I think about dying now, for example?

SC: Say if you were to suddenly fall down on the floor and realise that you were dying.

Joyce: Yea, and say: 'This is it, the end'.

SC: How would you feel about it?

Joyce: Err, I'd just be sad for the family. ((pause)) Errm, I wouldn't be scared for myself. Because I am quite sure that where we are going is better than where we are. So that wouldn't bother me. And my parents felt that too. And I am quite sure my parents are happy to () reunited. But I would be very sad at leaving the family. Because I know my husband would be... I am not being big headed about it. But he would be as devastated without me as I would without him. I don't think he would easily find another partner. And I told him to go

ahead, but I don't think he would. So I think he would be very lonely if I went. So, therefore, I would be sad to think that I was leaving him. And I would be sad at the moment with the children. Because neither of them are married or settled down. If they were I wouldn't feel quite so sad about it. Err, I did... ((laughs)) I wrote letters, the last but one time I was on holiday. I suddenly thought: 'Well, nobody knows where this will be... And if my husband and I both die it's evidently my will that counts'. I have written a very complicated will. Errm, because of Malcolm, because I know if he just got all the money in one lump sum it would be gone and he would be in debt. In next to no time. So it's left with trusts and all sorts of things. Anyway, trustees. So I thought, well, we better know where this will be. So I left a little letter for them saying: Don't open this ((laughs)) unless dad and I got killed'. ((laughs)) And I left it on the dressing table. And, in fact, my daughter had seen the letter and she said, and I had signed over it, so she wouldn't open it. Anyway she said: 'OH MUM, YOU ARE AWFUL.' And I said: 'Why it's just a little note to you in case anything happens like a plane crash or anything'. You know, you suddenly think when you are going on holiday: 'Oh gosh, I hope we do come back'. ((pause)) And errm, you know, so, yes, I do think about it. It doesn't worry me, the thought of my own death. ((pause)) I am not worried with that. But leaving them worries me.

Even Matt, who seemed to be staunchly undeterred by the prospect of death because of his religious faith, also expressed dismay about death curtailing what he perceived to be important social obligations. Therefore he had not wanted to die when his children were younger because they would not have understood, and he also wanted to be able to spend part of his future retirement engaged in voluntary activities. This latter aspiration was cast in terms of being 'given' the 'time'. Presumably, because of his orientation towards Christianity, time was a gift from God. His assertion above of not being 'bothered' by death, therefore, was qualified by the following:

Matt: The only sort of way that as ever bothered me is that when the children were small, I thought: 'I hope it doesn't happen until they've grown up'. Err, 'when they can understand, and accept more easily, what they could do at eight or nine', you know. . . . The only thing that I would like to do is to be... live long enough to retire . . . to be able to become more involved in the voluntary work that I do. And to be given time to do that.

Evelyn who highlighted her religious beliefs, drew upon her faith to talk of life and death. Thus, because she felt that God had intended her to do more in her church, she was allowed to recover from cancer to carry on this work.

Evelyn: When I found out I had the cancer, this young man [from her church] said I didn't look very good and they took me in for a blessing. Before I had the operation my son give me blessing and that was proof that it was from heavenly father because he gave me, nearly in exact words, ((pause)) what the other man, ((pause)) what the other brother had said. And both of them said I would get better because I had more work to do in the church and now here I am.

Religion was very important to Evelyn. It was a key resource in helping her to understand death. When her husband died twenty years ago she couldn't 'get death out of her mind'. However, on becoming a Mormon after her husband's death she 'knows death and

understands death'. However, even though she highlights the importance of religion to her this is sometimes not enough. Her beliefs, therefore, parallel Hettie's view that religion did not always provide sufficient comfort and solace. In Evelyn's case, she finds it difficult to resolve her faith with the death of a child.

The only thing I aren't real sure of is when a child is taken. I just don't know I can't except that like what I can in older people. Why take a child when somebody is old and in agony and they haven't gone.

It is possible to argue, therefore, that religiosity helped people to come to terms with, and to be prepared for, death. This faith, however, did not override all concerns and anxieties - sometimes it was not enough. Moreover, some people could not come to terms with the prospect of death at all. For example, although Tim, his wife Mary, and Ros all stressed the importance of religious faith, they preferred not to talk or think about death. Tim was talking about how he could sometimes get 'browned off' when bad weather prevented him going for a walk and he would mope around the house. I then asked him if he had any particular worries that 'browned' him 'off'. His response highlights two concerns: (a) he was 'upset' by the prospect of death and (b) he did not want to be left on his own - thus he hoped he died before his wife.

Tim: The biggest worry is that you see your life coming to an end because of the advancing years and that upsets me a little bit.

SC: Do you say anything to your wife about this?

Tim: No, because I don't want to upset her.

SC: Do you think that is how she feels?

Tim: Yes, I'm sure it is. You know both of us are of the same mind. You know, I hope I go first and she hopes she goes first.

Even though Ros' religious faith was highlighted as being important to her, she did not draw upon this to talk about death - a subject 'you don't think about' because 'it is quite morbid'.

SC: Do you think you would like to live for another fifteen years or another twenty years [or

Ros: [oh, I don't like to think about it. I think it is quite morbid. I think you just go on living and you don't think about it. ((pause)) That's the best way to be. I mean, I never thought about it when I was younger. You don't, do you.

Death and control

Whether people were religious or not, the most common concern amongst the interviewees was the manner of death. They wanted a quick death without physical pain and suffering.

Mary and Tim are frightened of a slow death and want to live longer to spend more time with their grandchildren.

SC: Do you ever think about dying?

Mary: Yes, often, I do. It frightens me, yes.

SC: What do you mean by often?

Mary: Well, it's just if anybody is poorly or bad with something. I'm glad I'm still here.

SC: Do you mean your friends and people that you know?

Mary: Yes.

SC: Are you frightened of dying?

Mary: Nnnnn. We all are, aren't we. Aren't you?

SC: Oh yes, I am.

Tim: We are frightened of finding out the reason for dying. Is it going to be cancer, or is it going to be something straight out.

SC: How would you like to die?

Mary: Quick, but not yet. ((laughs)) Until my grandsons have grown up.

SC: Do you think you will know when your time is up?

Mary: I don't think about that either.

Others were frightened of the prospect of a painful death.

Don: [Death] is not something... ((sighs)) It's not something I really think about... You know, I don't think: 'I'm gonna die'. But when I do think about it, erm, ((pause)) I don't like the idea of dying. It frightens me. One of the reasons why it frightens me is cos I wouldn't like, err... I wouldn't mind if, you know, I fell asleep on the settee and that would be it. You know, once you're gone you're gone. ((pause)) But, both ma mother and ma father died of cancer. And I think it's a ((pause)) horrendous way to die. And I've got a very severe feeling that that's the way I will be going, you know. Err, ((pause)) . . . I think there is a very, very strong possibility if both your mother and your father, for whatever reason, err, died, through the disease, I think there is a good chance that I will.

Joyce wants a quick death but she feels that the final outcome is God-given.

SC: How would you like to die then?

Joyce: Oh heart attack, so I could go quickly. Both my parents went quickly from heart attacks. ((pause)) That's definitely best. We nursed the father in law through lots of strokes. Having had a stroke and losing the faculties and the power of this and that, and... He ended up in a wheelchair, and then bedridden and then a vegetable. It was absolutely awful. I wouldn't like to see that happen to any of us. But then, of course, it's not for us to judge, is it; or decide. ((pause))

As well as wanting to avoid a painful death, most did not want to live beyond what they perceived as their natural life span. Deep old age was seen as a relatively short period and to extend it was, therefore, repulsive.

Joyce: Err, I don't want to live to be very old. I have made my mind up upon that. ((pause)) In fact I often say, jokingly, I am going to get a cyanide pill. But will I have the faculties to realise when it's time to take it? ((laughs)) Because I don't want to get to be old and dodderly. I'd rather go when I am still enjoying things. And I have seriously thought of giving the doctor a note which says if ever I should end up in intensive care ((pause)) after a few days, when it's obvious I am not going to make a full recovery, then I would rather you just switch the machine off.

Implicitly, Joyce is also supporting euthanasia - something that many others were in favour of. Showing how death was generally accepted, albeit at an appropriate time (that is, within deep old age), some of the following extracts also show support for euthanasia.

Matt: The only thing that frightens me is aving an illness that completely incapacitates me . . . and I am totally reliant on others . . . and that's when I believe in euthanasia.

Dave: The only thing about dying is: when you are going to die, you are going to die - don't worry - you know.

SC: Have you ever thought about the way you would like to die?

Dave: For me, I can say I don't think I would like to die prematurely ((pause)) in a car crash.

SC: What do you mean you wouldn't like to die prematurely?

Dave: To die naturally.

SC: Live your natural life span?

Dave: Yea. ((pause))

SC: What do you think about euthanasia?

Will: Euthanasia, well, . . . if a person is terminally ill ((pause)) and is suffering, ((pause)) then, why not.

SC: Have you thought about death?

Will: I could face it I think. ((pause)) Oh, I think could face it. . . . It's years and years back, many a century ago back; but you read in books, papers and reports; in your mental institutions, in your workhouses: when a person got beyond relief, or beyond all help, ((pause)) then there was a pillow or a mattress put over their faces and they were just quietly left to go. Now then, what's wrong ((pause)) in saving a person suffering for years ((pause)) when there is absolutely no ope for em. So long as they agree. And a lot of em, ((pause)) they aren't in a position to agree, ((pause)) because they are that ill, they are that sick. . . . And I look at it this way: I have had a long life. I have had a good life. I have had satisfaction out of life. I have done things I have wanted to do ((pause)) and I have been quite content with life. . . . I have had a good time, I have had a good life, I have enjoyed it.

Death denial

A small number of the interviewees expressed not just a fear of death, but a desire to avoid it altogether.

SC: How do you feel about dying?

Tim: I don't want to . . . there is still a lot I want to do, all sorts of things.

SC: What sort of things do you want to do?

Tim: Well, live this life for a lot longer. As the wife has said, I want to see the grandchildren truly on their feet. The grandchildren.

SC: Do you want to continue doing the things that you are doing, or do you want to do other things?

Tim: No, no, I have no ambitions.

SC: Is there nowhere you want to see or go?

Tim: No, not really.

After Don had talked of wishing to avoid a painful death, I asked him if it was the manner of death which was his main concern.

SC: So, are you saying that it is just the method by which you go and you accept the fact that you have got to go?

Don: No, I don't accept going. I don't accept going. I don't wanna die. I mean, I would like to live till I'm three hundred and fifty, you know. If there's something eternal to mek it longer, I would like that as well.

Such strong sentiments, however, were restricted to 3 of the interviewees. Interestingly, all 3 claimed to be religious. Thus, as noted, religion may not be considered as the main vocabulary of motive by which death is understood. The three extracts below contain many of the themes mentioned in the statements already quoted. In addition, they emphasise the

importance of social relations and support, and there is also a strong critique of death-related beliefs and practices in medicine.

Don: We sat with me mam for a fortnight in the sister's house [when his mother was dying]. ((pause)) Which, a lot of people find this very, very strange, ((pause)) was a terrific fortnight, it was one of the best fortnight's of my life, because, as a family we knit... We knitted together-not that we was ever apart-err...

Claudia: *Well, I am not afraid of death.* . . . The only thing that I am afraid of is, err, ((pause)). . . having a stroke and being *absolutely* helpless. A burden [to

Jane: ()

SC: Sorry?

Jane: You should have asked if we believe in euthanasia.

SC: Well, I can ask that if you want: do you believe in euthanasia?

Two or three voices ((including Claudia)): Yes

Beverley: The only thing that I have is that I am afraid of dying on my own.

Claudia: Yes.

Beverley: I feel that with my family, me brothers and me twin ((pause)) *they died.* ((pause)) And I always say to them, you know, once my son came and I was asleep and he didn't bother to wake me and he went home. ((laughs)) And I went round and I said: 'Well, I could have had a stroke, you know,' ((pause))

SC: I wanted to ask you about death. Most people don't like talking about it. But what do you think about it?

Jack: ((pause)) I think, err, ((pause)) *I'm* quite happy to die when ma turn comes. I've no issue with that at all. I'd miss people. I'd miss ma family and ma friends. But, *no*, I've no great problem with it. ((pause)) Ma problem with dying is that people keep on living when they shouldn't do. ((laughs)) That would be my big fear. Modern medical technology is extending useless lives, in my opinion. I think it's quite a natural *thing.* ((pause)) Like everybody else about suffering when you are dying, I am as frightened as the next man, you know what I mean? ((pause)) I suspect that, err, I've never been put in the position yet... But I suspect that I'll have the sadness and regrets and the euphoria and all the rest.

Jack: ((wife calls from downstairs saying it is time for him to go)) Yes, now, I'm just coming now.

SC: Can we just finish it off?

Jack: ((shouts downstairs)) YEA, FINISHING OFF. I have no regrets. It's not a big issue to me, it was never at home. We saw people dying in the village. We saw miners dying, chest infections. We saw people being killed. I was used to playing the pipes at funerals. It's not an issue. It's not a big issue. It's something that happens, but I accept that it happens, and I accept that there is not a lot that I can do about it. ((laughs)) ((pause)) I think that health professionals can't get it into their heads that it is natural. Whining all the time about people dying, prevaricating over it. Why is it seen as a failure, for example? Somebody dies of a coronary, and you have done your best, why are you remorseful about it? ((pause)) It never

bothered me. ((pause)) I always took the view that that was. Sometimes I feel that health people they hold themselves up as Gods, you know? They can do this, that and the other. And the truth of the matter is that they can't do very much at all. But the only decent thing that they have done is cleaned up the water supply. Public Health, actually, has been the main thing over the last hundred years. ((laughs)) A lot of the cardiac surgery, for example, is, actually, a waste of money. ((wife shouts again and he says he is coming))

Death themes

I'm not sure how I feel about death

- a) Accept death and/or
- b) Self and inter-socially managed death and/or
- c) Quick exit and/or
- d) Silence about death and dying and/or
- e) Want to live on.

Given the flexibility of the imagined community to the group in shaping illness and ageing-related beliefs and coping practices, it is, therefore, not surprising that death and dying, which most fundamentally threatens ontological security, is also understood through this frame of meaning. For Anderson (1983), who, as noted, develops a theory of nationalism using the idea of imagined community, nationalism is replacing religion as the meaning system to connect the dead with the living. As a consequence, he argues that ordinary people come to feel that their lives are now part of a greater good (the nation). Therefore the ideas of sacrifice and mortality generally become more bearable. Similarly, Becker (1973) proposes that the idea of giving one's life can become heroic. As noted in Chapter Five, imagined community helped Hettie cope with her bereavements. It was 'imagined' because its members included characters and people with whom interaction was not possible - most particularly, her dead relatives. What is claimed here is that, even more so than in the way ageing and illness beliefs are constructed, the invocation of imagined community was most prominent in death-related beliefs. In general, then, death, as an end to existence, is the ultimate threat to ontological security.

At one level, the data show evidence of the demise of the influence of religion, being replaced by a sense of belonging to an imagined community through the narrative reconstruction of

biography. This draws from a variety of texts emanating from, and in the spaces between, medicine, working lives, popular culture and other sources. At another level, the data show the prevalence of religiosity amongst some of the group by the way in which religion provided a certainty and assurance or what Berger (1967) calls a 'sacred canopy' in giving meaning to death and dying. At a third level, it can be argued, that like illness and ageing, the understanding of death demonstrates Stainton-Rogers' (1991) concept of 'explanatory sympatricity', in that a number of competing ideas were drawn upon. As a consequence death took on multiple meanings for the group. This latter point is also evident in Aberdonians death-related beliefs - as is the use of religion.

Most people accepted their mortality (1a). For most who were religious, religiosity proved to be a considerable resource. Members of the latter group referred to the biblical three score years and ten (like the Aberdonians); Matt said he had been given a number - he was happy with this, even though he did not know what the number was. Joyce talked of her death in terms of 'going to a better place'. For Evelyn, her escape from death was because 'holy father' had chosen her to live because she 'had more work to do in the church'. 'So here I am', she adds.

Many also talked of death in interrelational or familial terms. Thus, some hoped to be united with deceased relations in the 'better place' and others highlighted concerns about leaving family (especially grandchildren). Such orientations concur with similar findings elsewhere (Gorer 1965; Seale and Cartwright 1994; Young and Cullen 1996). Interrelational resources within the imagined community were often used to supplement religious resources which, from what was said, appeared not to give sufficient reassurance. For example, Hettie largely drew upon her close orientation to dead relatives in her beliefs. She described religion as, on occasion, 'not enough'. In addition, comments were made about reincarnation which suggest a reconstruction of biographical narratives and a consequent reinterpretation of religious values. Thus Hettie described her dead husband's charismatic authority and her belief that he 'had been here before'. Others talked of reincarnation in terms of personal experiences and relationships, rather than in traditional religious terms. Others described how the death of relatives had bonded family members together in the way the family had helped the dying

relative manage their death. This was also expressed as a feeling of wanting to die in the company of family. I have termed all of these factors - that is, planning and making arrangements for those left behind, rejoining family members in heaven, the positioning of dead relatives in the imagined community and the reinterpretation of religious values in accordance with biography - self and intersocially managed death (1b). Most commonly 1a and 1b were combined.

Perhaps as an indication of sharpened consciousness and experience of physical pain, most interviewees, not unsurprisingly, talked of a desire for a quick and pain-free death. Thus if I asked how people wanted to die, the first response tended not to involve reference to religious practices, such as a full traditional funeral, but in terms which emphasised a quick and pain free death (1c).

In terms of death awareness, it has been argued that silence rather than denial is a common coping strategy. Gorer (1965), for example, reveals how he was shunned or met with embarrassed silence by friends when he told them he was in mourning for dead relatives. Glaser and Strauss (1965) describe medical practitioners withholding information from the dying patient and/or relatives in order to manage death in hospitals more efficiently and less emotionally. Philippe Aries talks of the 'beginning of the lie' in the mid 19th century where the dying patient is no longer informed of their fate and 'death is driven into secrecy' (Armstrong 1981: 651). These authors all support the view that death has become sequestered or hidden away (Mellor and Shilling 1993). Silence rather than denial, therefore, can be a key death-related coping strategy. For those who did not highlight any grief or mourning in their experiences, a small but significant minority expressed an aversion to talking about the prospect of their own deaths, saying, 'I don't think about it', 'I don't like it', 'It frightens me', and so on. Again reflecting a relational orientation, many said they found it hard to think of leaving grandchildren or of having 'a lot I want to do' before they died. The idea of ageing bodies as a project, therefore, comes into play again - seeing oneself in early old age helps to conceptually and temporally distance the prospect of the finality of death. The most extreme example of this view came from Don, who maintained that there were a lot of things he wanted to do. He

wanted to live until he was '350' (1e). Most particularly, 1d and 1e were combined with each other.

Conclusion

Together with the previous chapter, the above has shown that health beliefs take on particular meanings in later life in relation to ideas about illness, ageing and death. This is achieved through the reconstruction of life narratives drawing upon texts or scripts from working lives, medicine, family, religion, and others. This parallels arguments expressed previously that, as a result of postmodern fragmentation, which has accelerated intertextuality between and within cultural scripts, interviewees have a variety of means to reinterpret and subvert traditional forms of authority over beliefs; that is, to engage in explanatory sympatricity. In relation to the central research question of the study, the data show that beliefs reflect strategies to maintain ontological security which are most prominently constructed by reference to imagined community - the precise content of which differed in relation to biography, gender and social class. The following chapter summarises the argument of the study and raises questions about the limitations and potential of imagined community for the group and older adults generally.

Summary and conclusion: the limits and potential of imagined community

Introduction

Chapter One identified the aim of this study; to examine the relationship between social organisation and ageing as reflected in the health beliefs of interviewees. The analysis that followed reveals the most prominent relationship was between medical knowledge and beliefs, although the degree of correspondence between the two was by no means one of total domination of medicine over beliefs. Beliefs show the agency of interviewees who, in drawing upon a range of texts and narratives, are competent social actors, capable of creating their own narratives.

More specifically, the research question concerned the way interviewees constructed their beliefs. In response to this, data show that beliefs are both bound up with, and indistinguishable from, experiences of living in personal, social and chronological time - as this is interpreted by interviewees. This reflects the idea that there is a permeable relationship between body, self and society (Battersby 1993) and, more specifically, this also holds for older adults (Featherstone 1995; Featherstone and Hepworth 1990a, 1990b, 1998). In terms of one prominent means of conceptualising beliefs, it was argued that imagined community served as a dominant vocabulary of motive through which interviewees constructed their beliefs and related coping strategies and resources.

Drawing upon the work of Anderson (1983), and recent interpretations of his work in terms of ageing (Blaikie 1999) and death (Seale 1998), it was argued that communities could be described as 'imagined' because it was not always possible to interact with other members of

the group - for example, dead relatives and work colleagues, TV characters and other famous people, both dead and alive. Furthermore, the strong moral imperatives associated with such communities could also be considered as imagined because they were largely represented as values of the past; they were outmoded in the contemporary world. However, as members of these communities, interviewees and, by implication, older adults generally were thought of as custodians of moral ethics which emphasised community. The data show, therefore, that having a sense of belonging to a community acted as a key vocabulary of motive, providing moral imperatives which were reflected in the conceptualisation of beliefs.

This chapter explores further the idea of imagined community in terms of its benefits and limitations for the group and for older adults generally. In doing so, the chapter is informed by the notion of the body as an 'unfinished project' and considers the implications of this idea for the fabrication of social identity. To reiterate, there are arguments which suggest that the physical body can be considered to be in a continual transitional process, it remains an unfinished article or project throughout (Shilling 1993). In particular, data have illustrated this idea in relation to the numerous strategies and prescriptions suggested to accommodate illness and general physical decline.

More broadly speaking, society or the 'social body' can equally be considered as unfinished, that is, it is in a constant state of uncertainty itself as exemplified in the ephemeral dominance of 'body power' emphasising youthfulness in Western culture. For example, historical and cross-cultural variability in the social status of older adults shows that their current status may not necessarily be a permanent fixture of the future. Thus Hazan (1994: 54) notes how the status of older adults in traditional societies was relatively high, particularly in the absence of economic hardship. Owing to their social function, such societies offered older adults positions of control, since their purpose was to transmit knowledge to the group. They were also socially integrated via structures and processes which promoted strong ties, interdependency, and the general welfare of all valued members. This is not to deny that older adults were regarded as a distinct category, but to argue that its social meaning did not tend to carry with it the stigmatising implications found in more complex societies.

In a society now characterised by flux and social transformation, as noted, people are encouraged to make identity and lifestyle choices for themselves. Thus for Bauman (1997) there is a cultural insistence upon self-assertion. For Beck (1992), the development of a culture of self-regulation, self analysis, or self-reflexivity is part of a process of 'reflexive modernisation'. Emphasis is given to the way people are provided with opportunities to reflexively construct their identities and lifestyles (Giddens 1991; Lash 1994). However, to say that people are given the 'opportunity', could be seen as something of a generalisation which takes little account of social inequalities. 'Choice' takes place largely in social relations mediated by consumer culture. Thus, Giddens (1992) argues that in 'high modernity' we are *forced* to make lifestyle choices. In other words, Giddens is offering a theory of detraditionalisation which refers to the destabilisation of traditional sources of authority and subsequent lifestyles for human society. For Giddens, then, and for Beck (1992) the central strategy of 'reflexive modernisation' involves the encouragement of self-reflexivity. This suggests that modernisation is a new form of social control because people are being cajoled, coerced, or even forced to choose different lifestyles. However, what this study has shown is how ageing forces reflexivity upon older adults, something which has been neglected by the reflexive modernisation thesis (Turner 1995a).

The analysis has shown that, whilst many beliefs may be read as a product of reflexive social control, grounded in different sources of authority such as religion or medicine, they can also be interpreted as products of reflexive strategies of resistance to the wider social process of individualisation - as borne out in the centrality of imagined community as a vocabulary of motive. Data, therefore, show that interviewees created their own vocabularies to construct their own meanings and destinies. As Lash argues (1994: 115-6), individuals, set free from the overarching constraints of structures, are free to reflect on the rules and 'resources' of such structures. Thus, interviewees' responses to strategies of coercion or normalisation, from authorities such as medicine on how ageing bodies should be interpreted, and to vocabularies of motive, such as the work ethic, were of central concern in the analysis. In this context the data are seen to reflect a subjective monitoring of life narratives. In other words, it is accepted that the world is characterised by doubt, uncertainty and meaninglessness (Lash and Urry 1994), involving a general demise in the influence of traditional sources of authority or

'metanarratives' (Lyotard 1984). Yet much of the data reflects individual attempts to create meaning and certainty by drawing upon and reconstructing knowledge from alternative sources of authority.

As regards the previously mentioned idea that ageing forces reflexivity upon older adults, reflexive awareness of physical decline among interviewees would, it could have been claimed, be likely to have an acute influence on their health beliefs. For example, following the influence of ageist ideologies, one could imagine that beliefs would have reflected negative and stigmatising values from society at large. However, this was not a strong theme in the data. Recourse to generationally-situated life narratives amongst the interviewees served as resources, which provided them with a sense of coherence and purpose; they served as counters to the symbolic violence of *ageism* as a disempowering ideology.

Returning specifically to the idea of the social body as unfinished, it could be argued that this has implications for the interviewees and for older people generally. Furthermore, in theoretical terms, it suggests that macro-level theories of analysis, such as political economy, whilst useful in showing the role of economic organisation in shaping structured dependency (Phillipson 1982), can neglect how such influences are interpreted by older adults themselves. As noted, recent writers have argued that rapid social transformation has led to a situation where structures of authority over individuals can no longer be regarded as overarching (Bauman 1997; Giddens 1991; Beck 1994; Lash 1994). In noting such a turbulent and changing contextual backdrop to the construction of beliefs, this chapter asks if the approach and findings of this study can be considered as a contribution to the problem of sociology, that is, towards understanding the relationship between the individual and society. It also asks what the potential of imagining community is for the subversion of stigmatising representations of later life? In other words, the chapter explores in more depth the implications of imagined community for the continued fabrication of beliefs by the group and for 'later life' as a social identity more generally.

Understanding health beliefs as a problem of sociology

Prior to exploring the implications of imagined community further, it will be useful to summarise the preceding chapters in light of the claims made in Chapter One. These claims can be considered as twofold. First, this study should be seen as a development of approaches adopted in the health beliefs literature and - with specific reference to older adults - the work of Rory Williams. Second, it also serves as an empirical contribution to the problem of sociology in that beliefs are examined in relation to issues of agency and structure. This has been achieved by drawing upon approaches and the use of analytical concepts which transcend the idea that agency and structure are separable.

To re-iterate, in Chapter One it was argued that there has been a tendency in sociological theory to consider agency and structure as a *dualism* rather than a *duality*. This has been reflected in previous work on health beliefs which, therefore, leaves room for theoretical development. Whilst it was not disputed that recognition of the relationship between the individual and society was prominent in existing sociological work in the area, it was argued that there was scope for research which drew upon approaches which explicitly theorise the link between individuals and society. This study, it is argued, has adopted such approaches.

In Chapter One it was noted that the life course approach and the sociology of the body explicitly transcend the dualisms present in classical sociological theory. In terms of the former, individuals are considered in the context of their relationship with history. This study has followed this principle, therefore, in that data collection took the form of life history interviews - the methodology of the study being discussed in Chapter Two. Furthermore, throughout the analysis emphasis was placed upon the issue of time in terms of how this has served as a resource for the construction of beliefs. For example, it was argued that experience, in biographical context, is crucial in influencing beliefs. In terms of the sociology of the body, it was noted that self, body and society are seen as mutually constitutive, showing how the physical body serves as a key link between the self and society. This approach was shown to provide what Turner (1992) calls the 'missing link' in the structure/agency debate in that key emphasis is given to the role of the body in shaping experience. For example,

analysis showed how there was a relationship between interviewees' state of health and their beliefs. Moreover, the way they were regarded as a medical category in terms of their bodies was also shown to have a bearing upon the conceptualisation of beliefs, as was the influence of popular ideas about ageing which linked physical decline with decrepitude, senility and dependence. It was argued that interviewees re-interpreted and reconstructed such negative stereotypes in ways which reflected their agency.

Chapter One also outlined the main analytical concepts used in this study which helped reflect the aim to transcend the idea that agency and structure are separate issues; that is, of texts, biography, vocabularies of motive, narratives, generative discourses and the habitus. The relevant background to the development of these concepts was given in Chapter One. What should be noted again here was that their use is intended to capture the fluidity of the relationship between individuals and society, as reflected in interviewee beliefs. Thus, it was noted that *texts* are considered as genres for understanding that help to capture the idea that there is a mutually constitutive relationship between body, self and society. It was also noted that the idea that interviewees drew upon different texts - like books in a library - to construct their beliefs, helped to emphasise their agency as competent social actors.

The idea of *biography*, whilst not innovative, or new, was thought to complement a focus on agency. Thus, Williams' (1990) argument that beliefs are crucially influenced by the biography of older adults, as was the general argument in the health beliefs literature that the experience of individuals is highly significant, were both applied in the analysis of data.

The concept of *vocabularies of motive*, it was argued, showed how a number of different repertoires or *narratives* of explanation could be considered to be available to the interviewees. Thus analysis has shown that a range of vocabularies of motive were present in the data. However, the vocabulary of motive of *imagined community* was most prominent. This provided a sense of ontological security, something which the instability of physical decline and the stigma attached to ageing in popular beliefs made imperative. Therefore, and because of their ageing, the very marginality of interviewees from participation in everyday life

made it necessary for them to imagine community; in so doing, this gave interviewees a sense of being authors of their own narratives about health and of self-esteem.

As noted in Chapter One, in the approach of narrative realism, narratives are thought of as being predetermined by society. This implies that individuals are simply passive puppets of pre-existing narratives over which they have little control. The data has shown that this situation was clearly not the case with the interviewees. For example, there was a lot of resentment expressed towards a medicalised and stereotypical narrative that ageing can be considered as an illness. By contrast, and reflecting the idea of the *death of the author*, data show that interviewees could not be considered as the sole authors of their beliefs. Thus, analysis has shown how the *generative discourses* of medicine, work and religion were prominent. However, they figured in an interplay between cultural and subjective narratives. In effect, data also show how beliefs reflect a *narrativised performance of later life*, which also illustrates Bourdieu's idea that the *habitus* of individuals brings together agency and structure in the values and beliefs that they espouse.

In what ways, then, does the approach and findings of this study make a contribution to the problem of sociology? How does it build a bridge between the individual and society? Quite simply, it can be argued that this study provides empirical evidence which illustrates the fluidity of the relationship between agency and structure. Beliefs are not reducible either to the self or to society. They reside in an embodied space between these two realms. They are not determined exclusively by overarching structures, nor are they free-floating constructs of the self. This study shows that beliefs reflect complex interaction of human agency and society, which involves an interplay of biology, biography and society. The data and the approach of this study, therefore, complements the theoretical idea that agency and structure should be considered as a duality rather than a dualism (Giddens 1984). For example, the analytical concept of text has been used to emphasise the interrelational character of the constitution of beliefs rather than their determination. It has also shown that, whilst the idea of structure is beneficial (for example, Chapter Three outlined the extent and influence of the structure of medical knowledge), less emphasis needs to be given to the constraining nature of structures and more attention needs to be given to their enabling features. In the final analysis, the

social world is both a product of human activity, and something which profoundly influences social conduct and phenomenon such as health beliefs. This idea is reflected in the approach and findings of this study.

Imagined community: limits and potential explored

As Becker (1973) has argued, human social life can be considered as a theatre for the provision of heroic and sacrificial roles which takes its sustenance from the potential threat of death to security. Illustration of this idea was found in the data. For example, Hettie represents herself as independent, as a fighter against impurity and as somebody who is continuing to do God's 'good work' through charitable activities in the face of adversities such as bereavement, bodily crisis and dramaturgical stress. In so doing, she pursues the ideal of imagined community: thus key members of her community are dead relatives. For Becker, the world can be understood as a theatre for heroism through a new 'elevation to eternal life', which promotes the idea of immortality, not through traditional religious views of an afterlife, which have declined, but through a basic need for self-esteem and a feeling of usefulness. For example, this can occur through practices which involve doing 'good work', not necessarily religious, which can be left behind for the living.⁵ Indeed, heroism and self-sacrifice was often implicated in the data. For example, many expressed how they felt good about helping others, to 'put things back into the community' through activities in pensioners clubs or the church, even in doing unpaid work in a garage, or in woodwork, and so on. Most specifically, the explicit reference by Jack that he would feel unhealthy if nobody wanted him anymore illustrates the idea that health beliefs are grounded in a social identity which carries the imperative of connection.

The data therefore call into question the idea that Western individuals' sense of self can be thought to be neatly contained within the body; that is, the cultural narratives of individualism and self-reflexivity have become embodied, leading to a view of the body as an expression of

⁵ For example, Becker gives the examples of skyscrapers, cathedrals, 'great' works of art, a family that 'spans three generations', and other works.

identity (Becker 1995; Shilling 1993; Turner 1992). As a consequence, self and the body are seen to be coterminous; they are conceptualised in such a way that discounts any formative or generative influences from the social relations in which they are embedded. This view of the self as an *individual* entity represents the dominance of a container metaphor in Western thought (Battersby 1993). Indeed, older people themselves articulate feelings of the self being contained or trapped within the body (Featherstone and Hepworth 1990b; Featherstone and Hepworth 1991). The idea of the mask of old age invokes the idea of a 'cage' which imprisons the self of older people (Biggs 1997; Featherstone and Hepworth 1990b; Featherstone and Hepworth 1991) and this is evidenced in the feelings of disaffection with the outward appearance of the body expressed by some of the interviewees, particularly women, in the data analysis. This feeling of disjunction between self and body in later life can be seen as a conflict (Hepworth 1991). The incongruity between having an ageing body, which is publicly conceived to represent an ageing self, and an inner feeling of a younger sense of self, is illustrated in Stanley Middleton's novel, *Vacant Places*.

One does not feel old inside the person. Painful joints, fatigue, failing powers are increasingly noticeable, but the real self is still young, still indefatigable, blest illimited. I do not expect you to understand that; you think a moment's perusal of my face in a looking glass should disabuse my mind of such mistaken ideas. It is not so. (Hepworth 1991: 93)

As noted in the data analysis, being labelled and stigmatised on the basis of bodily appearance provoked resentment amongst some of the interviewees. However, this resentment can be internalised by older people themselves. Biggs (1997) suggests that ageist beliefs and practices act to cage the self in the body, producing feelings of alienation between self and body among older people, an experience which has warlike characteristics:

as ageing gathers pace, it is increasingly difficult to re-cycle the body and it becomes a cage, which both entraps itself and denies access to the world of choice. An endgame emerges with older people being at war with themselves, an internalised battle between the psyche and the body. (Biggs 1997: 59)

Clearly, then, theoretical approaches which stress the rise of the individual self in Western society, the dominance of a container metaphor for the self and the 'mask of old age', reveals how older people are marginalised and, at times, are engaged in a conflict with their own bodies. However, it can be argued that such approaches themselves are overladen with marginalising assumptions; that is, the emphasis upon exclusion and subordination, or

structured dependency leaves little or no room to explore questions such as how older people themselves (a) deal with such marginalisation and (b) resolve or come to terms with feelings of conflict between self and body. Put simply, if the social world can be so hostile to older people through ageist values and beliefs which they can internalise themselves, how do they tolerate such a situation?

Theories of the marginalisation of older people, therefore, whilst not to reject them outright, can be seen as only a partial take on the importance of life course and generational factors in the shaping of health beliefs in later life. For example, the feelings of isolation which increased morbidity and awareness of impending death bring may influence older adults into taking a highly moral view of their sense of self (Williams 1990; Kleinman 1988; Seale 1996). Such moralising can be constituted through the application of religious beliefs (Williams 1990) or the work ethic (Ekerdt 1986; Kohli 1988) as vocabularies of motive for older people. Thus, later life becomes a project where individuals seek to maintain a sense of self-identity, which simultaneously, expresses their concerns about wanting to be independent (Seale 1996:76), and wanting to feel connected or a sense of belonging (Mehta 1997: 254). It is within this context that data showing an orientation towards the collective or relational, rather than the individual, among older people needs to be considered.

Collective values are strongly evident in the interviewee data as a whole, which it was argued, shows a vocabulary of motive which sees the self as connected or as collective rather than as individuated. Gilligan's account of the social construction of women's identity as informed by: 'a standard of relationship, an ethic of nurturance, responsibility, and care that grounds morality in connection' (Gilligan cited in Becker 1995: 3) has parallels here. In later life the relational performances of women continue to be an important part of the management and performance of identity. For example, as a way of protecting the self against ageist values and practices (see Mathews 1979). In addition, the importance of maintaining social relationships, particularly with family and friends, has been shown to provide a sense of ontological security to older men as well as women. For example, widowed people in mid and later life can sustain ties with spouses who are now deceased (Moss and Moss 1996). This was evident in the case study material. Maintaining relational bonds of intimacy can involve

'talking with the deceased, thinking about what the deceased would have thought or done and internalising the orientation of the deceased' (Moss and Moss 1996: 166). Social relationships amongst older adults are, therefore, not just limited to observable interactions. Phenomenological exploration of the inner worlds of older adults, then, can reveal how links are maintained between the living and the dead in terms of consciousness and intentionality, in ways which highlight their agency (Hallam *et al* 1999: 59).

Regardless of gender, older people have been shown to maintain relationships with family in later life as a means of linking past and present, so rendering their life story a coherent whole which involves continuity (Coleman *et al* 1998). Moreover, an orientation towards a sense of connectedness and social reciprocity has been held to provide a psychological resource for older people to draw upon to resist negative stereotypes of old age. Thus, maintaining relationships with family and friends, allows older people to reject the idea that they should be thought of as being old (Thompson *et al* 1990 and 1992). In other words, seeing oneself as a useful social actor can provide a key coping resource to reject the idea that one can be thought of as belonging to the negative social category of 'old age' produced by ageist values and beliefs. As Thompson *et al* argue, it does not seem unreasonable that older people do not want to be thought of as belonging to a negative social category, which the term 'old age' tends to invoke.

Given that the stereotypes and associations are largely negative, dissociation of oneself from the category of old age might be a very reasonable position to adopt: for who would want to be associated with negative attitudes or prejudice, especially if one knew they were not true of one's own self or life? (Thompson *et al* 1990: 122)

The idea that older people draw upon the ideal of the collective self as a vocabulary of motive in the framing of their beliefs was, then, a key concern of this study.

Drawing upon Becker, Bauman (1992b) argues that the modern world contains many strategies for immortality as a means of coming to terms with the reality of death by transcending the limits of human existence imposed by mortality, one of which is the urge to heroism. Drawing upon such ideas, it can therefore be argued that imagining community acted as an impetus for the expression of transcendence, heroism and sacrifice and this was

reflected in data. Thus the idea of imagined community (Anderson 1983) provided interviewees with the means to transcend the present which many felt they did not belong to. Feelings of belonging to moral communities also gave a rationale for the urge to feel useful and needed through self sacrifice and, therefore, bolstered self-esteem. Thus, as noted, amongst those who could be considered to be in deep old age - that is, in close proximity to death - imagining community was most prominent. It provided a feasible means of coping with physical decline and the situations interviewees found themselves in. However, it played the part of a palliative. It did not transform illness into health, or 'old age' into youth, but it made them tolerable. Later life has a devalued status and poverty, illness, isolation and social exclusion are its common associates (Vincent 1995). Moreover, given the absence of public or informal support networks for many older adults, it is unsurprising that imagining community has been shown as a prominent strategy (Blaikie 1997). In other words, in a society where self-reflexivity is emphasised rather than community, interviewees, as competent social actors, create their own. As noted, recent writers maintain contemporary society is characterised by the collapse of traditional authority and there is now a great deal of uncertainty and insecurity in everyday life. With the dominance of the ethic of choice within a market based form of provision, a range of do-it-yourself strategies is now available to individuals to build and maintain ontological security. Imagining community, needs to be seen in this context. It is the most achievable strategy available to older adults. However, other than enhancing self-esteem, it does not provide a concrete resource.

It is, then, very important to note that imagined communities, whilst they act as a potential set of resources for older adults, do not contain members who will be physically present to express warmth, love or companionship when needed most. A good number of older people live alone and this increases with age. For example, for those above pensionable age in 1981, 30% lived alone and by 1994 this had increased to 39%; the 1994 *General Household Survey* records that 33% of men and 62% of women aged 75+ lived alone (Blaikie 1997: 45). Indeed, over half of the interviewees lived by themselves. In addition, whilst some said they would like to die at home or in the company of family, recent evidence shows that only 19% of all people aged 65 and over died at home (ONS 1998: Table 17). This figure decreases with age. The older a person is, the more likely they are to die away from home. For those aged

85 and above, only 12% died at home. Imagined community, therefore, has its limits, but still serves a central purpose for the group.

For Blaikie (1999: 163-4) there are two ways to deny the problems of the present. First, one can embrace the past to the extent that a 'golden age' emerges. Second, one can disclaim all continuity with it and assert one's self sufficiency in the present. Thus the past becomes an alternative rather than a prelude to the present. Both these strategies were apparent in the way the group imagined communities for themselves. Thus Hettie, like many others, felt she was living out of her own personal time. The past was a nicer place and she and her dead relations belonged there. It was the values of the past which gave her a sense of security and protection. She said she abided by the values of her imagined community, as constituted by dead relatives, nice people on TV and famous people who had dealt with adversity. These characters helped her flesh out and construct little narratives which she blended with a religious narrative in outlining her idea of community. This was Hettie's major resource in helping her to cope with bodily crisis and the loss of significant others.

However, in her own words, this was sometimes 'not enough'. The stress and pain could be 'too much'. Hettie was, in my opinion, lonely and frightened - as were many others in the group. Following the idea of reflexive research practice outlined in Chapter Two, perhaps this should be asserted as the singularly most important finding of this study which requires attention beyond sociology. Hettie asserted that she 'had friends' and that she 'didn't need anybody else - thank you very much'. Yet she was very emotional, traumatised and upset. She was bereaved and her orientation to her dead family could be seen as a reflection of the loss of significant others for those in grief (Moss and Moss 1996).

Similarly, for the group, imagining communities had its limitations. Thus, illness was largely conceived in terms of a sign of impurity or otherness which infringed borders of purity. At one level, therefore, unlike the Aberdonians, illness was regarded as thing-like and external to the individual. It was held to be less a product of inappropriate behaviour or moral conduct than a reflection of the uncontrollable and impure nature of the external world. Hettie, for example, likened illness to the 'bestiality of nature'. Many others in the group similarly drew connections

between illness and impurities such as dirt, morally reprehensible conduct and values such as sexual promiscuity, lack of respect for authority and untidiness, criminality, and others. From this perspective, therefore, the imagined community was fallible. It did not guarantee protection against illness as an 'invader' or 'destroyer'. However, despite bodily crises and the loss of significant others, as long as people could feel they were productive and followed 'useful' roles, they would not consider themselves to be ill.

Ageing was associated with illness. This increased with the movement from early old age to deep old age. Most saw themselves in the former, rather than the latter - although the two were not regarded as mutually exclusive categories. Similar to the Aberdonians, the group seemed almost obsessed with the idea of 'getting out', 'helping others' and 'putting something back into the community'. Like Laslett's conception of the 'fourth age', deep old age was held to be a compressed period equated with decline, decrepitude and passivity. It was argued, therefore, that given the blurring of age-based identity, beliefs could be seen to reflect particular sets of meanings grounded in biography. Above all, similar to other research findings (Thompson *et al* 1990 1992), the group would not represent themselves as being ill - they had illnesses, but they were not ill since illness was associated with deep old age.

A sense of belonging to imagined communities, then, helped people resist the idea they could be considered as ill. For example, moral communities led people to say things like they only used doctors 'when absolutely necessary' because they had been brought up to do this; alternatively, they did not 'tell them everything'. There was, then, a real danger that proportionally, the group did not use health services in relation to need. If this situation is generalisable and, moreover, if health care continues to be rationed in later life (Mihill 1994), this suggests a state of affairs which does not bode well for older adults.

In terms of death, community was highly significant for the group. For instance, when illness experiences were represented as life threatening, a strong view came across that - in escaping death - they had been chosen by God; to continue 'his work' or to 'put something back into the community', to carry on 'my work in the church', and so on. Above all, just like the Aberdonians, the group had diverse death-related beliefs. Religion was a significant

resource for a minority which was often interpreted in a personalised way. In addition, making plans for those left behind or dying in the company of family were held as desirable, although neither was mentioned by people living alone. Some expressed an aversion to death and dying in ways which could be construed as a reflection of cultures of 'death denial' or 'sequestration' (Aries 1974 1983; Gorer 1965; Mellor and Shilling 1993).

To summarise, imagining community provided a resource to resist negative representations of later life. However, it has its limits: the stereotypes of later life still endure and it does nothing to eradicate inequalities in later life. As many have noted, the social category of 'old age' invokes particularly negative stereotypes in Western society (Bytheway 1995), resulting in stark inequalities (Vincent 1995). Thus, as noted, most older adults live alone, and this was reflected amongst many interviewees. Furthermore, despite the expressed wishes of many, only a minority die at home (Young and Cullen 1996). Unless there is a radical change in attitudes to 'the elderly', the indications are that exclusion and disadvantage are likely to continue. Imagining community has been shown as a way of tolerating such a situation, it does not change it. This study has shown, therefore, that whilst the invocation of imagined community may be imperative, it may also be considered as an indictment of a society which makes it necessary in the first place.

Postscript: the construction of older adults as parvenus?

A number of writers have begun to argue that the increasing targeting of older adults by merchandisers and market research may promise an increase in more positive representations of later life (Blaikie 1999; Featherstone and Hepworth 1995). In general, this derives from the arguments that social status is based on what one consumes rather than what one does (or did) in working lives. Thus for Veblen (1994), a new 'leisure class' emerged towards the end of the 19th century. It accumulated status by emulating activities involving waste, the demonstration of 'uselessness' and being incapable of 'productive work'. Veblen describes unproductive pursuits, practices and displays - such as the over consumption of food and alcohol, fickle and expensive fashion trends and clothing, which made women incapable of productive work (for example, the whalebone corset). Foxhunting and other social gatherings similarly allowed the display of 'conspicuous consumption'. This made social mobility possible for the 'captains of industry' and others who were previously denied this on the basis of lack of birthright. The leisure class were seen as peer leaders and others emulated their conspicuous consumption in order to climb the social ladder.

In the context of increased mass production and consumption from the latter part of the nineteenth century, a number of writers have followed Veblen's lead and argued that consumption rather than production is the central social arena for social reproduction in the major spheres of social life (Bourdieu 1984; Edgell *et al* 1992). As noted, some writers have begun to explore the implications of the rise of consumer society for older people. Thus, for Featherstone and Hepworth (1995), older people are target-marketed by merchandisers in ways which blend the idea of the heritage, family and community. This is often depicted with a rustic look and an association with a younger or mid-lifestyle orientation. The aim is to sell goods and services to older people under the guise of 'positive ageing':

following a lingering tradition dating at least back to images of later life in Victorian painting, positive ageing is intimately associated with the countryside. Rustic imagery is a persuasive characteristic of successful retirement . . . the front cover of Hill Samuel's Financial Monitor for summer 1993 included a feature on 'Action Time For Pensions' highlighted against a five-bar gate leading to a pathway across a vista of summer fields stretching endlessly away to cloudless blue horizon . . . An important force

behind the . . . 'ageing industry' . . . is a growing sensitivity on the part of merchandisers to the potential new markets in middle and later life. (Featherstone and Hepworth 1995: 32)

In addition, television comedy has increasingly begun to represent older men in terms of the older 'boy' at play, so emphasising a revival of youth. Thus Martin describes the series *Last of the Summer Wine* as:

disarming because its images are reworkings of the stereotyped and familiar. The setting is an idyllic Yorkshire village which evokes nostalgic sentiments about moorland landscape, Englishness and lost community while reminding its urban viewers, as a central element in the primary joke, that 'community' means everyone knowing everybody else's business. Our three heroes [old men with nicknames - Compo, Clegg and Foggy - that reflect their schoolboy natures] either escape the prying eyes, or, as often, defy them and turn every attempt at surveillance and control into an occasion for joyous resistance - a sort of raspberry blown at Michel Foucault, as it were. Indeed, since most of the community sanctions concern loss of respectability, all that is required is to follow Compo's lead and not care a toss for it. The formula only works as well as it does because the three old boys are encumbered by wives or families. Many of the jokes have them improvising temporary escape routes for friends still caught up in the serfdom of marital obligations to monstrously powerful women. (Martin cited in Blaikie 1999: 167)

However, there is a serious flaw in such representations; they do not match reality for the majority of older adults. In the words of Blaikie:

Heritage asserts the value of family and community at a time when more and more older people live alone . . . Since 1961 the number of older people living alone has more than doubled, whereas the proportion of households containing three or more people has fallen by a third. (Blaikie 1999: 164)

On the other hand, there is some evidence of older people 'at play', for example in 'Long Stay Winter Breaks' (Blaikie 1999: 166-7), or emigration to warmer climates (Ely 1988). However, the extent of such experiences is debatable. For the interviewees, class-based financial constraints of social class meant that many could simply not afford holidays, let alone extended winter holidays in warmer climates. Indeed, holidays were not represented as times for 'playing', but rather for the experience of cultures which displayed 'old world' values. Playful 'old boy' behaviour was not a dominant theme among the men interviewed. Generally speaking, conspicuous consumption was conspicuous by its absence. For the group, what they bought and displayed as possessions were held to be much less significant than actions which linked them to moral communities. This was reflected in wanting to feel useful and productive. Thus, the continual assertion of morality within beliefs reflected not only lives of hardship, endurance and toil, but a self-expressed desire to avoid or stay out of 'consumer society' and of resistance to the ideal of consumption as a status practice.

Undoubtedly, it is difficult to dispute the burgeoning literature and argument that sees consumption as central to the reproduction of social structures. Indeed, as Bauman remarks:

consumption is firmly established as the focus, and the playground, for individual freedom, the future of capitalism looks more secure than ever. (Bauman 1992a: 51)

However, a majority of older people without the ability to pay, or the health to participate in conspicuous consumption practices, are excluded from consumerism. Indeed, consumerism was almost aversive to the interviewees and their resistance to it did not appear to have any adverse effects upon them. On the contrary, it seemed to give them a further impetus - if not the main one - to assert their membership of imagined communities which represented bipolar opposites to self-indulgent conspicuous consumption. Even though consumption is the dominant element of social organisation, the identity choices within such a context are repugnant to the group.

For Bauman (1997), the postmodern fragmentation of the contemporary world has led to the creation of 'parvenus'; that is, those who do not quite fit in properly. In large part, his description of parvenus could equally be applied to older adults.

The habit of nomads is the desert . . . The sight of tents pitched yesterday on the site of the overnight stay is reassuring: it fences off a plot of the desert so that it may feel like an oasis and give sense of purpose to yesterday's wanderings. These tents pitched yesterday, being but tents, call, however, the bluff of self-congratulation. . . . Wherever they come and dearly wish to stay, the nomads find themselves to be parvenus . . . somebody already in, but not quite of the place; an aspiring resident without a resident permit . . . The older tenants hate the parvenus for awakening the memories and premonitions they struggle to put to sleep. But they can hardly do without parvenus, without some of them being branded parvenu, set apart . . . charged with carrying the bacillus of restlessness in their bodies it is thanks to such a branded part, and them only, that the whole may think that the bad dreams and the morbid premonitions are other people's fates and do not quite apply to themselves. The parvenu needs a parvenu in order not to feel a parvenu. And so nomads fight other nomads for the right to issue residence permits to each other. It is the only way they can make their own residence feel secure. The only way they can fix time which refuses to stay still is to mark the space and protect the marks against being effaced or moved. (Bauman 1997: 72)

The habit of older adults is the desert of the contemporary world which devalues and excludes them. In order to make it tolerable, this study has shown how the creation of imagined community can be considered as a means of creating an oasis in the desert. However, the oasis does not eradicate the desert, it simply constructs an imaginary fence. As parvenus, older adults do not feel they belong to the contemporary world - imagined community only gives them a tenuous grasp. The other residents of the world, need to consider 'the elderly'

as parvenus to also provide them with a sense of security. They are not old, being old is something which happens to somebody else. At this moment, they are safe from it. Parvenu, then, needs a parvenu in order not to feel a parvenu - they are not old. Issuing a residence permit based on consumerism or community is the only way both groups can feel secure. The world is constantly changing, however, the maintenance of beliefs and practices related to residency credentials allow younger and older parvenus to mark their space.

Moreover, as writers like Laslett (1987, 1989), have argued, given increasing longevity and improvements in health, radical social change is a real prospect. Perhaps it would be optimistic to forecast a demise in consumerism if the growing number of older people continue to seek refuge in imagined community as the interviewees have done and as other writers have depicted (Blaikie 1999; Seale 1998). Even though baby boomers may take with them a youthful disposition into later life in the next century (Blaikie 1999; Featherstone and Hepworth 1990b), the likelihood of wishing to impose a sense of security and purpose in order to fend off impurities invokes the ideas that it is older people as parvenus who will continue to seek refuge in imagined community. Indeed, imagined can become practised, particularly if it is underpinned by economic and political power?

Appendix

Transcription symbols

((laughs))	No, no ((laughs))	Double parenthesis contains author description
[the doctor]	he [the doctor] said	Single square parenthesis contain author explanation
HELL	It was HELL	Capitals, except at the beginning of lines, indicate especially loud sounds relative to the surrounding talk
[SC: for some [time BB: [yea	Left brackets indicate the point at which a current speaker's talk is overlapped by another's talk
<i>Italics</i>	<i>Oh, it was awful</i>	Italics demonstrate some form of stress via pitch and/or amplitude and/or pronunciation
()	It was () and it effected ()	Empty parentheses indicate the transcriber's inability to hear what was said
...	and he said... That's what I mean	Three dots immediately after text show an unfinished sentence
...	...you see, this was beyond my ken	Three dots immediately before text mean that preceding text of extract has been omitted
...	Mary . . . was wonderful	Three dots prefixed and followed by spaces indicate that the extract has been abridged

Derived and developed from Silverman (1993: 118).

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