Social Theory and the Aging Body

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Introduction

The importance of the aging body to social gerontology is in many ways obvious. For example, illness can limit the functioning of the body and this can have psychological, political and social consequences which stimulates the interest of gerontologists of all backgrounds. Moreover, health is conceptualized in terms of body maintenance and such activities form a central feature of consumer societies (Featherstone & Wernick, 1995). A further reason the aging body is central to social gerontology is that the biomedicine has devised the means to foster intellectual respectability to a range of 'scientific' ideas concerning aging. Biomedicine can also practically alter the boundaries of the physical body; it can reconstruct bodies through plastic surgery; it can interfere with genetic structures; and it can move internal organs from one body to another. As Shilling (1993) argues, there is an irony here: the more we know about bodies and the more were are able to control, intervene and modify them, the more uncertain we become as to what the body actually is. The boundaries between the physical body and society are becoming increasingly blurred. In this respect, in the field of social gerontology, the body represents an important and significant area of study.

The paper addresses, therefore, the question as to how the biological aging body acquires meaning, and also how the meaningful body itself, in its turn, influences and limits such signifying processes and social efforts as to change the body. This is done by focusing upon the different negative and positive representations of the body that have taken place in recent years. In particular, the notion of corporeality within the biomedical model and the naturalisation of the aging body is analysed. Then, the paper will look at the aging body in one particular social location, gender and point to the social construction of the body and aging. The paper's particular interest is in the gendered aging body as it is intertwined with science and politics.

The next section raises questions as to the body and social gerontology, in particular it illuminates the negative and positive representations of old age which have manifested in recent years to understanding the body.

Old Age and the Body

There has long been a tendency, in matters of aging and old age, to reduce the social dimension of aging to a derived set of life 'stages' (Cole, 1992) which are said to determine the experience of old age. Accordingly, being old would primarily be a private experience of social adaptation to inevitable physical and mental decline and of preparation for death (Powell, 2000). The aging body is seen primarily in negative, stereotypical terms.

Thus representations of what it is to be old have been shown to structure the ways in which individuals and social groups alike recognise old age in others and in themselves. In their analysis of retirement magazines, Featherstone

and Hepworth (1993), for example, argue that the types of images of old people presented in specialist magazines are consonant with attempts at focusing on the positive side of being old. This is usually linked to the Third Age, those in early retirement and the continuation of a full round of leisure and other activities. The message here is that there now exist opportunities for consumption (McAdams, 1994; Gilleard & Higgs, 2001) and enjoyment in old age which act as a counterpoint to traditional images of people of the Fourth Age.

Physical appearance and Aging

Although social gerontologists have only recently begun to conceptualize the body, there is, however, a concern amongst older people about their lived bodies (Katz, 1999). Friedan (1993) argues that consumer culture promotes this concern and then exploits it. Morris (1998) agrees, asserting that consumer culture is pre-occupied with perfect bodies, spread through glamorized representations of advertizing. The visual image is increasingly dominant in western culture. Thus, consumer society reinforces and creates negative language and images of later life. In turn, this can produce a slide into symbolic or social death (Powell, 2000). There is an inverse relationship between images of old age and the participation in social life (Bytheway, 1993). By consumer culture emphasising youthfulness–'the body beautiful'–it is increasingly marginalizing the identities of older people in later life.

Literary evidence of the sudden realization that old age has caught up with the young self is plentiful - see for instance Bytheway's (1993) account of Bernard and Mary Berenson's encounters with their aged bodies or J.B. Priestley's description of the sudden realisation that he had become old. The visible physical manifestations of senescence therefore constitute a disguise that conceals the real, unchanged, self (Featherstone and Hepworth, 1993). Bytheway and Johnson (1998) assert that we need a well-constituted image of what old looks like before we could recognize the signs in our own images.

Social gerontologists can study persons of a certain age, but their reality seldom reflects that of the subjects they study when their bodies are ignored, because becoming, and being, old are embodied processes. Simultaneously, becoming, and being, old are about the corporeality of being old, the experience of holding on to physical/mental integrity and reasonable health (Baltes & Carsterson, 1996). It is therefore important to focus on the construction of identity that is imposed upon the discourses of exteriority and interiority that impinge upon the body.

Bio-medicine and the truth stories about bodies

The major theories of Michel Foucault (1977) show the extent to which institutional medicine objectifies the 'sick' body, once it has been medicalized. For Foucault (1977) the body is not natural but created and reproduced through discourse. Foucault maps out how medical power became a disciplinary strategy which extended 'control over minutiae of the conditions of life and conduct' (Cousins & Hussain, 1984, 146) of individual bodies. The medical profession became an institution in which the advice and expertise of professionals was geared to articulating 'truths' about bodies (Armstrong, 1983). Medical domination through observation and scientific discourses objectified 'sick' bodies as 'diagnoses began to be made of normality and abnormality and of the appropriate procedures to achieve the norm' (Smart,

1985, 43). In this way examining the body of older people was central to the development of power relationships in social situations:

> 'The examination is at the center of the procedures that constitute the individual as effect and object of power, as effect and object of knowledge. It is the examination which by combining hierarchical surveillance and normalizing judgement, assures the great disciplinary functions of distribution and classification' (Smart, 1985, 49).

> As Frank (1990, 135-6) notes, the medical model occupies a privileged position in contemporary culture and society:

'Medicine does occupy a paramount place among those institutions and practices by which the body is conceptualized, represented and responded to. At present our capacity to experience the body directly, or theorize it indirectly, is inextricably medicalized'.

The way in which biomedicine has interacted with older people is a subtle aspect of control and power (Katz 1996). This interaction legitimises the search within the individual body, for signs, for example, that s/he 'requires' forms of surveillance and processes of medicalization (Powell & Biggs, 2000). This legitimation permeates an intervention into older people's lives, because professional practices of surveillance are said to befit older people--because of the discourse of declining, or pathological aging (Powell & Biggs, 2000). Biomedicine, hence, constructs the identities of older people as objects of power and knowledge:

> 'This form of power applies itself to immediate everyday life which categorises the individual, marks him by his own individuality, attaches him to his own identity, imposes a law of truth on him which he must recognise and which others have to recognise in him. It is a form of power which makes individuals subjects' (Foucault 1982: 212).

Unfortunately, the medical model perceived old age, in particular, as related to physical, psychological and biological problems of the 'body'. Such 'problems' of the aging body were tied to narrow individualistic explanations such as that aging bodies 'decay' and 'deteriorate' (Powell, 2000). In western culture, therefore, the aging body has been perceived as the 'bottom line'– subject to relentless growth and decay and 'body betrayals' (Biggs & Powell, 2001). Insofar as there is a history of aging, there is also a history of medical discourses of power which have attempted to colonise narratives that would understand the body (Powell & Biggs, 2000). According to Katz (1996), the effects of the decline analogy can be seen in the hegemonic dominance of medico-technical solutions to the 'problems' of aging that bear on the 'body'. As Biggs & Powell (2001, 95) point out:

> 'This has led to a skewing of gerontological theorizing and research towards geriatric medicine and the relative failure of more broadly based social and life-course approaches to impinge upon thinking about old age.'

The dominance of the medical model and its understanding of the aging body has colonised definitions of old age and negative discourses pertaining to aging. It has also sought to re-invent itself as the 'saviour' of aging via the bio-technological advancements that foster re-construction of the 'body' and to prevent the aging process (Wahidin & Powell, 2001; Powell & Biggs, 2002). It appears:

> "established and emerging master narratives of biological decline on the one hand and consumer agelessness on the other co-exist, talking to different populations and promoting contradictory, yet interrelated, narratives by which to age. They are contradictory in their relation to notions of autonomy, independence and dependency on others, yet linked through the importance of techniques for maintenance, either via medicalised bodily control or through the adoption of 'golden-age' lifestyles" (Biggs & Powell, 2001, 97)

The medical model also has tended to disembody older patients by ignoring their 'lived bodies.' Research by Powell and Biggs (2000) indicates that medical discourses of power play a key interventionist role in societal relations and in the management of social arrangements. That is, medical 'experts' pursue a daunting power to classify, which has serious consequences for the reproduction of knowledge. The power to classify also serves to maintain power relations (Powell & Biggs, 2000).

Schrag also (1980, 252) powerfully illustrates that the medical model provides a:

> 'subtle and erosive process [to individual identity]. Almost every agency of education, social welfare and mental health talks the seductive language of prevention, diagnosis and treatment; and almost every client is held hostage to an exchange which trades momentary comfort and institutional peace for an indefinite future of maintenance and control'.

'Lived bodies' play not only a crucial part in the identity formation of older people via medical discourses but also, of equal importance, in the social constructions and representations of the body between older men and women. While the naturalisation of the body has been pointed out and contested its 'objective' stance via the appropriation of social constructivist insights, gender is a key identity variable identified and evaluated, a dividing practice between men and women. Gender, therefore, is important and significant for the further gerontological study of aging, identity, and embodiment.

Gender and the aging body

Feminism has focused on the ways women's bodies were controlled and dominated within patriarchy. A series of social institutions – medicine, the law and family – were implicated in the control of women through the control of their bodies. According to Twigg (2000) feminism drew our attention as to how women are represented in culture as more embodied than men, as representing the body itself.

The 'body' within social gerontology pays insufficient attention to the ways in which gendered bodies have always enjoyed varying degrees of absence or presence in old age - in the guise of 'female corporeality' and 'male embodiment' (Gittens, 1997). Indeed, there are discursive strategies whereby 'the body' and 'the social' are dissociated in the first place. In this framework, woman is saturated with, while man is divested of, corporeality. Older women have higher rates of chronic illnesses than do men, and their bodies outlast those of men. In clinical settings, in old age, women outnumber men in nearly all waiting rooms. Yet she is divested while he is invested with sociality. Gerontologists need to acknowledge that knowledge is 'gendered' and is male. The absent women in social gerontology were the women in the body excluded from the social. It is male bodies that animate the social - they appear for a fleeting moment, only to disappear immediately, in the space

between 'corporeality' and 'sociality'. Thus, it is not simply a case of recuperating bodies into the social, but of excavating the gendered discourses whereby gendered bodies were differently inscribed into and out of the social in the first place. The crucial point here is not the more familiar story of her saturation with corporeality but the less familiar one of what happened to his body. As a needed qualification, Harper (1997: 169), reminds us that because women are always embodied and men are not, 'men become embodied as they age' through the experience of the experiential and constructed body.' So the gap between women and men may narrow, in some ways, as they age.

Indeed, Feminists have underlined the limits of Cartesian thought which considered the subject as disembodied and, above all, a-sexual (Braidotti, 1994). In the representation of the female body, the dichotomy between body and mind has been used to emphasize sexual difference. On the one hand, we have masculinity which is defined in relation to the mind and the "logos," while the feminine is defined in relation to the body and its procreative functions, an essentialist construction, par excellence. (Twigg, 2000). As Adrienne Rich reminds us, women have had to deconstruct the patriarchal stereotype which links the female body with its procreative function: "I am really asking whether women cannot begin, at last, to think through the body, to connect what has been so cruelly disorganized" (1976, 184). With this incisive sentence, Rich stresses that women have to overcome the damning dichotomy between soul and body, in order to re-appropriate their bodies and to create a female subject, in which the two entities are complementary. Contrary to andro-centric and Euro-centric philosophical tradition, feminist philosophical studies have emphasized that the body is a symbolic construct, located in a specific historical and cultural context: in other words its conceptualization can no longer ignore the close nexus between sex, class and race (Blaikie, 1999). Women often find themselves defined as 'the other' (the residual category) over against men, just as blacks do so against whites and gays do so against straights (Harper, 1997). They are the ones in the shadows, not in the positions of power, the defined, not the definers. To put a point on this dualistic construction, one may remember Professor Henry Higgins, who sang, in My Fair Lady, 'Why can't a woman be more like a man?'

Contemporary cultural representations of aging focus on the body because this provides the clearest evidence of the historical inequality between gender differentiation: the body of women is inscribed with oppressive ideological mystifications (Friedan, 1993; Sontag, 1991). Western literature and iconography are full of anthropomorphic discursive representations of old age as a woman with 'grey hair', 'withered', 'faded', 'pale and wan face', 'foul and obscene' (Friedan, 1993). The old woman becomes a symbol of 'evil' and an allegory of time which completely corrupts everything. In Portrait of an Old Woman by Giorgione (1508-1510), the devastation impressed on the curved figure, balding with few teeth and deep lines on her face, her eyes pervaded by sadness, acts as a reminder of the transience of beauty. It provides a terrible warning of what is to come, hence the scroll laid on one of her hands reads: "with time" (Greenblatt, 1980).

The notion of 'intertextuality' can be used as it is a mechanism by which the social world is fabricated and this explains why cultural 'ideologies' continually perpetuate perceptions of aging and gender. Postmodern perspectives can facilitate an understanding of how older people can intertextually re-construct cultural narratives to explain their representations of identity and self-

identity. Such a strategy involves a challenge to the homogeneity of the social category 'elderly' as an embodiment of the 'times up' medical narrative. When the issue of social identity in later life is analysed Foucault's (1977) contention seems powerful in articulating that there has been a growth in the localities of power and knowledge that seek to inscribe physical and social bodies with discourses of normality and self-government. In the search for a stable identity not dominated by both professional and cultural discourses of power, older people must 'achieve' it through 'ontological reflexivity' (Giddens, 1991). Accordingly, the self-identity needs to be consciously constructed and maintained. The aging self has a new pathway to follow, stepping outside dominant discourses of medical and patriarchal reason, to include a process of safety, self-exploration, self-struggle and self-discovery, it is anything but given.

Conclusion

It would seem that the aging body is yet another mode of embodied subjectivity for gerontologists to unravel. The re-territorialization of the aging body by society, and paradigmatically by social gerontology, is a strategy, which parallels the denial of subjectivity within the main traditions of scientific medical and social practice. The concept of the 'body' itself may take on particular sets of meanings for older people, both men and women, whose subjectivity of identity formation conflicts with the objectified scientific definition. In terms of the latter, the explanatory frameworks derived from bio-medicine help to reinforce stereotypes that late life is synonymous with and indeed caused by being old. Medical narratives of the body, far from totalizing knowledge about bodies, obscures the social construction of identity and practice. What has been attempted to bring to the fore, are the different ways medical and cultural knowledge of aging are socially constructed in western society.

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