The fourth age is a troublesome concept, an inevitable outcome of the emergence of the third age as a period of personal growth and active engagement. The philosopher Helen Small (2007) comments that what matters most about old age is the human being’s heightened exposure to contingent harms related to serious ill health. The ambivalence with which ageing is considered is evident in the way that as we grow older we spend increasing amounts of time thinking about this fact, while at the same time trying not to think about it and what it implies. Small’s observations are reflected in the concept of the ‘social imaginary’, developed by Gilleard and Higgs (2010), which depicts the fourth age as a black hole from which there is no return and which, like a black hole in space, cannot be fully understood. In cultural studies there has been a heavy emphasis on theorising the third age, with its opportunities for personal growth and development. Arguably, the lack of attention paid to the fourth age has contributed to the continuation of objectifying discourses concerning this stage of the life course.

In policies for older age in most welfare systems of the world, the aim of maintaining independence for as long as possible is ubiquitous. This aim assumes a shared understanding that independence has such high value that professionals have a responsibility to preserve it. There is also a strong moral dimension to older people’s personal struggle to maintain independence and not be a burden on family or society. However, this policy discourse inevitably leads to the question, ‘When independence is no longer possible, what happens next?’ Although the preservation of independence is a core cultural value, the loss of independence is poorly understood in terms of its significance for older people (Twigg 2006). Unsurprisingly, even those older people who are considered by others to be frail tend to disassociate themselves from the old (Nicholson et al. 2012). As Gilleard and Higgs (2000) have pointed out, unlike the third age, a fourth age identity is not one with which people willingly wish to identify. Conceptualising identity in the fourth age therefore requires us to address a particularly complex set of questions. At the same time it will be argued that what we learn about the fourth age reveals much about the whole life course.

The fourth age is characterised by the combination of advanced chronological age, bodily decline, loss of functional health and mobility and increasing dependency on others for help with everyday activities. However, these characteristics are rarely straightforward, are not biologically or temporally determined, and vary in how they are interpreted by older people and those around them. Gilleard and Higgs build on their black hole metaphor to argue that older
people make a transition over an ‘event horizon’ to become subjects of the fourth age when it has been decided by professionals that they have lost the capacity for self-care. Having made this transition they pass ‘beyond the possibility of agency, human intimacy or social exchange’ (2010: 215). Of course, decisions concerning whether such a transition has occurred vary according to time and place, in line with changing norms, values and structural constraints. At the current time in the UK and elsewhere, constraints on resources available for care services mean that stricter rules apply concerning people’s eligibility for help. In turn, such changes influence the perceptions and practices of professionals working with older people about their capacity for independent living.

Irrespective of professional judgement, individuals have their own views on their capacity for self-care and when they judge that they are losing it. The point at which someone is no longer able to drive a car, or to bathe themselves, or walk to the shops, for example, signifies the end of a familiar way of life and the prospect of further decline. Developing a better understanding of older people’s experiences of declining health and self-reliance in advanced old age remains an important task for gerontologists. In some ways it matters less whether the fourth age is ‘unknowable’ as a cultural concept than that a better understanding of older people’s experiences of declining health and self-reliance is developed. This is important in order to promote a fuller understanding of the life course as a whole.

The final stage

The contours of the fourth age must be examined not only in relation to the third age but also in terms of its closeness to death (Twigg 2006). Coleman and O’Hanlan (2004) argue that there is a need to re-think our perceptions of the fourth age and the contemporary cultural failure to engage with conditions of physical decline at the end of life. Demographic trends are relevant to such a reconsideration, as the link between old age and death has never been stronger than it is at present. At the turn of the twentieth century, around a quarter of the population lived beyond the age of 65, compared with more than 85 per cent at the turn of the twenty-first. Over this period, a long life has become normalised to the extent that a person who dies prematurely is regarded as having been ‘robbed’ of life. The future-orientated, planned life characteristic of contemporary Western cultures is predicated on the assumption of a long life, but in the fourth age, the nearness of death makes the future difficult to contemplate.

Dying in old age is typically an extended process in which it is difficult to pinpoint the time when an individual is dying from, rather than living with, a condition, even when the condition is known to be incurable. The lengthy dying trajectories of old age have been described by Bern-Klug (2004) as ‘the ambiguous dying syndrome’, by Nicholson et al. (2012) as an ‘uncertain and dwindling process’ and by Lawton (2000) as a period of ‘liminality’, where social death has preceded biological death. This picture of lengthy decline is the opposite of what older people say they want, which is not to linger in poor health but to die before they become a burden on others (Gott et al. 2008). The idea of social death is particularly strong in the context of dementia and in relation to care homes, which remain stigmatised as places where the old are abandoned (Johnson et al. 2010). Elias (1985) described this graphically as the hygienic removal of the dying to behind the scenes of social life.

The ambiguity of older people’s dying matters a great deal in terms of their entitlement to services. In most countries, the development of palliative care has been associated with cancer care, and although there is widespread recognition that these services should be extended to the complex health conditions associated with old age, it has been difficult to achieve this in practice (WPCA 2014). As a result, older people are frequently denied access to palliative
and hospice care services (Gomes et al. 2011). At the same time, there are reasons to question whether palliative care, as currently organised, is always appropriate for older people. At a global level it is strongly influenced by the model developed in North America and Europe. Within this model openness and awareness of death are regarded as essential pre-requisites of the ‘good death’, enabling the dying individual to exercise choice and control over their dying. However, there is evidence that even when seriously ill, many older people tend to resist the idea of openness about death, and talk about it in oblique terms. Gott et al. (2008) argue that this should be understood as a valuable coping mechanism that has the effect of ‘bracketing out’ illness in order to minimise its impact on personal identity.

The ‘service user’ identity

In the fourth age it becomes increasingly likely that an individual will use health and social care services. The potential for loss of individual identity associated with becoming a service user has been documented over decades (Robb 1967, Townsend 1981, Hockey and James 2003). The term ‘service user’ (as opposed to ‘client’ or ‘patient’) is intended to convey the idea of purposeful engagement with services. Recently, the rhetoric of personalisation and individualisation has become dominant among service agencies in many parts of the world. The concept of personalisation reinforces the message about the importance of maintaining independence and enabling older people to remain at home.

However, older people—particularly those in the oldest age groups—are still at risk of becoming institutionalised. The likelihood of being admitted to a care home increases with age. In a wider sense, older people are at risk of institutionalisation in their own homes if, for example, they are obliged to eat meals or go to bed at a time decided by service providers. Paradoxically, the rising interest in personalisation has been paralleled by concerns about the rising cost of services associated with ageing of the population. The consequent drive for economy has been prioritised over the importance of services tailored to individual needs and preferences (Lloyd 2010).

Empirical research frequently focuses on the potential for improving practitioner knowledge and organisational processes, in order to overcome the loss of identity associated with medicalisation and institutionalisation. Grenier (2006) for example, highlights how being classified by health professionals as ‘frail’ can mean that frailty comes to stand for an individual’s total identity. In her view, it is important to distinguish between being frail (as professionally classified) and feeling frail. In her research, older participants identified times when they felt frail, which were related to illness and impairment and traumatic events in life, such as bereavement. These disrupted an individual’s sense of self. In Grenier’s view, a better understanding of older people’s feelings about frailty could lead to more personalised services in which individual identity could be preserved. Other researchers have identified how practice that preserves identity and personal dignity is often achieved as a result of the efforts of health and social care workers. These efforts are often in spite of unsupportive organisational structures and cultures within services (Calnan et al. 2013, Kontos et al. 2010).

Fine (2013) questions why care is currently characterised as an impersonal product to be consumed by older people rather than as the outcome of a relationship between carer and cared for. He draws attention to the insecure and exploitative working conditions of paid and unpaid carers and argues that attempts to individualise services should give due recognition to the individuality and rights of both parties within the care relationship so that the benefits to older people are not at the expense of care workers.

These insights from research and analysis point to the importance of the motivations of individual practitioners and to the structural constraints on good practice, but because they
are framed within older people’s relationships with care services they do not fully address the broader question of identity in the fourth age. Understanding declining health and increased dependency is important not only to improve professional practice or service environments but to develop a more complete understanding of ageing. The next part of this chapter explores the relevant conceptual and theoretical explanations that have been developed, focusing on continuity and change, the relationship between the individual and social dimensions of identity, and reflexivity.

**Continuity and change**

Evidence suggests that older people can identify a point in time when their circumstances changed irreversibly, placing them in a qualitatively different position in life than experienced previously. Heikkinen (2000), for example, identified the ‘boundary conditions’ of the ageing experience, which were described by participants as deteriorating health, deteriorating sense perception, frailty, pain, impaired memory, mobility problems and loss of human relations (particularly the death of a spouse). In her research on frailty, Grenier (2006) refers to the ‘emotional threshold’ that marked participants’ sense of having become frail. Participants in a study by Lloyd et al. (2012) described how their realisation of ageing was inextricably linked with health problems. Describing the loss of mobility arising from a painful knee condition, one commented, ‘That’s when I knew old age was upon me and no mistake’. A related theme is the sense of being cut off from the world, of being ‘a fish out of water’, that accompanies those irreversible changes to everyday life that are brought about by declining health.

The need for help associated with the loss of functional health and mobility also generates significant changes in social and familial relationships. These include adjustment to new patterns of dependency between parents and children as family members take on caring roles, the loss of intimate relationships through bereavement and the introduction of new relationships between older people and care workers, who enter the most personal and private spaces of life. Such changes pose significant challenges to personal identity and highlight the extent of change and the emotional effort required of older people. However, Coleman and colleagues (1999) argue that in advanced old age an increased focus on more intimate and personal dimensions of life is evident, which can be seen as a way of preserving a sense of self, through allowing the preoccupations of earlier life to recede. For Coleman and colleagues, this suggests that there are important continuing themes in old age that play a part in enabling individuals to cope with loss and change through the care and support of those with whom they share emotional bonds.

**The individual and the social: reflexivity in the fourth age**

Explanations of the process of adjustment to changed circumstances and the maintenance of identity draw attention to theoretical work on reflexivity, which can be understood as an individual’s awareness of their relations with the world around them and of how this world might be preserved or changed. Lloyd et al. (2012) discuss the exercise of ‘mind over matter’ that was evident in the accounts of their research participants. This was interpreted as participants’ attempts to maintain dignity and personal identity. These accounts also demonstrated how participants understood that, in time, matter would trump mind and that an adjustment would be necessary between their aspirations and their physical and mental capabilities. Indeed, some participants commented that you could go too far with struggling to be independent.

This acceptance of bodily limits is explored by Higgs and Rees-Jones (2010), who developed the concept of the ‘arc of acquiescence’, which describes metaphorically the process of gradual
withdrawal from body maintenance activities characteristic of the third age. The arc of acquiescence can be envisaged as a trajectory, which is elongated for those with social, cultural and economic capital so that those with more resources are able to postpone for longer the limitations associated with bodily decline. Higgs and Rees-Jones draw on Bourdieu’s conceptualisation of habitus, the life-long dialectic between ‘disposition and position’ through which individuals set limitations on their perception of choices and settle on a position. Bourdieu argued that the process of social ageing involves ‘the slow renunciation or disinvestment (socially assisted and encouraged) that leads agents to adjust their aspirations to their objective chances, to espouse their condition, become what they are and make do with what they have’ (1984: 110). Bourdieu pointed out that this process might entail self-deception about what one is or has but arguably, in the fourth age, such deceptions become difficult to sustain because of the unavoidability of bodily decline and death. Thus in the fourth age, the dialectic between disposition and position becomes particularly problematic because dispositions—or perceptions of choice—are diminished, even for those with social, cultural or economic capital.

Developing an understanding of the fourth age demands particularly close examination of perspectives on the relationship between agency and structure. In their analysis of social identities across the life course, Hockey and James (2003) refute binary thinking about agency and structure. For them, an understanding of the body as ‘a fluid and dynamic element in a complex system of identification’ enables structural and agency perspectives to be brought together. Marshall and Clarke (2010) identify agency as the human capacity to make a choice and to be intentional. Thus, at all stages of the life course, agency requires cognitive abilities and the capacity to act reflexively and intentionally. For Marshall and Clarke, while people vary widely in the resources available to them through the life course, all people possess agency. Since impaired cognitive abilities present a major challenge to the ability to act intentionally and reflexively, there is arguably a contradiction in their perspective on agency that becomes evident in the context of cognitive impairment. On the other hand, Bartlett and O’Connor (2010) argue that Bourdieu’s concept of habitus has the potential to promote new conceptualisations of cognitive impairment that go beyond individual experience. They argue for a more culturally contextualised understanding of power relations in dementia in order to overcome the over-psychologised view of dementia that currently exists. They concede that this might lead to an over-socialised view that everything about dementia is perceived to have an external, structural cause, but they are insistent that a radical change is needed in societal perspectives on dementia.

The ‘internal conversation’

In their observation about the general tendency to over-socialise or over-psychologise explanations of individual agency, Bartlett and O’Connor have highlighted a key problem. This is tackled by the critical realist Margaret Archer (2003, 2000) with a radically different approach. She rejects attempts to collapse the binary divide between agency and structure, such as those discussed above, and argues that a conceptual distinction between the two is both logically and pragmatically necessary, in order to allow sufficient room for a fuller understanding of each to develop. Importantly, she maintains that the reflexive process at the interface between agency and structure takes place at the individual level in private. She refers to this as the ‘internal conversation’, which is shaped and influenced by different levels and types of knowledge. Archer conceptualises human experience as being located in the natural, practical and social orders, which are separate but intertwined. In the natural order is embodied knowledge from which emerges the ‘habitual body’, described by Archer as the ‘inner map’ (2000: 132), that enables the human being to live without the need constantly to work out the relationship between body and
environment. The sense of being a ‘fish out of water’ described above can be understood as a reaction to a disrupted habitual body, which occurs, for example, when balance is affected by a stroke or vision becomes impaired. In Archer’s view it is in the natural order that an enduring and continuous sense of self is formed.

The practical order involves practical knowledge, or ‘know-how’—the skills learnt throughout the life course, which, like the proverbial bike-riding, tend to stick. They can be lost through incapacitation (the loss of ability to drive, for example), but new skills, such as the use of a walking stick or a hearing aid, can be acquired. It is in the practical order that Archer envisages the internal conversation and the formation of a concept of self or personal identity, which unlike the sense of self, can be lost or re-established. The reflexive process, or internal conversation, occurs at this conceptual level in the practical order, embracing concerns from any of the three orders.

Reflexivity also involves social-order concerns, including the structural factors that facilitate or constrain individual agentic actions (as in Bourdieu’s dispositions and position, discussed above). Hence, for example, the reflexive process of a person who has a stroke that causes loss of mobility—or a disrupted habitual body—is likely to include considerations about learning new practical skills, such as the ability to manoeuvre a wheelchair or use a walking stick. Structural factors, including the availability of resources, will facilitate or impede their access to mobility aids. In the social order also are prevalent cultural norms concerning disability and the use of mobility aids, which will affect how people feel about using mobility aids. Social relationships are also an important resource to call upon for help in adjusting to loss of mobility. The process of reflexivity is thus strongly influenced by social-order factors, but in Archer’s view, it is in the practical order that the process of reflexivity occurs and involves the combination of concerns about physical well-being (natural order), competence in day-to-day living (practical order) and a sense of self-worth (social-order). In relation to the fourth age, this perspective is helpful in explaining the continuities and changes discussed above and the heterogeneity of people in the fourth age that defies the one thing they have in common: their physical decline.

Moreover, reflexivity is conceptualised by Archer (2000) and Burkitt (2012) as not only cognitive but also emotional in nature, a particularly important point in relation to those whose reflexivity is ‘fractured’ by distressing circumstances. In these circumstances, individuals can become stuck and unable to adopt purposeful courses of action. For example, they might be in despair about their loss of independence or bodily strength or they might dread asking for help because they fear being thought of as a burden. Burkitt makes the pertinent point that fractured reflexivity is a common experience rather than being confined to a particular category of individuals. This point underlines the feminist perspective that dependency is a normal feature of human life (Lloyd 2010). The concept of fractured reflexivity is helpful in explaining the above discussion of older people’s ability to recognise a point in time when they feel old or frail. At such times, the involvement of others becomes necessary and the process of reflexivity is communicative rather than autonomous.

Communicative reflexivity can be understood as an internal conversation that requires the involvement of others to bring to a satisfactory conclusion because the individual is unable, autonomously, to do so. The losses and changes discussed above disrupt an individual’s concept of self, with considerable emotional consequences. It should also be borne in mind that the changes faced by older people often occur when they are also experiencing bereavements. When the scale of the disruption to older people’s lives is considered it is unsurprising that the involvement of others in the process of reflexivity can be a boon.

Of course, the skill and sensitivity of those involved will determine whether they are a help or a hindrance. Grenier’s observation, discussed above, about the need to recognise the emotional aspect of feeling frail is highly relevant to this point. When professional support is given

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in a respectful, informative and sensitive way, evidence suggests it makes a crucially important contribution to the reflexive process. So too does the emotional support provided by family and friends (Lloyd et al. 2012, Coleman et al. 1999). An important point to bear in mind, however, is that the processes of bodily, mental and social change that occur in the fourth age are continuous, and the internal conversation is therefore particularly demanding at this stage of the life course.

Conclusion

The perception of the fourth age as an inevitable outcome of the ascendance of the ideas about the third age has been an important focus in cultural gerontology that has generated a range of perspectives on the process of adaptation and reflexivity as people come to terms with the inevitability of decline and impending death. The boundaries of the third and fourth ages are not clear, and it might be concluded as a result that the fourth age is not a clearly defined period of life. However, a better understanding of the experience of decline and frailty that we all eventually face, and which for most of us will occur in old age, is essential to our understanding of the life course. Contemporary cultural and professional practices categorise people in advanced old age as frail, vulnerable and dependent, while policies emphasise the cost of providing care. As a result, older people’s perspectives on their experiences of declining health and changing daily life have been obscured, but there is increasing interest among gerontologists in bringing these to the forefront of gerontological theory building. The perception of personal identity as emergent from the interplay between natural, practical and social orders of life provides a fuller view of human agency that is grounded in the continuous sense of self. This view of what it is to be human can take us beyond the event horizon and opens up new possibilities for cultural gerontology.

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