Beliefs and practices surrounding ageing speak to fundamental conceptions of who we are as human beings and how best to live. Anthropologists work closely with people in diverse social-cultural settings to gain access to their complex perspectives, expose unexamined assumptions, and highlight striking cultural differences. Looking beyond the view from the West, anthropologists use studies of ageing in diverse settings not only to understand others, but also to critically examine their own societies, unsettling familiar ways of thinking and revealing underlying values.

The aim of this chapter is to highlight a range of responses to some of the fundamental questions ageing poses: Where are the best sites of elder living and elder care: the self-reliant individual, the family, the market or the state? How do we deal with the transience of the human condition? Must situations of frailty and decline entail the loss of social personhood? What does it mean to age well? Two prevailing themes in Euro-American answers to these questions stand out: One is that living independently in late life is ideal (the value placed on independence and the importance of avoiding dependence); and another is that decline in old age is bad (the value of agelessness and self-maintenance). These themes merit further scrutiny by juxtaposing to alternatives. Although Western theories of ageing form just one among many global models, they are often uncritically presumed to be culture-free and universally valid, as evident in the biomedical, public health, and media discourses on ‘active,’ ‘healthy,’ and ‘successful’ ageing now circulating around the globe after having originated in the West. A central aim of the anthropology of ageing is to make interventions into presumably universal, Eurocentric models: to show how what is often taken for granted as ‘natural’ or ‘fact’ is instead, to an important degree, cultural, emerging out of particular cultural-historical and political-economic circumstances.

**Where is the best site of elder care: the individual, the family, the market, or the state?**

In contemporary Western societies, the self-reliant individual is often idealized as the best source of elder care. Although state and market support systems exist, in the form of social security and elder housing, and are considered important security options should independent living fail, and while families also offer help, the ideal is to live independently. A central theme in
American discourse on ‘successful ageing’ is independence, a goal tied to individualist notions of personhood. US gerontologists John Rowe and Robert Kahn present dependence as one of the worst fears connected to ageing, reporting: ‘Older people, like younger ones, want to be independent. This is the principal goal of many elders, and few issues strike greater fear than the prospect of depending on others’ (1998: 42). Eighty-five percent of US persons aged 65 and older do, in fact, live either singly (30.1 percent) or with only their spouse (54.8 percent) (US Dept. of Health and Human Services 2010). The figures are similar in Europe (Klinenberg 2012: 157). In reality, frail elders in Western contexts receive much help from family members, but they tend to shun receiving full financial support, co-residence, or intimate bodily care (such as toileting and bathing) from kin. Anthropological studies find that many Americans consider being fully dependent on younger relatives in such ways destructive to their sense of dignity and value as a responsible person (Clark 1972).

Independent living and ideals of health and well-being in old age are often linked in gerontological discourse, yet it is important to consider that throughout Asia and in most of the developing world, living intimately with others in a condition of appropriate interdependence is generally regarded as much more normal and valued than is living independently (Brijnath 2012, Cliggett 2005: 13–15, Ikels 2004: 9, Lamb 2013, Sokolovsky 2009: 110–11). In India, people tend to describe living alone, at any age, as ‘not part of human nature,’ ‘impossible,’ and ‘unthinkable.’ ‘We had no concept at all even that a person could live alone!’ one retired widowed math professor exclaimed after suddenly finding herself alone, with both her children settled abroad (Lamb 2009: 175). Most Indians do not wish for full dependence, preferring to die while their ‘hands and feet are working’ (Vatuk 1990), and many feel anxiety that their children may not come through to offer adequate care (Cohen 1998, Lamb 2009, 2013). Yet most elders find it entirely appropriate to reside with, depend on, and receive respectful care (seva) from junior kin, just as those in Europe and America find it entirely appropriate and valued for minor children to be dependent on their parents.

In societies emphasizing the family as the appropriate site of elder living and elder care, the cultural norms justifying why family members should care for their aged (and why the aged should wish to live with their families) are complex and varied. One widespread cultural model of family-based elder care is that of intergenerational reciprocity: adult children are morally obligated to care for their elder parents in exchange for the tremendous support and sacrifice the parents earlier extended to their children in producing and raising them. This is a model very familiar in Asia, Africa, and Latin America (e.g., Brown 2013, Cliggett 2005, Ikels 2004, Lamb 2000). In India, elders and their juniors often state that it is precisely what parents once gave to their young children—including co-residence, food, material support, love, time together, assistance with daily routines, and toileting—that adult children will later reciprocate to their parents when the parents become old (Lamb 2000). From such a perspective, not only children but also elders can be very appropriately dependent on kin for material, emotional, and bodily support.

Such models of intergenerational reciprocity intersect varyingly with local gender norms. Cliggett (2005) finds that in rural Zambia, cultural ideals of motherhood emphasize the sacrifices and energy that mothers in particular invest in raising their children. Men do not share the same bargaining power in relation to their children, while old women can make the claim that ‘I did everything for you, I carried you on my back, I fed you from my breast, so now you can sacrifice for me’ (p. 21). Diana De G. Brown relates a fieldwork conversation in Brazil with Dona Luiza, a widow of 78 and pillar of the local Nativo community: ‘When I asked her who would assume the main burden of care for her, she replied, “Ah, my daughters.” And when I asked her why her daughters but not her sons, she gave me a look indicating that I was being particularly dense—“Because I took care of them when they were children. Now it is their turn to take
care of me’” (2013: 130). Daughters are the most appropriate caregivers, Dona Luiza explains, as they have taken care of their own children and know how to do household caregiving tasks, but Dona Luiza adds: ‘My sons, ah, they will also help out’ (p. 130). In most parts of Asia, it is sons and daughters-in-law—and sometimes the eldest son and his wife in particular—who bear the primary responsibility of caring for parents, while daughters marry out to join their husbands’ families, assuming care obligations for in-laws.

Other principles of kin-based elder care emphasize less an ethic of lifelong reciprocity and more a sense that elder parents are simply inherently deserving of respectful care. The East Asian notion of filial piety is a prime example of such an ideology. With its roots in Confucian writings, the notion of filial piety is found in China, Japan, and Korea. According to the *Classic of Filial Piety*, Confucius (551–479 BC) said, ‘In serving his parents, a filial son reveres them in daily life; he makes them happy while he nourishes them; he takes anxious care of them in sickness; he shows great sorrow over their death; and he sacrifices to them with solemnity’ (cited in Ikels 2004: 3). Ikels’s volume *Filial Piety: Practice and Discourse in Contemporary East Asia* (2004) offers the rich ethnographic data of eleven fieldworkers examining how old patterns of filial piety are under pressure and changing in China, Japan, Korea, and Taiwan, as people contend with population ageing, China’s one-child policy, industrial development, and emerging ideologies of gendered and aged egalitarianism.

Cultural-moral models of individual versus family-based elder care exist in relation to political and economic contexts. The model of individual self-reliance and healthy, active, productive ageing prevailing in many Western nations complements well, for instance, current neoliberal ideals about personal responsibility, self-governance, and minimizing of public support. Stephen Katz observes how activity and self-reliance have become a ‘panacea for the political woes of the declining welfare state and its management of so-called risky populations,’ including the growing numbers of aged (2000: 147). Most developing nations lack sufficient resources to provide the kinds of social security offered elders (to varying degrees) in developed nations, making family support particularly important. Some states have harnessed conventional family moral systems to national elder care policies, enacting laws mandating family support of the aged. Brazil’s ‘Laws for the Elders’ (*Leis dos Idosos*) mandate families to take responsibility for the care of their own elders, a step that Brown finds ‘reinforces and legitimizes traditional practices as modern answers to an inadequate health service for the popular classes’ (2013: 134–35). In India, the Maintenance and Welfare of Parents and Senior Citizens Bill of 2007 (enacted into law in 2009) stipulates that adult children must care for their aged kin, or risk being fined or imprisoned (Lamb 2013: 74–6). In China, the government has recently taken to promoting Western-style individual-centered active ageing practices, including daily exercise, as a means to ‘translate into fewer health costs’ and to create ‘a more stable social order’ (Zhang 2009: 212). At the same time, Chinese law-makers have passed an ‘Elder Rights Law’ similar to India’s, requiring grown children to visit their parents, and ensure that their parents’ financial and spiritual needs are met, or potentially face fines or jail (Hatton 2013).

Even in societies emphasizing family care as a cultural and national policy, there is a widespread perception that multigenerational family living is on the decline, often interpreted as a feature of westernization and modernity (e.g., Cohen 1998, Lamb 2009). Some development discourse interprets such a move beyond the family as ‘progress,’ yet in places such as India the trend of moving beyond the family as the nation witnesses the emergence of old age homes is regarded much more ambivalently (Brijnath 2012, Lamb 2009). Demographer Kevin Kinsella reports: ‘Although the tendency has been for multigenerational households to become relatively fewer in the more developed world, two- and three-generation households are still the norm in most developing countries’ (2009: 27).
Medicalization, anti-ageing, sexuality, and the body

Along with independence, another theme in contemporary Western approaches to ageing is the medicalization of the ageing body and sexuality. Although some in the US and UK are uncomfortable with the notion of dying hooked up to elaborate machines and are promoting ‘right to die’ initiatives, it is still common for elders to be swept up into medical institutions over the final days, months, and even years of life. Anthropologist Luisa Margolies writes movingly about her own mother’s final five months of life in seven different medical institutions, where, without really pausing to question or to heed her mother’s clearly expressed wish to be allowed to die, US medical practitioners engaged in an ‘all-out assault to defeat death’ (2004: 230). Such practices accompany a deep discomfort with ageing and dying, as medicine becomes a way to control and even forestall bodily decline and death (Kaufman 2005). Byron Good reflects on the key salvational role that biomedicine plays in American culture, where death, finitude, and sickness are found in the human body, and ‘salvation, or at least some partial representation of it, is present in the technical efficacy of medicine’ (1994: 86). The American Academy of Anti-Aging Medicine (A4M) celebrates its active agenda of anti-ageing biomedical research that has, reportedly, brought millions to the realization that ‘Aging Is Not Inevitable’ (Lamb 2009: 140, cf. Mykytyn 2006).

The medicalization of sexuality in North America is part of this broader anti-ageing trend. For men, the unprecedented success of Viagra offers a cure for a bodily condition previously considered normal in older age. One of the top American news stories of 1998, Viagra ‘naturalizes lifelong performance of phallocentric sex as a marker of healthy aging’ (Wentzell 2013: 3). For women, the situation is more complicated and ambivalent: women’s sexuality and sexual performance have been much less medicalized (Loe 2004: 125–66); yet until the recent discovery that hormone replacement therapy (HRT) can be medically dangerous, HRT was near ubiquitous in North America among menopausal women (Lock 1993).

The medicalization of the ageing body and of sexuality is much less prevalent in most non-Western contexts, even within industrialized nations with highly advanced medical technologies, such as Japan. Emily Wentzell finds that, ‘despite the traditional association of penetrative sex with successful masculinity, many older, working-class Mexican men faced with erectile difficulty reject “youthful” sexuality and drugs that facilitate it in order to embody a “mature” masculinity focused on home and family’ (2013: 3). Linn Sandberg (2013) encounters similar perspectives in Sweden, finding that older men view intimacy as more or other than sexual intercourse—involving touch, softness, and feelings of love in a committed relationship—suggesting that the story may be more nuanced in the West, too. In India, common views are that asexuality is normal and desirable in older age for both men and women, as bodies naturally become ‘cooler’ and ‘drier’ with age, and as elders appropriately move on to more spiritually-focused, post-reproductive life phases (Lamb 2000: 197–204).

Anthropological research reveals similarly that even something so widely regarded as biological and universal as menopause varies profoundly (Beyene 1989, Lock 1993, Sievert 2006). In many non-Western cultures, there is a rarity or complete absence of menopausal symptoms; hot flushes, for instance, are not universal, and menopause is not ‘naturally’ experienced as negative. Yewoubdar Beyene (1989) finds that Mayan peasant women in Mexico have very positive attitudes toward the stopping of menses, which can signify a youthful return to a carefree sexuality without the worry of pregnancy, and do not associate menopause with any physical or emotional symptomatology. A term easily translated as ‘menopause’ is not even found in all languages. The closest Japanese equivalent, konenki, means more ‘the change of life’ and may or may not be associated in women’s minds with the cessation of menstruation (Lock 1993: 3–45). The most
common ‘symptom’ of konenki is shoulder stiffness. Anthropologists suggest that intersecting cultural, environmental, dietary, reproductive, and genetic factors all probably play a role in explaining such diverse experiences (Beyene 1989, Lock 1993: xxi, 38–9, Sievert 2006). Aspects of cultural, environmental, and biological context impact ideas and experiences of sexuality and the body over the life course, encouraging people to embrace or medicalize sexual and bodily changes as they grapple with how best to age.

**Personhood and dementia**

Cultural meanings of dementia are also profoundly varied, and illuminate local understandings of age, care, personhood, and what constitutes ‘normal’ and ‘natural’ decline. Writing from North America, Lawrence Cohen reflects on how Alzheimer’s narratives have served as a ‘form of dependency anxiety’ in an ‘aging public whose members are organized around their independence’ as critical to ‘available forms and narratives of successful aging’ (2006: 7). Despite a ‘personhood movement’ within some clinical, lay, and academic spaces to rediscover the person ‘lost’ within the logic of dementia diagnosis and care (Cohen 2006: 3, Kitwood 1997, Leibing 2006), a person diagnosed with Alzheimer’s is widely regarded in biomedical and Western social contexts as facing a ‘loss of self’ and ‘social death.’ Janelle Taylor indicts US society’s discomfort with situations of bodily and cognitive impairment. She asks, ‘Why is it apparently so difficult for people to ‘recognize’—as a friend, as a person, as even being alive—someone who, because of dementia, can no longer keep names straight?’ (2008: 324). Taylor portrays the ‘processes of “social death,” social exclusion and abandonment’ experienced in the US by persons with dementia (p. 325), who are regarded as ‘the not quite (or no longer) fully human’ (p. 332).

Cross-culturally, cognition and memory are not always crucial to the designation of social personhood, and the experience of senility within interrelational family dynamics can be more important than the ability (or failure) of an individual to maintain self-reliance. Lawrence Cohen (1998) finds that those in India readily identify senility with the spread of ‘bad families’ rather than isolatable disease processes. A dominant narrative in Indian gerontology has been that ‘it is only meaningful to speak of senile old bodies in the context of fragmented or nonexistent—and thus “Western”—families’ (p. 17). Within traditional multigenerational ‘Indian’ families, senility and even ageing itself would not emerge as problems. Bianca Brijnath’s later (2011) research shows increasing recognition of Alzheimer’s as a ‘disease’ in India, while nonetheless revealing how Indian families still very much treat dementia within the context of family caregiving and intimacy, seva (service), and love.

John Traphagan explores both biomedical framings of senility in Japan and the more familiar Japanese concept of boke, translatable as something close to ‘being out of it’ (2000, 2006). Boke is understood to be a state over which one has some control. Engagement in activities intended to delay or prevent boke is not simply a matter of individual activity; it also carries moral weight as a social responsibility. The moral component of boke is related to Japanese notions of reciprocity and interdependence; it is appropriate for elders to receive care within the family but not to over-burden others in ways that preclude engagement in ongoing reciprocal relations. Boke elders experiencing relatively mild symptoms are not represented as a serious problem, but rather as ‘cute’ family members in a way similar to that of a dependent child. One television drama portrayed a boke grandfather as one generally enjoyable to live with, with a pleasant smile on his face. ‘Even when he wandered off, it was an opportunity for joviality when he was ultimately found’ (Traphagan 2006: 273). Yet as a person enters into more severe states of boke, one becomes dependent without the apparent possibility of reciprocation, thereby removing the boke elder from the social interdependencies that make one a good person in the Japanese
context (p. 275). Boke presents, then, a problem not precisely of the failure of independence but rather of the failure of appropriate interdependence.

We see that understandings of senility in any cultural context speak to conceptualizations of what makes a good person. Some personhood models allow for a broader range of cognitive and physical capacity than those currently prevailing in Western medico-cultural settings, and highlight social-familial interrelations more than individual functioning.

How to deal with human transience: permanent personhood and meaningful decline

Each of the themes explored thus far—of independence and dependence, of medicalization of the ageing body and its alternatives, of dementia and personhood—speaks to a broader theme, that of how persons within societies approach the fundamental transience of the human condition. In the West, there is a profound tendency to prevent or deny the changes and declines of age. Contemporary American attitudes about ageing and personhood feature ‘permanent personhood’ or ‘anti-ageing’ models (Lamb 2009: 137–9), evident in the gerontological Successful Ageing and Active Ageing theories as well as lay discourses. In such cultural models, persons strive to maintain an agelessness as they move through later life, in fact denying changes of (old) age. Prevalent assumptions are that if change does occur in late life, such change is predominantly negative in character—entailing loss, decay, meaninglessness, and ageism (Gullette 1997), and it is hence no wonder that people would fight against the changes of age. Pursuing lifelong vitality and youthfulness can certainly be appealing and inspiring as well, although critics argue that anti-ageing and successful ageing models insufficiently recognize socio-economic and health disparities, set people up for inevitable ‘failure,’ and hinder the possibility of learning from the full spectrum of the human experience (e.g., Holstein and Minkler 2003).

An alternative Indian Hindu perspective is that life fundamentally entails decline and transience—not only in old age, but as an essential feature of the human, material condition. Coming to realize this transience can be a positive and enlightening move, potentially making both ageing and dying meaningful. According to the classical Hindu model of life stages, two of four stages constitute older age: the ‘forest-dweller’ (vanaprastha) and ‘renouncer’ (sannyasi) stages, life phases intended to be devoted to spirituality and loosening worldly ties. Few Hindus actually move to the forest or become wandering renouncers, but many do speak of late life as an appropriate and valuable time for focusing increasingly on God and spiritual awareness, as part of preparing for the transitions of dying and grappling with the reality of human transience (Lamb 2000). Talk of readiness for death and acceptance of decline, in fact, seems to be expected cultural discourse among older Indians, and highlights the widely held Hindu view of the impermanence of the human condition—the temporariness of any individual’s stay within any one human body amidst the natural cycle of births and deaths of worldly existence or samsara. Related Buddhist perspectives popular in many Asian contexts are that change is entirely normal: everything that arises also ceases.

Conclusion

We have seen the specificity of cultural ways of ageing. No one way can be considered essentially correct or incorrect, advanced or backward, natural or unnatural, humane or inhumane. However, to the extent that Western models are becoming globally hegemonic—at times recognized not as cultural but rather as ‘fact,’ especially when grounded in biomedicine and science—it is useful to explore alternative perspectives, to unsettle the certainties of Eurocentric models, and
Beyond the view of the West

to bring the fields of anthropology and gerontology more fully into conversation. One lesson for those in the West, perhaps, is that they might do well to come to better terms with conditions of human transience and decline, so that not all situations of (inter)dependence, debility, and even mortality in late life will be viewed and experienced as entailing a loss of social personhood and a failure to age well.

References


43


