The Body in Old Age and Dependency: A Territory of Threat and Uncertainty

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Abstract
This paper explores the image of the body in physically dependent elderly men and women and the way in which this image reconfigures their identity creating new meanings. In old age, the body becomes related with illness, with disablement and with its own material finiteness. Representations of the body are thus constructed around pain, deficiency, and fragility. The research was carried out from a qualitative perspective, performing in-depth interviews, with participant observation and a subject ID card as data collecting techniques. The identity of the interviewees who consented to be recorded was protected.

The data were analyzed constructing concepts and theoretical and empirical categories with the support of the Etnograph V.5. software for qualitative data. The findings reflect discourses on the body that turn on its deterioration and limitations that prevent old people from functioning adequately in life. Metaphors were identified telling of a sense of “deteriorated identity”; most participants saw themselves as “a burden”. They also showed symptoms of annoyance and shame regarding their sick or fragile bodies, as well as a constant memory of the healthy or “ideal” body of the past, which is hegemonic in our culture.

Keywords
Body, old age, dependency, identity

By the end of the twentieth century, under the media pressure of consumer society, the body had become the central point of one of the dominant preoccupations of this society: The need to enjoy a healthy body, immune to prejudice and disdain, in good physical form, a more or less narcissistic body, directed outwards, within the dominant esthetic canon, which calls for biological deterioration to be slowed down or dissimulated as much as possible. The meanings attributed to the body depend on the scenarios—with their diverse social, religious, cultural, and scientific components—in which it lives, and whether that body is male or female. The body—that is to say, the body as a representation—behaves as a semiotic object, as a text written in various forms of language: gestures, words, postures, and movements (Pera 2012).

Analyses of the body as representation are brought to bear from mainly psychoanalytic, anthropological, psychological, medical, and sociological points of view, without forgetting the influence of religion and the arts. Similarly, the body has different meanings according to the age or life-stage it represents, but also its gender; there are important differences in the meanings of the body whether it is that of a man or a woman.

Body also has its subjective and social aspects, that is to say, there is an individual representation and

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a collective imaginary of the body. Body, soul, and social life constitute a sole unit of human existence—body and world occur simultaneously. The body is a representation of the possibilities of the subject, every bodily movement expresses interrelation with the other and with others (Baz 2000; Galende 2004; Sartre 1996). By means of the body we interpret, give meaning to and relate ourselves with the world, the “lived-in body” is a system of possible actions with oneself and with others (Merleau-Ponty 1975).

The present study explores the subjective dimension of the body in old age and its relation with the reconfiguration of identity in elderly men and women with physical dependency in the city of Durango, Mexico.

In old age, the body is associated principally with illness, disabilities, deterioration, and its materially finite nature as a concrete entity. This study concentrates on disability and physical dependency as a consequence of the chronic illnesses that produce the fragile bodies of old people, and the self-images they construct around pain, insufficiency and/or failure of vital organs. The bodies of aging people “no longer respond”, they have lost the capacity to satisfy the minimum needs of daily life, and depend on others for their survival. To a significant extent, the experience of losing physical capacity affects not only the bodies of the elderly but also their identity, their perception of themselves.

Analysis of the meanings assigned by participants to their bodies centered on the relation discourse/illness/representation of the body, in which both subjective aspects (images, representations) and objective aspects (illness, functional limitations) stand out. The use of metaphors for expressing body image and the way in which the participants expressed it reveals the perception they have of their bodies and their constant struggle with the “ideal” body that predominates hegemonically in our culture and which they have left behind many years before.

**BACKGROUND**

The illnesses that cause greatest physical deterioration to elderly people are those referred to as chronic-degenerative. Such patients develop a disabled body, unable to respond to their basic needs and presenting “deficiencies” that prevent elderly adults from performing by themselves tasks in the world of everyday life. This is experienced as a series of losses that, as old age advances, are reflected mainly in the body, which becomes an unequivocal sign of the passing of time and consequent deterioration, but there are also repercussions in the psychic sphere and the social dimension. Indeed, old age “speaks” through the body, and, once it has taken up residence in it, produces uneasiness and anxiety. Chronic illness, aging and the presence of physical disabilities render the bodies of elderly people—their principal instruments—fragile; As Herzlich remarks: The language of illness is the language of the body (Herzlich 1995; Castro 2000), and if illness produces disablement for bodily movement, the body becomes the clearest evidence of a deterioration, the final effects of which are fatal, to a greater or lesser extent nobody above a certain age escapes this fragility (De Beauvoir 1970) which, for many such people, means entering into a situation of vulnerability.

Hence, it is that in developed countries, the percentage of the population over 65 with serious problems of dependency amounts to between 10% and 20%, this figure being tripled or quadrupled in those over 80 (Pérez and Yanguas 1998); in the United States, for example, it is calculated that between 3% and 6% of inhabitants between 65 and 74 present difficulties for carrying out at least one activity, and that this percentage is from 10% to 20 % in persons of 75 or older (Pan American Health Organization 2006). In the countries that make up the OECD (Organization for Economic Co-operation and Development) (2006), the percentage of over-eighties is increasing more rapidly, and with it, the physical deterioration that
impedes their autonomy and functionality. In other words, the difficulty for performing basic functions increases with age and is presented in a greater proportion in women (OPS 2006), so that human and material resources directed at attending to dependency in the elderly has become a matter requiring urgent attention in the immediate future in the developed countries (Jacobzone 1999; E. Kim and Ch. Kim 2004; Pérez 2000; Institute for the Elderly and Social Services [IMSERSO] 2006; Casado and López 2001).

In Mexico, hand in hand with the increase in life expectancy among older people, the risk of developing health problems also increases. In a study carried out by Gomes (2006), using data from the National Survey of Health and Aging (Encuesta Nacional de Salud y Envejecimiento en México [ENASEM] 2001) and the National Health Survey (Encuesta Nacional de Salud [ENSA] 2000), found that the most frequent illnesses in advanced age are hypertension, arthritis, and diabetes. Arterial hypertension takes the first place, affecting 31% of the men and 50% of women, followed by the rheumatic diseases, that affect 24.2% of men and 28% of women. Finally, comes diabetes, in 14.6% of men and 17.8% of women.

Another more recent source shows a certain variation in the health panorama of elderly people. Diseases such as diabetes and arterial hypertension are health problems met within an increasing number of adults and, particularly, elderly people (for instance, the National Survey of Health and Nutrition (Encuesta Nacional de Salud y Nutrición [ENSANUT] 2006) finds the prevalence of these two illnesses to be significant in the population aged between 60 and 69). In a substantial number of cases, chronic illnesses generate disabilities and dependency affecting the performance of the basic activities of daily life.

Likewise, the National Survey of Health and Aging (ENASEM 2001) notes that 15% of individuals aged 60 years and over experience limitations in the basic activities, and 13% in the instrumental activities, of daily life; the major percentage of this population are women (26% versus 16%), and 53% of those aged 80 or more have such limitations (Montes de Oca 2007).

Going beyond the figures, it is important to salvage the meaning of the experience lived during this prolonged later stage of life in the presence of illnesses of long duration with progressive deterioration and wearing out of the body. In this perspective, we need to set our gaze on the significance this experience has for the actors since—beside the men and women who suffer disablement in their own bodies—the impact on those who look after and care for them is also considerable. Actions of caring are directed above all at the care of the body, for this is where illness manifests itself, but it is also necessary to pay attention to the emotional and cognitive question, which is where the meanings of an annihilating experience that limits their position in the world are to be read.

THEORETICAL FRAMEWORK

Without intending to carry out an in-depth review of studies on the body, it is worth mentioning some theoretical referents that place the emphasis on the subjective and symbolic aspects, that is to say on individual subjectivity and also on the social subjectivity related to the body and disablement.

The Psychoanalytic Approach

The psychoanalytic interpretation holds that individuals develop a narrative of the body, a “corporal novel” reflecting the way in which they are facing up to or dealing with the changes in bodily circumstances—which may include the loss of a limb, illnesses or surgery, exceptional events, or just the inevitable transformations of the different stages of the life course, old age, like puberty before it (Baz 2000: 42). Freud and Ferenczi (cited in Iacub 2007) contributed the concept of “externalization”, when, because of the deterioration, loss or limitation of a
limb or part of the body, subjects cease to perceive it as something that is a part of themselves; in other words, they see it as something foreign, reified. Iacub incorporates ideas of Veysset and Maisondieu in order to interpret the configuration of the image of the body in old age. Veysset introduced the concept of the “dissociated body” which identifies the body in an advanced age that has lost the capacity to create images and resolve a conflict of identity (Iacub 2007). Maisondieu, on the other hand, relates how in old age a disintegration of the self appears when faced by a deteriorated body image that induces the thought of death (Iacub 2007). This perspective gives a special importance to language-discourse, since this is what enables the body to pass into the symbolic world and transforms it into a code in which possibilities of experiencing, feeling, within a social order acquire value. All this leads us to the recognition of a “nature” of the body as effect of a historical and cultural activity (Baz 2000: 98-99).

**Sociological Perspectives**

**Socio-historical approach.** In this approach, Iacub (2007) analyzes the presence of violence in the ways in which the Greeks and the Romans represented the body in old age, and consequently, the nostalgia for youth that signals a conjugation of identity that would be altered by aging. Simone de Beauvoir, on the other hand, suggests that in old age, even when illness is present, some of the signals of suffering are denied, to the extent that the patient believes in the possibility of putting a halt to them or making a recovery. Although disability due to a progressive chronic illness or an accident tends to be irreversible, the testimony of the body counts for less than the attitude adopted in the face of it. It is thus that the impact on the body established by illness in old age is not limited to the actual physical deterioration, but also embraces the subjective representation one has of it (De Beauvoir 1970). It represents a different way of “being in the world”, a form of existence characterized by a “permanent loss of the sense of integrity with which individuals normally experience” (Toombs 1993: 111). This way of experiencing old age and accompanying illness impacts strongly upon the image of oneself as subject, through the vision and perception of the body, in other words, it impacts on identity.

**Genealogical approach.** From the point of view of social theory and with his own genealogical approach, Michael Foucault (1977) made important contributions to explaining the role of bodies in a socio-political context, emphasizing the effects of power on them. His studies on sexuality, prison, medical and psychiatric institutions involved the construction of a micro-politics of the regulation of the body and a macro-politics of populations (Turner 1994). The concepts of bio-power and bio-politics are important in Foucault’s position. From this perspective, the body is “created” by means of networks of discourse and the interplay of power relations, to which the application of discourse gives origin. Foucault reconfigured the notion of the self, advancing to a more active self, one that transcends; a oneself that is obstinate and can be configured to perform acts of resistance (Tulle and Mooney 2002). The Foucaultian notion of power is also applicable to sick and disabled bodies, for the force of social discourses regarding this phenomenon has a strong repercussion on the individual, subjective experience of older adults. As Bover (2009: 26) remarked, the subject recognizes his subjectivity in words, in discourse, names his body with the founding power of the word.

**Interactionist perspective.** From symbolic interactionism, the forms of subjective representation of the body in elderly people with disablement integrate what Goffman (2006) calls “bodily signs” of a worn out and deteriorated physique. Such signs are revealing of a social stigma and reveal a central part of the identity of the self. A similar thesis is the idea that the body comes to be the ontological part of aging, to the extent that any manifestation of fragility, such as an injury, disease or the appearance of
biological aging, is a threat that affects the sense of oneself (Tulle 2008).

Within the collective imaginary, there is a social and individual resistance to aging, to the deteriorated body, there is a refusal to accept the decline of the faculties, whether physical or mental. A fear of aging appears, cushioned by the hopes that are invested in medical science, the promises of scientific knowledge that holds out the hope of finding a cure for the degenerative illnesses entailed by increasing life expectancy (Olvera and Sabido 2007). In old age, illness places the body in center stage, while the representations made of the corporal image enter into friction with a certain “ideal of the perfect body”, without fissures or failings, that holds sway hegemonically over our culture (Vaggione 2007).

Social constructionism. For the social-constructionist approach, the body in old age is represented by a discourse of deficit through the presence of illness and deterioration of the body. As a consequence of this, a transgression of identity arises, since self-esteem is affected along with security as social and family roles are relinquished. Discourses of deficit are constructed on the basis of illness, pathology and dysfunctionality are shared by health professionals, society, and the patients themselves (Gergen 2006). Different representations of the body coexist and mingle in medicine; medical discourses of the body are a product of society, orienting forms of behavior and producing effects upon them. While at the present time, the medical discourse is not the only one that exists where health and disease are concerned, we cannot avoid the fact that often we are not able to speak of our bodies and their functioning without recourse to medical vocabulary. Nonetheless, regarding knowledge about the body, discourses and practices of various types—scientific, religious, and popular—coexist implicitly in the task of defining where illness begins and ends (Olvera and Sabido 2007). According to the above mentioned authors, the biographies of elderly people with sick bodies are nuanced by the fear of decline of productivity, by the precarious nature of a body that no longer responds to the minimum demands of autonomy and independence. It is also threatened by uncertainty regarding a future that speaks of the finite nature of one’s own existence as represented objectively by the body. All these objective and subjective elements act to configure the identity of men and women at an advanced age.

Recent socio-cultural and demographic changes, interacting with the constant growth of the culture of consumption, have given new impetus to the proliferation of gender studies and studies of the body and the emotions. As concerns the far-reaching demographic changes, population aging has highlighted the place occupied by elderly people in present-day society. Besides, advances in the field of medicine have facilitated an increase in life expectancy with inevitable consequences for the labor market, the health system and the economies of all countries. At the demographic level, both the fall in fertility and increase in life expectancy have accentuated the weight of the elderly population.

Of the theories reviewed, the present work emphasizes the contribution of social constructivism, given the importance assigned in this approach to language-discourse in the construction of identity, and the form in which those discourses reveal the social reality of old age.

**QUESTIONS GUIDING RESEARCH**

(1) What is the body image of elderly individuals with presence of physical illness and dependency?
(2) How is identity reconfigured on the basis of discourses regarding the body that elderly men and women make about themselves?

**METHODOLOGY**

The methodology used in the present work was of a
qualitative nature, the techniques of data collection were the in-depth interview and participant observation. Likewise, a questionnaire was applied in order to investigate the health conditions and socio-demographic data of the subjects of study. The sampling method was intentional, and the sample consisted of 20 adults aged over 70, of whom 11 were women and nine men, with heterogeneous characteristics as regards sex, socio-economic level, and types of ailments. The criteria of inclusion were: suffering some limitation for performing the basic activities of daily life; residence in the municipality of Durango, Mexico; and voluntary participation in the study. Recruiting was carried out through key informants in the health institutions (physicians, social workers, directors of programs for older adults). Data analysis was performed using Ethnograph V5 qualitative data software. The narratives of each interview enabled an analysis of related concepts, similar phrases, existing relations, identification of patterns, sequences and differences to be drawn up. This facilitated inclusion of emergent categories and subcategories and the obtainment of a better reading of the phenomenon studied in order to draw up a list and a map of codes (Hernández and González 2000; González 2007). The list and the map of codes integrated in the categories helped to reveal certain themes or themata (Rodríguez 2007), which are persistent notions with generating power on account of the diversity of specific contents they may display in their particular contexts. That is to say, the participants’ themes reflect images and beliefs related with the image of the body in advanced age. The categories that were built up for the analysis, although related to a common theme—that of subjective identity—differ since each participating subject has a discourse of his/her own. The discourses reflect aspects of an identity that shows itself rationally, coherently, but also on a metaphoric plane; it is possible to interpret the biographical material from an empirical but also a theoretical point of view.

**RESULTS**

The results show a discourse of deficit that alludes to the aging body, one that is reproduced not only by health professionals but by society in general. This discourse is constructed on the basis of illness, deterioration, and dysfunctionality that is present in the subjects of study (Gergen 2006). Social reproduction of discourses on the body in old age results in a transgression of identity, affecting self-esteem and security as a result of relinquishing social and family roles. The losses that become apparent as illness advances are visible mainly in the body, which becomes the unequivocal sign of the passing of time and consequent deterioration. For the elderly, their bodies become the clearest evidence, as age continues to advance, of deterioration and disability; to a greater or lesser extent nobody above a certain age escapes this condition (De Beauvoir 1970). From the point of view of the present work, the body presents a series of wants, losses, complaints, and insufficiencies that produce unpleasant emotions in elderly people. As the author has already mentioned, the triad aging-illness-chronic disability finds its most notable expression in the fragile bodies of elderly individuals where illness becomes the discourse of the body.

The predominant discourse, not only of the elderly, but also of health professionals, family members and beyond, in social discourse, is one that alludes to a devalued image of older people, a deteriorated identity of men and women who have embarked upon old age and with it, disease. The following table shows the characteristics of participants’ illnesses and the impact on their lives (see Table 1).

The data show the degree of vulnerability of the interviewees since they relate directly to that of the deterioration that is affecting them, and which limits them progressively in their day-to-day activities. On the other hand, this physical vulnerability creates representations of the body that configure new
identities in the participating subjects. The following section will present the narratives of the categories most relevant for the analysis.

**Categories of Analysis**

The “old” and their old bodies. Images of the body in elderly people are built around pain and organic failure or deficiency. Their bodies “no longer respond”, they have lost the capacity to satisfy the minimum needs of daily life, and now depend on others for this. This is experienced by the interviewees as a series of physical losses that affect to a considerable degree of their identity, their perception of themselves (Tulle 2008).

Rosa María expresses her perception of her body:

Not long ago, they gave me oxygen: I was three days with an intravenous drip and—what do you know?—I was in control again; I said to myself, that’s the end of it then, but no, I can feel my body’s worn out, I’ve no strength left... because with not eating... (aged 86, suffers chronic obstructive pulmonary disease)

Juan Lorenzo:

I wish I could move properly, carry on working, be able to do something better, above all be able to do my things... Well no, when you don’t even have mobility, I mean the same ability to do things, anyway, in old age, I forget a lot of things and, well, it’s not the same, but it is nice to be doing something... when you can... (aged 83, suffers cancer of the colon)

For the participants, the fact of lacking strength in the body and not being able to carry out certain tasks is a form of dispossession that devalues them (Bourdieu 1998; Ferrante and Ferreira 2008) and leads them to deconfigure their identity while excluding them from a social context in which only bodies that are useful and productive have a place (Tulle 2008).

The medicated body. For elderly people, the body also suffers deterioration as a result of deficiencies in alimentation. They cease to eat properly, in part because of trouble digesting certain foods, but also out of loss of interest or apathy set in train, among other causes, by a poor state of health and the excessive ingestion of medicines. Elderly people complain that the excess of medicines affects their stomachs and so the representation arises of a body that is under attack through the medication administered to reduce the biological manifestations of inevitable decline (Tulle 2008). Videlicet, the following narrative:

Ana María: A short while ago, when I was ill with such a bad pain, the doctor came to see me and gave me medicine, and the pain went away, but so much medicine, I mean, for years now...

Researcher: Would you like to stop taking pills?

Ana María: ...No, (rather, I’d like the doctors) to say “stop taking them”; but soon the day will come anyway when, no... the stomach can’t take any more pills; but after all, God has already been pleased to give me many years of life... (90 years of age, suffering from thrombophlebitis)

The means of control that medical treatments impose presents diffuse limits between what is recommendable, safe, healthy, and the perception of the receiving subjects, who in many cases identify them as forms of aggression that injure their bodies.

The excluded body. Other narratives of interest for this analysis express the limitations affecting some participants as regards access to the public-sector health services for attention to the illnesses suffered by their bodies—aggravated by the fact of lacking the economic resources necessary for defraying the costs of medicines and private medical attention. These individuals are possessors of bodies devoid of health, sick and impaired bodies; they are, as Lisdero (2009) said, bodies expelled, excluded from a health system on account of not having been enrolled in the various social security programs. The narrative of a daughter-carer makes clear that old people (and their bodies as an essential part of them) are also objects of exclusion.
Table 1. Diseases That Occasion Physical Disabilities in the Participants

<table>
<thead>
<tr>
<th>Name of elderly adult</th>
<th>Disease/Ailment</th>
<th>Comorbidity</th>
<th>Daily basic activities requiring assistance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ma. Dolores</td>
<td>Arthritis/Osteoporosis (fracture from fall)</td>
<td>Depression/Insomnia/Gastritis</td>
<td>Getting up, dressing, bathing, walking around room, going to toilet</td>
</tr>
<tr>
<td>Rigoberto</td>
<td>Diabetes</td>
<td>Prostatic illness/Heart problem/Gastritis</td>
<td>Getting up, dressing, bathing, walking around room, going to toilet</td>
</tr>
<tr>
<td>María Santos</td>
<td>Back problem</td>
<td>Arthritis/Bronchitis</td>
<td>Getting up, dressing, bathing, walking around room, going to toilet</td>
</tr>
<tr>
<td>Roberto</td>
<td>Back problem (falls)</td>
<td>Prostatic illness/Depression/Heart problem</td>
<td>Getting up, dressing, bathing, walking around room, going to toilet</td>
</tr>
<tr>
<td>Juan Lorenzo</td>
<td>Cancer of colon</td>
<td>Parkinson’s disease</td>
<td>Getting up, dressing, bathing, walking around room, going to toilet</td>
</tr>
<tr>
<td>Rosa María</td>
<td>Asthma</td>
<td>Arrhythmia</td>
<td>Getting up, dressing, bathing, walking around room, going to toilet</td>
</tr>
<tr>
<td>Cosme</td>
<td>Back problem</td>
<td>Hypertension/Arthritis, ulcers on legs</td>
<td>Walking around room, bathing, going to toilet</td>
</tr>
<tr>
<td>Rosalba</td>
<td>Parkinson’s disease</td>
<td>Hypertension/Arthritis</td>
<td>Getting up, dressing, bathing, walking around room, going to toilet</td>
</tr>
<tr>
<td>Eulogio</td>
<td>Cancer of pancreas</td>
<td>Ulcers on hips</td>
<td>Getting up, dressing, bathing, walking around room, going to toilet, eating alone</td>
</tr>
<tr>
<td>Jorge</td>
<td>Parkinson’s disease</td>
<td>Diabetes/Hypertension/Prostatic illness</td>
<td>Getting up, dressing, bathing, walking around room</td>
</tr>
<tr>
<td>Leonel</td>
<td>Embolism</td>
<td>Chronic bronchitis</td>
<td>Getting up, dressing, bathing, walking around room, going to bathroom, eating alone</td>
</tr>
<tr>
<td>Genoveva</td>
<td>Hepatic cirrhosis</td>
<td>Diabetes/Renal problems</td>
<td>Getting up, dressing, bathing, walking around room, going to toilet</td>
</tr>
<tr>
<td>Pablo</td>
<td>Renal insufficiency</td>
<td>Back problems/Sequels of embolism</td>
<td>Getting up, dressing, bathing, walking around room, going to toilet</td>
</tr>
<tr>
<td>Imelda</td>
<td>Parkinson’s disease</td>
<td>Fractured hip</td>
<td>Getting up, dressing, bathing, walking around room, going to toilet</td>
</tr>
<tr>
<td>Ana María</td>
<td>Fall</td>
<td>Thrombophlebitis</td>
<td>Getting up, dressing, bathing, walking around room, going to toilet</td>
</tr>
<tr>
<td>Irene</td>
<td>Cancer</td>
<td>Fractured hip</td>
<td>Getting up, dressing, bathing, walking around room, going to toilet</td>
</tr>
<tr>
<td>Consuelo</td>
<td>Fall</td>
<td>Gastritis/Pulmonary prob./Insomnia</td>
<td>Getting up, dressing, bathing, walking around room, going to toilet</td>
</tr>
<tr>
<td>Abelardo</td>
<td>Leukemia</td>
<td>Diabetes/Herpes</td>
<td>Getting up, dressing, bathing, walking around room, going to toilet</td>
</tr>
<tr>
<td>Ma. Elena</td>
<td>Cervical Myelopathy/Quadriplegia</td>
<td>Herniated disc/Hypertension/Gastritis</td>
<td>Getting up, dressing, bathing, walking around room, going to toilet, eating alone</td>
</tr>
<tr>
<td>Rosenda</td>
<td>Fall</td>
<td>Diabetes/Hypertension arterial/Arrhythmia</td>
<td>Getting up, dressing, bathing, walking around room, going to toilet</td>
</tr>
</tbody>
</table>

Note: Source: questionnaires.
say, “You know what? We’re going to take (her) somewhere else”. (Rosario, aged 48, daughter-carer)

The body as a burden. In another vision of the body, the interviewees see themselves as passive and dependent subjects, the management of their bodies being transferred to their carers. These are bodies devoid of health, bodies disabled as regards basic functions, bodies that have to be mobilized by others, carried from one place to another. In this context, the metaphor arises of the body as a “burden” that implies not only the physical body but also the social body represented by old age. The concept of “burden” arises as an idea of oneself that configures identity.

Yes, they put me down here for the “check-up”... they put me here and they sit me in a chair and there I am until they come and lift me out of the chair and they put me up here again on top of the bed, and then where do they take me? Here to bed... When they get me up, my whole leg hurts like you’ve got no idea. (Imelda, aged 78, suffering from Parkinson’s disease)

...I almost never leave (the room)... sometimes when they bath me they take me to the bathroom... when I want to go to the toilet they take me there and they bring me back again... and that’s my life; there are times when they switch on the TV for me... but my eyes start watering, at times that happens and it’s uncomfortable and so I can’t see (the television); sometimes I can, but only for a little while. (Ma. Dolores, aged 93, suffering from arthritis and depression)

The experience of being in someone else’s care (generally a daughter or a wife) implies that the body no longer cares for itself, it is in someone else’s hands, it is, as it were, a body in custody, for care is indispensable for functioning and survival. In some cases, besides the carer, the participants make use of instruments that enable them a minimum degree of functioning without the help of a carer, such as walking frames, wheelchair, crutches, visual and auditory apparatus:

... that’s it, if it wasn’t for my wheelchair, I couldn’t even go out into the yard to see the plants, the daylight, imagine... (Maria Elena, aged 70, suffering from cervical myelopathy)

The shame of the body. Another inevitable feature of this state of dependency is the sense of shame felt elderly persons on having to exhibit their bodies to medical personnel or carers or as regards “intimate cares”. Shame arises not only on revealing the genitalia, but on account of the signs of old age the body presents as a whole; it is not the same thing to unveil a young body as to expose an aging one, as Baz observes: “Inevitably, those who no longer inhabit the proposed body model—that is to say, the body possessing youth, strength and esthetic appeal—experience a ‘shame of the body’” (Baz 2000: 111).

This experience is also permeated by questions of gender, generation, and family relationships; it is not the same to have one’s body cared for by someone of the same sex as by someone of the opposite sex, or by someone who, apart from being of a different sex, is of another generation or, finally, by someone who has a family relationship to the patient as opposed to one who has none. When a husband is caring for his wife, or vice versa, a situation of trust is naturally experienced; a similar state of trust may exist when receiving care from a close family member of the same sex and generation. In other cases, however, particularly when a daughter has to care for an elderly father, the situation may be more awkward:

I remember that I also had to “navigate” my father, when he was hospitalized in the “Seguro” (health service hospital) and I was working and I stayed with him and “navigated” him, ...I remember that he burst into tears, he wanted my mother to be there, but my mother had had an operation; she wasn’t even aware when my father died, not until afterwards; and so ...I had to give him the bedpan, and everything; and he cried, the tears came to his eyes and he said: “Ah, daughter, just to think that you are going to know me as I am, instead of your mother (who’s) so ill you have to...”. I (even) had to insert suppositories; first he cried and wouldn’t let me do it because he was so ashamed. And what do you do? (Francisca, aged 63, daughter-carer)
Well you see, my sisters almost don’t help, they work, they’re married, so...; besides she won’t let anybody else change her or bath her apart from me...; sometimes my sister-in-law comes, but do you think she’s going to let her change her? Not on your life! It’s not the same trust... not at all... (Patricia, aged 54, daughter-carer)

The intimacy of the body calls for a private space, with access restricted to a limited minority. When the approach to the body is not consented, it becomes an “invasion of privacy”, implying interference in the private sphere, of territorial privacy and bodily intimacy in particular (Pera 2012).

Anger toward the body. Another emotion that arises faced with the limitations of the sick body is that of annoyance or frustration. When the expression of anger arose in the participants, it was due mainly to their inability to fulfill the expectations of functioning that they were able to fulfill before. An example comes from Jorge’s narrative:

Well, at times I grumble, I grumble to myself because I used to be agile and now I’m just “damaged goods”, and so I get annoyed at myself because I want to get up and I can’t and I start yelling at my wife and my children... (aged 75, suffering from Parkinson’s disease)

In Jorge’s narrative, it transpires that the actual disablement of the body can be of less importance than the attitude adopted toward it (De Beauvoir 1970). The impact of illness in old age is not limited to the physical deterioration of the body, but also involves the subjective representation one makes of it. To have a “damaged” body, as Jorge perceives it, is to have a body that is no longer useful, productive, autonomous or independent, aspects to which a great social value is assigned.

The following figure shows the principal representations expressing the significance of their bodies for participants in the survey. The narratives reflect, on the one hand, the subjective configuration of their egos, and the elements shared by a social order that identifies the bodies of elderly people as something that has lost its reason for being (see Figure 1).

DISCUSSION

To have an aged, sick body is not only a physiological experience, nor can we reduce it to consideration of the physical body alone. Old age and illness are a source of fear and uncertainty for those who experience them. This perception is conditioned to a considerable extent by the knowledge that exists at a particular time and in a particular social context. While at present, there is a medical and political discourse emphasizing health and well-being in old age, a contrary discourse also exists: One that presents old age in terms of deterioration, illness, and dysfunctionality, aspects that inevitably become evident in the body. Illness appears in narratives as an experience or event situated in a certain order of ideas; awareness of this affords us another point of view from which to investigate life and the body (Vaggione 2007).

As Baz (2000) observed, the word “body” brings with it a torrent of meanings, supplied by affective-evaluative and historical-cultural frameworks of reference. For her, it is important to visualize the discursive material that arises in connection with the body not as a merely intra-psychic phenomenon but as reflecting a collective subjectivity in the context of a cultural universe. Men and women who lack autonomy are bearers of an identity that reflects information of their individuality, of their egos. This information that is transmitted by the person concerned is manifested through the expression of the body in view of those who observe this expression (Goffman 2006). Goffman, from a symbolic-interactionist point of view, uses the term “social” to refer to all those signs of corporal information that bring together those properties. As these signs are accessible in a frequent and regular fashion and received as a routine, they can be called “symbols”. This author distinguishes “prestige
symbols” and “stigma symbols”, the latter being reflected in “marks” in the body (Goffman 2006: 37).

In advanced age, such “marks” are seen in the deterioration of functions, the deformation of parts of the body; they also take the form of instruments that compensate for the incapacity of basic functions: wheel chairs, walking sticks or frames, glasses, hearing aids, or even artificial respirators. Such instruments and apparatus go on to form part of the bodily schema, and hence of the body itself, to the extent that it progressively assimilates the vestiges of the individual, and even more so, the social past (Bourdieu 2000; Ferrante and Ferreira 2008; Merleau-Ponty 1975). It is thus that shame of the body comes into being, a stigma of the corporal image, in those who no longer comply with a proposed body model, a predominant image of a young, healthy and competent body (Baz 2000; Goffman 2006).

In this scenario, the aging of the body undoubtedly represents a powerful threat to the identity of the participants. Their concept of themselves, their sense of ego, seems to become diluted, “falling apart”, so that it is better to conceal it. At this point, a “biographical interruption” takes place as a consequence of ceasing to be and do whatever it is that defines and underwrites the concept of ego (Bury 1982). Hence, the existence of the participants in the survey is characterized by a constant loss of the sense of their own wholeness, and a lessening of that certainty with which individuals generally live (Castro 2000); their identity is reconstructed in function of illness, deterioration, and in some cases, the expectation of death, aspects to which a variety of meanings is allotted.

Another element that takes on importance when chronic illness arises in old age is the self-devaluation

| Body Image      | • Deteriorated  
| Emotions        | • Concept of self and self-esteem devalued  
| Feelings        | • Of burden and loss  
| Thoughts        | • Negative  
| Beliefs         | • Lack of productivity  
| Ideas           | • Youth a synonym of autonomy and self-sufficiency  

**Figure 1.** Narratives of the Significances of the Body in Advanced Age. Source: the author’s own data.
of the participants on account of their dependent state which lacks autonomy and the physical competences that would enable them to form part of the social world. The isolation and stigmatization to which disablement leads, produces what Gergen (2006) calls the “discourse of deficit”, which is constructed on the basis of illness, pathology, and dysfunctionality, a discourse which is underwritten by the professions involved in attention to physical and mental health. Disablement and deficiency arise from the cultural, symbolic world, where, paradoxically, the disabled body is perceived as something to be pitied and cared for but which, on the other hand, generates rejection, frustration, self-aversion in as much as it represents an undesired experience.

The period of old age and the context in which it comes about respond to a normative dimension, that is to say, they bear reference to what we believe to be appropriate or correct, and the narratives of the participants seem to confirm that “the adequate” is youth, the capacity for being autonomous, self-sufficient; when this is no longer possible, powerful emotional repercussions come about due to the fact that the subject’s identity is falling apart. In this sense, one should try to understand the logic of the emotions, examining how objectives, beliefs, and the evaluation of what is happening leads elderly people to experience particular emotions and what underlies them (Armon-Jones 1986; Lazarus 2000).

Narrating oneself—when one no longer has a body with the capacity for autonomy—reflects feelings that are “fitted” to certain ways of feeling old age, whose expressions of deficiency are interpreted as personal failure. Hochschild (2008: 127), for example, argued that “The sphere of the social extends much further than what our actual images lead us to believe when we ignore the existence, properly speaking, of social patterns of thinking”. The vision that men and women have of their identity corresponds to certain dominant social, but not necessarily true, representations. Generally, these are based on stereotyped images of old age associated with decline and dysfunctionality.

CONCLUSIONS

In advanced age, not everything is actually represented in the body. Subjectivity goes beyond a worn-out, physically deteriorated body which no longer responds. Identity, then, is intertwined with thoughts, feelings, ideas, and beliefs related to an ideal of oneself, but also to the culturally established stereotypes, myths, and beliefs. As Ferrante and Ferreira (2008: 422) pointed out, social identity is “naturalized” in as much as the body that is its bearer is a social body; it is through the forms of “carrying” the body that the relation with the social world is expressed.

The body as a unit of analysis in advanced age can be explained from different theoretical approaches, whose contributions help us to understand it, revealing the connecting thread between individual subjectivity, the cultural imaginary, and collective subjectivity. The present work sets forth the identities that are built on the knowledges and discourses that predominate at a particular historical moment and in a specific context. Sickness and disablement form part of those knowledges, since, in agreement with other studies, here the body is identified as a subjective construct. Illness and its relation with the body, as Bover (2009) pointed out, is a social fact that belongs to the field of the human sciences, rather than just that of biology or medicine.

Likewise, one can only agree that, among the actors in this research, the representation of the body not only portrays what one no longer is, but also the meaning of being and existence as a man or woman of advanced years in the world and in life.

Notes

1. This work forms part of a broader study entitled: “Dependencia y cuidados en la vejez avanzada de hombres
y mujeres en la ciudad de Durango. Un análisis de la subjetividad y la formación de identidades”.

2. According to this conceptualization, fragility is an intermediate state between independence and dependency. The extremes of life present us as more fragile beings; it is through exposure to pain, partial or complete disablement that this fragility makes its presence felt through the body.

3. The reference here is not only to physical, but also social, types of vulnerability, using as a basis, the analysis of the indicators of the National Survey on Disablement in Spain (Encuesta Nacional de Discapacidad en España) carried out by Ferrante and Ferreira (2008), who suggest that the population group that presents disablement is in a situation of social vulnerability. At the same time, according to Castel (1997), such social vulnerability leads them to occupy low positions in the social space.

4. Ferrante and Ferreira (2008), follow the theoretical theses of Bourdieu on setting forth/proposing that the position of agents in social space, and specifically in the context of capitalist societies, is determined by their ascendant or descendent social trajectory and by their physical properties, these being either socially admired or stigmatized (Bourdieu 1998; Ferrante and Ferreira 2008). In this sense, these authors propose that the possession of a disability or, more precisely, of a disabled body, implies for whoever suffers from it, a dispossession in terms of symbolic capital that gives rise to and expresses itself practically in limitations in the capacity for both manipulation of the body itself and the physical space.

5. By embodied signs, Goffman refers to those deformations in the body that limit its proper functioning.

6. The concept of themata has been set forth by Moscovici and Vignaux (in Rodríguez, 2007). In Rodríguez’s words, it is useful for interpreting qualitatively the centrality of the components of a representation. Themata are potential contents that arise from the collective memory and language, which in turn promotes the elaboration of actual contents.

7. The word custody is used here, metaphorically, to describe bodies that are under the care of, for instance, a family member who is responsible for maintaining the body in adequate conditions of subsistence, that is by carrying out actions of caring. Lisdero (2009), restricts the use of the word “custodia” to those whose bodies have become the responsibility of a clinic or other health institution, but for our purposes, it can cover all those in the charge of the domestic carer; these sick, disabled bodies, no longer able to function alone, pass into the custody of carers in the family or in health institutions (Normally, of course the word custody is applied to persons too young—or mentally incapable—to ensure their own survival, or to persons consigned to prison pending trial).

References


Bio

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