Health & Place 17 (2011) 885–894

Contents lists available at ScienceDirect

Health & Place

journal homepage: www.elsevier.com/locate/healthplace

'Only old ladies would do that': Age stigma and older people's strategies for dealing with winter cold

Rosie Day [a,*], Russell Hitchings [b]

[a] School of Geography, Earth and Environmental Sciences, University of Birmingham, Edgbaston, Birmingham B15 2TT, UK
[b] Department of Geography, University College London, 26 Bedford Way, London WC1H 0AP, UK

ARTICLE INFO

Article history:
Received 29 August 2010
Received in revised form
6 April 2011
Accepted 28 April 2011
Available online 6 May 2011

Keywords:
Elderly
Ageism
Cold
Clothing
Identity
Fuel poverty

ABSTRACT

Concerns over the welfare of older people in winter have led to interventions and advice campaigns meant to improve their ability to keep warm, but older people themselves are not always willing to follow these recommendations. In this paper we draw on an in-depth study that followed twenty one older person households in the UK over a cold winter and examined various aspects of their routine warmth-related practices at home and the rationales underpinning them. We find that although certain aspects of ageing did lead participants to feel they had changing warmth needs, their practices were also shaped by the problematic task of negotiating identities in the context of a wider stigmatisation of older age and an evident resistance to ageist discourses. After outlining the various ways in which this was manifest in our study, we conclude by drawing out the implications for future policy and research.

1. Introduction

In the UK, there is widespread concern over the welfare of older people in winter. In particular, there is a concern to make sure that they are able to heat their homes adequately and keep their bodies warm. To this end, a range of initiatives have been organised involving national and local governments, the private sector and the third sector. These concentrate on financial subsidies to mitigate energy costs and on improving the energy efficiency of home systems, as well as giving advice. Such initiatives, although costing the taxpayer, have a relatively high level of support; however, older people themselves are not always compliant. Aside from the winter fuel payments which go automatically into bank accounts without a claim having to be lodged, uptake of assistance can be patchy (Gilbertson et al., 2006). Small scale studies have concluded that behind some of this is a tendency for older cohorts to retain attachments to past ways of doing things and inaccurate health beliefs (Wright, 2004; Harrington et al., 2005). Overall, the problem of older people and winter is framed and diagnosed as the coming together of vulnerable bodies, energy inefficient homes and heating systems, financial poverty, and old fashioned attitudes.

In this paper we take a critical eye to this and, by looking more closely at older peoples' winter practices, propose that we recast our understanding of some aspects of their strategies as a form of resistance to the implicit ageism of discourses around older people and winter warmth, and an active negotiation of identities in the face of the wider stigmatisation of older age in UK society. In doing so we draw on a qualitative study of 21 older households in the west Midlands which took place over the cold winter of 2008–2009. We start by briefly reviewing some theoretical positions on the social construction of (old) age and on age and identity on which our argument draws and discussing policy designed to promote older people's, welfare in winter, before describing our methodology and moving on to an interpretation of findings relating to clothing, warming devices and ventilation. Finally, our discussion considers implications for thinking about interventions and signposts some worthwhile areas for further research.

2. Dimensions of age and ageing

The simplest and most taken for granted sense in which we understand age is chronological: the amount of time we have lived, usually given as the number of years marked at our last birthday. Several authors have sought to distinguish further dimensions of age however, drawing attention to the complexity of what at first seems straightforward (Coupland et al., 1991; Laslett, 1989; Aapola, 2002). One of these is biological age, namely the degree to which one has gone through the biological process of ageing or senescence. This may be further unpicked as having

* Corresponding author. Tel.: +44 121 414 8096; fax +44 121 414 5528.
E-mail address: r.j.day@bham.ac.uk (R. Day).

1353-8292/$ - see front matter © 2011 Elsevier Ltd. All rights reserved.
doi:10.1016/j.healthplace.2011.04.011

genetic (inherited) and environmental (lifestyle; pollution related) aspects (Coupland, 2009). Biological age is usually assumed to have a correspondence with chronological age, within parameters, and indeed we sometimes use chronological age as a proxy for physical condition. Departing somewhat from these are social dimensions of age. According to Laslett (1989), these include the 'social' age which is that attributed by others, and the 'subjective' age experienced by the individual, which may be more achronic, emphasising rather the continuity of the sense of self.

In how we societally conceptualise ageing, the physiological and biological dimensions tend to dominate, reflected institutionally in the dominance of the discipline of medical gerontology, or geriatrics, over social gerontology. But opposed to the pathologising medicalisation of ageing and the dominance of biological constructions of it (see Estes et al., 1984), strongly social constructionist approaches have foregrounded the role of language, discourse and culture in shaping our understanding of age, coining the emblematic phrase 'aged by culture' (Gullette, 1997, 2004). Critics have also problematised the assumptions of linear chronology that western cultures use to organise their understanding of ageing and thereby have problematised the meaning attached to chronological age (Guillemard, 1996). Further, critical analyses have exposed how chronological age becomes incorporated and implicated in systems of societal organisation and control, an indispensible tool for beaurocracies and social policies (see Bytheway, 2005; Laz, 1998). Aapola (2002), in fact accords institutional age a separate dimension in the social construction of age. Social policy itself then, by using chronological age to define and organise its target group, can contribute to the overriding representation of the chronologically older as weak and dependent (Arber and Ginn, 1991). For example, the coerced dependency of older people through retirement policies especially has been discussed at length by structured dependency theorists (Townsend, 1981; Phillipson, 1982).

The social constructionist view has in turn though been accused of de-emphasising the physicality of ageing to the extent that it is almost ignored (see Twigg, 2007; Morell, 2003). Such critics of highly constructionist analyses argue that a focus on culture and discourse alone, whilst potentially liberating us from biological determinism, can result in accidental oppression by not acknowledging the bodily changes and challenges that the latter part of the life course can bring about (Morell, 2003; McHugh, 2003). Something of a bridge between the rather polarised views of the cultural analysts versus the medical gerontologists has been afforded by a growing interest in embodiment within social gerontology: an emphasis on the experience of social reality that nevertheless sees this experience as highly embodied, and therefore incorporating a strongly material dimension (e.g. Dumas et al., 2005; Öberg, 1996; Morell, 2003; Twigg, 2004). Often squared by recourse to critical realism and/or phenomenology, such an approach makes it possible to 'acknowledge the physical reality of the body without abandoning the subject to biological reductionism' (Twigg, 2007: p. 290). This position allows a more open approach to understanding the interplay of factors affecting experiences in older age and it is one on which we drew in positioning our research.

3. Ageing, identity and place

Laslett's aforementioned notion of the 'subjective' age calls attention to the potential disparity between a person's age-identity and their chronological, biological or social age. It is evidently a common phenomenon that people profess to feel a different age internally from that which they appear externally, or their age in years passed. At least two conceptual labels have been proposed in this regard: the 'ageless self' (Kaufman, 1986) and the 'mask of ageing' (Featherstone and Hepworth, 1991). The first encapsulates the continuity of the individual's personal identity, which does not necessarily hold age to be of primary importance (Gilleard and Higgs, 2000) whilst the second describes the subjective sense that the ageing physique actually hides and gives lie to the more youthful feeling person within.

Of primary importance in understanding the formation of older age-identity is recognising that it is in western societies a stigmatised identity. Because of this, being 'old' is a label that many will go to significant lengths to avoid (Rozario and Derienzis, 2009; Falk, 2001), precisely because it is deemed an inferior identity. As a society, we are ageist. Explanations for this run from the structural – older people are coerced to be economically unproductive and dependent, and therefore hold lower status (Phillipson, 1982; Townsend, 1981) – to the psychodynamic: we shun older bodies because we are terrified of our own decline and death (Greenberg et al., 2002; Young, 1990). Either way the result is that, to use Goffman's terms (Goffman, 1963), older age is an attribute that is deeply discredited. Visible possession of this attribute lowers the social status of the individual. Moreover, stigma links a discredited attribute with a stereotype, which imaginatively associates the attribute with a further array of undesirable characteristics (Goffman, 1963; Link and Phelan, 2001). In the case of advanced age, this typically includes infirmity, dependence, old fashioned attitudes and tastes, mental and physical slowness. Whilst such an association arguably may not always be false, the application of stereotypes leads to a blindness to diversity and an over-assumption of similarity among people with the particular stigmatised attribute.

Possessors of the stigmatised attribute however often also hold these beliefs; rather than being rejected outright, these schemas may be internalised to a greater or lesser degree (Goffman, 1963). In the case of age, ageist stereotypes have often been internalised at an earlier age, only to be confronted with regard to the self as the individual ages. Ageist stereotypes may be viewed as master narratives (Rozario and Derienzis, 2009) which serve as a resource for older people to orientate their self-expression, selectively conforming to and transgressing various aspects. Laz (1998) views age – at any age – as an accomplishment, a performance: something to be 'done right'. Given the discussion above, performing older age requires the negotiation of various norms and expectations as well as the sometimes unruly body on which these are inscribed.

Identity is also both constituted and performed in place. As such, places can be positive resources on which to draw in building self-identity. In older age, familiar places such as the home – including the objects and possessions within it – and the neighbourhood are invested with emotional and symbolic meaning and help to maintain a positive affirmation of self (see e.g. Peace et al., 2006; Rowles, 1980; Wiles et al., 2009). When a strong attachment and sense of place is present with regard to the home it can be a therapeutic landscape, good for health and wellbeing and potentially even life lengthening (Williams, 2002; Wiles et al., 2009).

However, this congruence between place and self can be threatened as evolving physical needs require attention. Work on the increasing delivery of care in the home (see e.g. Milligan and Wiles, 2010) has highlighted how the spatial and temporal ordering of the home and the objects and practices within it can be destabilised by the intrusion of care services and associated objects, as well as the accompanying blurring of boundaries between private and public with regard to both the homespace and the body itself (Twigg, 1999). In such a situation, the home must restabilise into new configurations through ongoing processes of negotiation, which may involve clashes between for example conceptualisations of the home as a clinical space and as a personal, meaningful place (Wiles, 2005). Dyck et al. (2005)