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## Comfort and medical ambivalence in old age

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## ABSTRACT

This article, based on three years of longitudinal research, analyzes the role of technology in creating or inhibiting comfortable lives in old age, from the perspective of elders themselves. By understanding the oldest old as technology users, we can appreciate elders as savvy tech-operators, ambivalent users, and non-users. Combining science and technology studies and medical sociology frameworks together provides a basis from which to examine technogenarians in action, (or chosen in-action), and the complex relationship between biotechnology and well-being.

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## 1. Introduction

Old people's lives are filled with assistive devices, household technologies, pills, and other tools. Everyday technologies as well as biomedical interventions can be part of the way older adults pursue, maintain, and negotiate life. In this context, the old are cyborgs in contemporary life, blending machine and biology in both their personal identities and their relations to the external world [1]. And yet, this everyday relationship with new and old technologies varies. We need an understanding of technogenarians to fully comprehend their various reactions to biotech interventions. By understanding elders as technology users, we can appreciate elders as savvy tech-operators [2], ambivalent users [3] and non-users [4]. Combining science and technology studies and medical sociology frameworks together provides a basis from which to examine technogenarians in action, (or chosen in-action), and the complex relationship between biotechnology and well-being [5]. This article analyzes the role of technology in creating or inhibiting comfortable lives in old age, from the perspective of elders themselves.

Consider Alice, age ninety-four, who learned to depend on a talking watch and calculator, a walker and eyedrops, as her eyesight waned. Most, like Alice, learn to use such tools strategically for self-care—to enhance their own mobility,

comfort, and quality of life. And yet, Alice disliked how eye doctor and nurse visits came to dominate her life as her blindness progressed, and came to see these as incursions on quality of life in old age. Like her, many elders express concern about the sheer number of pills and procedures in their lives, and may work to actively resist medicalization in order to accomplish self-care and personal comfort. Thus, in the context of active aging, elders employ technology selectively.

My research has explored how many among us are ambivalent and even questioning of medical solutions in our lives, prioritizing comfort above all else. In my two decades of research, I have encountered midlife and elder men and women talking back to and resisting the Viagra phenomenon; college students—the so-called Ritalin generation—expressing ambivalence about self-diagnosis and dosing; and the “oldest old” in America—elders 85 and older—expressing concern about medicalizing forces, or the sheer number of pills and procedures that fill their days. This cross-generational medical and technological ambivalence is a sign of our times; in an age of great technological progress and change. A small but growing field of research in medical sociology empirically addresses bio-medicalization and ambivalence in children and adults in relation to contested syndromes such as chronic fatigue, depression, ADHD, and mass vaccination [6].

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## 2. Methods

Gubrium and Holstein [7] argue that knowledge of old age should come from the aged themselves. This research was conducted with this in mind, using in-depth interviews coupled with both life course and symbolic interactionist approaches. A life course approach emphasizes common themes, continuity and change across one's lifespan, and how these biographical aspects can shape contemporary realities, such as technology use. A symbolic interactionist framework focuses on how individuals actively participate in their environments and create social realities and meanings through these interactions. My focus here is to use both of these approaches to understand how biography, place, and social context shape elders' active technology use and concurrent meaning making.

Because all informants for this study were born before 1930, their social scripts as well as approaches to aging, health and technology probably differ from those born in later birth cohorts [8]. For example, many nonagenarians have learned to live in moderation, and to appreciate and use technologies as they became available, including radios, sewing machines, kettles and slow cookers.

Data were collected through interviews and participant observation with a total of 30 individuals (23 women, 7 men) aged 85–102 who are actively aging in place—a common U.S. policy term associated with being rooted in a community and attempting to live independently as one ages—in upstate New York. Initial contacts were made through connections with senior services centers, senior activities programs, social clubs, and local newspaper coverage. The majority of individuals interviewed were also participating in the author's longitudinal research project on nonagenarians ageing in New York, and have taken part in a series of interviews from 2006 to 2009. Interviews took place in their homes (apartment, condo or house), located in two counties in upstate New York, one rural and one an urban and suburban mix. All took part in at least one in-depth semi-structured digitally-recorded interview during this period, with most participating in at least three in-depth interviews over the course of three years. Interviews included open-ended questions across the life course, focusing on each individual's family, educational and work backgrounds as well as current daily routines and approaches to aging and self-care. All interviews were taped, transcribed, and coded thematically.

In addition, ethnographic methods were employed to collect data about lived day-to-day experiences, in a context of active aging. All informants were more or less ambulatory, and this aspect of active aging clearly shaped their identities and daily routines. Beyond regular visits to homes, between 2006 and 2009 I participated in informants' lives and daily routines outside their homes, including intermittent doctor visits, grocery shopping trips, social club meetings, exercise classes, neighborhood meals, funeral services and religious rituals. In addition, I logged approximately 150 h observing a combination of regional ageing-related meetings and conferences, touring institutions dedicated to elder care, and conducting interviews with professionals in elder support and care.

This sample is largely representative of the national U.S. population in the 85 and over age group. According to the U.S. Census category of the 'oldest old' (85+), 70% lived in non-family one-person households and 79% of the women in

this category were widows. In terms of racial demographics, over 90% of those over 85 years of age were White; 6% were Black. The thirty informants in this study reflect those demographic patterns, as well as imbalanced gender ratios in this population group.

These individuals co-ordinate their own care in the context of a normal range of ageing-related sensory, cognitive, and physical difficulties. At the same time, most experience ageing-related strengths including domain-specific knowledge and daily task management skills [9]. Notably, none of the individuals in the sample are wheelchair-bound; all are ambulatory in some way and this dramatically shapes their self-care regimens. In general, most nonagenarians in this sample prefer to be totally independent, or to go beyond family assistance to utilize social networks, formal transport services (including paid drivers and public transport), or delivery services for day-to-day needs. The question, then, is how do these actively-aging nonagenarians independently manage self-care and daily routines?

There still exists a dearth of research that explores elders' experiences with built environment and everyday task accomplishment [10,11]. The following sections aim to fill in these gaps, exploring how, for old individuals, constructing a self-care routine is technology work. For old individuals who are their own primary caretakers, everyday mundane devices can be significant in designing an ever-changing self-care repertoire to enable self-sufficiency, as well as control, independence and health. At the same time, elders may eschew bio-technological options that are perceived to inhibit comfort and ease.

## 3. Technology as innovation and intervention

Ageism and paternalistic tendencies in design are often subtle and may occur despite intentions to the contrary [12]. Technology created for elders is perceived as innovation and intervention, to make activity possible. I argue that such material technology already exists in a field of activity. Elders, who are actively aging, inhabit this field of activity, and perform technology work to aid in achieving comfort and well-being. Yet, even when elders are included as designers in new, profitable "aging enterprises" [13], they rarely are acknowledged as active agents. Thus it is unclear if an elder-based technological habitus is truly taken into consideration when it comes to biomedicalization or gerontechnology.

In our introduction to our 2010 volume *Technogenarians: Studying Health and Illness Through an Aging, Science, and Technology Lens*, Kelly Joyce and I wrote,

...Old people are not passive consumers of technologies such as walkers and drugs. Elders creatively utilize technological artifacts to make them more suitable for their needs even in the face of technological design and availability constraints. In this way they are technogenarians; individuals who create, use, and adapt technologies to negotiate health and illness in daily life. Combining science and technology studies and medical sociology frameworks together provides a framework to examine technogenarians in action [14].

This study continues to build on our call for qualitative empirical study of technogenarians in action, to understand how elders actively use and/or reject technologies to maintain health, well-being, and maximize comfort. This

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