OUTI JOLANKI

Fate or Choice?

Talking about old age and health

ACADEMIC DISSERTATION
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KIITOKSET

Vuosien puurtamisen jälkeen väitöskirjatyöni on valmistumassa. On aika kiittää kaikkia niitä henkilöitä, jotka ovat minua tällä mielenkiintoisella, mutta joskus hieman kivikkoisella tiellä auttaneet ja joita ilman työ ei olisi valmistunut. Ohjaajalleni, professori Marja Jylhälle olen suuressa kiitollisuudenvelassa. Olen hyötynyt Marjan laaja-alaisesta vanhenemistutkimuksen tietämyksestä ja tiedemaailman tuntemuksesta. Hän on ollut asiaankuuluvan kriittinen, mutta myös kannustava papereitteni kommentoija ja keskustelukumppani. Kiitän Marjaa myös monenlaisesta henkisestä ja käytännön tuesta ja kannustuksesta näiden vuosien aikana.

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Tampereella elokuisena iltana,
Outi Jolanki

LIST OF ORIGINAL PUBLICATIONS

I Jolanki, O, Jylhä, M and Hervonen, A (2000): Old age as a choice and as a necessity. Two interpretative repertoires. Journal of Ageing Studies 14 (4): 359–372

II Jolanki O (2004): Moral argumentation in talk about health and old age. Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine 8 (4): 483–503

III Jolanki O (2008): Discussing responsibility and ways of influencing health. International Journal of Ageing and Later Life 3 (1): 45–76 doi:10.3384/ijal.1652–8670.083145

IV Jolanki O (2009): Agency in talk about old age and health. Journal of Aging Studies. In Press. Corrected proof available online: doi:10.1016/j.jaging.2007.12.020

ABSTRACT

In this research the aim was to find out how old age and health are discussed by people who themselves are seen and treated as old. Its focus was to study these people's talk about their experiences of old age and health. While I do not believe that other people's experiences are directly available for us to discover, it is still important to analyse what kinds of elements are included in people's talk about their experiences and in their self-identities. This information will help gain a deeper understanding of how "being old" and health are perceived by those people who may see themselves, and who are seen and treated by others, as ageing or old.

The focus of the research was to identify the different perspectives raised by people in their talk and to find out how those perspectives were used in talk. The research questions were concerned with how people defined old age and being old as a social position, in relation to other people and in the context of one's own life entity, and with what meanings health received in this context. I was particularly interested to learn how people talked about their own and other people's chances to influence their health and ageing, and whether they felt that people were responsible for their own health. The theoretical framework for the research was underpinned by social constructionism and the discursive perspective, which entail the idea that talk is action. The datasets consisted of biographical interviews with people aged 90 or over and group discussions in which the participants were 70 years or over. The main tools of analysis came from discourse and rhetoric analysis. These methods made it possible to study how different arguments were used in talk to explain, defend and legitimate one's own decisions and actions as well as other people's actions.

The research findings showed that it is too simplistic to talk about the experience of old age in terms of denying age or resisting negative stereotypes of old age. Rather, older people have various ways of thinking about and defining old age and health. Being old is an ambivalent position. Mobilizing the category of old age in talk about oneself seemed to make the agentic position problematic. In their talk about old age and health, the people in this study balanced between different views and ways of talking. I called these different ways of talking the decline, activity and wisdom discourse. Discourses are cultural resources that people use to construct meanings of old age and health and their own identity as old. In the decline discourse,

the participants in this study constructed old age as self-evidently a time of poor health and losses, which serve to explain and legitimate ill health, dependence on other people and need for help. The activity discourse was used to construct old age as something the individual can choose and have an influence on. It was used to construct oneself as active, healthy, a needed member of society and independent. Within the activity discourse, health was constructed as something that is malleable by means of one's own actions and as a matter of individual responsibility. On the other hand, the participants qualified the idea of responsibility by mentioning various factors that are beyond the individual's influence. Talk about old age as wisdom was the "weakest" discourse in this data, possibly indicating that that there is little real support for the idea that old age is seen in society as a time of wisdom and that older people represent that wisdom. The most important discovery, however, was that these different discourses were used by the same people to give meaning to and construct their identities. These discourses were also contrasted with one another, but talk about old age is best described in terms of negotiation and renegotiation about one's positions and the meaning of one's own actions and decisions. Both old age and health talk involved moral argumentation. People's talk revolved around chances to influence one's own health and life in old age, and on the other hand, around the question of how far old age is a fate that is beyond individual influence.

I approached the interviews and group discussions as interaction situations in which both interviewer and interviewee are active participants. Individual interviews place more pressure on the individual interviewee. Health proved to be a particularly dilemmatic topic in this regard because of the heavy ideological and moral baggage it carries in contemporary western culture, and talk about one's own health can present a threat to one's face. A common concern in individual interviews was to explain and justify one's own health-related choices and actions. Various discursive and rhetorical devices were applied to construct one's own activity and good health. The research showed that the group discussions involved more negotiation between different views. Sensitive and conflicting views were also raised in group discussions. In other words this research did not support the view that group discussions are conducive to unitary views and discourage talk about sensitive issues. The social constructionist view on reality and social facts is that for analytical reasons, it is important to look at the meanings given to old age and health by older people themselves. This does not mean to say that social constructionist research ignores "social facts", structures, bodily being or power relations. These, too, can be made a topic of analysis in order to see whether and how they become visible, are made a meaningful and important part of one's own ageing. Rhetorical studies provide a powerful tool for exploring the argumentative basis of age categories and identities.

Rhetoric analysis, importantly, pays attention to how talk about old age and health is a presentation of identity and a way of constructing an accountable and worthy identity. The particular benefit of this enterprise is that it allows us to study the arguments applied in making some versions of reality look more plausible or better and to ignore or "silence" other versions. Discursive studies have demonstrated their strength in showing how one and the same person can use different and even conflicting age categories and discourses, and how the meaning of the topic at hand is constructed in interaction, negotiated and accepted or refuted. Both discursive and rhetorical analysis provide tools for studying the ideological and moral meanings of old age and health – an important topic in times when health seems to carry strong ideological and moral connotations, and when the growth of the elderly population is repeatedly brought up in public debate.

I see that constructionist and discursive studies have a crucial role to play in ageing research in addressing the different ways in which old age is made reality – physiological, political or experiential – and in studying what is achieved with different versions of reality. What kind of identities, politics, services, demands of individual conduct do they make appear natural, inevitable and reasonable, or alternatively, unnatural, avoidable, impossible and irrational? How is age used to classify and categorize people into different sites of everyday life? How individual and groups themselves use different age categories and whether and how these are linked to social and political rights and valued or devalued social positions? How category of old age is used either to enable agency or what type of reasons and justifications are used to curtail people's potential? How do older people see their prospects of enacting agency? Some of the topics were approached in this study. All of these deserve further research.

TIIVISTELMÄ

Tutkimuksen tarkoituksena oli selvittää millä tavalla vanhenemisesta, vanhuudesta ja terveydestä puhuvat ne ihmiset, jotka kronologisen ikänsä ja sosiaalisen asemansa pohjalta nähdään vanhana. Tutkimuksen kohteena on siis puhe vanhuudesta ja terveydestä kokemuksena. Tämä rajaus tarkoittaa, että en oleta tutkijalla olevan suoraa pääsyä tutkittavien kokemukseen. Mutta on kuitenkin tärkeää analysoida sitä, mitä erilaisia elementtejä puheessa omasta kokemuksesta tuodaan esille tärkeänä omassa elämässä ja määriteltäessä omaa itseä. Näkemykseni mukaan tätä kautta voidaan tutkia millaisina vanhuuteen ja terveyteen liittyvät asiat näyttäytyvät niille ihmisille, jotka nähdään ja joita kohdellaan ikääntyvinä tai vanhoina ihmisinä.

Tutkimuksen keskiössä on siis puhe. Tarkastelin sitä, millaisia erilaisia näkökulmia ja argumentteja tuotiin esille ja miten niitä käytettiin puheessa. Tutkimuskysymykset kohdistuivat siihen, miten vanhuutta ja vanhana olemista määriteltiin sosiaalisena asemana, suhteessa muihin ihmisiin ja omaan elämänkokonaisuuteen, sekä siihen millaisia merkityksiä terveys sai vanhuudesta puhuttaessa. Olin erityisesti kiinnostunut tutkimaan sitä, miten tutkittavat puhuivat yksilöiden mahdollisuuksista ja omista mahdollisuuksistaan vaikuttaa omaan vanhenemiseensa ja terveyteensä, ja toisaalta katsoivatko he, että yksilöt ovat vastuussa omasta terveydestään. Tutkimuksen teoreettisena viitekehyksenä oli sosiaalinen konstruktionismi ja diskursiivinen perspektiivi, jotka sisältävät ajatuksen siitä, että puhe on toimintaa. Puheella ei vain kuvata asioita, vaan puheella ja puheessa rakennetaan kuvaa itsestä tietynlaisena ihmisenä, omasta asemasta yhteiskunnassa ja suhteessa toisiin ihmisiin. Tutkimuksen aineisto koostuu elämäkerrallisista haastatteluista (Tervaskanto 90+-projekti), sekä ryhmäkeskusteluista, joihin osallistujat olivat 70-vuotta täyttäneitä tamperelaisia. Aineisto analysoitiin diskursiivisen psykologian ja retoriikka-analyysin keinoin.

Tutkimus osoitti, että vanhana oleminen rakentuu ambivalenttina tilana. Tutkittavat tasapainoilivat erilaisten vanhuutta ja terveyttä koskevien näkemysten välillä. Tutkimus toi esille sen, että samojen ihmisten puheessa vanhuus saa monia merkityksiä ja samat henkilöt voivat määritellä itsensä vanhana ja ei-vanhana. Iän kieltämisen tai negatiivisten vanhuusstereotypioiden vastustamisen sijaan diskursiivisen tutkimuksen näkökulmasta on parempi sanoa, että erilaiset näkemykset ikääntymisestä ja vanhuudesta ovat osa vanhojen ihmisten ajattelua. Olen kutsunut näitä erilaisia näkemyksiä dis-

kursseiksi. Näen diskurssit kulttuurisina resursseina, joita käytetään puheessa rakentamaan kuvaa omasta itsestä. Tutkimus osoitti, että vanha-kategorian tuominen puheeseen kyseenalaisti toimijaposition. Tyypillistä oli myös, että puhuttaessa vanhoista ihmisistä osallistujina ja tarpeellisina yhteiskunnan jäseninä puheessa käytettiin paljon perusteluja ja retorisia keinoja. Argumentoinnin laajuus kertoo siitä, että argumentin sisältö voidaan ymmärtää kiistanalaisena ja ollakseen uskottava se tarvitsee laajoja perusteluja.

Vanhuus rakentui puheessa kohtalonomaisena heikkenevän terveyden, menetysten, yksinäisyyden ja luopumisen aikana, jonka perusteena toimii ikä itsessään. 'Vanhuus ei tule yksin'- tyyppiset sanonnat kiteyttävät tämän diskurssin. Toisaalta ns. aktiivisuusdiskurssia käytettiin rakentamaan kuvaa vanhuudesta asiana johon voi itse vaikuttaa ja sen kautta ja avulla myös perusteltiin näkemystä vanhoista ihmisistä ja/tai itsestä aktiivisina, itsenäisinä, yhteiskunnallisina toimijoina ja tarpeellisena osana yhteisöä. Aktiivisuusdiskurssi sisältää myös ajatuksen, että terveyteen voi itse vaikuttaa omilla toimillaan ja yksilö voidaan nähdä terveydestään vastuullisena toimijana. Toisaalta täydellisen vastuun ajatusta lievennettiin tuomalla esille erilaisia tekijöitä, jotka vaikuttavat terveyteen eivätkä ole yksilön hallinnassa. Vanhuuteen kohtalona viittaaminen toimii tällöin puheessa keinona perustella lisääntynyt avuntarve, ja torjua ajatus siitä, että yksilö voisi täysin omilla toimillaan hallita elämäänsä – ja terveyttään. Viisausdiskurssi oli 'heikoin' diskurssi näissä aineistoissa ja siihen liittyi laajaa perustelua ja argumentointia. Se, että väitteet vanhenemisen tuomasta elämäkokemuksesta vaativat laajaa argumentointia voi kertoa siitä, että vanhat ihmiset itse kokevat, ettei näkemys vanhuudesta viisautena ole 'elettyä' todellisuutta nykykulttuurissa. Tarkastelin haastatteluja ja ryhmäkeskusteluja vuorovaikutustilanteina, joissa molemmat osapuolet ovat aktiivisia osanottajia. Yksilöhaastatteluissa nousi vahvasti esille omien valintojen ja terveyteen liittyvien tekemisten perustelu ja oikeuttaminen, kun taas ryhmäkeskusteluissa käytiin enemmän neuvottelua eri näkemyksistä. Myös sensitiivisiä, ja osin ristiriitaisiakin aiheita käsiteltiin, vaikka usein on ajateltu ryhmäkeskustelujen ohjaavan keskustelua yksimielisyyteen ja sensitiivisten aiheiden välttämiseen.

Sosiaalisen konstruktionismin omaksuma näkökulma todellisuuteen ja sosiaalisiin faktoihin on se, että analyyttisistä syistä on tärkeää tarkastella myös ihmisten omaa merkityksenantoa ja tulkintoja tutkittavana olevasta asiasta. Tämä ei tarkoita 'sosiaalisten tosiasioiden', rakenteiden, ruumiillisuuden tai valtasuhteiden sivuuttamista, vaan sen korostamista, että nämäkin asiat voidaan ottaa diskursiivisen ja retorisen analyysin kohteeksi ja tutkia sitä miten ne mahdollisesti tulevat näkyviksi ja saavat merkityksen osana yksilön vanhenemista. Retorinen analyysi tarjoaa välineitä tutkia sitä, miten jokin todellisuuden versio saadaan näyttämään uskottavammalta tai paremmalta kuin jotkut toiset, ja miten toiset todellisuudentulkinnat sivuutetaan tai vai-

ennetaan. Retorinen analyysi on tuonut esille sen, että puheella vanhuudesta ja terveydestä myös representoidaan ja rakennetaan sosiaalisesti hyväksyttävää identiteettiä. Diskursiivinen tutkimus tarjoaa välineitä tutkia sitä, miten yksi ja sama ihminen voi käyttää erilaisia, jopa ristiriitaisia ikä-kategorioita ja diskursseja. Diskursiivisen tutkimuksen avulla voidaan myös tutkia vuorovaikutuksessa tapahtuvaa merkitysten rakentumista, niistä neuvottelua ja hyväksymistä tai hylkäämistä. Sekä diskursiivinen että retorinen analyysi tarjoaa keinoja tutkia vanhuuden ja terveyden ideologisia ja moraalisia merkityksiä – tärkeä teema aikana, jolloin terveyteen näyttää liittyvän vahvoja ideologisia ja moraalisia sivumerkityksiä, ja jolloin väestön ikääntyminen on jatkuvasti julkisten keskustelujen kohteena. Konstruktionistisen ja diskursiivisen tutkimusotteen yksi tärkeä tehtävä vanhenemistutkimuksessa on tarkastella erilaisia tapoja joilla vanhuudesta tehdään todellisuutta – fysiologista, poliittista tai kokemuksellista – ja sitä, mitä erilaisilla todellisuuden versioilla saadaan aikaan. Millaisia identiteettejä ja vaatimuksia yksilöiden käyttäytymisestä ne saavat näyttämään luonnolliselta, välttämättömältä ja järkevältä, tai vaihtoehtoisesti vältettävältä, mahdottomalta ja irrationaaliselta? Miten ikää käytetään eri arjen konteksteissa luokittelun ja kategorisoinnin perustana? Millaista toimijuutta ts. mahdollisuutta valintoihin, päätöksiin ja toimintaan ikäpuheella tuotetaan? Miten vanhat ihmiset näkevät omat mahdollisuutensa toteuttaa toimijuutta? Nämä ovat joitakin tärkeitä kysymyksiä, joita olen itse tässä tutkimuksessa sivunnut ja joissa lisätutkimus on tarpeen.

1 INTRODUCTION

"I'm not really that old, but I have been around for some time"
Woman, aged 92

Old age and health are common themes in everyday talk today, both in the media and in public policy discussions. I became interested in this topic when years ago I read a biographical interview of a woman aged 92 who, on being asked how she felt about "growing old", fiercely denied she was old. The interviewer was clearly taken by surprise, stuttering the apologetic answer that she did not mean to say the interviewee was old, but she just wanted was to know what she thought about old age in general. This shift in focus from the individual interviewee to ageing in general saved the situation. The interviewee relaxed and started to talk about the topic, and in fact later in the interview conceded to being old and referred to herself as old. This episode made me wonder why the question about growing old had triggered such an emotional outburst? The fact that the interviewer was surprised (as indeed I was) by the agitated response to an apparently innocuous question from a person who was 92 and who had agreed to be interviewed in the Vitality 90+-project (Tervaskanto-projekti), speaks volumes about our way of thinking and about how cultural age categories are so taken for granted that we lose sight of their constructed and social nature. This episode started me thinking about the relationship between chronological age categories and their meaning in the construction of identities and about the role of language in all this.

It is very common in everyday talk for people to make a distinction between the "good old days" when older people were respected and the present day when they are not. Often what are seen as traditional or agrarian communities are idealized as good places for old people to live, in contrast to "bad" modern, industrial or urban communities (Stearns 1992). However, studies of cultural representations, social and economic conditions and experiences of old age have shown that the historiography of old age entails varying and partly conflicting perceptions about old age and different ways of organizing older people's lives (Haber 1983). As Haber (1983) says about the history of old age, "clearly there was never a golden age of senescence in which the old were treated with veneration. For many individuals … grey hair and wrinkles seemed reason for contempt instead of honour; their age

alone was not deemed worthy of respect. Nor did attitudes toward the old ever veer sharply from adoration to contempt. The aged were not loved as a group at one moment, only to be hated collectively the next" (ibid., 5). *"Gerontogracy"*, i.e. a position of authority and respect was not necessarily "*achieved"* simply with the advancement of age, but it was more often "*acquired"* (Keith 1982, 106, italics in the original; see also van der Geest 1998) for example through property and social networks and influenced by health status, gender or the need for labour (Arber and Ginn 1991, Blaikie 1999, Haber 1983, Koskinen 1983, Pitkänen 1994).

In the current public discussion about old age and old people the main focus tends to revolve around health or financial issues. In the media, old people are placed either in heroic roles with an active lifestyle and positive outlook on life, or represented as objects of care who either would deserve better care or who are threatening to drain society of its financial resources (Blaikie 1999, Hepworth 2004b). The grandparent role or that of a liberated retiree with a "snowbird" life, seem to be among the few positive roles attached to old age. In the first part of the twentieth century, what Blaikie describes as "population panic" led to alarmist views of older people depleting the nation's resources and blocking social development – much in the same way as is happening today (Katz 1996, Phillipson and Powell 2004, Vincent 2003). The development of the science of medicine and demography, coupled with the birth of the welfare ideology, contributed to the construction of old people as a separate age group and as a problem that needed to be resolved (Blaikie 1999, Fennell, Phillipson and Evers 1988). Blaikie quotes press speculation about the future of ageing society: "a future Britain with deserted cities and idle factories while the spa towns were clogged up with pensioners in bath chairs … industrial retardation, spiralling welfare costs, a lack of economic enterprise, higher taxation … and a decline of 'creativity' and energy in the national psyche" (Blaikie 1999, 37). This text that dates from the 1930s bears striking similarities with today's alarmist discourse (Phillipson and Powell 2004, Tulle 2004). In this discourse old people are implicitly divided into two groups: idle and selfish pensioners and older people with ill-health who present a burden and a fiscal threat to society.

While it is possible to disregard conventional age categories and to slot oneself in a different category, it is much harder to change one's structural position or to change other people's perceptions of oneself as a member of a certain age category, or indeed to change the underlying perceptions in which these views are often grounded. To be a member of a certain age category is to have rights, duties and obligations related to that particular category (Hockey and James 1993). Age and ageing are easily seen as taken-for-granted parts of our daily lives, as a basis for our social position and as part of our identity. But how do we know that we are in fact ageing? (Hockey and James 2003)

Our structural position gives one answer to that question. Furthermore, cultural representations of old age are conveyed today in numerous visual cultural products such as films, television programs, and public and private photographs that purport to portray old people, thus offering cues as to how to recognize one's own ageing and oneself as a member of the group of elderly people (Bytheway 2003, 31). Therefore the reflection we see in a mirror is never just a reflection of our body, but it is loaded with a cultural repertoire of visual images already embedded in our imagination (Bytheway 2003, 31, Hepworth 2004, 10). But by studying social structures or cultural representations we cannot yet say how those people who are seen and treated as old view and experience "being old". I set out to study how these people who are defined by others, and sometimes by themselves, as old, talk about their own age and the various issues that seem to be so central to discussions of old age and health in today's western societies. My research relates to a growing pool of work that focuses on the experiential aspect of ageing and health, and particularly to discursive studies on the use of language as a tool for constructing meanings of old age and health.

This study is concerned with the meanings assigned to ageing, old age and health in the talk of older people themselves. The focus of analysis is on the different and perhaps contrasting themes appearing in discourses concerning the relationship between ageing and health, on the one hand, and on the individual's possibilities and responsibilities in the areas of ageing and health, on the other. The aim is to illustrate and analyse the ways in which older people negotiate and reason about issues of age and health and how they contrast their personal experiences with the present cultural discourses of active ageing and individual responsibility for health. Furthermore, the aim is to look at different research settings, including individual biographical interviews and group discussions, as contexts of data collection. I also discuss the contributions of social constructionism, discursive studies and rhetoric to ageing research.

A special focus of interest in this study is with the meanings attached to "being old" as a social position, both in relation to health status and other people. Secondly, I am interested in the meanings assigned to "health" in relation to old age and to the ideas of individual responsibility for health. My third interest is in the ways that the ideas of individual agency are used and developed in the talk of older people: to what extent do older people feel that they are capable of influencing their ageing and health?

People's lives are extremely complex and it is impossible for scientific research, from whatever perspective it approaches old age and health, to gain but a few glimpses of what it means to "be old" in this historic time, society and culture. This research represents my attempt to unravel some of these aspects of the experience of old age.

2 EXPERIENCES OF OLD AGE AND HEALTH

2.1 The importance of personal accounts in studying old age

Why study older people's own views of ageing and being old? The study of experiences of old age means addressing those people who it is thought have personal experience of ageing and studying the different meanings that ageing and old age receive in people's thinking and everyday lives. It has been suggested that in this way, the researcher can gain an insider's view of ageing and old age (Thompson, Itzin and Abendstern 1990, 1–2) and in this way proceed to explore the meanings attached by individuals to old age on the basis of their unique life history (Heikkinen 1996, 194). In other words personal views of ageing and health can pave the way to a deeper understanding of the experiential level of ageing, which is otherwise inaccessible by other research methods or datasets (Bytheway 1996). Adopting the experiential perspective on ageing and health also implies the recognition that the people studied are seen not just as sources of information and respondents, but as agents and active participants in the study. As Gubrium and Wallace (1990) point out, it is not only researchers or other experts who theorize about age, but older people themselves conceptualize and build theories of their lives and the meaning of being old. Collecting data on people's experiences is also an important way of giving older people a chance to convey their views on different aspects of their everyday life, such as housing, services and care and social relations (Peace 2002).

Research on experiences of old age does not, however, provide an all-embracing and unproblematic gateway to individual life. It has been argued that research focusing on experiences of old age has tended to espouse the somewhat romantic goal of giving a voice to older people (Luborsky 1993, Silverman 1989); after all it is always the researcher who collects the data and conveys the different individual voices through his or her analysis (Fox 2005, Kenyon, Ruth and Mader 1999, Luborsky 1993). Experiences are not necessarily unified or coherent (Gubrium 1993a, 1993b). Studies of people's experiences often assume that the complexity and diversity of individual lives

equal experience, failing to recognize that life may not be "simply there for the asking" to be revealed to a researcher as experience of old age (Gubrium 1993b, 56, see also Gubrium 2005). It is impossible directly to access others' experiences, but they must always be conveyed to other people in one way or another. Collecting data about individual experiences of being old requires what Polkinghorne (1996) has called "translating" a possibly "nonreflective flow of experiences" into spoken or written form using concepts available in that particular language (ibid., 80–81, see also Bytheway 1996, 620). In spite of these reservations, following Bytheway (1996), it can be said that the experiential perspective offers valuable insights for researchers into the kind of meanings that are related to old age by people who inhabit a social position of old as opposed to other positions available in society, and who in their daily lives are treated by others as old.

2.2 The importance of chronological age in individual life

Studying older people's own views of old age and health ties in directly with the question of how and why we begin to define ourselves as old or come to realize that other people see us as old (Bytheway 1996, Hockey and James 2003). Another side of this question is how the researcher knows who to select for investigation. The most obvious choice is to recruit people who are conventionally defined as "old" based on their chronological age. Chronological age thus serves as a taken for granted measure of one's "oldness", even though the research itself might question existing self-evident meanings of age. The use of chronological age as a measure of "oldness" has been criticized on the ground that it has lost all meaning as a dividing principle in modern life. Structural age barriers have become less rigid and cultural norms about age-appropriate conduct have loosened to the extent that some researchers have referred to the blurring of age categories and to "uni-age" (Featherstone and Hepworth 1991). Others have suggested that these trends are not really indicative of greater equalization among age categories, but rather of a devaluation of old age and increased idealization of youth and youth-related activities (Johnson 2005, Thane 2005) and that in practice, talk about "uni-age" means that all people should "act and look young" (Nikander 1999). While there has been some tendency to question the self-evident meaning of chronological age in individual lives, it does still play an important role in the way that social structures are organized and individual people positioned in society. Categorization based on age also serves as a central way of constructing one's own identity in the contemporary

world. According to Hockey and James (2003), age "has become one of the key bases for the production of social identity, acting as a way to classify and order the passing of time in an individual's life" (ibid., 3). Furthermore, age is a frequent and common topic in the media and in people's everyday discussions. As Hockey and James (1993) say, children are praised for acting not like children but as grown-ups, and at the same time older people are praised for looking youthful or younger than their chronological age. Birthdays, retirement and other life events based on chronological age are a fundamental part of contemporary everyday life, and stories of different kinds of age-crises appear frequently in the media (Blaikie 1999, Vincent 2003). Even though structural boundaries between different age groups and age-related social norms have loosened, chronological age is far from irrelevant, but an important and inescapable part of life in contemporary western societies (Bytheway 2005a).

However, the meaning of age as a basis for defining one's own identity is by no means clear. Personal experiences of old age are not just personal as opposed to social and cultural meanings. Hockey and James (2003) argue that in everyday life, we often treat age and ageing as self-evidently existing biological phenomena, constructing the natural course of life as a passing of time from birth to death. Yet in the modern world it is difficult to imagine how identities could be constructed without referral to age, and much of our behaviours are interpreted by other people in the light of our chronological age (ibid.). Age also carries ideological and symbolic meanings, since it implies social and moral rights and obligations (ibid.). Age, then, is not just one thing or a purely material or symbolic entity, but in age-identity biography particulars, biology processes and social and cultural meanings are intricately interwoven and very hard to separate from one another in individual experience (Hockey and James 2003). Furthermore, individual experiences and the meaning of age vary culturally and historically, in different life circumstances, and even in different places (Ruth and Kenyon 1996, 4–5, Gubrium 1993a, xvi, Heikkinen 1996, 194).

Several studies have shown that it is indeed extremely difficult for people to define old age. Often when respondents are asked to define their age, or asked whether they consider themselves old or what they think about growing old, they will initially and sometimes consistently either deny that they are old or claim that they do not feel old. Old age may be defined in terms of increased chronological age (Jyrkämä 1995) or calendrical cues (Karp 2000), but this does not mean that the respondent describes him/herself as old. When asked about their own age and personal definitions, people may talk about increased awareness of their own chronological age, which they often say has crept up on them and does not quite fit in with their views of themselves. It also seems that regardless of the number of years

they have lived, people in their sixties, eighties or nineties all have similar comments that they "don't feel old" (Minichiello, Browne and Kendig 2000, Morell 2003, Thompson et al. 1990). These same findings seem to recur irrespective of the methods employed, i.e. whether the data are collected with quantitative questionnaires (Jyrkämä 1995, 99–100), in qualitative interviews (Conway and Hockey 1998, Karp 2000, 68–69, Williams 1990), using ethnographic and anthropological approaches (Kaufman 1986, Thompson et al. 1990) or in discursive (Nikander 2002), phenomenological (Heikkinen 1993, 1996, 2004) or psychological research (Tornstam 2007, Öberg and Ruth 1994, Öberg and Tornstam 1999, 2001). Rather than describing themselves as old, participants in different studies prefer to call themselves "elderly" (Morell 2003, 73), "older" or "ageing" (Jones 2006, 89 Minichiello et al, 2000, 260), "young-at-heart" (Hurd 1999, 424) or "still a young person looking out of an older body" (Jones 2006, 5).

Clearly then, "old" is an identity not easily adopted or accepted. Earlier findings have also drawn the attention of researchers on the reasons for this denial of old age and definitions of old age. The following provides an overview of earlier research into the definitions and meanings given to old age by older people themselves. The examination is confined to qualitative studies specifically interested in the way that older people talk about old age, the position of older people in society, their relation to younger people, and their understanding of the meanings of health in old age. The reluctance to call oneself old or to be called old by other people is most often explained by the overwhelmingly negative attributes attached to old age. The origin and the meaning of these different attributes, however, are explained in different ways in different studies.

2.3 Old age and health

Thompson et al. (1990) collected life story interviews from 55 British grandparents aged around 60 to over 80. They were asked whether they saw themselves as old, how they defined the onset of old age and how they thought their appearance had changed. According to Itzin (1990), even though the participants admitted that their health had declined and that wrinkles and grey hair had changed their appearance, the majority firmly denied that they "felt old". Old age was defined on the basis of health and physical ability and most typically described as a "combination of incapacity, inability and ill-health" (ibid.,128). However, many respondents also said that old age was an "attitude of mind": declining health and one's limited lifetime were accepted as inevitable, but at the same time people were keen to emphasize

the importance of remaining active and trying to carry on doing the same things one had done before (ibid.). As Itzin (1990) observes, very few of the interviewees "fit with the stereotypes of old people as being passive, inactive, helpless, dependent, rigid in their thoughts or behaviour, old-fashioned, or unproductive"; "instead their lives are characterized by variety, vitality, diversity, activity, energy, interest, by 'youthfulness' in attitude, outlook, and activity" (ibid., 121). According to Itzin the negativity of stereotypes of old age makes "dissociation" an understandable and reasonable reaction, and even a "commendable form of resistance to the pressures and injustices of the prejudices against the old" (ibid., 122). She concludes that older people's attitudes about themselves do not conform to the social attitudes and negative social stereotypes of old age (ibid., 130). According to her the problem does not necessarily lie in "actual age" or "the actual conditions of being old", but in "the label, the category, the classification, the identity – simply being *identified* as old" (ibid., italics in the original).

It has been suggested that the experience of ageing and old age is so intimately linked to deteriorating health and the emergence of aches and pains that "ill health comes to stand for old age" (Conway and Hockey 1998, 479). Several studies applying different methods and theoretical approaches have reported similar findings and argued that not only ill health but feelings of slowness, tiredness and weakness and loss of interest in doing things or in the outer world are part of the experience of old age (Ballard, Elston and Gabe 2005, Fox 2005, Jyrkämä 1995, Karp 2000, Vakimo 2001, Vincent 2003, Öberg 2003).

Previous research has also suggested that health problems and different aspects of bodily changes that are interpreted as age-related, serve as "body reminders" of growing old (Karp 2000, 70) or as "accepted parameters of normal ageing" (Degnen 2007, 77). According to these findings, ill health in old age is taken as a fact that applies to ageing and old people in general, and yet in most studies individual participants tend to dissociate themselves from this view and seek to define themselves in different terms. In most of the studies quoted above, the participants were interviewed once or their lives were followed for a few months. In the phenomenological studies by Heikkinen (1993, 1996, 2000, 2004), the same Finnish people were interviewed at the age of 80, 85 and 90. Based on these studies Heikkinen coined the concept of "boundary conditions" to describe the experience of ageing in which deteriorating health and senses, frailness, pains, impaired memory, and loss of human relations constitute "vulnerability factors" (1993, 271, 1996, 193). Heikkinen (2004) argues that increased awareness of one's "bodiliness" is the crucial element in the old age experience, which heightens with increasing age. Bodiliness refers to slowness, tiredness, weakness and sensory decline and to the awareness of the finitude of life (ibid.). Heikkinen

found that at age 90, many interviewees who had previously denied they were old now admitted that they had become old – although there still remained some who resisted the idea (ibid. 2000, 474–476, 2004, 575–576.). Heikkinen (2004) explains this process of increasing awareness of the body, its physical decline and the finitude of life in phenomenological terms as reaching "being-in-the-world" in extreme old age. This means that people have become accustomed to their "bodily burden" and learned to compensate for any functional decline and optimise their abilities, while the meaning of the body has "waned" and all attention is turned to "existence", while ignoring other personal concerns and anxieties (ibid., 579).

Heikkinen's studies are important in showing that by following the same people over several years, it is possible to study ageing as a process that unfolds over time and in which bodily changes and social and cultural factors are intertwined. They also suggest that awareness of body changes may take precedence over other concerns when the functionality of the body or existence can no longer be taken for granted. One problem I see with the phenomenological approach is that it may conceal discrepancies and strengthen the impression that reaching old age is a similar process for everyone. For example, Heikkinen argues that most of the people who at 80 did not consider themselves to be old had changed their mind by age 90 (ibid.). However, she does not discuss at any length the fact that some people still denied being old even at the age of 90. Furthermore, the idea that people reach a state where they are no longer troubled by "personal anxieties and concerns" and feel they have lived a full life, may be seen as the imposition of a normative demand on those people who do not necessarily share such feelings.

Health problems or ill health in old age, it seems, are not the only crucial element in definitions of old age; others include becoming helpless as a result of health problems (Itzin 1990, 128–129, see also Karp 2000 70) and thus dependent on other people, losing control of one's life and becoming a burden to other people or society (Bryant et al. 2001, 934; Fox 2005, 489–492; Gubrium 1993b, 19–23, 57, Vincent 2003, 16). Many people express the wish to remain independent so that they can look after themselves (Lin, Hummert and Harwood 2004, Minichiello et al. 2000, Thompson et al. 1990). Health is said to play a crucial part in the maintenance of autonomy (Heikkinen 1996, 195), and with experiences of pain and illness people begin to feel they have lost control over their life (ibid., 474–475). Very few studies have elaborated on the exact meaning of the concepts of independence and dependence (Dant 1988). Ageing studies have been criticized for reproducing western ideals and values of independence and autonomy, without taking account of the cultural specificity of these concepts. Researchers who have adopted a cross-cultural and culturally sensitive perspective have pointed

out that dependence may be related to old age, but it is not necessarily experienced in all cultures as demeaning or as related to a less worthy social position. Instead, receiving help from children and other family members may be seen as a legitimate and self-evident part of the normal life course. (Fox 2005, van der Geest 1998, Torres 1999.) Indeed, there have been calls for more culture sensitive research (Fox 2005, Torres 1999, Wray 2004).

2.4 The social position of older people

In their study Thompson et al. (1990) also addressed the meaning of work and retirement, social relations and grandparenthood. Old age is not necessarily defined in terms of retirement and a position outside the world of work, but some interviewees said that leaving work had created a void and a sense of purposelessness in their lives, making them feel outsiders and useless in society, which in turn contributed to their feeling old. Other studies have also shown that retirement may contribute to a sense of being useless (Jyrkämä 1995, 103), or to the feeling that older people are regarded by others as useless and outsiders in society (Conway and Hockey 1998). However Thompson et al. (1990) reported that their interviewees were critical of the view that retirement from work was considered reason enough to be labelled as unproductive and useless. In their interpretation, the interviewees gave accounts of grandparenthood and community participation with the specific purpose of dissociating themselves from this negative stereotype (ibid.). In other studies, too, accounts of involvement in volunteer work (Lin et al. 2004) and informal help for children or other people (Morell 2003) as well as participation in political organizations (Conway and Hockey 1998, Minichiello et al. 2000) have been interpreted in a similar fashion as a way of questioning negative stereotypes of old age.

According to Minichiello et al. (2000), sentiments of uselessness and an outsider position come from various practical changes, such as retirement and moving to a nursing home, but also from poor access to the physical environment, difficulties with housing or low income, the lack of adequate services or meaningful roles or even employment. Minichiello et al. argue that all these structural, financial or social issues are experienced as a "form of ageism" and that older people themselves feel the result is that older people's roles in society are rendered marginal, the resources they have are wasted and their participation in society is made difficult (ibid.).

In an interview study of 18 Australians aged 65–89, Minichiello et al. (2000) specifically addressed the question of how becoming old and meanings and experiences of ageism are experienced. The concept of ageism refers to stereotyping old people in a negative way and discriminating them on the

basis of the negative stereotypes attached to chronological age (Bytheway 2005b). Based on the interviewees' descriptions of oldness, Minichiello et al. (2000) drew up the following list of characteristics: "not trying, withdrawn, isolated, irritating, self-oriented, living outside the mainstream, unattractive, uninteresting, frail, senile, silly, over the hill, narrow-minded, a burden, lonely, vulnerable, dowdy, and unproductive" (ibid., 259). According to Minichiello et al., this list goes to show that older people themselves have internalized and accepted ageist stereotypes and prejudices through their perception of what old means to them (ibid., 260), even though their accounts of their activities and capabilities are intended to create an image of themselves as "aged persons" who differ from the negative stereotype (ibid., 274). Other studies argue in a similar fashion that while older people use these definitions to label other people as old, they also distance themselves from these definitions because they are seen to represent ageist stereotypes that do not adequately represent their view of themselves (Hurd 1999, Lin et al. 2004, Morell 2003).

However, old age is also defined in terms of liberation, even though this is given different meanings by different people: some refer to freedom from responsibilities at work or looking after children and caring for one's spouse, or at least the freedom to choose the level of engagement in caring relationships, and being able to pursue new activities and opportunities in one's own life (Thompson et al. 1990, see also Vakimo 2001, Williams 1990, Wray 2004). According to Lin et al. (2004), having no clear status in society or the community and awareness of the finitude of life may lead to seeing oneself as being beyond the reach of social norms and obligations, which can therefore be ignored. From this perspective, then, old age brings with it the right to transgress social norms and values.

2.5 Social relations

Relationships with family members and younger people are not necessarily depicted as an "age" topic, but rather as a source of emotional and practical support and appreciation (Thompson et al. 1990). Age comes to play a role in intergenerational relationships when these are constructed as relationships between younger and older generations and when older people balance between the need to help their children and on the other hand not to interfere but to allow younger people "live their own lives" (Thompson et al. 1990, 192, see also Hinck 2004, 784–785, Wray 2004, 32). Age may be raised as a relevant issue in cases where older people view that their role as the "head of the family" comes from their being the oldest family member (Morell 2003, 76). On the other hand, widowhood can be experienced as offering

freedom from care responsibilities and a difficult marriage and providing the opportunity to pursue one's own interests in life in old age (Clarke and Warren 2007, Hurd 1999, Ruth and Öberg 1996, Vakimo 2001). It has been suggested that the definition of old age in terms of depression, loneliness and an outsider position stems from practical issues and losses, such as losing a spouse and friends, being unable to attend social events and to meet other people due to ill health, but also from a feeling that old people are "not wanted" among other, younger people and in society in general (Gunnarsson 2009, 43, Lin et al. 2004, 269, Williams 1990, 67).

Relationships between older and younger people have been conceptualized as "interactive ageism". Minichiello et al. use this concept to describe interviewees' experiences of verbal insults or derogatory comments about older people, being pushed in the street and treated with impatience or indifference (ibid., 267). Minichiello et al. (2000) say that in encounters with health care professionals, interactive ageism refers to experiences of being neglected or treated as unimportant, of not being consulted about major decisions, or even of being expected to tolerate pain and discomfort and having limited access to preventive treatment (ibid., 271). From this perspective experiences of ageism include being stereotyped or being seen as old, but also being discriminated against or treated as old (ibid., 275). By interactive ageism, Minichiello et al. also refer to interpersonal interactions in which younger people may see that they are "pampering" or "looking after" older people or making benevolent jokes, but older people themselves may experience younger people's conduct as diminishing or patronizing, with the result of loss of autonomy and independence (ibid., 265). Conway and Hockey (1998) similarly report that participants in their study who were members of an organization for pensioners' rights resented the "baby talk" with which they were addressed and felt that they were treated as "daft", "stupid" or "on their way out" simply because of their age (ibid., 482, see also Jones 2006, 87). Experiences of ageism have also been reported in situations where decisions are made by other people and for older people about suitable ways to behave or things to do for a person of a certain age (ibid., Hurd 1999, 428). Interactions giving rise to similar experiences have also been reported in more formal surroundings in shopping, political meetings, and with health care professionals or other care workers (Conway and Hockey 1998, Hurd 1999, Kontos 1998, Ylänne-MacEwen 1999).

Hockey and James used the concepts of infantilization and patronizing to describe the relationship between younger and older people (1993, 2003). They suggest that people who are categorized as old walk a tightrope between experiences of being looked after and cared for and being patronized by younger people (ibid.). In practice this means a tendency to see all older people as ill, frail and cognitively impaired due to their chronological age,

which may lead to their being assigned to a child-like position and making decisions on their behalf (ibid. 1993). Hockey and James (1993, 2003) argue that infantilization and patronizing are common elements of children's and older people's social position and that in western culture, old age is seen through the metaphors of childhood and dependence, which is also reflected in older people's experiences. Intergenerational relations are complex and multilayered phenomena and cannot be reduced simply to relations between different age groups. However most findings of the studies discussed here lend support to Hockey and James's argument. It has been argued that while people may resent patronizing and infantilization, they feel there is nothing they can do about it (Conway and Hockey, 1998, Minichiello et al. 2000) – although again some studies do discuss ways in which older people can try to change things and other people's attitudes. It has been suggested that some older people withdraw from activities and avoid situations or environments in which they anticipate unpleasant experiences or experiences of not being welcome (Minichiello et al. 2000, Morell 2003). Morell (2003) says that declarations of independent activity and engagement in communal activities can be depicted as "thinking practices" adopted by older people to contrast and disqualify stereotypical views of old age (ibid., 73). According to Minichiello et al. (2000), people may even adopt strategies of "educating" their families and children to think differently about older people. Studies of people living in institutional settings show that residents may take action against being patronized and develop and adopt group strategies to retain control over their lives (Gubrium 1997, Hazan 1994, Kontos 1998).

Overall the research findings seems to suggest that images and experiences of old age are largely negative. This is not to say that the experience of being old is depicted as being totally devoid of any positive elements, but it is not clear whether these elements are attributed to "being old" or simply seen as accompanying life at a certain stage. One common cultural representation of old age is to link it with accumulated life experience and wisdom (Johnson 2005, Cole 1992). Studies that specifically address self-development in old age suggest that ageing and deep old age may bring about an experience of wholeness and "fuller existence" that comes from accumulated life experience, the realization of the finitude of life and getting to know oneself (Heikkinen 2000, 2004, Karp 2000). On the other hand studies of older people's personal experiences reveal ambivalent views in this regard. People may feel that their long life has given them accumulated experience and a deeper understanding of life which could be seen not just as an individual but a social resource (Lin et al. 2004, Vakimo 2001, Williams 1990, 67–68). They may also argue that older people deserve to be respected for these qualities, although not many people necessarily consider this to be reality in their own everyday lives (Conway and Hockey 1998, 482, Thompson et al. 1990, 24). Minichiello et

al. (2000) point out that to acknowledge older people as "venerated elders" involves certain risks. They report that the participants in their study felt that if they failed to meet younger people's expectations of being wise old people, that made them feel even more devalued (Minichiello ibid. 268).

These research findings suggests that being old is experienced first and foremost as a devalued position, and that the identity of old is either denied or accepted with some reluctance. People may admit that while they may be old in terms of their chronological age and physical appearance, they don't feel old and certainly wouldn't described themselves as old. The explanation offered for this is that people deny or admit the realities of old age, or that they have internalized negative cultural stereotypes and ageist views, or that they resist and dissociate themselves from them. Dissociation from the body that no longer functions or looks the way it used to, is explained in psychological terms as a "defence strategy" that allows the individual to dissociate him- or herself from a devalued group (Öberg and Ruth 1994, Öberg and Tornstam 1999). Some researchers have concluded that the denial of age is an indication of chronological age having no real meaning for people as part of their self-identity. Concepts such as Kaufman's (1986) "ageless self" or Karp's (2000) metaphor of age as a "stranger" seek to explain the reported ambiguity of the experience of old age as something external to the individual (Williams 1990, 71). From this perspective the affirmation that one does not "feel" old can be seen as a strategy of differentiating oneself from stereotypical negative images and also of showing that one's true self is different (Karp 2000, Thompson et al. 1990).

Based on an analysis of the life stories of 60 interviewees, Sharon Kaufman (1986) argues that chronological age is not central to defining the self or identity, but the "ageless self" draws meaning from the entity of life, biographical details and the cultural and social environment in which one lives (ibid., 6–7). Physical and social changes are acknowledged as part of growing and being old, but the ageless self maintains continuity despite these changes (ibid., 7). The idea of the ageless self has been criticized for depriving old age of all positive meanings; for ignoring the fact that a long life experience may yield resources, experiences and understandings that younger people lack (Andrews 1999, Biggs 1997); for ignoring the existential aspects of the bodily being; and for reducing old age to decline and ill health (Öberg 1996). While I concur with this criticism, Kaufmans's argument is important in pointing out that chronological age is not necessarily experienced as a salient part of one's own identity, and that in constructing their identities people may draw from different sources such as life-long interests and activities (ibid., see also Gergen and Gergen 2003, Gubrium 1993a, Thompson et al. 1990).

The theory of the mask of ageing (Featherstone and Hepworth 1989, 1991) has it that there is a discrepancy between cultural views of old people and being treated as old, and personal views of oneself and one's own age. According to this theory the discrepancy arises from the conflict between negative cultural stereotypes and personal experiences of ageing, and personal aims and goals that may differ from social norms and values of age-appropriate appearance and conduct (Featherstone and Hepworth 1991). The theory has been interpreted to suggest that cultural representations are externally imposed and different from people's sense of self. As a result, it has been criticized for reproducing the western dualistic notion of a separate body and self (Andrews 1999, Öberg 1996). It has been suggested that the theory of the mask of ageing should be complemented by turning the focus of research to embodiment and embodied ageing (Öberg 1996). Furthermore, it is felt that the qualifying concept of persona or social masks would better describe the discrepancy of experiences of bodily ageing and sense of self (Biggs 1997, 2004). Hepworth (2004a), however, argues that instead of fostering the dualistic division, the theory was originally intended to describe variations and ambiguities in the experience of ageing in the context of contemporary western culture. Therefore, it would be more appropriate to talk in the plural about masks, which are not only imposed by culture but which also offer scope for individual agency. Therefore, instead of seeing the "inner" or "authentic" self as different from negatively understood cultural representations of the ageing body, the view is adopted that personal experiences draw from cultural representations of old age (ibid.)

The research suggests that older people may have internalized or seek to distance and dissociate themselves from negative stereotypes and resist ageist treatment and their devalued social position, while acknowledging the reality of social losses and their changed body and declining health. In this context, people may seek to define old age, themselves or old people as a group in more positive terms. Dissociating, distancing, resisting, admitting and conceding are recurrently used to describe the complexity of the experience of old age. Talk about the realities of old age brings along the idea of the true meanings of old age. A person who denies reality may be seen as unrealistic or worse, as having lost touch with reality. On the other hand, talk about internalizing or resisting stereotypes and ageist views makes old age a matter of individual and internal attitudes. In what follows I review the earlier research that has focused on unravelling complexities and conflicting meanings of old age in older people's own talk.

2.6 Negotiating and redefining meanings of old age

In recent years a growing body of ageing research has complemented the experiential approach on old age by focusing on language and the use of age categories in talk. These studies often adopt a constructionist view of meanings of old age as a socially and culturally constructed phenomenon. Old age is seen as a situationally and contextually defined phenomenon subject to negotiation. The experiential approaches discussed earlier have turned the focus of research to older people's agency. Agency is not always explicitly raised as a central concept, but the theorization still touches explicitly or implicitly on the individual's chances to influence his or her life, ageing and ways of being old. Language-centred studies further strengthen the view of older people as contributors to and producers of cultural perceptions of old age. From this perspective different negative or positive views of old age are used by older people themselves to make sense of their experiences of old age.

The studies discussed earlier (Heikkinen 1996, 2000, Kaufman 1986, Minichiello et al 2000, Thompson et al. 1990) indicate that older people themselves see old age as a matter of self-evident decline and on the other hand, at least to some extent, as being dependent on one's own choices and attitude to life. The view put forward is that by not giving in to difficulties and adversities or to defeatist and negative stereotypes of old age, the individual can change the meaning of old age and have an influence on his or her own life in old age. Studies looking more closely into language use and the contexts of defining old age have shown that it is possible to discern multiple views of old age in people's thinking. Some studies have highlighted the central role of activity talk in accounts of old age experiences. Accounts of activity appear to be a common theme in talk about one's own ageing (Hurd 1999, see also Gunnarsson 2009, Laz 2003, Lin et al. 2004, Morell 2003). Activity receives different meanings from a general stance or attitude to being socially, physically and mentally active, for instance to engaging in volunteer work (Hurd 1999), or being socially involved and intellectually active (Lin et al. 2004) or carrying out various everyday life routines such as cleaning, cooking and shopping (Gunnarson 2009) or bicycling, doing crosswords or just staying at home reading a book (Clarke and Warner 2007, Heikkinen 2004). It is pointed out that people need to keep busy, keep moving, involve themselves in different activities, and maintain a positive attitude to life and their own ageing. In this way it is possible to avoid or postpone real old age, understood as poor health, loneliness, isolation and dependence.

However, a detailed analysis of people's talk makes it clear that the same people may voice contrasting views. This ambiguity and the variety of definitions of old age in older people's talk were evident in Hurd's (1999) study of visitors to a senior citizens' centre. According to Hurd "the credo of activity", that is arguing for activity, independence and authoritativeness, was a way of constructing oneself as member of the not-old group in contrast to the sedentary and inactive visitors to the centre. At the same time, the participants also drew attention to the precariousness of their status as members of the not-old group (ibid., 427). From this point of view, in their talk about old age and health, older people define, reinterpret and negotiate their identities as well as realities of everyday life (ibid.).

It has been reported that when asked to talk about their own ageing, people often compare themselves to other old people. These comparisons are usually made with people who are thought to be worse-off, which in practice means that divisions are made between those who are seen to be able and active and those who are depicted as frail or really old. In these cases health and physical capability serve as criteria for defining who are "really old" (Hurd 1999). On the other hand, those who are in good health, active and engaged in social life are mentioned as exemplary figures, as heroes of old age who can overcome the difficulties of old age by applying their ingenuity, strength of mind and by taking an active and positive stance to life (Hurd 1999, Vakimo 2002). People who are categorized as "really old" can be depicted as victims of old age, but also in somewhat moralistic terms as people who have not been active enough or tried hard enough to overcome their difficulties. These studies indicate that older people themselves may see ill health, loneliness and social withdrawal as a result of their own choices and as leading to a sedentary and inactive life (Hurd 1999, see also Lin et al. 2004).

As part of a larger project on the cultural meanings assigned to older women in Finnish culture, Vakimo (2001) conducted an ethnographic and discursive study of daytime dances. The participants ranged in age from 43 to 84 years, the majority being aged from 60 to 75. Based on data collected in questionnaires (120 respondents), interviews (9 women and 3 men) and observations, Vakimo concludes that when they talked about going to the dances, women constructed for themselves an active, busy and on-the-move identity in contrast to the negative identity of frail old people who stay at home in their rocking chairs (ibid.). Their mobile and physically able body served as proof that they were not old, and going to the dances was a way of reinforcing this image (ibid). These findings indicate that old age and health in old age can be considered malleable by means of one's own actions. For example, daytime dances (Rönström 1998, Vakimo 2001) were depicted as an opportunity for some fun and socializing, but also for physical exercise

and memory training (Rönström 1998, 261, Vakimo 2001, 247–248). The authors do not elaborate on these findings, but it is interesting how in this way everyday chores and interests become framed as important for maintaining one's activity and for their beneficial effects on physical and mental health. In this way they also take on instrumental value as health enhancing activity.

2.7 Discursive and sociolinguistic studies of old age

My review so far has covered studies dealing with experiences of old age and approaching their subjects not just as respondents, but as active participants who may either adopt an old age identity or resist or seek to redefine what is seen as a stereotypical negative view of old people. In the past few decades research has shown an increasing interest in the meaning of language and the situated and contextual nature of old age descriptions. This aspect of the old age experience has been addressed most particularly in the growing body of interpretive and discursive studies. Discursive studies focusing on the micro context of talk are interested to offer a detailed analysis of language and how different meanings of age, old age and health are put forward, negotiated and accepted or refuted in talk.

Studies looking at how the category of old age is used in older people's talk have found that old age is used not only as an explanation for different and mostly negative everyday events, but also to question the value of one's own views (Bodily). As Bodily (1991) observes, to say "I'm 73 years old, I have no opinions" is a form of ageism employed by older people themselves, with chronological age offered as the only reason for the worthlessness of their views. Bodily (1991) is intrigued to know why age is so readily and unreflectively used to explain all sorts of everyday phenomena and calls for a more detailed study of the use of age categories in talk (ibid.). Most discursive studies today take the concept of ageism as a topic of study rather than a pre-existing explanatory factor. However, the questions presented by Bodily are important and the growing body of discursive research has addressed the use and complexities of age categories in older people's own talk.

From a discursive perspective, conflicting views of old age, the relationship between old age and health and chances to do something about health are treated as discourses available in culture and society that people can draw upon in constructing their and other people's identities. The focus is on a detailed analysis of the different meanings given to "being old". One of the strands of discursive research is Foucauldian social constructionist

research. In a study of people living in a retirement community, Katz (2000, 2005) found that people frequently referred to activity and activities as key elements in their lives. Participants described their personal identities as activity oriented and portrayed themselves as being actively involved in society, thus arguing for a different view of seniors compared to earlier images of withdrawn and passive observers (ibid.). And yet, according to Katz, these people also criticized and resisted organized activities, which they found meaningless (ibid., 144–145). Even though they participated in several activities and accepted activity itself as beneficial, these people were aware of the "regulatory" and "instrumental" meanings of activity and of its potential use as part of an "ethical regime of self-disciplining in later life" (ibid., 144). The participants can be seen to enact their agency by highlighting their desire to choose what kind of activities they wanted to engage in instead of engaging in activities organized for all, in spite of personal differences and aspirations (ibid., 145).

In Tulle-Winton's (1999) study of retired people's housing decisions, these people planned their retirement years in advance, made housing decisions that are compatible with prevailing expectations of appropriate housing for older people, and anticipated future ill health in old age (ibid., 291). Accounts of activity and keeping busy were common in the participants' talk, and they also distanced themselves from those older people who did not have a busy lifestyle but who had "let themselves go in old age", conceding to the limiting and negative meanings of old age (ibid., 292). According to Tulle-Winton the participants' talk showed that they engaged in planning and investing in their future, preparing for the future time of ill health and committed themselves to the obligation to keep busy (ibid., see also Tulle and Mooney 2002). However, they refused to take up the stereotypes of old age as a period of disengagement, and only one of the participants who was less affluent and who had severe health problems expressed a more fatalistic view of health and the future as a matter of luck (ibid., 294).

In Eileen Fairhurst's (1998) study the views of middle-aged men and women about growing older clustered around three themes: the inevitability of ageing, the fear of old age and the separation of self and the body. Fairhurst says that the participants in her study regarded physical activity as beneficial to their health, but accepted that they could not prevent the inevitability of old age (ibid., 266). The participants walked a tightrope between the ideas that one had to accept the inevitability of physical ageing and "let nature take its course", but one still had to take care of one's own health and appearance so that one could "grow old gracefully" (ibid.). However, this balancing act took on another meaning as well. The participants argued that one should not "go too far" or try too hard to be youthful, since that might lead to a transgression of the rules of age-appropriate conduct (ibid.).

These findings shed interesting light on the moral nature of age identities. Fairhurst's study goes to show that definitions of being "too old" or "young enough" are flexible and that in constructing their own identities people have to try and strike a balance between them (ibid., 261–262).

Jones (2006) has explored the phenomenon of "denial of ageing" by studying how women aged between 60 and 90 positioned themselves or other people as old or not old. Jones argues that the context of the original topic of the study, i.e. ideas about sexual activity in later life and the age difference between the interviewer and interviewees, elicited age talk. The participants did not deny being old, but constructed their own age identities in a more subtle way by positioning older people as not quite full adults. In other words, the interviewees positioned themselves as belonging to a different category than older people (ibid., 83–84.) Furthermore, they positioned themselves as still young behind "the mask of ageing", or as "a special old person" (ibid., 85–87). In this context these positions enabled the participants to align themselves with a group of people who were sexually active and liberated (ibid.). Nevertheless, positioning oneself as old and appealing to one's own experience of ageing allowed the participants to reject and resist normative ideas about senile old people (ibid., 87–88). In short, people modify their membership of the category of old age depending on the context of talk and the topic at hand (ibid.).

The discursive studies have also studied how meanings of health and age identities are constructed by and for older people in everyday encounters with health care workers. It has been argued that explaining health troubles by reference to old age may even lead to situations where old age is regarded as a diagnosis (Sankar 1984); therefore health problems are considered "normal" and not worth treating. Based on her studies on an acute, adult-care medical unit, Latimer (1997a, 1997b) argues that, paradoxically, it is important for an older person to be assigned to and to remain within the impersonal category of patient. Being seen as a patient means being seen as someone who has real medical problems and who therefore needs attention at a medical unit (ibid., see also Latimer 1999). Being classified as old, by contrast, may involve the risk that health problems are rendered as a "natural" decrement of old age (Latimer, 1997a, 1997b, 1999). Latimer (1999) suggests that some old people in hospital "lie low", that is, cooperate with staff and show that they are compliant, responsible and reasonable, thus earning the status of an adult person as opposed to being "just" old.

Sociolinguistically oriented discursive studies are more closely focused on language use and on how age-identities and notions of ageing and old age are constructed in interaction. From this perspective "the notion of 'denial of age' ceases to be conceptualized as a perceptual-cognitive reality of the speaker and the attention is directed to how age identities are achieved

in social interaction" (Nikander 2002, 113). The focus in this case is not so much on whether or not people see themselves as old, or whether they adopt "ageistic" attitudes or negative stereotypes, but rather on the different meanings that old age receives and on the grounds on which people assign themselves to different groups or deny belonging to them. The conflicting meanings of old age become understandable as different interpretations of old age in cultural circulation. These interpretations are available as resources with which to construct an age identity for oneself and to account for one's own conduct as a person of a certain age. (Coupland and Coupland, 1993, 1998, Coupland, Coupland and Giles 1991, Coupland, Coupland and Grainger 1991, Nikander 1995, 1999, 2002, 2009.) From a discursive perspective "being old" is not a category only constructed by younger people for older people, but older people themselves contribute to constructing this category and to defining the meanings of old age and the onset of real old age (Coupland, Coupland and Grainger 1991). "Age disclosures" are used to position oneself into a certain age category, but also to take distance from normative age categories (Coupland, Coupland and Giles 1989, see also Coupland, Nussbaum and Grossman 1993).

Based on two datasets of intergenerational talk between older and younger women and on health interviews with these women, Coupland, Coupland and Giles (1989; see also Coupland, Coupland and Grainger 1991) say that the direct request to talk about one's own health elicited age disclosures and age-related talk. What is important is that the participants were not asked about their age, but the link between health and chronological age was established by the participants themselves (ibid.). When older people talk about ill health, reference to chronological age serves as an "adequate explanation" for poor health, but on the other hand in "*disjunctive usage*" the link between old age and ill health was invoked to be able to distance oneself from the position of old (ibid. 137, italics in the original). In this kind of talk the participants described themselves as being active, having good health and needing no help (ibid. 137–143). The study by Coupland, Coupland and Grainger (1991; see also Coupland, Coupland and Giles 1989) on intergenerational interactions between peers and on the other hand between older and younger women showed that in peer talk, the discussion centred around several issues and life experiences (ibid., 194). Between young and older discussants, on the other hand, age was made salient in the older participants' identity construction. Younger participants made evaluations of older participants' life position, needs, wants, abilities and attitudes and oriented to their being potentially dependent and passive and potentially lonely, frail and in need of help (ibid., 200). In other words, the older participants were seen not so much as persons, but as representatives of a group of old people (ibid.). A common feature in younger people's talk

was their overly positive and supportive language, “over-accommodation” (Coupland and Coupland 1993), or patronizing talk that is linked to “protective” or “nurturing” styles of talk (Coupland et al. 1991, 203; see also Coupland and Coupland 1993, 283). Another common feature were the look-on-the-bright-side type of comments that serve to mitigate and close talk about troubles (Coupland et al. 1991, 204–205; Coupland and Coupland 1998, 169). The authors suggest that this kind of negative self-appraisal can adversely affect older people’s self-esteem and by the same token their well-being. However language use in different contexts can have even more concrete implications for older people’s health and well-being. In institutional interactions younger people and staff may mitigate older patients’ accounts of discomfort and health problems, which then serves to deny the reality of their experiences (ibid. 206, see also Coupland and Coupland 1993).

Health talk can be seen as one form of facework in which people define their identities to the interviewer (Coupland, Coupland and Robinson 1992, Coupland, Robinson, Coupland 1994). In a study of health-related interviews, Coupland et al. (1994) showed that how-are-you type of elicitations engendered “positive self-appraisals” or mitigating negative health evaluations. Hedging strategies can assume various forms, for example a “good news – bad news format” (ibid. 222, see also Coupland, Robinson and Coupland 1994, 112), which means an “I’m alright” type of answer followed by an admission of some health problems and a reassessment of the original statement. Hedging can also mean qualifying initial negative self-appraisals by saying “I’m not too bad” or justifying negative self-appraisals (“I had a bad fall”) (ibid. 223–224). Hedging also refers to “relativized appraisal” (ibid., 224). This means that assessments of one’s own health can be accounted for in relation to particular personal health problems, the advancement of age or by referring to a “presumed norm” depicted in “good for my age” or “as well as can be expected” type of statements (ibid., 224). The study shows that in the interview context, what is meant to be opening small talk can be interpreted as health-related and thus present a face-threat, which is managed by the interviewees in different ways (Coupland, Coupland and Robinson 1992, Coupland, Robinson and Coupland 1994).

Coupland, Robinson and Coupland (1994) applied Goffman’s concept of frame to study how in the opening phase of a consultation the doctor and older patient negotiate the frame in which health problems are discussed. They showed that patients and doctors can construct different frames in their talk, and patients also enact their agency to resist the medical frame in doctor’s talk. Doctors used the medical frame to undermine patients’ deterministic views of ill health in old age (ibid.). Coupland and Coupland (1998) showed how doctor-patient encounters can also be constructed as

a site where the doctor can "recontextualize" the patient's experiences and "revalorize" patients' lives (ibid., 183). Also, the doctor-patient consultation can be seen as an ideological context (Coupland, Robinson, Coupland 1994) in which doctors and patients balance between different tasks (Coupland and Coupland 1999). According to Coupland and Coupland (1999), doctors conveyed "the anti-ageist ideology of modern geriatrics" for instance by encouraging patients to see their health problems as treatable or subject to alleviation and even assume greater control over and responsibility for their health. In order to do that, however, the doctors had to undermine "self-disenfranchising" statements by elderly patients and argue that health can indeed be improved even in old age. The elderly patients, however, routinely appealed to their chronological age as a self-evident reason for poor health, and in this way too resisted the need to adopt healthier lifestyles (ibid., see also Coupland and Coupland 1994, Coupland, Robinson and Coupland 1994)

In the study of Coupland, Robinson and Coupland (1994), representations of age were also interwoven with health-identity (ibid., 83). Patients routinely made statements along the lines that "old age doesn't come alone", and since the idea of natural decrement in old age was so strongly rooted in older people's thinking, doctors had the difficult task of trying to change patients' conceptions (ibid.). According to Coupland and Coupland (1999) this kind of situation is potentially face-threatening for both parties. Doctors may come to question patients' experiences or their right to control their own lives, and patients' talk can be heard as an attempt to question the doctor's authority (ibid., 1999, 196–202, see also Coupland, Robinson and Coupland 1994). Accordingly, both doctors and patients engaged in a balancing act between different moral arguments, negotiating their relevance and relative value.

Coupland and Coupland (1993) say that ageism can be defined as repression in interaction where older people's talk about problems or troublesome life situations and circumstances are "lightened" by younger people pointing to the positive side of things. "Looking on the bright side of things" type of talk is one form of ageist talk that is used to mitigate the severity of an older person's complaints (ibid., 285). However, Coupland and Coupland (1993) argue that older people themselves frequently engage in this kind of "lightening work" and present their problems as not serious or deserving attention (ibid., 285). Ageism can thus also mean self-repression (ibid.). Based on their empirical studies Coupland and Coupland (1993) argue that older people engage in self-disenfranchising discourse. This, they continue, can have serious practical consequences in a health and medical context (ibid.). It may mean that older people themselves see that old people are too old to change their habits, to lowered expectations of the

need for and utility of medical treatment and to accepting poor health and discomforts as a necessary part of older people's lives (ibid., 288). In other words in the capacity of patients, older people can have "disempowering" and overly deterministic and negative views of their health, which may lower their expectations of the possibility for improved health, for medical care and personal control in matters of health (ibid., 297).

Coupland and Coupland (1993) point out that situated talk is the level at which ethical arguments and medical ideologies are implemented. However upon closer analysis of situated talk it becomes evident that ageism and anti-ageism can take on different and conflicting meanings (ibid., 297). From this perspective, then, ideology can be approached and studied as positions in local arguments (ibid., 297). Both patients and doctors position the patient differently and shift the ideological ground of positioning when responding to each others' speech turns. Patients may elicit old age, on the one hand, and lifetime habits and life with few pleasures, on the other, as factors that not only undermine the utility of medical treatment, but legitimate smoking and drinking. Doctors, then, were faced with the difficult task of trying to persuade patients to take control of their health and to demonstrate the health damaging effects of "unhealthy" habits. On the other hand, doctors threatened to undermine the legitimacy of patients' own arguments and their right to independent decision-making. (ibid., 297–298.)

Lin et al. identified an element of tension between positive and negative age identities in an Internet discussion group where their participants addressed two questions: "What is old?" and "Are we old?" According to Lin et al. (2004) all themes were pervaded by the same understanding that physical deterioration was inevitable and undeniable, although the participants employed "framing tactics" in which age identities were constructed through the themes of wisdom and maturity, freedom and active engagement in contrast to the negative age stereotypes of withdrawal and decline (ibid.). The view put forward was that by engaging themselves in a busy social life, taking exercise and showing firm resistance against ageism, and managing the "struggle of ageing" with a "confident disposition", it is possible to mentally transcend the process of decline (ibid., 270). Lin et al. discuss their findings in the light of social identity theory and argue that the participants of this discussion group employed different methods to cope with their devalued status and to achieve a more positive group identity. Through "psychological reorientation" or "active engagement", the participants were able to change their group membership and move to the group of young, or by framing old age as wisdom they were able to redefine the older age category as positive rather than negative (ibid., 271). When people talk about their age and define themselves as old or not old, they are at once constructing age identities and negotiating "societal age stereotypes"

(ibid., 272). The authors also give separate consideration to the context of Internet group discussions. In their view, the group discussion may have endorsed positive themes, since being positive seemed to be the norm for the group. They also assume that online discussion as a method of data collection may have favoured wealthier and more educated people (ibid.).

Nikander's study (2002, see also Nikander 1995, 2000) showed how Finnish men and women in their fifties may use seemingly conflicting age categories to construct their identities. The focus of this study was on people's meaning-making activities and on the interactional processes through which different meanings of age were brought forward, negotiated and rejected or accepted. Definitions of being "too old" or "young enough" proved to be flexible when people constructed different age identities (Nikander 2002). From a discursive perspective talk about being surprised about turning fifty or not feeling old are rhetorical and discursive devices used to construct oneself as energetic and active, which serves as way of resisting conventional age categories (ibid., 98–113). Alternatively, placing oneself in the category of someone aged fifty is used in talk to construct oneself as "mature" and different from immature young people (Nikander, 2002, 98–113). Nikander's study explicitly addresses the morality of age order. In the context of discussing age categories, ageing was constructed as inevitable physical decline, but people distanced themselves from this category. Talking "against linearity", that is, denying that one is old or that age had any meaning in one's own life, proved to be potentially reprehensible. Talk about the "essential" or "inner" me was a device used in talk to argue for the continuity of one's own identity, while people may acknowledge that changes have also taken place. Talk about the "essential" me allowed the speaker to claim that ageing had no personal relevance, without having to break the rules of age-appropriateness. (ibid.) Nikander (2002) concludes that "arguing for continuity" and "conceding change" are essential elements of age talk that are used for different purposes. From this perspective talk about the "essential me" is not taken as a sign of an unchangeable self, but as a concept that people may use to distance themselves from a negatively understood old age identity or to legitimate conduct that deviates from expectations of appropriate behaviour in old age (ibid.). The morality of age talk was also visible in the way that participants talked bout the need to "act one's age" and not to behave childishly or trying to pass for someone younger. The point was nonetheless made that one should try to remain youthful and resist ageing (ibid., see also Nikander 1999). From this perspective attempts to categorize oneself as not-old or to dissociate from what others may consider one's proper age group, for instance talking against the "linearity of age", may be deemed as "not acting one's age" and thus as reprehensible (Nikander 2002).

When they are asked to talk about their own age, people engage in what Nikander calls "mundane theory construction" on the meanings of chronological age for oneself (2009, 868). Interviews need then to be seen as contexts in which interviewers' questions about views on ageing open an "argumentative space" with different "potential models and cultural scripts of being 50 and of age-bound activities, preferences and characteristics" that are related to these different models and scripts (ibid.). Nikander points out that since various definitions and legitimate and reasonable ways of presenting ageing and being 50 are culturally shared, talk about age is by necessity rhetorical and dialogic (ibid., 868). In her recent study Nikander (2009) focuses on exploring how bodily or psychological change and their cultural meanings are constructed with a recurrent discursive device called "provisional continuity device". She argues that this device was used by the study participants to show that they acknowledge change as an inevitable part of human life, thus conceding that possible age-related changes have taken or may take place in their lives. At the same time, however, they distanced their present selves from expected "normal" problems related to ageing such as physical ill health, pains and ailments or slowing down. (ibid.) According to Nikander (2009) these accounts were recurrently constructed in a three-step process ("A, B, but A"), meaning that in constructing their personal identities the participants undermine the meaning of ageing to their own identity. The speaker then admits the possibility of changes, but eventually returns to the original argument (ibid.). Thus the salience of ageing to one's own health and bodily being is recognized and undermined at the same time. In other words change is acknowledged, but located outside personal experience or to distant future (ibid.). What is interesting in this device is that it allows the speaker to construct him- or herself as "rational", for instance that he or she is aware of the "facts of life" and makes no attempt to deny them (ibid., 873). Nikander argues that this device can provide a more general tool for studying the interplay of identity construction and cultural imperatives and moral meanings of different age categories (ibid., 874).

In the sections above I have summarized the findings of studies that have specifically addressed the meanings of old age in older people's talk. These studies show that health seems to have an essential role in defining what it means to "be old". In what follows I will turn my attention to research that has addressed the meanings given to health and how old age becomes visible in health talk. The morality of age talk was clearly evident in the studies discussed, and health in ageing seemed an equally morally loaded topic. In the following I will also discuss the morality of health talk as it is manifested in these studies.

2.8 Personal experiences of health

Older people's health perceptions have become a focus of interest for many reasons. A recurring finding in large-scale population studies is that self-ratings of health predict mortality more accurately than so-called objective measures of health (Idler, Hudson and Leventhal 1999, Jylhä 1994). Another "mystery" (Sidell, 1995) or "paradox" (Henchoz, Cavalli and Girardin, 2008) of large-scale studies is that older people's self-rated health tends to remain relatively stable or even improve with age, even when their "objectively" measured health declines and the number of chronic diseases and difficulties with activities of daily living increase (Blaxter 1990, Bury and Holme 1991, Leinonen, Heikkinen and Jylhä 1998, Victor 2005). Large-scale population studies do not provide a very useful framework for exploring the content of self-ratings or the different meanings given to health. Jylhä (1994) has shown that on closer inspection of responses to survey questions concerning one's own health, it becomes apparent that it is very difficult for people to offer one single definition of health; instead they draw from a range of different sources, including their present life situation, comparisons with their own earlier health and other people's health, diagnosed diseases and medication, the presence or absence of aches and pains, social relations and activities (ibid.). It is easier to understand the complexity and contradictions of health definitions when it is accepted that health may assume different meanings for the same people in different situations and in different contexts (ibid., Jylhä 1994). To unravel these paradoxical health views, it needs to be accepted that there does not exist one singular health, but different views of health (Stainton-Rogers 1991), and that this is a multidimensional, relational and context-bound issue (Jylhä, 1985, 1994, Lyyra 1999).

Another factor behind the growing interest in people's own health views is the critique against the negative medical understanding of health as the absence of diseases and the perceived need for a more holistic approach. In this vein it is argued that health should be addressed as a social, environmental and cultural issue rather than analysing decontextualized health views and people as carriers of those views. (Bury 1997.)

When people are asked about their views and definitions of health, what is it exactly that they are talking about? Studies of personal health views can be divided into those that explore what constitutes health and those that are interested in the causes of diseases and illnesses (Sidell 1995). The findings on personal views about health and illness and the explanations offered for their causes indicate that health is understood in terms of the absence of diseases or not being ill, and in functional terms as the ability to manage everyday chores and to cope with difficulties. Other explanations refer to what people do or can do in order to improve their health, with

health understood primarily in terms of physical fitness and having energy. Furthermore, health is defined in terms of psycho-social well-being and as a physical resource and the capacity to resist illnesses (Blaxter 1990, Cornwell 1984, Herzlich 1973). So although the concept of health is readily linked to issues of illnesses, it is still clearly something more than just the absence of illness (Radley 1994, Radley and Billig 1996).

2.9. Agency and morality in health

Talk about experiences and definitions of health often include implicit or explicit references to the origin or reasons of good or poor health. In addition, health talk largely revolves around questions of how and to what extent the individual can influence his or her health. Health talk, then, is also talk about individual agency, even though this concept is not always explicitly addressed in research. According to Herzlich's (1973) seminal study, individual character and predisposition are seen to have a role in improving or maintaining health, but illnesses or diseases are thought to have their origin in the social environment (ibid., 38). It has been argued that people can take all the blame on themselves for not looking after their own health or for taking unnecessary risks (Blaxter 1993, Calnan 1987, Cornwell, 1984). However Blaxter (1993) has shown that when accounts of health are analysed in more detail, it is clear that heredity, work and social circumstances, personal disposition and own conduct are all seen to have some influence on the individual's health. Several studies have shown that individual responsibility for health is a common topic in people's talk, which implies a close intertwining of morality and health. The morality of health refers here to the extent to which individual people can have an influence over their health and are responsible for their health (Backett 1992, Blaxter 1993, 1997, Cornwell 1984, Williams 1990, Williams 1993). Although people may construct a difference between minor health complaints and serious diseases and do not necessarily consider themselves responsible for serious conditions (Cornwell, 1984), their failure to recover or to resist the adverse effects of illnesses may be "attributed to either lack of motivation or a defective will" (Pollock 1993, 53). If health is seen, as Williams (1990) has argued, as a reward for modesty and virtue (see also Williams 1993) and unhealthiness implies an element of "personal failure" (Blaxter 1990, 14), then good health may mean "a morally worthy state" while illness is "discreditable" (Cornwell 1984, 127, see also Conrad 1994).

Cornwell (1984) coined the concepts of public and private accounts to explain why the respondents in her study initially expressed views that

emphasized individual responsibility and the opportunity to exercise an influence over health (public accounts), but later on qualified and mitigated these views in their "private" accounts. She argues that the research context strengthens public accounts, that is, normative and individualistic views about the need to look after one's health. As a consequence, research interviews tend to elicit "public accounts" of health, but if the necessary space is given to the respondents, they will offer private accounts to complement and qualify public accounts (ibid.). However private accounts, Cornwell (1984) suggests, describe more accurately how the participants see their own chances and responsibility to improve their health. She also says that the sample of working class people in her study were more inclined to express fatalism than to admit that individual actions have any major role in health (ibid.).

Backett (1992) has also discussed the distinctive characteristics of research as a context for health talk. She argues that no matter how impartial or neutral she tried to be, the participants' talk about health received a moral tone. The talk moved between arguing for attempts to lead a healthy life and confessing to "lapses" or weaknesses in these attempts (ibid., 262–263, 267–269). According to Backett this shows that in contemporary western cultures, health is a morally loaded topic that necessarily has to be taken into account in health studies (ibid.). Gareth Williams (1993), too, has discussed health as a morally loaded topic in contemporary western culture and the research interview as a context for health talk. On the basis of his case study of 64-year-old women suffering from rheumatoid arthritis, Williams (1993) argued that coping with chronic illness and ageing can be seen as one way of pursuing the virtue of independence in self-care, and the interview situation can serve as an opportunity to execute this and other virtues. From this perspective the morality of health views can be interpreted as a way of depicting oneself as accountable in situations where one's health may be deteriorated and is made a topic of inquiry for other people.

The research reviewed here indicates that there is much variation in the ways that individual responsibility and influence over one's health are understood and in the ways that the morality of health talk is explained. Studies focusing on older people's health views have shown that, even though ill health is often explained by reference to old age, even these people mention individual responsibility and chances to make a difference to their own health. Some studies argue that the differences in accepting responsibility for one's own health or fatalistic explanations such as seeing ill health as unavoidable in old age are a matter of individual "positive" or "pessimistic attitudes" to one's own health and ageing (Berman and Iris 1998, Bryant et al. 2001). It is argued that poor health in old age is not a fate, but at least partly in the individual's own hands. This kind of explanation has been criticized

for being too individualistic and for reducing health views to individual attitudes and components of people's mental lives. It has been argued that instead, individual health views draw on and become understandable in social, cultural and historical settings (Williams 1993). From this point of view talk about health and illnesses is always both personal and general, and individual talk partakes general beliefs and shared theories about the nature of the world (Radley and Billig 1996, 223). In short, it can be argued that to talk about one's own health is to account for proper or improper conduct and a way of constructing oneself as a worthy and virtuous person (Radley and Billig, 1996).

One of the pioneering studies seeking to place the morality of health and attitudes to illness and old age in a broader cultural and historical setting is Rory Williams' (1990) seminal work on Aberdonians aged 60 and over. Williams says that good health was seen by his subjects as a reward for a modest and virtuous life. However, old age was represented as a result of failing strength and being unable to resist diseases; in short, old age equated illness (ibid., 63). According to Williams responsibility for health means both fostering one's own strength to resist illnesses and the abllity to manage tasks of everyday life. Strength can be seen as a genetic characteristic, but even so the individual is responsible for trying to keep up his or her strength and should try to perform normal activities and not to give in to difficulties (ibid.). Williams maintains that people cannot be classified as representatives of a single type, nor can their talk about old age and health be taken to represent a unified pattern. Instead, people's views about old age and health were ambivalent and divided: true old age was an inevitable process of physical decline to which the individual should adapt and which is a legitimate reason for giving up activities, whereas early old age can be resisted by means of being physically, socially and mentally active and refusing to give in to adversities (ibid.). Williams describes old age as a "dilemma of resistance and surrender" (ibid., 77). While people accepted personal responsibility for "an active attitude" (ibid., 77), they also felt that real old age "could not be helped" (ibid., 81). Old age is seen by older people as a "discreditable identity", and an "unlucky outcome, which could not be helped" (ibid., 81).

Williams (1990) argues that even though his respondents felt that retirement brings with it an obligation to maintain a high level of activity, the idea of engaging in activity without meaning or purpose was widely condemned (ibid., 1990, 66). Being obsessed by activity and such things as doing crossword puzzles to "keep the brain active" were also seen as pitiful (ibid.). However it was also pointed out that individuals can be held responsible for failing to foster their own health and for contributing in this way to their declining health. From this perspective, old age could be seen

in as “moral failure” and even as an indication of lacking “self-discipline” (ibid., 81). Williams suggests that these attitudes to illness and old age and the de-emphasis of one’s own health problems and the emphasis of one’s own efforts to resist illnesses and to keep up daily activities and perform normal tasks is borne from the cultural influence of Protestant ethics, but also from the values of the generation born before the Second World War (ibid.). In a similar fashion, Bury and Holme (1991) suggest that reluctance to “complain” about or call one’s own health poor may be related to the historical era and the social circumstances in which older people grew up (ibid., 163). Williams (1990), however, also suggests that looking after one’s own health and leading a healthy lifestyle are mainly middle-class values (see also Cornwell 1984). In spite of the individualist tones appearing in some of the respondents’ talk, Williams (1990) says that the attitudes and values adopted by his respondents did not reflect individualist but rather self-sacrificing and collective values.

Similar findings about the balancing of individual responsibilities with fatalistic views of chances to influence one’s own health have also been reported in more recent studies. Heikkinen says that people in their eighties and nineties in her study regarded ill health and deteriorating functional ability as a “natural process” beyond their control and influence (2000, 474, 575–576), although occasionally they did describe their attempts to resist ageing and look after their health (1996, 2000). In a recent study by Gunnarson (2009) among 20 interviewees aged 75 to 90 years, both people who were in good health and those who had health problems gave accounts of daily exercise as a way of resisting age-related physical decline and as something one should do. Gunnarson (2009) emphasizes that the respondents’ interpretations of activity and exercise were situational and personal. For some, exercise meant one daily walk, for others it was a whole day filled with physical activity (ibid., 40–41).

Previous studies suggest that while older people do accept the importance of assuming personal responsibility for their health and for following current guidelines regarding a healthy lifestyle, they also call these into question. Some studies have sought to address and explain this duality.

2.10. Questioning and qualifying health-enhancing activities

One of the concepts often used in describing people’s experiences of ageing is that of resistance, but this concept has received various meanings in research. This refers to resisting the negative stereotypes and devalued status of old

age as well as other people's views about old age, or to resisting the feeling of being old or "giving in" to old age. In some studies people's readiness and willingness to take actions to improve their health in old age has been conceptualized as resistance to the impairing effects of old age. On the other hand resistance is also used to conceptualize findings according to which individual people may question the benefit and effects of individual actions to improve one's own health. In what follows, I will review studies that have explicitly discussed old age and health in terms of concept of resistance.

The study by Ballard, Elston and Gabe (2005) questions women's willingness to engage in what they call "age-resisting activities". In their interviews with women aged 51–57 years, the authors wanted to find out if these women were willing to engage in and had employed "age-resisting activities" in their personal lives and whether they regarded them as beneficial (ibid.). Ballard et al. (2005) coined the terms of "public" and "private" ageing to explain the discrepancy detected in their own and in many other studies between inner feelings and outer signs of bodily ageing. Based on their study they argue that the experience of private ageing is largely invisible and arises from age-related physiological changes within the body, while public ageing is related to visible bodily signs such as wrinkles or grey hair. Social interaction between people of different ages also creates awareness of one's bodily ageing (ibid., 175–178). Ballard et al. argue that less visible physiological changes in the body are seen not as malleable but rather as irreversible, an inescapable fate for all people. Among the "age-resisting activities" adopted were dying one's hair, using cosmetics and dressing in a youthful way. Only few women took physical exercise to keep fit and lose weight and took hormone replacement therapy to maintain their health and youthful appearance (ibid.). They conclude that while the body is felt to be flexible and manipulable to some extent, age-related changes in the body offer only limited scope for individual control (ibid.,183). Social class is given some role as an explanatory factor, but Ballard and colleagues argue that public ageing is related to and reflects the social and cultural ideals of contemporary society. Private ageing, they maintain, is distinct from the social area and reflects personal identity (ibid.). With time, growing old leads to a deeper awareness of bodily ageing and succumbs to "the social mask" (ibid., 182).

Also, Crossley (2002) argues that when the individual bodily state and health are seen as a result of the inevitable biological trajectory, or when genetic factors are given a crucial role in health, individual responsibility is undermined. Crossley's focus group discussions on the attitudes and opinions of women aged 64 to 93 towards health issues suggest that the negotiation of blame and responsibility were closely intertwined with health views (ibid.). Crossley argues that in the course of the discussion the participants

developed three positions, labelled as "positive mental attitude", "genes and luck" and "rebellion". The first position had it that difficulties (such as old age) can be overcome with the right attitude, the second emphasized genetic factors and the lack of individual control over these factors, and the third reflected rebellion against being overly obsessed about health or leading a healthy life (ibid.). According to Crossley these positions were developed in interaction with one another, but they were nonetheless attached to certain groups of people. Her explanation for morally loaded health talk owes much to Robert Crawford's (1994) ideas of health as a central value and a "way to pursue moral personhood" in contemporary western culture (ibid,. 1482). Crossley, however, focuses on the negotiated nature of these positions and on the dynamics of group discussions in which originally morally loaded views of blame and responsibility are qualified later on (ibid.). Resistance positions in particular reflect, in her view, the way that lay people can resist restricting cultural ideals that are imposed on them (ibid., 1482).

In Foucauldian inspired ageing and health research, the focus is often on how different versions of age and old age construct and are a part of power relations of society and culture. Conway and Hockey (1998) interviewed 15 people aged 50 to 81 years and found that they equated old age with poor health. Some, however, argued that health was the individual's own responsibility, while others referred to social inequality and poverty as major causes of poor health. Conway and Hockey argue that the participants in their study enacted their agency in several ways: they resisted and challenged the authority of medical experts and what they saw as disempowering and patronizing treatment of older people in health care, sought alternative therapies and questioned the over-prescription of drugs. Some questioned the ideas of individual responsibility for health, while others assigned more responsibility to individual people (ibid., 491).

According to Conway and Hockey people may explain both how they have changed and what remains the same, or part of "the essential me" (ibid., 480–481). Being old may also be associated with a body which is in decline both in terms of functionality and appearance. Tension was experienced between external bodily symbols of old age and a subjective sense of "an ageless self", and thus there was also a conflict between the "mask of old age" and more positive perceptions of self-identity (ibid., 480). Dissociating oneself from a "failing" body can be seen at once as an individual and political strategy of constructing old people who are worthy and valuable in society (ibid.). Conway and Hockey suggest that when health is understood in broader terms and related to socio-economic structures and older people's social position, the individualizing discourse of "looking after yourself" is called into question and collective factors such as poverty and social inequalities are given a more prominent role in health (ibid., 489).

In negotiating the personal meaning of physical decline and social losses, older athletes in Dionigi's (2006) study argued that "regular physical activity" helped to improve health in every way and that by using their bodies as much as possible, they could postpone the onset of frailty and age-related diseases (ibid., 187). According to Dionigi these people both mobilized and resisted contradictory discourses of ageing and physical activity at the same time (ibid.). In their talk they expressed the view that old age equates with physical decline and social losses, yet these can be resisted through one's own actions (ibid.). The experience of being old can thus be defined in terms of pleasure, ability and pride (ibid., 187). In resisting ageism and the discourse of decline in old age and in emphasizing their involvement in physical activity and having a busy social life, Dionigi says, these older athletes reinforced and conformed to dominant values and ideologies associated with an active life, fitness promotion and independence. However physical activity also served as an empowering experience that offered as sense of achievement and a way of self-expression (ibid., 191).

The female members of a fitness centre interviwed by Paulson and Willig (2008) also expressed the view that health can be seen as a balancing act between different discourses. They defended the position that they could influence their health through activity and physical exercise, by taking vitamins and so forth, but they also talked about being out of control and about ageing as biological decline. Paulson and Willig say that the decline discourse was used to resist requirements of weight loss and to argue that it was appropriate for an older woman to be overweight. The activity discourse, on the other hand, was used to argue for and demonstrate one's own agency (ibid.). Thus women balanced between contrasting discourses and negotiated the role of "biological determination" and the scope of individual agency in health in old age. Practical actions such as going to fitness classes to prevent further bone fractures and engaging in an activity discourse can then be seen not as a means of conforming to disciplining practices, but of enacting one's own agency. (ibid.) Interestingly, dancing or attending fitness classes (Paulson and Willig 2008) and participating in competitive sports (Dionigi 2006, Tulle 2003, 2004, 2008) can be interpreted as resistance to expectations of what is considered "age-appropriate" (Coupland 2004) conduct for older women or expectations of them to be active and take exercise but not to do "too much".

The studies reviewed above employ a wide range of different perspectives and methods. Their findings indicate that it is not easy for people to adopt the identity of old age. Experiences of old age are intertwined with experiences of health and bodily changes. Both age and health seem to be morally loaded topics that have to do with people's age-appropriate identity and social conduct. The importance assigned to social values and norms, cultural

representations and bodily changes varies. In some studies they are seen as separate, or that bodily sensations outweigh other factors when a person grows older. In other cases it is argued that these cannot be separated in any clear-cut manner. Views, attitudes, opinions or positions taken towards ageing and health in ageing have been explained by reference to internalized negative attitudes and resigning to them. Alternatively, it has been argued that older people may resist negative stereotypes and either define themselves as different from ordinary old people or define old people as a group who are different from these negative stereotypes. In somewhat different terms, it has been argued that people can attempt to resist old age and physical decline by means of physical or social activity, or they can resign to the realities of bodily decline. In this case the old age experience is mainly ascribed to the individual and his or her interpretations and characteristics. Furthermore, in some studies body and bodily decline have been given primacy over social and cultural factors. From a different perspective it has been argued that views of old age need to be looked at as social and cultural constructions which guide interpretations of bodily changes. In relation to this some studies emphasize the role of everyday social interaction and different contexts as sites where meanings of old age and health are constructed in practice. In my own studies I have adopted the perspective which emphasizes the interrelatedness of social, cultural and bodily aspects of old age in people's experiences. In addition, my studies emphasize the importance of studying language use and how the different aspects of this experience are given meaning, elicited or rejected as salient parts of old age and health. My own work then takes a social constructionist and discursive approach.

3 AIMS OF THE STUDY AND RESEARCH QUESTIONS

This study is an attempt to explore the meanings given by older people in their talk to old age and health. The analysis focuses on the different and perhaps contrasting themes articulated in discourses on the relationships between ageing and health, on the one hand, and on the individual's possibilities and responsibilities in the areas of ageing and health, on the other. The aim is to illustrate and analyse how older people negotiate and reason about these issues and how cultural discourses on ageing and health are used to construct one's own experience of old age. The methodological goal of the study is to add to the growing body of discursive studies in ageing research, and particularly to see if and how a detailed analysis of talk using rhetoric and discourse analysis can generate useful new insights. In addition, the purpose is to study and discuss the meaning of different research settings, such as individual biographical interviews and group discussions, as contexts for age and health talk.

The first study of this thesis focused on the meanings given to old age and health and older people's position in society in older people's talk. The second study was concerned with moral argumentation in talk about old age and health and with how people explain, legitimate and defend their actions and decisions in regard to their daily activities and health-related conduct. The third study dealt with questions of personal responsibility for health and how people can influence their own health. The focus of the fourth study was agency and the question of whether the category of old is constructed as an agentic category.

The main research questions are:

What are the meanings given to "being old" as a social position and in relation to health status and to other people?

What are the meanings given to "health" in relation to old age?

What are the meanings given to the ideas of individual responsibility for and chances to influence one's own health?

How are the ideas of individual agency used and developed in talk about old age, health and social position of older people; to what extent do older people think that these are within or beyond their influence?

4 THEORETICAL AND METHODOLOGICAL CONSIDERATIONS

4.1 The social constructionist and discursive approach

This study draws on the ideas of social constructionism (Gubrium and Holstein 2008, Holstein and Gubrium 2000a) and the discursive approach (Potter and Wetherell 1987, Wetherell and Potter 1992). Social constructionism calls into question the existence of unproblematic "social facts" as well as the view that social reality is directly available for scientists to discover, measure and describe (Berger and Luckmann 1966). Both social constructionism and the discursive approach emphasize the importance of language as a situated and interactional phenomenon with which reality or different versions of reality are constructed (Holstein and Gubrium, 2000a, Nikander 2008a, Potter and Wetherell 1987). Language is not seen as reflecting reality, nor it is taken as a transparent medium for describing reality, but it is seen as a central means for assigning meaning and constructing different versions of reality. In other words social reality is constructed in and through language, and when we talk we use language and its categories to reproduce and maintain social order. Michael Billig (1996) refers to the "two-sidedness of thinking", meaning that talk is not only about arguing for something, but also explicitly or implicitly about arguing against alternative views. Language use, it is maintained, has concrete consequences. Different versions of meanings of old age and health construct individuals and their actions in a certain way and maintain certain ways of thinking, while undermining alternative versions of the social world and ways of conducting oneself (ibid.).

As a theoretical orientation in ageing research, social constructionism and the discursive perspective open up the possibility to "think differently", to question taken-for-granted truths about the meaning of age categories, or meanings of being old, or meanings of health in old age, and to study different and possibly contrasting ways of defining old age and health. I do not wish to commit myself to the view that there is no reality beyond

categories of language, or to deny the existence of the material and "the extradiscursive" (Weinberg 2008, 35) aspects of human life. Rather, the social constructionist and discursive approach applied in this study is interested in how these different topics are given meanings, made visible and perhaps important and relevant parts of one's own or other people's lives. Following Holstein and Gubrium (2000a), it can be said that age and age-grades are not just something experienced or encountered, but they are categories and concepts that people use to describe and interpret their experiences and construct their identities as certain kinds of people.

The discursive perspective is not one method, but rather a theoretical orientation with different practical applications. More specifically, in this study I combine ideas of situated and action-oriented discursive constructionism (Potter and Hepburn 2008) with Foucauldian influenced discourse analysis (Wetherell 1998, Wetherell and Edley 1999). In practice this means adopting the view that both the situated nature of talk and the institutional practices and social structures within which talk is embedded need to be taken into account. A conversational situation such as an interview or everyday talk between friends forms a microcontext for talk, but in their talk people draw from broader social and cultural discourses (Wetherell and Edley 1999). Discourse analysis offers tools for exploring different "versions" of social realities produced in talk and how different, sometimes conflicting meanings attached to health and old age are brought forward, negotiated, accepted or discarded in talk (Nikander 2002, Potter 1996, Wetherell and Potter 1992).

The concept of discourse has received various definitions**.** One way to define discourse, and at the same time the focus of analysis, is to say that discourse means that "the concern is with *talk and texts as parts of social practices*" (Potter 1996, 105, italics in the original). Potter's definition narrows the focus of discursive study to practices and encounters occurring at the practical everyday level and in interaction, instead of tracing broader collective discourses (ibid., 105). In this way he dissociates himself from "the Foucauldian notion of discourse as a set of statements that formulate objects and subjects" (ibid., 105). Here in this study I have applied both of these interpretations of discourse. The concept of discourse is used here in the broad sense of ways of thinking and talking about the topic at hand in different everyday encounters, but also as ways of organizing society and the positions of individual people within society, which then have practical consequences for people's lives and construction of identities (Miller 2008, Wetherell and Edley 1999). Discourses convey messages of what is possible, preferable, forbidden or impossible for an individual person inhabiting a certain social position – such as "being old", but by studying talk and interactions we can see also how different discourses are put to use in talk.

In the context of this research, discourses are best defined as "resources" used by individual people to make sense of old age and their everyday experience of old age (Hepworth 2004, 9, Holstein and Gubrium 2000a, 99). Discourses do not, however, determine our ideas of old age or health, but they can be resisted, redefined and negotiated, even though some discourses may be more compelling than others (Gubrium et al., 1994). Discourses are thus also connected to social norms and values and to age-appropriate conduct and social positions of members of different age categories. They enable or limit the ways in which individuals can think about themselves, and how their lives are organized, but do not determine it totally. Some room is always left for individual agency, and the meaning of age categories and perceptions of age to individual people can be uncovered by studying how they are experienced and enacted in everyday life (Holstein and Gubrium 2000a).

In this study I have drawn from the ideas of both the discursive perspective and rhetoric analysis. The central idea of the discursive perspective is that in talk we produce multiple versions of the world and our own identities and we can choose from different versions. This directs the attention to the argumentative and rhetorical context of talk. (Billig 1996, Gubrium et al. 1994, Nikander 2008). Wetherell, Taylor and Yates (2001) say that the views put forward in rhetoric emphasize that talk is often functional, aiming to persuade listeners about the factuality of one's arguments and to make them sympathetic towards those arguments (ibid., 17, see also Edmondson 2007). The focus of analysis is on the way that talk is used to make one's own arguments look righteous, plausible and convincing (Billig 1996). Michael Billig (1996) has emphasized that we are not totally free to choose from these different alternatives since some things may be considered more natural and self-evident than others. In the case of old age and health, this means that as members of a certain culture and society, we cannot say just anything about ourselves as old or about old age and health.

One of the key concepts in studies on the meanings given to "being old" and on definitions of health is that of identity. The simplest way to define identity is to say that it is "our understanding of who we are and who other people are, and, reciprocally, other people's understanding of themselves and of others (which include us)" (Jenkins 2004, 5). The concept of social identity adopted here distances itself from the psychological understanding of identity as individualistic or unitary and based on or reflecting the authentic inner or core self (Dittman-Kohli 2005). In contrast to this "static" (Coupland, Nussbaum and Grossman 1993) or "essentialist" conception of identity (Hall, 1996, 1999), identity is here viewed as "processual and dynamic" (Coupland, Nussbaum and Grossman 1993, xxiii). Furthermore, following

G.H. Mead's theory, self and social identity are seen to be firmly grounded in social interaction. Mead (1934) considers the development of significant symbols, language, communication and social interaction as essential for the development of self. Self is borne out of and develops in social interaction, which includes and is possible only through shared symbols, and it becomes expressed in language and in communication (ibid.). According to Joas (1980), Mead's theory stresses the *practical intersubjectivity* of self (ibid., 13–14, italics in the original), which means that selves are constructed in practices of everyday life as "joint activity of human subjects" (ibid.).

According to Jenkins (2004), viewing identity as a dynamic concept means adopting the view that identity does not simply exist, but it requires people to associate themselves with something or somebody and at the same time to distance themselves from something else (ibid., 4–5). Similarity and difference, belonging and not belonging are central elements of identity construction. Difference is the reverse side of belonging and an equally essential element of identity (Coupland, Nussbaum and Grossman 1993, Hockey and James 2003, Jenkins 2004). Defining oneself as a certain kind of person always requires that one also defines what kind of a person one is not (Hall 1999, Jenkins 2004).

The meaning of age identity is far from unequivocal, and here identity is approached as "a negotiated, unstable assemblage of ideas and perceptions within which 'age' competes with other imperatives such as gender, class, and ethnicity" (Hockey and James, 2003, 4). These different potential aspects of identity "both delimit and afford opportunities for the practices which make up everyday social life" (ibid., see also Hall 1996, Jenkins 2004). In other words, "old" (or other age categories) may or may not be made a meaningful identity category in older people's talk, and the analysis needs to look at the discursive means by which different age categories are constructed as meaningful or not, how different "ages" are defined and what kind of identity or identities are constructed on the basis of age.

4.2 Analytical tools of rhetoric and discursive psychology

The analysis proper in this study consists of preliminary steps of coding the data to prepare them for a detailed analysis of talk. This preparatory process is described in Chapter 5 in the context of different datasets. Here I present the main concepts and methodical tools used in the detailed discursive analysis of talk.

At the conceptual level, doing discourse analysis means studying how people "account for, explain, blame, make excuses, construct facts, use

cultural categories, and present themselves to others in specific ways, taking the interpretive context into account" (Nikander 2008, 415). Age or health are not taken as a self-evident part of people's identities, but the focus is on how people "do age", that is "the practical ways people ascribe, reject, display and refuse age identities in interaction" (Nikander 2008, 417, see also Coupland, Nussbaum and Grossman 1993). In the present research, another key interest is whether and how health or other issues receive meaning as part of older people's age identities. Discourse analytical ageing research, then, is interested in whether and how old age or health are constructed as "salient" (Edwards and Potter 1992) parts of people's lives and identities.

In this research I used the concept of subject position as an analytical tool to study how the participants defined themselves or other people and how they constructed their identities. The concept of subject position has it that we can all define ourselves in many ways, we can adopt or reject offered positions, and that our self-definitions may vary in different contexts (Wetherell and Edley 1999, 337). It therefore allows us to study how, in their accounts of everyday situations, people describe themselves as "I", and position this "I" as different from or similar to other people, and thus possibly construct group identities as "we" (ibid., 335–337). To take up a certain position in talk is not necessarily a conscious or a free choice, and certain positions are often considered more proper, believable or realistic than others. Positions taken in talk also have normative and moral dimensions since they entail ideas about how one should act or behave (Edley and Wetherell 1997, Wetherell and Edley 1999).

Conventionally, morality refers to shared notions of good and bad, or right and wrong, which can be used to define both people and their behaviour. In philosophical discussions morality is also related to questions of individual agency and the nature and possibility of free will. Moral philosophy engages itself with the question of the existence of universal morality versus morality as a cultural issue. In particular, the relationship of the universal notions of "good" and "bad" and normative rules of conduct have received much research attention. In this study I confine myself to viewing morality as culturally constructed and inherently normative, in other words I am interested in people's views on how to talk and act in a way that is considered acceptable in a given society, or how to justify transgressions of commonly held views of appropriate conduct. Here, morality is approached as "morality-in-use" (Jayyusi 1984, 1991, Nikander 2002) or "lived morality" (Bergmann 1998). This means that while I acknowledge these different conventional aspects of morality, I am mainly interested to analyse the participants' talk in closer detail to see whether they construct the issue at hand as moral, i.e. whether (and how) they use different words, expressions and proverbs that construct the issue at hand as moral, for instance as something that

needs to be explained and justified (Nikander 2002). Specifically, what this means here is that I will try to see whether the participants link old age and health with terms conventionally seen as moral, such as age-appropriate or inappropriate conduct (Nikander 2000, 2002), or give accounts of their health and health-related conduct in terms of what one should and should not do (Backett 1992, Lupton 1995).

A major difficulty in any study of morality is how to separate social from moral order, if indeed this can be done at all. As Bergmann (1998) has pointed out, morality is so embedded in our everyday lives that it is virtually invisible. If morality is ubiquitous, how can we study it? How do we know what is moral talk and what is not? Nikander (2002) has discussed the various difficulties and pitfalls involved in studying morality or in adopting predetermined ides of what morality or moral topics are. She particularly highlights the "fuzziness", "analytic ascription" and "psychologisation" of morality (ibid.). By "fuzziness", Nikander refers to fact that morality is so pervasive a feature of everyday life that it often goes unnoticed (ibid., 9). "Analytic ascription", then, refers to the risk that in orienting to the morality of the topic at hand and in searching for moral meanings, the researcher may become trapped in "circular argumentation" (ibid., 159). The significance of moral meanings may thus be ascribed or imputed into data, giving rise to the question of whether they really are "member's concerns" (ibid., 160). By psychologization, Nikander refers to the danger of rendering morality to "*individuals* and their *psychology*" (ibid., 162).

In sum then, the topic of morality is fraught with difficulties. Another problem raised by Jayuusi (1991) is that researchers studying morality have to try and set aside their preconceptions, but acknowledge that they are also drawing on their own cultural understanding of moral order (ibid., 247). The researcher cannot just "step outside" of morality or language to analyse moral talk. In conducting empirical analysis I see no other way out of this dilemma than to critically question the concepts used and to scrutinize one's preconceptions (that we always have) about the topic at hand. Then, by focusing on the aspects and discursive devices occurring most commonly in moral accounting, it is possible to make claims about the morality of the topic (Bergmann 1998, Nikander 2002). For the purposes of the present research the question about the relationship between morality and rationality is important. Jauyysi (1984) says that morality and rationality are irrevocably intertwined in everyday language. Accounts of morality are then accounts of reasonable and rational behaviour (ibid.). The findings of several empirical studies of health show that rationality and morality are routinely linked in people's talk (Baruch 1992, Backett 1992, Lupton 1995).

Definitions of the concept of agency also vary. Human agency can refer to the very general notion that "people are the authors of their own thoughts

and actions" (Burr 2003, 121), which highlights the human ability to give meaning to events and objects and to act on those meanings. Most often, it is accepted that in order to talk about true agency, individuals need to have the ability or opportunity to engender change in themselves and in social order (Burr 2003, 182; see also Barker & Galasiński 2001, 45).

Agency itself is often taken for granted in research, but Wray (2004) criticizes the assumption that agency can be taken as a self-evident part of the way that people conceptualize their identities or actions, or that agency means one and the same thing for all people (ibid., 24). Gubrium and Holstein (1995) have argued that human agency is often taken as self-evident, but people do not necessarily see themselves as agents or as having the opportunity to influence their own lives, for instance by enacting their agency in situations of everyday life (ibid.). The discursive perspective on agency has it that rather than taking people's agency as a self-evident starting-point for analysis, we need to look at how people describe themselves and account their everyday life situations in order to see whether or not they themselves construct themselves as agents (ibid.). To do this it is also necessary to acknowledge that agency does not necessarily have a clear-cut or self-evident meaning for individual people, but instead agency can be seen as "a practical outcome of the interpretive work" done by study participants as they bring out their decisions, choices and actions as a topic for discussion (Holstein and Gubrium 2000a, 42). The analysis on agency concentrates on "the way in which 'doing things' is represented in discourse which includes studying who is positioned as doing what kind of things, in relation to what, or whom" (Barker and Galasiński 2001, 144). This means paying special attention to how people position themselves as people of a different age or of a different health status; how they position themselves in relation to other people; how they describe their decisions, choices and actions or wishes and aspirations to act; and whether they accept that they can make a difference to their own lives.

The tools of rhetoric and conversation analysis adopted in this study for purposes of investigating how participants construct the factuality of their talk and righteousness of their arguments and themselves as convincing and plausible speakers, are common-places, lists, detailed descriptions, active voicing and extreme-case formulations. Rhetoric has it that there are certain conditions for talk, and some issues serve as "common-places" which in the light of cultural knowledge are considered self-evident and "natural" (Billig 1996). Common-places refer to ways of talking that have lost their constructed nature and appear accountable, natural and self-evident facts and are therefore hard to ignore or defy (ibid.). In talk, common-places can be distinguished as factual statements that do not seem to require further argumentation. To argue against common-place views, then, requires much moral argumentation work in order to be convincing and believable (ibid.).

Proverbs such as “old age does not come alone” or “there’s no fool like an old fool” are examples of common-places in everyday language use.

Lists and detailed descriptions are used in talk to give an impression of oneself as a neutral observer who just lists the facts and describes events without being partial in any way or without advocating some particular message (Edwards and Potter 1992, Potter 1996). Extreme case formulations refer to different expressions used in talk to legitimate claims, such as “never”, “always”, “all people” or “no-one” (Pomerantz 1986). Extreme formulations can be used to argue that something is right or wrong on the basis that it is habitual or common (always look after health) or extremely rare (never sleep during the daytime). The concept of “active voicing” was coined by Robin Wooffitt to describe the quoting of other people’s talk within one’s own talk with a view to supporting or creating a contrast to one’s own arguments (Potter 1996, 160–162). These other speakers are often represented as “outside wittnesses” whose position as convincing witnesses may be based on physical presence or on some authoritative position, such as a doctor in medical talk (ibid.). A person who is assigned to a position of authority can thus serve in talk as a “reliable witness” (Edwards and Potter 1992, 108).

To summarize, in this study I approach the experience of old age as a phenomenon constructed in and through language. Secondly, I look at how older people construct their identities in age and health talk, their agentic potential in relation to these issues as well as their views of moral meanings attached to old age and health. The discursive and rhetorical tools described above provide the instruments that are needed to study how this “construction work” is done in practice. The discursive approach has it that talk does not take place in a vacuum, but always in some context. This means recognizing that methods of data collection also provide also a certain context for the topic studied. Below I move on to describe in more detail the datasets and the process of preparing the data for the analysis proper.

5 TALK AS DATA

5.1 Biographical interviews

My first studies drew on data collected in the Vitality 90+ project in 1995–1996 (Jylhä and Hervonen, 1999). The qualitative data for this project comprised 250 biographical narrative interviews (184 women, 66 men) which were carried out in Tampere, southern Finland. The respondents were recruited by mailing a questionnaire to all community-dwelling people aged 90 or over in the area, and contacting those who gave their consent to take part in a personal interview. The interviews were conducted by women interviewers in their thirties and forties with a training in health care or the social sciences. All the interviews were tape-recorded and transcribed, and they ran in length from a few pages to dozens of pages each. The transcriptions were done word by word, and emotional tones such as stress of words, pauses and hesitations were omitted. In both datasets the participants' names and other identifying details were changed for reasons of anonymity.

The group of interviewees aged 90 or over was somewhat selected. Most respondents lived more or less independently in their own homes; some were in service housing or in nursing homes. In this dataset, health talk was framed by the life story, and the respondents were included in the analysis specifically by virtue of their exceptionally high age. The original mailed survey approached all people aged 90 or over in the region concerned, whereas most of the respondents in the biographical interviews were a rather select group of people and exceptional even within their own age group: most of them still lived alone and were relatively independent. In other words, age and health were made salient issues in advance, before the interview situations.

The interviews usually began with asking the respondents to tell their life story from their childhood onwards; follow-up questions on predefined topics were asked later on. For this reason the interviews can be called both biographical and narrative. The interview guide included several topics. Directly age-related questions included the following: what do you think about growing old; what is the secret of old age in your view; and what would you like to say to younger generations? However, the issue of age also surfaced in connection with other questions. Health talk was both

self-initiated in biographical narration and prompted by the interviewer's questions concerning the respondent's present health. The interviewer would usually ask: "What is your health like?", and then proceed to more specific questions about illnesses and bodily symptoms, reasons for good health, exercise, diet and daily routines. Different questions were often fitted into the context of the respondent's life history as a whole. However, the course of the interviews varied, and in most interviews sections of free biographical narration alternated with questions. At times the interviews resembled freely flowing everyday conversations more than strict question-answer type interviews.

For the purposes of detailed discursive analysis, it was necessary to take steps to reduce what was an exceptionally extensive material for qualitative research. A special application of content analysis (Seale 2005, 188) was developed in order to ensure that the remaining material covered the variation in the talk. The aim was not to conduct a numerical analysis by counting instances, but instead to gain an overview of the vast material to make sure that my arguments about the most common ways to talk and on the other hand the "deviant" cases in the data were based on a "critical investigation of all … data" and not on "a few well-chosen 'examples'" (Silverman 2005, 211–219, see also Silverman 1993).

The process of selecting and reducing the material for detailed analysis combined factual and heuristical coding (Seale 2005, 203–204). These different dimensions of coding are not completely distinct procedures, but for analytical purposes it is useful to treat them as such. Heuristic codes can be drawn from the researcher's theoretical concepts and used to retrieve segments of data for more in-depth analysis (ibid.). Here heuristic coding refers to the process in which I read through the interviews and wrote down short general remarks about the central themes concerning age, which were then condensed into the following keywords: deterioration, sickness, frailty, senility, independence, dependence, liberation, outsider, useless, needless, participation, life experience, and wisdom. Each interview was characterized by a list of these conceptual keywords. Factual coding meant listing general information about the interviews, such as whether or not the interviewee talks a lot about health, and whether the interview was curt or verbose and extensive, or listing special features such as remarks about different activities and interests, work and occupation or bringing the family and friends into talk. This coding and categorizing process was used in two studies employing biographical data (I, II). On the basis of this categorization, 50 interviews were selected in the first study for more detailed characterization, of which 20 interviews were singled out. My aim was to cover the variation that is typicality and deviant cases of talk about old age. These 20 interviews were analysed in detail using the tools of discourse and rhetorical analysis, looking

specifically at the content and construction of age, i.e. what was said about age and how.

For the second study, the first step was to identify different themes brought out by the participants as issues relevant to health. These themes were divided into two categories: those concerning action taken by oneself (such as diet, exercise, mental attitude), and those constructed as external factors (such as old age, constitution and genes, environmental and transcendental factors, modern medicine). In this phase I categorized talk about old age to the latter category, but a more nuanced analysis later on showed that this division was too simplistic. Earlier studies of lay health beliefs have shown that these themes occur frequently in health talk. In this study my aim with this procedure was to gain as broad coverage as possible of the content and variation of health talk. On the basis of the content analysis 40 interviews were singled out (20 women, 20 men) for more detailed analysis. Some of the interviews were the same as in the first study, but this selection process was carried out independently. There were marked differences between the respondents' talk in terms of how much emphasis they placed on depicting themselves as basically "healthy" or as having problems with their health. The interviews were selected with a specific view to covering this variation. In addition, they were to include disclosures of old age. These two sub-studies form a continuum in the sense that in the first study I provided a more detailed overview of the whole dataset at hand, even though both sub-studies paid attention to the interactive nature of interview talk. In the second study I analysed more closely how the interviewees' talk proceeded as a back-and-forth movement between different arguments and explanations and justifications of one's conduct in matters of health. The selection process developed to reduce the vast amount of data was necessary to gain an overall view of the content of the interviews. However, this was a rather involved process of interpretation and therefore the selection process is itself was integrated as part of the analysis, even though the final methods on which the findings are based were those of discourse and rhetorical analysis.

5.2 Group discussions

The group discussion data consisted of four group discussions with six participants each, including myself in the capacity of moderator. The research participants were recruited by convenience and purposive sampling. First, I recruited participants to whom I had easy access (members of an art club that I attended) and asked them to recommend other suitable participants. On the basis of my experiences with the first group, I contacted the manager

of a local service facility and with her help recruited more participants. The discussions were held in the city of Tampere in southern Finland in 2000. The participants ranged in age from 71 to 86 years. Each group had five discussants (11 women, 9 men). Lasting from 60 to 90 minutes, the discussions were audio-recorded with the consent of each participant and transcribed word for word (~130 pages).

Transcription is not simply a technical procedure that takes place before the analysis proper, but it is always part of the analysis itself (Silverman 1993, 117, 2005, 163, Nikander 2008b). Also, judgement and interpretation is involved in decisions about the style and detail of transcription. Therefore transcripts can never be perfect or final, but the style of transcription needs to be adapted according to the research task at hand (Kvale 1996, 170–172, Silverman 2005, 163). Based on my analyses of the biographical data and my growing interest in the interactive nature of the focus group data, I felt it was important to have a more nuanced transcription of the interactive elements of the group discussion data, i.e. to notate such elements as emphasis, overlapping talk, pauses, laughter or particularly quiet talk. In this work I followed Silverman's (1993) recommendations. Background information (age in years, education and occupation at the time of retirement, marital status, housing, health status) was collected after the discussions by self-report questionnaires.

The discussion groups consisted of a mixture of female and male discussants who differed in terms of their health status, marital status, education and housing situation. Group 1 had 5 male participants, all of whom attended the same art group, and the discussion was held at the place where that group used to meet. The participants of the three other groups were resident and non-resident clients of a service facility, and these groups met on the premises of the facility. This facility is a municipal centre that provides services for retired people aged 60 or over. Service users pay a small service fee, but most of the funding comes from the local council. Services provided include meals, physiotherapy, barbering and hairdressing, library and internet access, as well as various leisure and recreational activities. The centre provides housing services for older people who are unable to cope with everyday activities in their own homes, but who do not require care in a nursing home or hospital. Group 2 consisted of 2 men and 3 women (two married couples and one single woman, non-residents), all of whom belonged to the service centre's literature circle. Group 3 consisted of 5 women (two residents and three non-residents). Group 4 consisted of 2 men and 3 women (residents). Groups 1 and 2 represent pre-existing groups, but in groups 3 and 4, too, the participants knew one another at least by sight, and some of them were friends. The groups were thus rather heterogeneous, which fitted in well with the original goals of reaching a wide variety of

people and tracing different perspectives and experiences. The discussions produced rich data with varying perspectives, but similar aspects and patterns of talk did emerge as the presentation of data analysis and the extracts seek to disclose.

To initiate the discussions, I introduced myself and described the research project. I said I was interested in the participants' own views about health in general and their own health in particular, and also in what health means to them in their everyday lives. The discussions then proceeded according to a set agenda, although largely on each group's own terms. This procedure provided a common basis for the discussions, but allowed different views to emerge within and between the groups.

The discussions focused on the following topics:

- definitions of health, personal and general
- the individual's own responsibility for health
- to what extent can health be influenced by individual action
- the most important things in one's own health, and possible future concerns about one's own health
- the relationship between age and health

The relationship between age and health was on the topic list, but it was also raised in the discussions without prompting. As a result, the discussions in each group were framed by ageing and old age. These topics were covered in all groups, although the weight they received differed from group to group. Although the main concern was with issues of health, other topics were also raised as the discussions unfolded. The exact wordings of the questions varied slightly between the different groups since the questions were fine-tuned according to the interaction and atmosphere in each group. Questions were not addressed to individual discussants, but to the group.

My approach to the data and my own role within that data was guided by the idea that the interviewer or moderator is never an impartial or neutral participant, but interviews and group discussions are situations of active interaction (Gubrium 1993a, Holstein and Gubrium 1995). It is important therefore that the interviewer is conscious of his or her role in interaction rather than trying to stand back and "blot out" his or her influence. My position in these group discussions was a dual one. I acted as a moderator with the task of making sure that all the participants were given the chance to express their views. On the other hand, I was an active participant in the discussions, aiming to encourage discussion. Some of the questions were designed to address potentially sensitive topics such as responsibility for health. After presenting these questions I made sure to give the participants

ample time to develop their views and not to curtail or control the direction that the discussion took.

The group discussions in this research could be called focus groups in that they were "focused" on health issues, and I as moderator steered the talk in these groups by my questions. The reason I chose to collect this data in the form of group discussions was that, as Barbour and Kitzinger (1999) say, they can provide a way of exploring the processes and formation of shared beliefs and values, people's experiences, opinions, wishes and concerns as well as ambiguities and uncertainties (ibid., see also Bloor, Frankland, Thomas and Robson 2001, Waterton and Wynne 1999). Focus groups can illuminate "the *normative understandings"* (Bloor et al. 2001) that are part of people's shared stock of knowledge, which is often taken to be so self-evident that it may go completely unnoticed (ibid., 4). Focus groups differ from group interviews in that questions and prompts are addressed to the whole group instead of asking questions of each person in turn (Barbour and Kitzinger 1999, 4–5). One of the benefits of having group members is that group interaction can offer an opportunity to study how different views are brought forward, formulated and reformulated and debated with other group members (Wilkinson 1999, 67, see also Myers and Macnaghten 1999). In addition, it has often been argued that group discussions offer a more equal situation for discussion since the situation reduces the researcher's influence and may give more room to the participants' views (Wilkinson 1999, 70).

The transcribed text was loaded into Atlas.ti, a qualitative data software package used in the preliminary stage of analysis to help organize the data and to gain a systematic overview of the content. The data were coded by constructing coding categories such as definitions of age and old age, definitions of I (as a particular kind of person, e.g. "writer"), definitions of other people, definitions of oneself or other people as old, health talk (concerning one's own or others' health), talk about different activities and interests (other than health) and relations with other people. Also, codes were created to list linguistic and rhetorical tools such as extreme case formulations, emphasized talk, humour and jokes, use of detailed lists, stories, use of outside witnesses and the context in which they were used. In order to explore *how* different categories, definitions and activities were *used* to position oneself or other people as a particular kind of person or persons, talk was analysed in more detail by means of discourse analysis as discussed in Chapter 4.

6 FINDINGS

6.1 Old age as a choice and as a necessity (I)
6.2 Moral argumentation in old age and health talk (II)
6.3 Discussing responsibility and ways of influencing health (III)
6.4 Agency in talk about old age and health (IV)

6.1 Old age as a choice and as a necessity

For the first sub-study I analysed biographical interviews of people aged 90 or over to see what meanings they gave to old age in their talk. The focus was on those parts of the interviews in which the interviewees either answered the questions about age, or spontaneously talked about their experiences and views of old age and growing old. I named the different ways of talking about old age as the choice and necessity repertoires. Through these repertoires, the interviewees sought to balance between two ideas. Firstly, within the necessity repertoire, old age was constructed as an inevitable process of physical and mental decline that all people have to face with advancing age. Within the choice repertoire, on the other hand, old age was constructed as one's own choice and in a more positive light.

In the necessity repertoire, health problems were constructed as a natural and therefore self-evident result of the ageing process. This is consistent with the findings of many other earlier studies on the experience of ageing. Here the key thing is to look in detail at the rhetorical organization of talk: for instance, how were arguments put forward and supported and what was achieved with this kind of talk. Firstly, old age and its "consequences" were constructed as a matter beyond the individual's influence. Secondly, this kind of interpretation of old age was used to justify certain issues discussed in the following. The interviewees routinely gave the following kinds of accounts of old age:

> No. 1089 W90
> "Old age doesn't come all by itself, you do always get these [illnesses]."
> No. 025 W94
> "…you won't be getting the sort of answers that are perhaps expected of me. I'm well aware of that but there's nothing I can do about it. I'm old so I'm old."
> (I, 363).

Detailed analysis of the rhetorical organization of talk in these extracts shows how the interviewees use certain devices to support their arguments. Extreme case formulations (Pomerantz 1986) such as "always" and "nothing", and factual statements ("you do always get") and established expressions ("Old age doesn't come all by itself") which often convey crystallized and "sedimented" ideas (Coupland and Coupland 1999, 194), all serve to construct ill health in old age as an external factor that brings health problems. Old age thus serves as an explanation, no further arguments are needed. The latter extract also shows how the tautological expression "I'm old so I'm old" serves to explain both the individual's failure to fulfil social expectations and gives ground to argue that there is nothing the interviewees can do about this situation. Following Giles and Coupland (1991), it can be said that old age is used here as category-based, stable, uncontrollable and external attribution.

The interviewees also made skilful use of "active voicing" (Potter 1996), that is quoted other people's talk in their own. Active voicing was often used to support or to create a contrast with one's own arguments, but not in any clear-cut manner. For example, active voicing was used to convey the idea that old age would also be a legitimate excuse for getting help and doing what one pleases. In one case the interviewee's talk was contrasted to the talk of her neighbour: "Don't' do so much. Why bother with that. Get someone to help you. Why bother when you don't have to. Do whatever you please … Don't work so hard" (I, 364). In her 'own' talk, the interviewee gives a list of her daily chores and in this way constructs herself as able and willing to try and keep up her abilities and strength. She could then be heard implicitly blaming other older people (including the neighbour whose comments she quoted), but she constructs herself as being "born that way"**.** What I did not address in the original article was that the interviewee balances between admitting that she has some problems with her health and daily chores ("Now, you always have to put the brakes on, will I get up or won't I? ... my back was aching terribly", I, 364) and arguing for continuing to engage in different activities.

In the original article I said that "within the necessity repertoire, a fact is constructed that old age means being useless and an outsider in the community" (I, 365), and further that interviewees may construct as a "fact" that they are outsiders and useless in society (I, 365). Today, I would be inclined to use a less dichotomous formulation and to say that by constructing being old as an outsider position, the interviewees give a legitimate explanation for their feelings of not being of any use to their family members or society at large. In hindsight, their talk could be interpreted in the light of the cultural values of work and the view that usefulness is firmly grounded in work-roles and instrumental accomplishments. This also allows them not to blame their relatives for their feelings of being an outsider or forgotten.

One interviewee (No. 103 W90) expressed her sentiments as follows: "I wouldn't want to be forgotten altogether, but I understand that if you're not going to die, then I suppose that it really is the fate of all of us when we get older. Younger people still have so much life around them and their thoughts are all on that." (I, 365). Here the interviewee referred to the idea that if one dies at a younger age, that means one will avoid being cast in the outsider position of old people. Very often, the interviewees constructed young people as "still" having "life around them", and being forgotten and an outsider in old age as a natural and inevitable fact and part of the human life course ("That's how it goes, but it's just life" I, 365). However, the interviewees also brought forward different views about the social position of older people. Active voicing was again used as a discursive device to draw attention to different sides of the issue. One of the interviewees quoted the discussions she had had with relatives: "Surely it's time for me to go now. No it isn't, we still need you. And I say that I'm no help to you, not any more. I'm old and I don't always talk about it." (I, 367). She used her "own voice" to raise doubts about her "utility" as "old" to other people, and the voices of her relatives to convey the idea that an alternative interpretation is also possible, i.e. that she is a needed member of her family. On the other hand, common beliefs about the appropriate time for certain events in relation to chronological time (Holstein and Gubrium, 2000, 79; see also Coupland, Coupland and Giles 1991) were put forth by the interviewees in their talk to make sense of their own experiences. These commonly held ideas are reproduced by recurring expressions such as "surely it's time for me to go now".

Constructing old age as a common fate for all people served also to mitigate the chances of the individual to influence his or her own life and health. The scope of individual agency and enacting agency was seen as limited within the necessity repertoire. Within the choice repertoire, old age was seen in more agentic terms as a matter of individual decision-making.

The basic idea put forward in the choice repertoire is that through their own actions, individuals can shape their own ageing and being old, promote their own health and prevent decline even in old age. In this context the participants often positioned themselves as healthy and able to look after themselves, but very rarely argued that they were in perfect health and had no health problems at all. More typically, they sought to balance between what had changed and what had remained the same. This was the case, for instance, with a woman interviewee aged 91 who on the one hand admitted to having some health problems but on the other hand constructed her identity as active and able (I, 366). She conceded that she had some problems with her memory and hearing, but belittled their effects on her daily life, and she defined herself by saying "I've always been one for a dance" and "I still go racing around" (I, 366). One common rhetorical tool used to back up

arguments (Potter 1996) for one's own activity was to list all the things one had done during a particular day. In the following example the interviewee listed her activities at the end of the excerpt.

> No. 1046 W 91
> "I get up in the morning, sometimes half past six. Then I air the bed and make my bed, get everything fixed. That's a job I do every morning. Then in the daytime I take the rubbish out. Then I walk around in the yard for a while; I haven't taken to a walking stick yet. And there are others here who go around with a stick and a walker." (I, 366).

The interviewees often called their chores at home a "job" or "work", which served to construct an identity of a "worker" ("an awfully big job", "another big job", "Don't you work so hard", I, 364). Talk about "work" or "dancing", or "still going racing around", or giving lists and detailed accounts of daily activities, was used to support one's arguments about physical ability and activity, and also to locate the person in a different domain than is usually expected of old people. I interpreted all this as well as comparisons of oneself with other, "less able" people as a way of redefining old age identity. Furthermore, in the original article I argued that in this kind of talk the interviewees "reproduce the negative stereotype of an old person" (I, 367). Today, I realize that this kind of strict division between negative and positive stereotypes of old age is too simplistic and dichotomous a way to describe complex phenomena. The interviewees used these different views or discourses to construct their identities, and to negotiate personal meaning of old age. It is interesting to observe that while the interviewees constructed old age in terms of self-evident decline, they also interpreted it as a matter that can be resisted through their own actions. In the example above, the interviewee constructs her identity as an active and outgoing person who has chosen not to use a walking stick, unlike those who "go around with a stick and a walker" (I, 366). Nonetheless the same interviewee also mentioned different strategies that she applied to cope with her impaired health (I, 366).

In hindsight, then, the necessity and choice repertoires are both used by the same people to accomplish different interactional tasks in the interview situation, but also to construct their own identity. In the biographical interviews a woman aged 92 initially identified herself with the group of old people ("I'm old and I don't always talk about it", I , 367) and said that it is "time for her to go now" (I, 367). Yet when the interviewer asked her how she felt about growing old, she said: "I don't feel like I'm getting older at all, not at all", and went on to elaborate her argument by describing her daily outings and exercise as follows:

No. 004 W 92
"I mean I go out every day. I haven't stayed in except for four days all this year. (omitted talk) Every day, I get up here, hold on to this here (shows), and think that oh dear, these stumbling old people, if I do this exercise one hundred times with each leg, that should do it. (I, 367)

The sentiment of not "feeling old" is here related to being physically active. Furthermore, it is constructed as a result of a conscious choice not to "stay inside" but to "get up and get out". Originally, I interpreted that the interviewee "dissociated herself from this group" by describing how she copes with her declining functional ability by taking exercise. It might be more appropriate to say that she both constructed herself as a member of the group of old people with ill health, but at the same time constructed her self-identity as I, as capable of controlling the "stumbling" body. In other words, she both distances herself from the category of stumbling old people ("these") and aligns herself with that category.

Instead of saying that the interviewees denied being old or having health problems, it is more appropriate to say that they sought to strike a balance between the necessity and choice repertoire. Being old was defined both as part of the entity of the life course, as an external factor, and yet as malleable through individual actions and activities. Yet another theme raised in talk about old age was the possibility of achieving wisdom and liberation with old age, that is being entitled to defy social expectations and conventional norms of behaviour (I, 364–365, 368–369). In the original article (I) I interpreted this talk about wisdom and liberation as being related to the choice repertoire. Today, I would be more inclined to see this kind of talk as a repertoire in its own right. As an example of wisdom and liberation talk, one of the interviewees, a woman aged 92 (I, 368), answered the question about whether she had changed during her lifetime by saying, "I suppose that I have become less constrained" (I, 368), going on to describe how shy she had been when she was younger. The explanation she offered for her shyness was her young age, a theme on which she then elaborated extensively.

No. 009 W92
"But at that time, I do not understand why at first I was so awfully shy and of course it was because I did not, really a child like doesn't know anything really (omitted talk). This is a fact. Common sense says it's like that**.** There's no two ways about it. That could comfort younger people who notice that they don't yet know anything. But that's how it is; you don't know anything when you're young. You haven't been able to pick up the experience; all you know is some things quite superficially. And what you've seen around, but that's entirely different from being there, being involved. To live it." (I, 368).

As illustrated by this extract, wisdom talk was used in these interviews to argue that based on their long life experience, older people have gained knowledge that younger, less experienced people simply cannot have. The interviewee constructed a difference between "the old", which stands for skill, experience and wisdom, and "the young", which stands for inexperience and lack of knowledge. This kind of argumentation was also used to support the view that "the old" deserve to be listened to and respected and to argue against the customary view of old people as useless, probably senile and in need of guidance from younger people (I, 364). The interviewee here uses various rhetorical tools to support her arguments. She uses a number of extreme case formulations ("awfully", "anything", "no two ways", "all you know", "quite superficially", "entirely different"), factual statements ("of course", "this is a fact", "common sense says", "that's how it is"), and appeals to having lived experience instead of just theoretical knowledge ("being there", "being involved", "to live it"), all of which makes her talk rhetorically very strong. The talk about old age as engendering experience and thus possible wisdom was always backed up by extensive argumentation. None of the interviewees claimed that they were "wise". This could have been condemned as self-praise. Instead, the participants emphasized their accumulated life experience as a factual result of having lived for such a long time, which gives them a broader perspective on life (cf. Nikander 2002, 167–174). Wisdom talk was quite rare; instead the interviewees argued more commonly to dispel doubts that they had lost their cognitive abilities. One interviewee protested at the patronizing manner in which she was addressed ("darling") or being treated as if she had lost her mind (I, 363–364). Active voicing (Potter 1996) and extreme case formulations (Pomerantz 1986) were used to accomplish several tasks, for instance to show that patronizing behaviour was a recurring experience ("they're always telling me") and on the other hand to argue that one was not yet "quite out of my mind" (I, 363–364).

In more general terms, the different repertoires stood in an asymmetrical relationship to one another. The necessity repertoire involved much less argumentation and the views put forward were presented as self-explanatory. On the other hand when the interviewees qualified their old age identity, argued for having good health or for being active and needed members of the community, they used various arguments and rhetorical devices. The findings suggest that a great deal of argumentation work is needed if people in extreme old age are to argue for their activity, ability or having a better understanding of life than younger people. Whenever a topic is supported by various arguments and rhetorical tools, that in itself serves to signal that the topic in question is disputed or controversial, and that the speaker knows that his or her arguments might not be considered believable (Billig 1996, Potter

1996). The wisdom repertoire also appeared quite rarely in these interviews. These findings indicate that in extreme old age, the understanding of old age as a period of decline is still very much predominant and that attempts to define old age in any other way require extensive argumentation. The same people used both the choice and the necessity repertoires in their talk and sought to balance between them, indicating that old people themselves still think of old age very much in dualistic terms. The experience of old age seemed to be dilemmatic and ambivalent. The necessity repertoire provided interviewees with explanations and justifications for health troubles, for their need for help and their dependence on others. However the admission that one does not have control over oneself or one's body carries the real risk that one might lose full authority. Usually, being assigned full adult status requires cognitive competence and bodily control (Featherstone and Hepworth 1991). Being seen as accountable (Shotter 1989, 1993) and the maintenance of full authority may be achieved by constructing oneself as independent, healthy and self-reliant, but this runs the risk of losing the right to expect help from others or to appeal to physical incompetence (Radley and Billig 1996). Also, given the prevailing image of old age as decline, the denial of physical impairment may sound unrealistic and unbelievable.

6.2 Moral argumentation in old age and health talk

In my second study on moral argumentation in old age and health talk, I was concerned with the different meanings given to health in biographical interviews with people aged 90 or over (II). The focus was on how the interviewees answered questions about their health, about what kind of moral arguments might be used in talk, and the meanings given to old age in this context. My approach leaned towards rhetorical aspects of talk. In addition, I was particularly interested in the interaction between interviewer and interviewee as a context for health talk. I concentrated on analysing just two interviews, which allowed me to explore how talk proceeded in the interaction between interviewee and interviewer. Asking people about their health may well pose a face-threat, especially in the case of ill health. The analysis showed that the participants applied different rhetorical devices to manage this threat. In their talk the interviewees also balanced between different moral arguments. The interviewees differed in terms of how much emphasis they placed on depicting themselves as healthy or as having health problems, but in their talk the interviewees moved on the axis of advocating good health and activity and conceding that they had impaired health and diminished activity.

In cases where they argued that they were healthy, the interviewees used various rhetorical devices to support their arguments. Detailed descriptions and lists of daily activities (Edwards and Potter 1992), bringing outside witnesses into talk (Potter 1996) and extreme case formulations (Pomerantz 1986) were all common in their talk. Another commonly used rhetorical tool was the so-called three-part position-concession-reprise structure (Antaki and Wetherell 1999). The purpose is for the speaker to give added weight to his or her argument by first conceding something that might be seen as a legitimate opposing argument, and by then returning to the original argument. Detailed analysis of talk showed how the interviewees oriented to the interviewer's questions. They constructed and negotiated meanings of health in relation to the context of the research interview, and oriented themselves to the interview situation as one that involved asymmetrical power relations and that required them to give truthful accounts of their health. One interviewee, Liisa Martila, a woman aged 92, defined her identity as someone who had been born strong, and as someone who has had "the gift" of good health and "the strength to work" throughout her life, and she went on to list her daily activities and make the point that she did her household chores all by herself (II, 489). The interviewer then asked about her daily outings.

> I: "So what about nowadays, do you go out at all?"
> Liisa: "Well, not really, I do sometimes go to these clubs. Once a week I go to town when Taina comes along. She's afraid that I may fall over so she carries my shopping bags. I haven't gone out, I like to be out here and do what I do here and stay healthy. What with my legs I can't really move around all that much anymore, but I can still keep my home nice and tidy. Every day I go around and do things, I sit down only for a short while, I never sleep during the daytime, I sit down only for a short while and then I think of something again and then I'm off again". (II, 489–493).

Here, the interviewer's question implied doubt that even though Liisa did depict herself as *having been* active and outgoing, that might *no longer* apply to her, and indeed Liisa did mention she had difficulties with mobility. By reformulating the main issue of the question and giving a detailed list of her daily activities, she managed to refute the face-threat and to construct herself as active and able *in her home*. The situated nature of this definition of health was apparent in her talk which constructed an "outer world" where she needed help, where she had problems with mobility and where she was vulnerable and "at risk" (Lupton 1995). Her home was constructed as a place where she was "still" active and able and where she remained healthy. The detailed lists of activities, remarks about sitting down only for a short while or never taking naps during the daytime were common elements in

these interviews and served to support the argument that the speaker is indeed an active and mobile person. At the same time, this extract illustrates another common feature of talk in these interviews, that is, balancing between "conceding change and arguing for continuity" (Nikander 2002), which was a recurring element in age talk. What I called "activity talk" was clearly linked with, but not the same as self-care talk. By self-care talk, I refer to talk about conscious actions taken to promote one's health, such as physical exercise, a balanced diet and controlling one's own health status (II, 492), but also controlling one's mind and adopting a positive stance to the adversities of old age (II, 497). For me, talk about practical actions taken in everyday life is different from more abstract activity talk. Self-care talk included talk about watching one's diet in order to control "cholesterol levels" and "weight" (II, 492), or walking between rooms since "that's good for the circulation" (II, 497), or trying to keep oneself occupied and "in touch with people" to prevent depressive mood (II, 497). The use of medical concepts to make sense of one's own health status and as guidelines for one's own conduct goes to shows how medical concepts have become an integral part of talk and practices of everyday life (Turner 1987, 1991).

When the participants conceded that they had trouble with their health and that they were struggling to remain active, they usually explained and justified their ill health and inactivity in different ways. The following extract comes from the interview with Anna Nieminen, a woman aged 90 who conceded that she had health problems. In this extract she first described her daily schedule and napping at the day hospital she visited once a week.

> Anna: "I've slept in the daytime maybe an hour or something. I'm beginning to get old; I need my rest. And I'm not, like I said, I'm in no trouble (omitted talk in which she talks about the stroke she had in her leg). But I can walk alright, I don't necessarily need my cane, but of course it tires more easily. I don't have the energy and I can't walk long distances anyway. But this hand it's a bit sort of, it can't cope with all these jobs, and it begins to hurt up here and then [unclear] but nevertheless it does move, and my eyesight, that's slowly going now (omitted talk). My senses, they're beginning to, I mean I do still recognize people, but it's not at all as if I were the same. I can't remember people. (omitted talk). Oh, I mean, this life has been quite a complex thing, but I suppose it's getting to the end of it. I'll be ninety-one in November, if I live that long.
> (omitted talk).
> Interviewer: So what about your health at the moment then?
> Anna: Well it's pretty good. I have to say I'm reasonably happy. I mean they do have to keep me steady when we're out and about, I tend to be

a bit unsteady when I'm out. But I mean I think I've managed pretty well really." (II, 495–497)

In these interviews the main recurring feature was that disclosures of old age ("I'm beginning to get old") served as a self-evident reason for the need of rest; no further explanation was needed. This provides a good example of how cultural "common-places" operate in talk (Billig 1987). Sleeping during the daytime, illnesses and the gradual loss of the senses were depicted as a self-evident part of life in old age. In "decline" talk as opposed to activity talk, old age was constructed as a process of bodily impairments, and disclosure of age legitimized inactivity, ill health and the need for help from others.

Conceding change (Nikander 2002) in health and in bodily functioning in old age were also often related to changes in oneself as a person ("it's not at all as if I were the same") and contrasted with one's younger self ("When I was younger, I could never stay still for very long and I was always coming and going whenever possible", II, 497). The argumentation goes that ageing has caused her to change from an active and mobile person to someone who needs rest and other people's help. Through the disclosure of age and temporal framing ("still", "end of it"), age was made salient (Coupland, Nussbaum and Grossman 1993) in relation to health and to identity. In the original article I interpreted the interviewee's comment that "I'll be ninety-one in November, if I live that long" to mean that she was aligning herself with the group of old people. I am still happy with this interpretation, although I do feel now that this remark could have been highlighted more. This statement after a long discussion about her health and bodily capabilities is indeed a strong indication of the interviewee aligning herself with the group of people whose life is coming to an end, and importantly, she concedes this is no longer in her own hands. For me, this comment means she is constructing her approaching death as the context in which her health is talked about and which sets the limits for her own actions and choices.

In an interview situation it is necessary for interviewees to be honest, but the revelation of health problems may constitute a threat to their own identity. Talking about one's body parts as separate from oneself, that is to say that "it (leg) tires", or "this hand … it can't cope with all these jobs" (II, 494) served to dissociate the speaker from the "failed" body (Turner 1991). In their talk the participants also dissociated themselves from physical objects commonly related to old age ("cane") (II, 494). These rhetorical tools were often used in the interviews to manage the face-threat created by the questioning of one's health. Another way to cope with this threat was to belittle the severity of one's health troubles by saying "I'm in no trouble" (II, 494), "but I can walk alright" (II, 494), "nothing really" (II, 496), "I've managed pretty well really" (II, 497). These expressions served to put the

interviewees' health problems into a practical context, e.g. managing in everyday life. At the same time, however, this kind of talk also served to argue that the person was not in trouble, despite his or her bodily ailments. "Being all right-talk" (Radley and Billig 1996) also serves as corrective "face-work" as the interviewee tries truthfully to disclose information about his or her own health (Coupland, Coupland and Robinson, 1992). My interpretation is that the interviewees' talk also serves as a way of retaining privacy and protecting oneself from the "gaze" of research after one has revealed health troubles (Radley and Billig 1996). In the context of describing her own activities, the interviewee's assurances that she is "not lying one bit here, it's all true" (II, 489) shows that the special context of the interview requires truthful answers. However, assurances of honesty also indicate that the speaker anticipates her activity will meet with a sceptical reception.

The findings showed that the interview situation and health talk generated complex and ambiguous moral arguments which were visible in the way that the interviewees balanced different arguments in their talk. This moral dimension was seen not only in the interaction between interviewee and interviewer, but also in interviewees' accounts of their daily schedule and lists of their physical, mental and social activities, physical exercise and healthy diet, or at least their awareness of how important all of this was, and in accounts of their failures to be active and look after their own health. What I have called "activity talk" concerned not only physical activity, but also keeping oneself preoccupied by doing household chores, participating in social activities and in general showing an active and positive attitude towards life.

Seeing old age in terms of decline and collective fate helped to ward off individual responsibility for ill health and inactivity, allowing the participants to retain their social worth and construct themselves as morally virtuous persons. Detailed accounts of activities, daily schedules and household chores and various linguistic and rhetorical tools were used to show that health problems were real and severe, and that the interviewees were trying to look after their health and be physically and socially active even in the face of adversity.

6.3 Discussing responsibility and ways of influencing health

In my third sub-study I was concerned with how participants of the group discussions thought they could influence and promote their own health, or how and whether this was possible in general; with how far people can be held responsible for their own health; and with what meanings are given to old age in this context (III). The data were collected in group discussions, a

different context from individual face-to-face interviews, which are still the most common way of collecting data about individual people's views on old age and health. My assumption was that group discussions might allow the researcher to step back and give the participants more scope to discuss and argue for and against different views. Indeed this aim was achieved: the group discussions provided a useful opportunity to study how different views were put forward, developed and negotiated in interaction between the discussants.

The significance of individual actions to health and responsibility for health are morally loaded questions. Against the background of my previous studies I wanted to see how the participants would discuss these issues if they were brought out in the open and made an explicit topic of discussion. In other words my approach was theory-driven rather than purely data-driven. The researcher, interviewer or moderator is always an active participant in the research process, no matter how neutral one tries to remain. My own position was a dual one. As well as being the group moderator, I also presented questions that were morally loaded and even provocative. I did not, however, try to control the topics or direction of the talk once I had asked by questions, but allowed the discussants to take the discussion where they wanted. Following this logic, the analysis came to focus on the discussants' interaction and on how questions and others' arguments were accepted, adopted, refuted or redefined.

The analysis showed that there was broad support for the view that people can indeed influence their own health, and that *in principle* they should bear individual responsibility for their health. The discussants were explicitly asked whether people are responsible for their health, and in all groups they answered in the affirmative ("quite a lot", III, 60, "yes it is your own responsibility for the most part", III, 63). However, in the discussions that ensued the discussants always moderated the burden of individual responsibility and raised issues that limit the individual's potential to control his or her own life and health. Old age was constructed as a period of inevitable health problems that limited the individual's influence and for which the individual therefore cannot be held responsible. It was common to describe one's health as "good for my age" or "satisfactory for my age" (III, 52), which links old age together with health and suggests that ill health is more likely in old age (Coupland, Coupland and Robinson 1992, Coupland, Robinson, Coupland 1994). On the other hand the participants made the point that through certain actions and their lifestyle, they can enhance their own well-being and even improve their health in old age. In their talk the participants balanced between these different views.

When I asked the participants whether they thought it is possible to influence one's health in any way, they usually answered in the affirmative. Physical activity (different forms of exercise) and social activity (social

participation) and mental activities (such as writing to newspapers), and things conventionally seen as part of a healthy lifestyle (healthy diet, non-smoking and abstaining from drinking) were seen as health-enhancing and as away of coping with diseases, too (III, 60, 63). However, they were also constructed as a means to consciously improve one's health.

One participant had the following answer to the question about whether there is anything the individual can do to improve his or her health:

> Liisa: "And then there's like physical exercise. I mean if you've got healthy limbs and you try to exercise, I'm sure that will help. Helps your muscles stay fit (R: yeah) but then this is definitively a factor (omitted talk) so I mean you do begin to deteriorate pretty soon when you're older not when you're younger, but when you're older (murmurs of approval) if you don't get any exercise that at least I, I personally". (III, 52–53).

This extract is a typical way of talking about the relationship between old age and one's own actions. Old age is constructed as a time of inevitable deterioration, but on the other hand exercise is described as a personal choice that makes it possible to improve one's health, at least to a certain extent ("if you've got healthy limbs", III, 52). However, when the discussants were given time and space to elaborate on their views, they tended to moderate the most extreme views of individual responsibility and the role of individual actions. One of the ways in which they did this was to initially construct a difference between those who were healthy and those who were not. In the previous extract the moderating factor is physical condition ("if you've got healthy limbs"), in some other cases serious diseases such as cancer. The participants also constructed a difference between a time when one can still do something about one's health and a likely future when this is impossible ("one day you will no doubt get to the point … really can't move" (III, 53). This remark, in my interpretation, was implicitly age-related, but it also showed that the speaker was being realistic rather than trying to deny commonly accepted "realities" of old age.

Not only physical health, but also mental agility and even mental health were constructed as issues that could be influenced by being socially active, for instance. Inactivity and staying at home or leading a sedentary life ("just lie down", "just stay there", never go anywhere", III 56) were put forward as possible reasons for feelings of loneliness or even depression (III, 56–57). In other words the view advocated was that by being mentally and socially active, it is possible for people to avoid mental problems and to choose how they want to behave. The view that social and physical activity somehow contributes to health was very common in these datasets. Metaphorical expressions such as "just lie down", "just stay there", "gets you down", "slump down in the armchair" were "doing far more than designating physical

positions" (Williams 1993, 104). These kinds of comments go to show how cultural, social and bodily aspects become intertwined in talk about health. However, the group discussion context allowed the participants to bring forward different views and argue for and against definitions of "activity", for instance, and to debate the question of how far people can influence their health. The group members talked about a variety of issues that could have an influence on health, but that were beyond the individual's control. One example was the individual's personal characteristics. The idea that people may represent a different "type" (III, 56) or that they are not "the same" (III, 63) or have "weak points" (III, 52) moderated the participants' talk in this respect. Constructing oneself as not an "outgoing type", for example, or making the point that people are different ("we're not the same", III, 56, 63) were common strategies for rebutting individual responsibility. To construct different "types" serves to define people, their characteristics, actions and motivations, but also to make judgements about the group in question (Nikander 2002, 125–132). The participants also made a clear distinction between minor complaints and serious diseases. It was felt that the latter were beyond the individual's influence, although the participants' own actions could help to enhance or diminish their potential to cope with the disease.

Another factor that was constructed as important to health was access to social resources. An unhealthy lifestyle was constructed as a result of lacking appropriate knowledge and education. Collective responsibility was raised as a factor that can level differences in people's qualities and resources (III, 63). Talk about collective responsibility was still quite rare, and individual responsibility remained the main topic. In part this may due to the fact that questions about responsibility and being able to do something about one's health directed the participants' talk towards individualistic explanations. Talk about responsibility revolved mainly around the question of how far people can choose to adopt a healthy lifestyle and how far their choices and actions are beyond their own control. An individual can be held responsible for his or her health to a certain extent, but not entirely. Serious diseases, differences in personal characteristics and access to social resources were constructed as factors that can either improve or undermine the individual's chances and abilities to look after their own health.

Interestingly, not all the participants claimed that they led a healthy life, although no one explicit said that theirs was an unhealthy lifestyle. However, anyone who admitted to leading less than a healthy life explained and justified this in different ways, expressing the view that one should try to look after one's health. Based on my analysis I suggest that the participants' talk was very much shaped and influenced by its context, i.e. the research situation. In the group of five men, when I asked whether the participants thought that people are responsible for their health, one respondent "translated" my

question by saying, "if you mean do I feel guilty for not going out for walks, then yes" (III, 62). The participants then concurred in unison that "you do feel that you could do more for your own health, you could do more" (III, 62). However the discussion then proceeded to qualify and moderate one's own influence, concluding that people differ in their personal qualities and resources. In short, health is not dependent only on the individual's choices and actions. Furthermore, the question of guilt shows how morally loaded the topic of health is. One important question has to do with how often the participants' implicit interpretations and reflections about the meaning of research questions are expressed and dealt with in health research. The findings here suggest that instead of trying to be overly neutral, it might sometimes be useful to bring different views out into the open. This might give the researcher and the participants the chance openly to address different interpretations of the research questions.

One of the participants told about his youth and his excessive drinking during youth. This kind of talk was very rare in these discussions. My interpretation was that this confession did not seriously threaten this participant's pro-health image since this episode was located in the distant past, and the main point of the story was his fortunate decision to stop drinking. In earlier talk he had also made it clear that he had a healthy lifestyle ("I do not drink and I don't smoke and I do enough physical exercise, although not very much, go for walks here and as I said I've done some exercise with the war veterans", III, 60). In hindsight, it might have been useful to analyse in greater depth the topic of resistance to health-promoting messages and disagreeing voices in the participants' talk. For example, analysis of the role of laughter and the use of irony might have offered interesting insights. Earlier studies have drawn attention to the difficulties involved in interpreting the role of laughter, but often laughter is used to qualify or even undermine what is said in talk.

The analysis also showed that group pressure does not necessarily prevent discussants from expressing contrasting and even conflicting views, as has sometimes been suggested. Rather, the discussants seemed to follow interactional courtesy rules so as not to offend other discussants or the moderator, yet by subtle verbal and nonverbal means managed to express opposing views. Based on these findings, then, my argument is that group discussions do not necessarily steer talk towards unified views or inhibit the voicing of individual disagreement or sensitive personal issues. Instead, they offer an interesting opportunity to study how research questions are received, interpreted, and accepted or rejected, and to see how views are developed in interaction among the participants.

6.4 Agency in talk about old age and health

In my fourth sub-study (IV), I wanted to explore group discussion data collected among people aged 70 or over to see whether and to what extent the participants talked about themselves and others as agents. Older people's agency has received much attention in ageing research in the past few years. My own previous studies had covered older people's agency only implicitly, but here the purpose was to examine in closer detail whether being old was constructed as an agentic position. In addition, my aim was to see whether agency could be addressed through a detailed study of people's talk. The concept of agency served as a heuristic tool with which the data was approached. Agency is a slippery concept whose meaning is not always clearly defined in research. In this study, the analysis of agency talk meant focusing on the participants' self-descriptions (I) and group descriptions (we) concerning decisions, choices and actions, or wishes and aspirations to act; on whether the participants thought they could have an influence on their own health; and on the meanings given to age and old age in this context.

The concept of subject position served as an analytical tool in studying the process of positioning oneself or others as a certain kind of person and in adopting or rejecting different positions (Wetherell and Edley 1999). The analysis showed that the participants positioned themselves as agents, but agency was not taken for granted, and whenever the category of old was mobilized, agency was challenged. The participants' talk concerned different aspects of their lives, not just health. For analytical reasons, I divided agency talk into three themes, namely health, personal interests and activities, and social relationships. In practice in the participants' talk about these themes often overlapped.

The participants' talk about health and bodily competencies involved ambiguities and balancing between different views. On the one hand, old age was seen as an inevitable process of physical and mental decline, as indicated by remarks such as "ailments of old age" (IV, 3) or "I'm sure we all have some medication" (IV, 4). The ageing body was put forward as a legitimate reason for one's health problems, and for having to give up physical exercise and to ask for help with household chores. In addition, it served as a legitimate explanation for difficulties in participating in social activities. In this context agency received the meaning of adapting to bodily changes and impairment, as well as lowering one's level of expectations. Furthermore, the participants constructed in their talk a point in life ("you get to the limit ( ) that you can't anymore, everything's gone", "out of this world" IV, 3) beyond which one could not be expected to influence one's own health or life. This marked a point when one's health was so impaired that it was impossible to

manage on one's own any more and to lead an independent life. Expressions such as "there is absolutely nothing you can do" and "lie there and being turned" or "so that you wouldn't have to just lie there in bed and be turned over" (IV, 3–4) were given to picture the worst, but nonetheless a possible future scenario. Originally my interpretation was that in this kind of talk old age becomes equated with the end of agency. Today I would alleviate this interpretation. I think that agency is not completely denied here, but seriously questioned. Following this logic, agency means the ability to make decisions and to express one's own will. But these findings indicate that this is not all. Agency seems to be closely related to the ability to act independently, without needing help from other people. These findings suggest that the process of physical impairment and becoming dependent on other people may entail giving up the agentic position both symbolically and in practice.

On the other hand, the participants also made the point that through their own choices and actions, they can indeed influence their own health. However, the analysis showed that the division to people who can have influence on their health and to those who can't was not clear-cut. Instead, the participants balanced between the range of their own actions and the necessities dictated by their declining health. As discussed, ageing was constructed as a process that might lead to a certain "point" where health and bodily being could no longer be influenced by one's individual actions. From a slightly different perspective, one participant said he goes to the gym in order to keep up his health so that he will be able to stay in his own home as long as possible "before I'm taken away to be looked after by others because they don't really do that do they" (IV, 4–5). Criticisms of the poor quality of care were voiced in other groups, too, even though this was often in a veiled manner. The key observation here is that the future when one will be "taken away" is constructed as a necessity, while one's own actions appear as a means for postponing this future scenario. In other words, there remains some scope for personal agency. This extract was accompanied with laughter, which according to my interpretation marks it as a sensitive topic. An interesting topic for future research would be to analyse these kinds of accounts in closer detail, to see whether this kind of motive for looking after one's own health is just an isolated incident or a more general phenomenon.

Individual differences were also brought up as relevant to health. Opportunities for individual agency in health matters were constructed as being dependent on and limited by these differences. In a discussion group of five women, one of the discussants was praised for her good health, but she was repeatedly described as "an exception" and as being "like a one-year-old" (IV, 4), and her good health was then constructed as an exception and a result of individual qualities. However, the participants also said it is

possible to take action to promote one's own health, such as taking physical exercise and doing crosswords, in order to "keep my senses about me" (IV, 4). Similarly, activities such as participating in a literature circle (IV, 8) or going to the gym (IV, 4) were described as means of maintaining one's health. All in all, the participants positioned one another as people with different characteristics, and good health was often attributed to genetic background, but equally often to conscious choices and actions.

The participants also talked about their personal interests and activities, such as volunteer work, literature clubs, handicrafts, writing for the local newspaper and dancing. Activities were given meaning as a means of self-development, but also as a way of helping other people or being useful in society. In this context the participants also talked about their personal qualities and interests. Here the category of old received ambivalent meanings. The participants said they were aware that their activities and interests could be rendered meaningless or de-valued simply because they were seen as "old". One of the participants described herself as being eager to learn new things and as someone whom her friends rely on as a source of information. Yet in her own talk she quoted an anonymous speaker as saying "somebody once wondered … She's an old woman ( ) hasn't been in working life for ages and all that, what does it matter what the word means" (IV, 8). According to my interpretation, active voicing allowed this participant to bring forward the conventional view that her eagerness to learn new things could be rendered meaningless because of her age, but she refuted this definition by constructing herself as "I", as an individual with an inner drive to learn new things (IV, 8).

When the category of old was mobilized in talk, agency became somewhat problematic. The analysis showed that the participants often constructed themselves as agents by distancing themselves from old age identity. Another way of constructing oneself as an agent was to redefine the meaning of old age. One participant said the reason he was involved in volunteer work in organizations was to help other people and to find purpose for one's life ("I'm of some use" IV, 7). In his final remark he stated that "we're still not completely useless here" (IV, 7). He did not distance himself from the category of old, but constructed the category of "we" old people who can have a meaningful position in society. His last remark constructed this topic as age-related and at the same time commented on the conventional view of older people's position in society. His talk does not in fact deny but qualifies older people's uselessness. Different everyday activities and interests were then often brought forward as "age-related".

In a similar fashion, in a group of five men, the participants were talking about politics when one of them turned to me (the group moderator) and said: "So the news continue to be of interest even at this age" (IV, 8). With

this remark the group members were positioned as members of a certain age group who are not self-evidently interested in the news. The underlying message here is that old people are no longer expected to be interested in social and political issues, but this view was now being questioned. In the original article my interpretation was the participants were seeking to redefine the meaning of "old people" and challenging the perception of older people as nothing more than objects of help in society, and instead advocating the view that older people can contribute to the well-being of other people and be agents on a broader social level. I think that this interpretation still holds, but I would now be inclined to pay more attention to the role of the research setting as a context for discussing different arguments. The last quoted extract is particularly interesting in this context: the participants here position not only themselves but the researcher as someone who is interested in their age. The research situation becomes constructed as a special kind of context that 'invites' the participants to view themselves from a certain perspective – that of old age.

In relation to other participants and peers, the group discussants positioned themselves as equals or as sources of help for one another. In the flow of the group discussion identities were defined and redefined. In the group of five women, the participants jointly defined one participant as outgoing and socially active and another participant as "active in a different way", i.e. as having quieter and more "introvert" activities (IV, 4–5). In these discussions being outgoing and socially active was constructed as preferable behaviour, and "inactivity" as something that seemed to require legitimation. In this example this was done by constructing the participants as different types (Nikander 2002, Holstein and Gubrium 2000) with different needs and motivations, and one participant's actions as "quieter" and "different" activities, but still activities. In their talk about old people in relation to institutional agents (doctors, physiotherapists etc.), the participants constructed "an old patient" more as an object of action than an agent. Immediately after the discussion mentioned above, the participant who had been defined as active and outgoing told a story about an encounter with a doctor. She said she had complained that she was unable to walk even one kilometre, and quoted the doctor's answer: "so how far should you still be able to walk, he said (general laughter), I said that I should still be able to go dancing and all, I showed him like this. Well yes, to slower tunes in that case." (IV, 5). The doctor's talk assigned the speaker to the category of old people, as the temporal expression "still" indicates, and implied that her ambitions for improved physical mobility were not necessarily rational or reasonable. The participant's response in which she declined the idea of reduced mobility by emphasizing that she ("I") should still be able to go dancing, can be heard as a comment to the doctor's talk and an attempt to

redefine her agency as old. It also challenges the doctor's definition of what is "age-appropriate activity" for an older person. The doctor's comments can be also heard as patronizing talk. Other participants also referred to encounters with health care professionals in which the conduct of professionals can be interpreted as patronizing and infantilizing (for an opposite setting, see Coupland and Coupland 1999, Coupland et al. 1994).

It was quite common for the participants to construct "old" as a subservient position in relation to young people, but this was also explicitly or implicitly criticized and questioned. Comments such as "news continue to be of interest even at this age" (IV, 8), "still not completely useless here" (IV, 7), "she's an old woman ( ) hasn't been in working life for ages… what does it matter what the word means" (IV, 8) place older people in an "underdog" position in relation to members of other age groups and calls into question older people's position as noteworthy social agents. Expressions such as "makes no difference where we are" (IV, 7), "how far should you still be able to walk" (IV, 5), "before they take me away to be looked after by others because they don't really do that do they" (IV, 4–5) implicitly question older people's social position. The participants' talk can be heard as negotiation of their agentic potential. A busy work and family life and the right to one's "own life" (IV, 6) were commonly related to the category of young. In particular, the idea of placing "demands" on young people and becoming a burden to them (IV, 6–7) was constructed by the participants as inappropriate. Older people's agency was then constructed as subservient to younger people's wishes and actions.

The participants also had different ways of defining the relationship between the "old" and the "young". In one group discussion the invitation to join a family at a Midsummer's party engendered the following response: "I said let them boys go. It's their turn now. What would we old grandmas do there, it makes no difference where we are" (IV, 6). Being old and older people's agency were here constructed in two ways. Firstly, "old grandmas" were people for whom it makes no difference where they are, or whether they attend festivities with other members of the family. Giving "room" to younger people, abstaining from making demands, and taking the view that what older people do is less important can be seen as part of the normal course of life and as part of age-appropriate behaviour. To add another aspect to my original interpretation, it can be argued that to talk about younger people's turn constructs older people as people who no longer lack anything, but who have experienced it all. Furthermore, in this kind of talk "we old" was constructed as agentic identity, i.e. "we old" are not being pushed aside, but making room for younger people.

7 DISCUSSION

7.1 Fate, choice or both? – Being old as ambivalent position

The following provides a brief summary of my findings and discusses the theoretical and methodological implications of my research. I also raise some of the limitations of the study and identify areas of interest for future discursive studies of experiences of old age and health.

This research focused on meanings given to old age and health in biographical interviews and groups discussions with older Finnish people and on how people raised and balanced between different arguments in talk about old age. The participants' talk was mainly concerned with the role of individual actions in one's own ageing and health. The experience of ageing and old age was linked to such topics as poor health, needing help and being dependent on other people, being lonely, forgotten, and useless to other people or in society. On the other hand, the participants stressed that older people can be in good health, be active, independent, useful and needed family members and members of society. Sometimes it was argued that older people have accumulated a deeper knowledge and understanding of life by virtue of their long life experience. As the discussion in Chapter 2 showed, these topics have been raised in numerous studies dealing with the experience of old age. Even though I present these topics as two separate lists, one of which is clearly in more positive terms and the other in negative terms, both of these lists appeared in the talk of the same participants. Many earlier studies have described these different positive and negative views of old age as positive and negative stereotypes that may be internalized or resisted and dissociated from. Some studies have argued that there is a difference between private views and public or external cultural views that may be imposed on people. From a discourse analytical perspective different ways of talking about old age and health are understood as resources used in talk to construct identities, to make sense of one's own ageing and also to explain, legitimate and negotiate one's own conduct. The participants of the study balanced between depicting old age and health in terms of fate and necessity to which one has to adapt, and as a matter dependent on individual actions and decisions. Talk about old age and health revolved very much around

matters of individual agency and morality. Drawing together the findings of earlier studies, different ways of talking about old age and health can be named as decline, activity and wisdom discourses.

In the *decline discourse,* old age was equated with ill health. When people conceded that their health was not very good, or that they were no longer able to do the things they used to do, or that they were no longer "outgoing" and socially active, the decline discourse provided the tools they needed to construct their position as an understandable and self-evident part of life in old age, and even the universal fate of all people. In this kind of talk old age also served as a legitimate reason for being of no use to other family members or in society at large, or for needing other people's help. Expressions such as "old age doesn't come all by itself" and "I'm old so I'm old" (I, 363), "I'm beginning to get old, I need my rest" (II, 494) openly relate old age with ill health and serve as self-evident explanations which require no further arguments. Age, here, is used as "external attribution", something that just comes and cannot be controlled by the individual (Giles and Coupland 1991). Aligning oneself with the category of old and as a member of the group "we old people", then, served to construct an identity for oneself that cannot be described as completely negative, even though it was related to issues that are commonly regarded as negative aspects or stereotypes of old age.

In the data collected for this research, relationships with younger social and health care professionals were often constructed in such a way that older people were categorized as being in ill health and as objects of others' actions rather than as agents. Participants often described these encounters through active voicing and by constructing their own agency as being challenged by professionals. However, my data do not give reason to argue that this is the only way to talk about older people as actors in the health care setting. The studies by Coupland and Coupland (1999) and Coupland et al. (1994) show that it is also possible to have an opposite situation where doctors aim to confront and disprove older people's views of old age as a time of ill health and convince their patients that their health can be improved. The participants talked about their relationships with other people such as their children in many different ways, but adopting the categories of young and old to describe people's relations usually signalled certain kinds of positions. Feelings of being forgotten and lonely were related to being old. These feelings have been reported in other studies, too (Hinck 2004, Minichiello et al. 2000, Thompson et al. 1990, Wray 2004). Describing oneself as lonely is potentially face-threatening, or can be heard as laying the blame on other people. My analysis here suggests that the participants evaded these threats by constructing loneliness and an outsider position as natural in old age and as "the fate of all of us when we get older" (I, 365, IV, 7–8). They

condemned the placing of demands on children's time and constructed old age as involving the risk of becoming a "burden" (IV, 7) to children who have "their own lives" to live (IV, 6). One aspect of the shared view of age-appropriate conduct seemed to be precisely to avoid becoming a burden (cf. Warness 1993, 330). Constructing younger people as having their own life, who are busy and who have their own lives to live, in implicit opposition to older people, can be interpreted as a way of reproducing cultural views of the appropriate and normal time for certain events in relation to the life course (Holstein and Gubrium 2000a, 79). This goes to show how shared cultural views are used to define oneself and one's position as old. However, relationships between older and younger generations can also be interpreted in terms of older people "giving room" for younger people, who have not yet experienced all the things that older people have.

As earlier research has shown (Heikkinen 2000, Gubrium 1993a, Kaufman 1986, Thompson et al. 1990, Vincent 2003), older people often express their fears of dependence and becoming a burden to other people. Constructing old age as a common fate for all people also served to undermine the individual's chances to influence his or her own life and health. To construct ill health as self-evident in old age served to show that the individual cannot be held responsible for poor health or being dependent on other people (I, 363, II, 495–497). The scope of individual agency and enacting agency were thus seen as being limited by the inevitable process of decline that follows with old age. It is an important discovery that dependence on other people, need for help and poor health are not just stated, but constructed as something that requires legitimation. It seems that through the decline discourse, it is possible to construct a worthy social identity for a person who does not fulfill the ideals of a healthy, able and independent person who can control his or her own life and body (Featherstone and Hepworth 1995, Turner 1995). It has been widely argued that this view of health and old age draws on western values of autonomy and independence. Critics of this view have pointed out that ageing research sometimes reproduces these ideas, and therefore called for a more culture sensitive approach. It has also been suggested that the idea of a self-sufficient autonomous individual is nothing more than an illusion. From this perspective we could embrace and value the fact that in their everyday lives, people are in various ways dependent on and a source of help for one another. (Dant 1988, Fox 2005, Torres 1999, Vincent 2003, Wray 2004.)

The main idea put forward in the activity discourse is not only that old people can be healthy, independent and needed in society, but that they can shape their own way of ageing and being old and promote their own health and postpone ill health and losses related to old age. Nevertheless the participants rarely argued that they were in perfectly good health or

had no health problems at all. More typically, they balanced between what had changed and what had remained the same in their health and in their lives. Indeed, what Nikander (2002) calls "conceding change and arguing for continuity" was a common rhetorical element in talk about old age health. The important observation here is that these discourses and different ways of talking about old age and health were not mutually exclusive or completely separate.

In order to define themselves differently than in the decline discourse, the interviewees used attributes commonly associated with younger people, such as calling their household chores or activities "jobs" (I, 363, 366) or "work" (IV, 7), or talking about how they "raced around" (I, 366). Similarly, the participants argued that "I never sleep during the daytime", sit down "only for a short while … and then I'm off again" (II, 491), or, as one participant said, needed a knee operation so that they could go dancing (IV, 5). These expressions served to construct an identity of an outgoing person who was actively involved in the community and society. The datasets differed in the sense that in the biographical interviews with people aged 90 or over, accounts of activity were very often presented in the form of lists (Potter 1996) in which the participants described in detail their daily tasks and physical and social activities. Other common rhetorical devices included extreme case formulations (Pomerantz 1986) and quoting other people with one's own talk (Potter 1996). Detailed accounts of daily activities, abilities and work help to place the individual to a different domain than is usually expected of older people. Therefore, in order to escape this kind of restrictive definition, a person who is approached as old will associate him- or herself with activities that are generally associated with younger people (Radley and Billig 1996). This draws our attention to the important point that talk about age and health is also a rhetorical performance in which people define their social identities (Radley and Billig 1996). When one defines oneself as independent, healthy and self-reliant, it is possible to preserve full authority and be seen as "accountable" (Shotter, 1993), but this runs the risk of losing the right to expect help from others or to appeal to physical incompetence (Radley and Billig 1996). Based on my research I have suggested that the use of detailed lists of one's activities and various rhetorical arguments indicate that the interviewees were well aware that in the light of conventional views of older people and of "deep old age", their claims might be regarded as less than credible and therefore they require extensive argumentation work. Detailed lists of activities were often accompanied by the admission of some changes in one's health. In this way the interviewees were able to show that they were not trying to deny the realities of old age. These concessions served then to support their claims for activity and dispel doubts that the speaker might have lost touch with reality. The fact that activity required extensive

argumentation suggests that the idea of old age as ill health and decline is still going strong, at least in the case of people in high old age.

In the activity discourse the interviewees also argued that older people can be seen as useful and needed members of the community, as people who are interested in social issues and who are keen to develop themselves in different spheres. Yet whenever the participants used the category of old age instead of talking about themselves as persons, as I, their agentic potential seemed to be called into question. When the participants described their own interests, their usually talked about themselves as I and constructed themselves as people who could make their own choices, decisions and do things. Within this context, individual agency was usually undermined by the use of the category of old in talk. The rhetorical device of active voicing was frequently used to bring forward different views and to support or oppose arguments to one's own. One interesting method of active voicing was to talk about oneself as I and to use other people's voices to convey "external" views of oneself as old. This is what one group discussant did when she talked about her eagerness to learn new concepts, contrasting herself (I) to the talk of an anonymous speaker by saying "She's an old woman ( ) hasn't been in working life for ages and all that, what does it matter what the word means" (IV, 8). These kinds of remarks allowed the participants to show that they were aware that their activities and interests could be rendered meaningless on grounds of their age alone. At times, the participants aligned themselves to the group of old people, but used accounts of their activities and interests to give reason to question the alleged attributes of old people. Statements such as "we're still not completely useless here" (IV, 7) or "the news continue to be of interest even at this age" (IV, 8) served to show that the participants were aware that they were not necessarily considered useful members of society or thought to be interested in social or political issues. The findings here lend support to earlier results indicating that it may be particularly challenging for older people to be seen and taken seriously as productive members in society and political actors (Conway and Hockey 1998, Thompson et al. 1990).

The participants argued that it is possible for individuals to influence and promote their own health. Not all participants claimed that they led a healthy lifestyle, but anyone who admitted to leading a not-so-healthy life explained and justified that in different ways and expressed the view that one should try to look after one's health. Among the elements of a healthy life and the ways in which it was possible to maintain or improve one's health, mention was made of not smoking, abstaining from drinking and having a balanced diet (II, 492, III, 60) and taking exercise (I, II, III, IV). Furthermore, social activity and a positive outlook on life were seen not only as beneficial, but as conscious and active means of improving one's

health. Inactivity and staying at home, i.e. being an introvert and leading a sedentary life ("just lie down", "just stay there", "never go anywhere", III, 56) were said to contribute to physical deterioration, but also to engender feelings of loneliness or even depression. Mental and social activity, therefore, were described as important to avoiding mental problems and to being able to make one's own choices. The participants constructed in their talk different "types" of people and ascribed activity or inactivity or being active in a different way to these types. Some studies indicate that this a common phenomenon in health and age talk (Crossley 2002, Nikander 2002). However, "activity" and "inactivity" were not always confined to different groups of people. The participants aligned themselves with the group of old people and at the same talked about themselves as I ("these stumbling old people … if I do this…", I, 367).

This kind of talk also suggests that it is indeed possible to control one's own body, to influence one's health and life in old age. It is interesting to see how many other elements of everyday life other than physical exercise were given the meaning of health-enhancing activities, such as doing crosswords, attending a literature club or writing to newspapers. These interests were seen to "have an effect between the ears" or to help "keep my senses" (III, 56–57, IV, 4), i.e. means of consciously maintaining one's mental agility. Activity was clearly constructed as an ideal and worthy of praise. Talk about inactivity, whether physical, social or mental, was constructed as a matter that needed to be explained and justified. Appealing to deep old age served to legitimate inactivity. However, even in biographical interviews the participants elaborated their reasons for being "inactive".

The participants also made the point that people are responsible for their own health and should try to look after their health. Nonetheless they also moderated and alleviated these arguments of individual responsibility and raised issues that limit people's prospects of controlling their own life and health. Among the factors that were considered to limit one's chances and abilities to look after one's health, reference was made to old age, serious diseases, genetic or personal characteristics and access to social resources such as education. These were constructed as factors that can either improve or undermine the individual's chances and abilities to look after their own health. In short, the argument was that in principle, the individual must be held responsible for his or her own health, but that responsibility is limited since individual health is also influenced not only by one's own actions and choices. Collective responsibility was mentioned as a factor that can level out differences in people's qualities and resources. However, it is important to note that talk about collective responsibility was still quite rare, and the main focus was firmly on individual responsibility. In their talk the participants balanced between the question as to how far people can choose to adopt a

healthy lifestyle and to what extent their choices and actions are beyond their control.

It was also pointed out that old age brings experience and knowledge that can lead to a deeper understanding of life. My original interpretation was that talk about wisdom comes under the activity discourse, but I now consider this a discourse in its own right. It could even be called a counter-discourse to both the decline and activity discourses, for it describes old age in different terms than the latter two. However it was a relatively exceptional, "weak" discourse. One possible reason for this could be that it was not specifically elicited. The analysis showed that the wisdom discourse was constructed using various rhetorical tools. The rhetorical organization of talk offers another explanation for the rarity of wisdom talk. It indicates that older people themselves know that arguing for "a wise old" identity may meet with a sceptical reception and requires extra effort. Whenever a topic in talk is supported by various arguments and rhetorical tools, this signals that the topic in question is disputed or controversial, and that the speaker knows that his or her arguments might not be considered believable (Billig 1996, Potter 1996). In fact, the participants in this study did not argue that older people are wise, let alone attach that definition to any individual participant. Wise is not a position one can easily opt for oneself, but it is treated in talk in a veiled manner, or claims to increased wisdom are qualified by laughter, for instance (Nikander 2002). In these datasets the participants constructed old age as a time of self-evidently increasing life experience and in this way avoided the pitfalls of "bragging" with their personal wisdom. However, the rarity of wisdom talk may indicate that regarding older people as representatives of wisdom and respect is not experienced as "lived reality". Rather, the everyday experience is to hear doubts voiced about one's cognitive faculties. Findings from other studies seem to lend some support to these results (Conway and Hockey 1998, Minichiello et al. 2000).

7.2 Theoretical implications

In the past few decades there has been much discussion about the changing cultural representations of old age and old people. It has been argued that "activity" and "positivity" discourses (Blaikie 1999, Bury 2000, Featherstone and Hepworth 1995, Gilleard and Higgs 2000, Hepworth 1995, Katz 2005) have gained ground over discourses constructing old age in terms of decline and losses. "Activity" has emerged as a keyword in much of the gerontological literature and public debate (Katz 2005). On the other hand, studies in the field of health sociology have argued that health is one of the "key concepts"

(Crawford 2006) of modern western societies that concerns people of all ages. Health, bodily being and performance are gaining ever greater importance in contemporary western societies, and the role of the individual and individual actions in maintaining health is being increasingly stressed (Crawford 1980, 2000, Radley 1994, Turner 1995). Based on the analyses in this research, the participants' talk about their activities and health-related actions and choices can be described in terms of "busy ethics" (Eckerdt 1986). "Busy ethics" has it that being active and constantly on the move are seen not only as beneficial to health, but as a normative demand. According to the activity discourse, health can indeed be "managed" and ill health postponed, even in old age, by individual actions. The idea that health is malleable by one's own actions is not particularly new. Historical studies have shown that similar ideas have circulated in ancient (Gruman, 2003), medieval (Thane 2005) and modern times (Cole 1992, Katz 1996). In short, it is not a novel idea that good and ripe old age can be achieved and should be aspired by leading an ordered life, by controlling one's eating habits, taking exercise and even maintaining a positive outlook on life and its adversities (Cole 1992, Katz 1996, Turner 1991). The message, then, is that by keeping one's body and mind busy, it is possible for individuals to postpone physical and mental decay and preserve their mental powers and remain useful in society (Cole 1992, 148–152).

According to Steve Katz (2005), "new ageing" has it that old age can be a time of opportunities, development, personal growth and self-fulfilment, and older people can be productive members of society or alternatively dedicate to their own desires and needs. Further, old age can be defined in different ways: individuals can choose how to define their own ageing and themselves as old. Katz (2000) argues that remaining active, a "resource for mobility and choice" in old age, is "a struggle" in society where activity has become a keyword and a solution for all sorts of problems linked to old age. Activity is also offered as an answer to the declining welfare state and its management of so-called risky populations (ibid. 147, Estes, Biggs and Phillipson 2003, 151–153, Hendricks 2004). The tendency to strengthen older people's agency can thus be seen as empowering, but at the same time it assigns responsibility for health and well-being to the realm of individual actions and choices (Gilleard and Higgs 2000, Tulle and Mooney 2002). In earlier times a healthy life and planning ahead were a real possibility only for select people. Today, these ideas are being distributed ever more widely and to much larger audiences. Furthermore, the chances to make choices and enact agency in matters of health and ageing are today available to a much wider group of people than before.

The findings here support the view that older people too are adopting the ideas of "healthism" (Crawford 2006) or "healthist" views (Lupton 1995) and practices, i.e. ways of governing oneself and one's own conduct and

acting rationally with a view to managing risks and threats to one's health. This line of thinking has it that people can themselves improve their life and health, making good use of the expert knowledge available to make decisions about one's own life – for the good of oneself and society as a whole. Doing what is best for one's health is thus seen as both rational and moral. (Katz 2005, Lupton 1995, Nettleton 1997, Tulle and Mooney 2002.) Underlying these discussions are well-known and widely debated Foucauldian ideas about the increased management of populations, societies, individuals and life itself through bureaucratic administration, scientific knowledge and people's own practices of self-governance and self-scrutiny. In contrast to a common criticism, Foucault's ideas bring forward the productive nature of this "development" and attribute its success to all positive and beneficial consequences for society and the individual. Societies are made more controllable and predictable, and at an individual level living environments and people's health are improved – even though normalizing and disciplining discourses impose ways of thinking and acting upon people, at once making certain other ways of thinking and acting unthinkable, immoral or unhealthy. (Foucault 1984, 1991, 1998, 2005.)

Hockey and James (2003) argue that children's and old people's bodies have become a matter of similar inspection of normality. Younger people are assessed in relation to their assumed normal stage of development, and older people in relation to their assumed normal state of decrement (ibid.). One difference is that adult people seem to be under a moral obligation to look after themselves and their bodies in order to prevent "premature" ageing (ibid.). Tulle and Mooney (2002) argue that the Foucauldian concept of government can be used to explain "key processes" through which relationships between bodies, identity and the management of old age are enacted in people's plans and decisions concerning anticipated health problems, the adoption of exercise routines and the adoption of a positive stance to life. Robert Crawford (2006) links "healthism" to the development and functionality of capitalism. He also sees that the pursuit of health in contemporary western culture is not just a pursuit of control and denial aimed at achieving a better health status, but a pursuit of moral personhood. He points out that seeking pleasure or releasing oneself from the constraints of an orderly life are ways for people to defy the regime of a healthy life (ibid., see also Lupton 1995).

Whether individual agency is prohibited or implicit in Foucault's theorizations and Foucauldian approaches has been a matter of much debate. As regards the cultural discourses discussed here, most researchers take the view that people do not have complete freedom to choose which discourses to apply. Although their conduct is not determined by these discourses, people can resist normalizing or rationalizing discourses (Katz 1996, 24). Katz (1996) argues that historically constructed discourses of old age and

the largely negative identities associated with old age have been subject to "reversals and alterations" taking place in practical encounters of everyday life, and it is these practical encounters that offer room for individual agency but also for collective action in old age (ibid., 25). Holstein and Gubrium (2000b) have developed the idea of ordinary life and local situated encounters as sites that provide scope for individual agency (see also Coupland 2004). Holstein and Gubrium (2000b) note that even though cultural discourses are shared and maintained by individual people, they are not all-encompassing but have gaps and leave room for alternative discourses and alternative ways of defining situations, identities and actions. The concept of "discursive practices" refers to the idea that various everyday life encounters and practical situations offer people ways to enact their agency and to construct and draw on alternative discourses and thus resist the disciplining gaze of "discourses-in-practice" (ibid., 225–226). As Gubrium and Holstein (2000b) argue, "moral imperatives of self-construction" are negotiated and renegotiated in the light of the options available in different situations and social environments. The fact that cultural representations, social values, norms guiding the organization of society need to be enacted at the local level of everyday interactions requires people's active involvement. This involvement and awareness of alternative discourses requires individual agency. (ibid.) It has been argued that identity should be seen as a process that is part of and arises from social interaction and broader social forces (Hockey and James 2003, Jenkins 2004). The difficulty of accepting this view of identity comes from the tendency to see everyday life in the light of theoretical dualisms such as agency versus structure and personal identity versus social identity. (ibid.). Jenkins (2004) suggests that if we look at social structures as social processes that entail individual agency, this dualism and black- and-white picture of social life can be overcome. Structures are therefore processes, becoming as much as being. And the individual does not have complete freedom to choose how to define one's identity or how to act, but nor is he or she totally constrained, either (ibid.).

The complex and ambiguous nature of the experience of old age, which was again apparent in this research, defies attempts to fix meanings and opens up opportunities for individual choices and decisions. As Bryan Green (1993) has eloquently argued, everyday life and ordinary speech offer chances to enact individual agency by means of "ruses of avoidance, tricks of deflection, evasions of objectification, slippages of intention, ambivalence, ambiguity, irony and paradox – an achievement of degrees of freedom – often inadvertently – by displacement rather than resistance. In linguistic terms, it is an exploitation of the reflexive properties and semiotic openness of human language" (ibid., 201).

As was evident in the participants' talk, self-identities are constructed in relation to different options available in different discourses. These findings show how cultural discourses are used in talk to do a number of things. Paradoxically, the participants were enacting their agency when suggesting that it is not possible to gain complete influence and control over one's health. Hockey and James (2003) say that claims to biological foundationalism construct age-based classifications as natural and inevitable, limiting or even denying the agency of very young and very old people. As the analysis here showed, this risk certainly applies to the old age category. However, as was also made clear by the analysis, constructing bodily decline in old age as natural and inevitable can be interpreted as enactment of agency. Describing old age in terms of self-evident decline and ill health serves to reject demands that one should be active as well as the "duty to be healthy" (Lupton 1995). On the other hand, constructing oneself as a "worker", "dancer", "participant in society", etc., can also be seen as a way of subverting the overly deterministic picture of old age as illness and defining older people through their health status and bodily being. Also, talking about oneself as "lazy" can serve as a "counter-discourse", which relates to Crawford's concepts of pleasure and release as means of defying demands of an orderly and dutiful life (2006). In this way the participants qualified the messages of the activity discourse and the belief that individuals can control their body and life. Similarly, avoiding organized activities (Katz 2005) and harbouring doubts about the beneficiary of health promotion messages (Conway and Hockey 1998) can be framed as enactment of individual agency. Conway and Hockey argue that self-identity can be seen as a form of empowerment when it is understood as a way of giving primacy to the personal experience and refuting "inscriptions of power and expertise that shape and target 'the elderly as a social body'" (ibid., 491). As Katz (2005) has pointed out, even though people may accept activity as the ideal, they do not necessarily accept all forms of organized activities and want to define and enact activity in their own, personal ways.

In the field of ageing research there have been some interesting and promising applications of Foucault's (1998) conceptualizations of self-care. In these studies being active or taking exercise are not seen as means of participating in one's own self-governance, but as a way of seeking well-being and happiness, of pursuing a "good life" on one's own terms (Schwaiger 2006, Tulle 2008). In particular, the topic of exercise has been theorized as a way of overcoming and managing with declining health, but also as source of enjoyment and "creative" activity (Tulle 2008). Or, as Dionigi (2006) argues, engaging in sport can provide an "empowering experience" and yield a "sense of achievement, pleasure, pride, independence and self-expression" (ibid., 192).

I chose to entitle my study "Fate or Choice?" to emphasize the ambiguity and complexity of old age and health talk and people's associated experiences. To answer the question, old age is constructed both as a fate and as a choice. I theorized different ways of talking about old age and health as different, partly conflicting discourses that people use to define their identities and conduct as old. My aim with this division was to highlight the ambiguity inherent in the experience of old age, not to suggest that it is possible to slot people and their experiences into clear-cut categories. The ambiguity of old age experience stems from different reasons. Perceptions of old age and old people are culturally somewhat negatively loaded, and therefore it is understandable that people are reluctant to accept membership of this devalued group. Aligning oneself with the group of old people made poor health, the need for help and being dependent on others a self-evident and justified part of life in old age. However, this position easily entails loss of status as an adult and loss of independent decision-making authority – as studies of older people living in institutions have shown. In the current cultural climate people who suffer ill health may be blamed for failing to have done enough to foster their physical, social and mental health. But being seen as a "victim" of old age is no positive identity either, hence confessions of being "lazy" serve to construct a morally dubious but more agentic identity. However, attempts to define oneself in any other than age terms may be interpreted as an act of defiance against the rules of age-appropriate conduct. Anyone who breaks with the current perception of old age as decline and argues that they are active, healthy and independent, especially if they have already reached deep old age, may be seen as trying to deny, or worse, having lost touch with reality. Backett's (1992) phrase "moral minefield of health" (ibid., 261) is certainly applicable to old age and the construction of old age identity.

Old age identity can be defined in terms of "lack of fit" (Hall 1996, Hockey and James 2003), or fitting very poorly. However the fact that old age identity or health identity fit poorly is not necessarily an altogether negative thing. Obviously, a sense of a coherent self or self-identity is essential for mental well-being and for the ability to function properly in society. Self-identity is constructed at the intersection of cultural representations, social values and norms, bodily sensations, the material environment and everyday interactions with other people and personal biographies. These are the resources that people draw on to construct their own identity, and they cannot be simply chosen or discarded. (Hockey and James 2003.) However there is a certain "emptiness" (Coupland 2004) and ambiguity about old age identities that leaves room for individual agency, that gives individuals the opportunity to define their own identity and personal meanings of old age. From this perspective the ambiguity of the old age experience and old age identity can be seen as a fruitful and enabling basis for identity construction.

7.3 Methodological implications

The social constructionist view on reality and social facts is that for analytical reasons, it is important to look at the interpretive work done by people, to explore their definitions of what the situation is about, what is important and what is not (Holstein and Gubrium 2000a). This does not mean to say that social constructionist research is committed to a relativist position or that it ignores "social forces", structures, or power relations. These, too, can be made a topic of analysis in order to see whether and how they become visible, are made a meaningful and important part of one's own ageing. Social constructionism has diversified to the extent that it might be more accurate to talk about "constructionisms" (Holstein and Gubrium 2008) with "data-driven" or "theory-driven" approaches and different views on the relationship between cultural representations, social factors and individual experience. What these approaches share in common, however, is the view that the researcher should always be suspicious of claims about truth, reality or privileged knowledge.

Hagestad and Dannefer (2001) have criticized ageing research of "microfication", i.e. the tendency to focus on individuals' psychological characteristics or "microinteractions" and to leave aside the macrolevel perspectives of social institutions, values and the like (ibid., 4). Researchers working on small-scale qualitative studies are often painfully well aware of the complexity of people's experiences and of the difficulties involved in generalizing findings from small-scale sources. Discussions and reflections on one's own findings against broader social forces or cultural representations therefore tend to be rather cautious. Yet, as Nikander (2009) in her discussion of this criticism by Hagestad and Dannefer says, the emphasis on interaction or people's stories of their own ageing does not need to mean that broader structural issues or the "mesolevel" of communities and social organizations are ignored (ibid.). The studies reviewed here give ample evidence to this argument. Hagestad and Dannefer's (2001) argue also that the current emphasis on agency has fostered too "rosy" a picture of the agentic potential of individual people. They call for studies that pay attention to the "darker sides" of agency, recognizing that people's choices and actions are in many ways restricted by the social environment and broader social factors (ibid.,14). I concur that it is important not to ignore the different ways in which older people's agency may be inhibited. Having said that, it is extremely important to acknowledge that older people are actors, and to study the different ways in which agency is enacted in everyday life.

Rhetorical studies, for me, provide a powerful tool for exploring the argumentative basis of age categories and identities (Edmondson 2007).

Rhetorical tools allow us to investigate, at different sites, what kinds of arguments are presented, by whom and to whom, and to unravel the "message" of talk or text. Rhetoric analysis, importantly, pays attention to how talk about old age and health is a presentation of identity and a way of constructing an accountable and worthy identity. The particular benefit of this enterprise is that it allows us to "bracket" predefined notions of "reality" and to study the arguments applied in making some versions of reality look more plausible or better and to ignore or "silence" other versions. Rhetorical tools then allow us to study how different versions of realities are made to appear like the only reality.

The discursive perspective shares some key elements in common with rhetorical analysis, but there are some important differences, too. Discursive analysis focuses on situated and interactional mobilization and the use of different concepts such as old age, which is crucial to studying the ambiguity and multiplicity of arguments. Discursive studies have demonstrated their strength in showing how one and the same person can use different and even conflicting age categories and discourses, and how the meaning of the topic at hand is constructed in interaction, negotiated and accepted or refuted. Both discursive and rhetorical analysis provide tools for studying the ideological and moral meanings of old age and health – an important topic in times when health seems to carry strong ideological and moral connotations, and when the growth of the elderly population is an issue of recurring public debate (Coupland 2004). Discursive studies allow us to explore how different ideologies of ageing and age-related and health-related identities are expressed, negotiated and renegotiated in different settings of lay and medical interaction (Coupland and Coupland 1994, Coupland and Coupland 1993). In their discussion of ageism and anti-ageism, Coupland and Coupland (1993) point out the complexity of concepts of ageism as both disenfranchisement but also as self-disenfranchisement and repression and self-repression. They call for research on ageism and disenfranchisement that looks at how individual and groups themselves use different age categories and whether and how these are linked to social and political rights and valued or devalued social positions (ibid., 280).

This discussion goes to show that research focusing on language use does not mean ignoring social forces, structures, bodily existence or politics. Identities could be studied from the perspective of how these factors surface and are made real as part of the experience of old age. As Hockey and James argue (2003), seeing old age and body in constructionist terms does not mean denying the "reality" of the body. Bodies have relevance to how other people view and treat a person (ibid.). Bodies also have to do with power and politics (ibid.), particularly so in today's world where older people's bodies, health and the "location" of their bodies (at home or in

institutions) is a matter of great political interest. As the studies of Coupland and Coupland (1994, 1999) have shown, talk about health-in-ageing and age talk can be seen to inhabit ideological views of medicine, old age, health, intergenerational relations and individual agency. Such matters as denying the need for and the utility of medical treatment or chances to enact agency over one's own health, body and life in old age deserve further research (ibid.). Latimer's studies (1997a, 1997b, 1999) of patients in acute medical units are important in turning the focus to the way that age categories may be used in a medical context. More research is needed in the field of social and health care services to see whether and how old age may become visible in that context and to explore older people's experiences in this field.

Nikander's studies (2000, 2002, 2009) and my own work show how old age is used in moral argumentation to typify people, to negotiate one's own identities, to explain and justify one's own and other people's actions. This is another area that warrants further research as the meanings of age continue to change, and as the population continues to age. It has perhaps been repeated too often that the world's elderly population, especially the oldest-old population, is growing, but Coupland (2004) makes the important point that the social sciences cannot simply sidestep this situation. Nikander (2009), too, makes an interesting and important point in suggesting that apart from studying cultural representations of identity notions in the media, discursive studies may offer a way to empirically test these notions (ibid., 876). Discursive gerontology, Nikander continues, can also offer a "theoretical and analytical middle-ground" in the debate about the relationship between individual experiences and social structures (ibid., 876). Thirdly, she suggests that there might be a long-term task ahead for ageing research to develop culturally, structurally and interactionally sensitive conceptualizations. Here she refers to the concept of gender that has been so fruitful in studies of cultural aspects of sex (ibid.). From my own studies, the discursive tool of "active voicing" offers some interesting insights into the micro-macro debate. This, for me, is one way in which cultural and social views, norms and values and encounters with other people can be made visible and brought to the fore as topics of discussion, to argue for or against views expressed in them. Quotations from other people's talk also have the potential to serve as tools for mediating views and experiences of older people's position in society. This is yet another important area of research. Furthermore, the concept of subject position offers interesting new insights into studying stereotypes and stereotyping in people's talk. Following the ideas of Wetherell and Edley (1999), when considered as positions taken in talk, stereotypical views need not be seen as artificial, distorted or unreal social views in contrast to personal, individual, non-conformist, complex, real and normal views. This division, which is sometimes reproduced in the studies discussed earlier, also

constructs a division between personal and social (ibid.). This division is not very illuminating, nor is it in the light of discursive studies very accurate.

In summary, I see that constructionist and discursive studies have a crucial role to play in ageing research in addressing the different ways in which old age is made reality – physiological, political or experiential – and in studying what is achieved with different versions of reality. What kind of identities, politics, services, demands of individual conduct do they make appear natural, inevitable and reasonable, or alternatively, unnatural, avoidable, impossible and irrational? How does age work as a basis for identity, or how is it negated? How do people move on from one identity position to another; for example, do "seniors" some day become "old"? How is age used to classify and categorize people into different sites of everyday life? How is the category of old age used either to enable agency or to make a certain kind of enactment of agency more appropriate than some other, or what type of reasons and justifications are used to curtail people's potential (what is considered thinkable or unthinkable)? How do older people see their prospects of enacting agency? These are some of the topics on which social constructionist, discursive and rhetorical analysis can shed crucial light.

The vantage-point from which I have approached my data has been that all research situations are active and that research on people's everyday lives cannot and does not take place in a vacuum. This means I have looked at my research interviews as active (Gubrium and Holstein 1995) and interactive situations that are situated in time and in place (Kvale 1996). A common criticism of interviews is that these are artificial settings that are far removed from real everyday life situations and that are characterized by asymmetrical power relations, i.e. one party does all the asking and the other one all the answering (Heritage 1984, 236–37, Silverman 1993, 117). Silverman (1989) has described as "romantic" the notion that interview data can provide direct access to people's experiences or automatically generate objective data, but he has also criticized the view that everyday talk is "uncontaminated" or "natural" as opposed to reifying and oppressing interview talk (ibid., 32, 1993, 90–114, see also Atkinson and Coffey 2003, 423). It has also been argued that interviewing is not a particularly specific activity in contemporary social life (Silverman 1993, 19); the only difference compared to earlier times is that mass media products have made interviews an increasingly familiar and common part of everyday life (ibid.). Therefore interviews cannot be self-evidently contrasted with "everyday talk", but it is better to say that we live in an "interview society" in which interviews provide a central tool for making sense of our lives and ourselves (Silverman 1989, 38–39, Holstein and Gubrium 2003).

While I concur with the idea that interviews need not be dismissed as a method of data collection on the basis of the criticism presented above,

I also feel that much of the criticism against interviews is well justified. In this interview data the power relations between interviewer and interviewee were at times clearly asymmetrical, and some interviews had an almost interrogatory tone with clear-cut question-answer sequences. However, not all interview data are always and exactly the same. The biographical interviews conducted in this research differed from the strictly standardized survey type interview. Rather than following a strict preset schedule, the biographical interviews were quite loosely structured, and in fact at times resembled free-flowing everyday conversations. When interviews are seen from an interactive perspective as social action, the style of interviewing can be made a topic of study rather than seeing it as a hindrance (Atkinson and Coffey 2003). This aspect was one element in the analyses of the interview data (I, II).

Context and the idea that talk is always situated in some context in time and in place are among the central concepts of discursive research. In the present case what this means is that we need to ask what kind of context does the research interview provide for talk about old age and health and about oneself as old. The biographical interviews were conducted by young people in gainful employment and therefore by definition healthy. The interviewees, on the other hand, were people aged 90 or over and living more or less independently in their own homes, so in that sense they were more able and presumably healthier than those living in assisted living or in nursing homes. Still, the contrast to the interviewers was stark. Radley and Billig (1996) have paid attention to the fact that people who are asked about their health are often assumed to have some problems, while the people who do the asking are healthy people going about their daily job (ibid.). Radley and Billig (1996) say that in the current cultural climate in which health and physical ability are highly valued, this kind of setting may present a challenging and ideologically dilemmatic context for health talk. The participants in this research said they were "in no trouble" (II, 494), that they had "nothing really" (II 496) wrong with their health, or that "I've managed pretty well really" (II, 497), even after revealing problems with their health and physical abilities. This kind of talk serves as a strategy of retaining one's privacy after revealing health problems and corrective "face-work" while trying to convey truthful information about one's health to an interviewer (Radley and Billig 1996). Other researchers (Backett 1992, Coupland and Coupland 1994, Williams 1993), too, have described health interviews as a special context. As Backett (1992) pointed out, her participants said they felt it was like "a priest" was coming to meet them. Even though the interviewee will always aim to be objective and impersonal, the interview is still an interaction situation and a rhetorical performance in which the interviewer is a participant and in which identities are constructed, performed and legitimated for both parties (Radley and Billig 1996).

Interview talk, in contrast to other kinds of sites, is "researcher-elicited" (Nikander 2009, Schegloff 1998). For me, however, the distinction is not between "naturally occurring" and "artificial" or "unnatural" data. The interview is a special kind of context. However, it is wrong to suggest that the preordained context of the research interview or cultural surroundings determine the way the interaction situation unfolds, or the way that the interviewee and interviewer are positioned. People are not puppets or "dopes" that simply follow orders, but they are agents who are capable of making their own definitions of what the situation is about, and how they should express their own views while respecting the interactional rules of the situation (Holstein and Gubrium 2003). Different studies have shown that people can artfully manage the situation and express their views, and do not simply voice or repeat commonly held and culturally accepted views. One important point that is often left unsaid is that interviews offer interviewees the opportunity to voice their views, showing that those views are considered a matter of wider interest – a point often made by the interviewees themselves. Therefore, instead of seeing the interactive element or interview context as a problem and obstacle to obtaining objective or unbiased information, interaction should be seen as an essential element of the research situation and made a topic of research.

My analyses of the interview data inspired my interest in the process of talk and in how people brought forward and defended and explained their health-related behaviour. The reason I chose to collect another dataset in the form of group discussions was that these discussions provided a way to study this process and to explore how shared beliefs and values could be constructed in interaction, as well as how people argue for and against their opinions, wishes and concerns (Barbour and Kitzinger 1999, Waterton and Wynne 1999). Furthermore, the group discussion context made it possible for the researcher or interviewer to take a backseat position (Wilkinson 1999, 70) and to make explicit use of group interaction to generate data (Barbour and Kitzinger 1999, 4–5). I do not suggest that group discussions take precedence over interviews or other methods of data collection, but simply argue that the group discussion setting allowed for a stronger emphasis on participants' own views and made it easier for them to generate concepts and identify priorities in their own terms (Barbour & Kitzinger 1999, 5). The concept of "own" can be tricky if it is understood to suggest a division between the individual's internal, "own" views as opposed to and separate from external "social" or "cultural" views represented by the researcher's agenda for discussion (Holstein and Gubrium 2003). In the present research data, the participants' "own" views simply meant that it was evident that with so many discussants, my own role was less prominent and views were developed more intensely through group interaction.

Indeed it became clear in the group discussions that the moderator's role is less prominent than in individual interviews, and the researcher and group members can have a more equal standing (Barbour and Kitzinger 1999, Waterton and Wynne 1999). In the group discussions the participants talked about how they could contribute to improving their own health, and even though they acknowledged that it is possible, in principle, for them to influence their own health, there were also differences in this respect. Some were keen to stress the importance of one's own actions and a healthy lifestyle, while others moderated and even criticized these views. The group thus showed contrasting and even conflicting views. It has been argued that in group situations there is the risk that shared views are imposed on all group members, effectively preventing dissenting views or talk about sensitive issues. In my own experience this is not necessarily the case: the participants here certainly raised contrasting and conflicting views about health and old age, and also talked about sensitive issues such as their own depression, loneliness, cancer treatment, and excessive alcohol use. These topics were constructed as sensitive in the discussions, but they were nonetheless actively raised. The atmosphere in the group situation seems to be particularly important. In these groups the members knew one another to some extent, and some were even friends, which seemed to make a difference to how open the discussions were. But even the amount of time and "room" made available for group members to develop their views seemed to be relevant. For example, when I asked the question about personal responsibility for health, the immediate response in most cases was to acknowledge that people are indeed responsible for their health. However, when they were given enough time to develop their views, they also elaborated contrasting views and balanced between different arguments.

I would suggest that group discussions could and should be more widely used for purposes of data collection in ageing research. There are many topics that could be addressed in this setting, such as cultural views and media representations of old people, and how media images are received by older people themselves, studies on the reception of health promotion advice and messages, experiences of living environments, and experiences of social and health care services.

7.4 Limitations of the approach

I have applied in this research a discursive and rhetorical approach. The rhetorical approach highlights the argumentative context as well as the way in which some arguments are made to look plausible, while others

are implicitly or explicitly contrasted and rejected. As a consequence, the findings of the analyses and the discussion of results are rather divided in tone. My intention has not been to argue that the experience of old age and health is dichotomous, or nothing but argumentation between two opposite poles. Instead, the occasionally dualist structure has served the purpose of clarifying the ambiguous nature of the old age experience. My approach has not been strictly either theory-driven or data-driven. My interest in different discourses arose from readings of the literature and from a closer analysis of the biographical interviews, before I had decided on the topic for my first sub-study. What initially inspired my interest in the biographical interviews was the way that the interviewees listed their daily activities when they were asked about their age or health. These interests continued throughout the research process, which drew the focus of analysis towards these topics. Having said that, my approach was certainly data-driven in the sense that I studied in close detail how different views were put forward, and I have tried to follow Silverman's rule (1993) to test my own analyses and findings by paying attention to deviant cases. Also, the collection of another dataset through group discussions provided an interesting alternative data source. If interviews are conducive to creating a question-response pattern and in this way to reinforcing the dualist image, the group discussions produced more complex and nuanced data that shed interesting light on how different views were negotiated and contrasted. Indeed, from this perspective, group discussion data offer an important contrast to face-to-face interviews.

The biographical data were collected in 1995–96 and the group discussions a few years ago. One may well ask whether a dataset collected today would reveal very different ways of talking about old age and health? My position on this is clear: the topics I have addressed in this research, i.e. the meaning of old age, the ambiguity of old age and health identity, the morality of health talk, healthism and the question of older people's agency and position in society have definitely not lost any of their importance; quite the contrary. Indeed, as is indicated by some recent studies, activity has become an increasingly prominent keyword in ageing research. Likewise, the discussion and debate about individual responsibility for health and healthist ideas has only gathered momentum. In short, I very much suspect that the views put forward in my analyses would be even more prominent today. With the growing number of pensioners in our society, older people's different roles as grandparents and as mentors in working life and life after retirement has received even more attention than before. In other words I would venture to guess that the identities and positions assigned to old age and available for older people have continued to diversify.

The aim in qualitative research is not to produce statistical generalizations, but rather to consider whether and how the results are transferable and

applicable to another context (Silverman 2005). One way of doing this is to weigh and compare one's results against earlier and current research and against results from other societies and cultures, which is precisely what I have tried to do in this research. This is one way of enhancing the validity and reliability of the research and at the same time of giving the reader the chance to assess these. Comparing one's results with previous research also serves the purpose of improving validity and reliability. Furthermore, it is important to show that the data have been studied critically and systematically and that contrasting and "deviant" cases have been taken into account and used to test one's own interpretations (Silverman 2005). In the case of empirical qualitative research this requires that the data collected and the analysis are shown to the readers so that they can judge for themselves the plausibility and rigour of the analysis (ibid.). Rather than using the data simply to dress the analysis, for instance by inserting brief exemplary quotations, it is better to use larger data segments and to illustrate in detail how the analysis has been conducted. This is not easy when the research is published in article format where editorial rules set specific limits on the size of data extracts and on the detail of analysis. In this study, however, I have included large data extracts and shown in detail how the analysis was conducted. I have also included both more common and less common ways of talk about particular topics.

The use of transcribed and translated data also raises questions about the actual data source. Is it the original spoken interview, or the transcribed text, or the translation data that ends up in the research articles? According to Nikander (2008b), the validity of research is enhanced by the use of audio or videotaped data that allow for multiple hearings, and showing both the original and translated data makes the process of translation more transparent (ibid.). The process of transcribing is also complex and requires many decisions regarding the detail of the transcriptions and on how the data are presented to the reader. Another important, but often neglected issue is the translation of talk from one language to another. (ibid.) The data analysed here were translated from Finnish into English, which inevitably involves subtle loss of meaning. Also, the analysis was done on the original Finnish data, which were then translated into English. One source of difficulty was the tendency of Finnish people to use the passive voice even when talking about their own doings, which translates very awkwardly into English. In cases where this led to my analyses conflicting with the English translation, I had no option but to exclude these sections from my reports. Another major decision that I had to make was whether or not to include the original Finnish data alongside the translated text, which adds to the transparency of analysis (Nikander 2008). I eventually decided against this, for two reasons. The first was a purely practical one, namely, the space restrictions placed on

journal articles. Another reason was a methodological one, but it concerned also the validity of analysis. For me it was more important to quote large data segments to give readers access to a wide variety of data and to illuminate the ways in which arguments were developed in interaction. This decision was a difficult compromise, and it can be considered a shortcoming of this research that the original data were not presented to the readers in the original articles. On the other hand, this was done to improve readers' access to the data and analysis.

7.5 Conclusion

In recent decades ageing research has paid much attention to older people's activity, agency and to their being able to enjoy a "positive" old age. A major focus in this work has been on the meaning of activity as a central concept in ageing studies. Clearly, the meaning of old age and ways of being old are diversifying, and concepts such as activitity, positivity or successful ageing have had an important role in encouraging a more positive perception of old age than implied by the "decline" image (Estes, Biggs and Phillipson 2003, Gilleard 2005, Minkler 1990).

The findings here suggest that in their talk about everyday life, people draw from different discourses of old age. The activity and positivity discourse has helped to undermine overly negative and deterministic decline discourse and opened up new ways of talking about old age and perhaps about the positions available for older people in society. The current emphasis on individual responsibility can be seen as having the effect of supporting and promoting individual agency. However, this at once entails the threat that individuals may be blamed for "failing" to age in positive and active ways (Featherstone 1991, Hepworth 1995). Paradoxically then, the decline discourse that so long has been condemned and denounced in gerontological research may provide older people with an escape from the regime of activity and afford them the right to be "passive". The interest in the meaning of old age as a spiritual quest can also be related to discussions about what actually is taken to be an active life, and whether physical and social activity which are largely accepted as an important element in promoting older people's health can be taken as the standard applicable to all people (Katz 2000, 143). Some studies have applied interesting methods to explore the culture bound aspects of searching the meaning for life in different cultures and old age, such as through volunteer work or spiritual seeking (Savishinsky 2001, 2004). It can be asked what is activity and who defines it? Can transgressions of conventionally accepted ways to be active be accepted as activity? (Katz

2005). Can refusal to be socially active be seen as "activity"? Or are these seen as problematic conduct that creates a "risk" of self-inflicted loneliness and depression?

Current ageing research is interested in the practical everyday strategies people employ to cope and manage with their present or anticipated difficulties and adversities in life. However, not everyone is prepared or willing to plan ahead; some may prefer to take every day as it comes. This way of thinking may contrast with the idea that individual citizens should be rational, plan ahead and prepare for future difficulties and health problems in old age. The concept of responsibility and people's perceptions of how far they can assume responsibility for their own health is an important topic for future research.

Furthermore, people do not necessarily see themselves as agents who can make a difference in their own lives. Many may have limited financial, social or physical resources to make choices and enact their agency in practical everyday life (Estes, Biggs and Phillipson 2003, Hendricks 2004). It would be important to study how people in different social positions and with different kinds of resources see their chances to enact changes in their lives and in their health.

The analyses in this study showed that older people balance their position as someone who is "of use" or "of no use" to other people and to society at large, and described their ways of participating in society. Future research should explore more closely the different ways in which and the spheres of society where this participation takes place. This research need not be *only* about the ways in which older people can be "productive" in society, even though this is an important aspect. In current discourses old age is still largely defined in terms of declining health and losses. It seems there is only little room for discussions about other aspects of old age and other opportunities and challenges that ageing may present to the individual. Old age presents people with serious questions about the meaning and finitude of life, and this awareness may develop over many years of living one's life (Heikkinen 2004). Being old is a process, not a stable state that remains unchanged once it has been reached. In other words in people continue to change, develop and orient to the future. Interesting research has been done on the ways people in old age take up new roles or discard older ones and search for new directions for their lives as volunteers or as spiritual seekers (Savishinsky 2001). Wisdom in old age, long life as accumulated experiences and self-development in old age have attracted increasing research attention in recents years (Edmonson 2005, Coleman, Ivani-Chalian and Robinson 1998, Coleman, Mills and Speck 2006).

According to Coleman, Mills and Speck (2006), the gerontological research interest in mental, spiritual and religious questions as well as in

public discourses has revived after decades of neglect. They argue that these issues are crucial in the search for meaning of life in old age and elements in personal well-being. These issues have also been found to concern older people, but their needs and interests remain largely unacknowledged (ibid.). However, Coleman, Mills and Speck say it would be wrong to make the generalization that older people are self-evidently religious and "stable" in their spiritual habits, for this would ignore both older people's ability to change as well as the possible existential and psychological challenges of old age. Discussions around older people's wisdom, the meaning of a long life experience and spiritual needs are related to broader discussions and demands among researchers themselves to see and study old age as something more and something else than a social problem or a health issue, and address the concerns and challenges but also opportunities for growth and development in old age (Edmondson 2005, Cole 1992, Kenyon, Ruth and Mader 1999).

Social constructionism and discursive and rhetoric analysis offer important insights to the study of these and other "realities", identities and experiences of old age and old people. One particularly important task for the social constructionist approach is to look at older people's own views and experiences of being seen and treated as old at different sites of everyday life. By using methods that focus on language use we can unravel different cultural representations of old age, social practices and ways of thinking and acting that are attached to old age. They also open up interesting perspectives on the many ambiguities of old age identity as well as on ideological and moral dimensions of old age and health.

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Appendix 1. Transcription conventions:

Article I
Interviewer: Q
Interviewee: A

Article II
Interviewer: I
Interviewee: fictional first name

Articles III and IV
overlapping speech starts and ends: / /
particularly quiet speech: * *
clear pause: ()
comment, unclear speech or possible interpretation in brackets: (unclear)
heavy stress in italics: *weak*

Appendix 2. Original data extracts in Finnish

Introduction (p.13) ”En minä niin vanha ole, mutta kauan ollut “, Woman 92

Article I

K: kysyjä (haastattelija)
V: vastaaja (haastateltava)

No.1089 W90
Ei vanhuus ihan yksin tule, kyllä niitä aina sitte tulee.

No. 1199 W91
Nyt toi näkö menny, mutta ny lääkäri vakkuutti mulle että kyllä se tolla iällä jo mennee vähä joka ainoolla, et ei sille voi mittään enää

No. 025 W94
(poisjätetty puhe) mutta eihän multa nyt tule kylläkään semmosia vastauksia kun minulta ehkä odotetaan. Kyllä mä sen tiedän, mutta en mä voi sille mitään. Kun mä olen vanha niin mä olen vanha.

No.1370 W90
K: Minkäslaiset asiat on onnellisimpia hetkiä ollu Teidän elämässänne?
V: Eiks' nuo liene eläkepäivät kaiken onnellisimpia. On niin huolettii.
K: Ahaa. Niin huolettomat eläkepäivät.
Niin paremmin huolettomat vaikk' eihän ko miull' on semmonen luonne ko mie en osaa ottaa, että mie istuisin täs. Koitan tehä ihte minkä pystyn suinkin. Ikkunat oon pesettänt vast kahesti. Tänä syksynä toisen kerran. Käi yks' pesemässä, että mie oon teht omat työt.
(poisjätetty puhe)
V: Kyllähän sitä nytkii sattuu semmosta tääll' ihmisii keskell', mitkä on tuttuja niin semmosta, että ko ne meinaa, ett' mie en tiijä mitää. Että ko mie oon niin vanha, niin se minnuu pistelöö vihaks. Ko ne ain neuvoo. Antasiit kysyä, eikä ain, ett' tie noin ja tie näin. Niinko on sekasin. En mie niin paljo tunne ihteeni, ett' mie oisin viel ihan sekasin. Ihan totta, ett' mie tuota en tunne ja ko ain neuvotaan, ett' noin ja noin pitää tehä.
(poisjätetty puhe)
V: Ja sitte ko mie noitakin virkkasin niin noitakin. Mie oon teht 6 noit pöytäliinaa. Ja tyttärentytär sano, no nyt teet tuota hänellekkii joku liina.

Mie sanon, ett' en mie tee yhtään liinaa. Miull' on 20 liinaa valmista. Jos ei niist mikään käy niin mie en käy opettelemaan enää liinan virkkaamista. Mie vast täs laskin niin 20 tuli. Siell' on tän kokosta ja siell' on tän kokosta. Ja mie en käy liinoja. Mie teen tuommosta mitä huvittaa. Jonkun lapun. En mie käy liinoja opettelemaan. Niiss on hirvee työ.
(poisjätetty puhe)
K: Entäs siitä sitten, että onko ihmisen hyvä elää 90 vuotiaaksi?
V: No, kyllä aika hyvä oli tähän saakka, ennekuin tää sattu. Ko kaiken pysty tekemään. Ja se käi nopeesti. Nyt ko pittää aina jarruttaa, että nouseeko ylös vai ei nouse. Niin, että siihen asti oll' aika hyvä ko kaiken pysty tekemään itse. Se on niin suur asia, ett' sitä ei ymmärrä millään. Älä tee nii paljoo. Mitä sie turhaa teet. Ota apua. Kun ei kerran tarvii, niin mitä sitä. Tekee silleen ko tekee. Minä käytin torstain tuon 2 mattoo ulkona. Hississä vein yks kerrallaan. (poisjätetty puhe) Ja oll' niin raitis huone sitt'. Ja lattian pyyhin. Ja perjantaina oll' toinen iso työ. Pyykki. Ja mie suttaan paljo pyykkii. Oon semmonen siis, että tykkään olla puhtaas. (poisjätetty puhe) Niin. Kyllä miull' on monta neuvojaa olt. Tuoss' on tuo (naapurin nimi). Älä sie tee nii paljo. Älä tee nii paljo. Mie sanon, ei voi luonteelleen mittää, ett' nii kauan ko suinkii pystyy. Täytyy yrittää.

No. 103 W90
K: Olette kuitenkin ulospäin suuntautunut ja sosiaalisesti suuntautunut, että te kaipaatte ystäviä ja sukulaisia.
V: En minä nyt tykkäis ihan unohdetuks tulla, mutta ymmärrän senkin, että kun ei kerran kuole pois niin siinä on se sitten, se taitaa olla kaikkien kohtalo sitten vanhemmiten. Nuoremmilla on elämä ympärillään ja ajatukset menee niihin.
(poisjätetty puhe)
V: Silloin kun noi oli lapsia tyttären lapset, jotka nyt on sitten itte äitiä, niin silloin ne kauheen mielellään tulivat mummulaan. Et sinä täältä mihinkään lähde, et sinä mikään vanha ole, ne sano. Semmosta se on, mutta tää on ihmisen elämää. Tää tulee joka ainoon kohdalle, paitsi niille, jotka nyt sattuu pääseen pois aikaisemmin.

No.1046 W91
K: Mites tämä vanheneminen, miten te olette kokenut vanhenemisenne? Oletteko huomannut mitään?
V: En oo huomannu mitään, että mää vanhenen.
K: Siinä ei oo mitään ikäviä puolia?
V: Ei ollenkaan. Kaikki on ihan hyvin. Ei oo pitkä aika, kun oltiin tuola (veteraanikerholla), sielä kun haitarit soi tai mitkä pelit sielä soi, niin sielä mentiin vielä rattanpeliä. Minä oon ollu elämässäni kova tansiin.

K: Mites tämä henkinen puoli, tuntuuko, että siinä on tapahtunu muutoksia, muistissa esimerkiksi?
No muistissa pikkusen on tullu semmosia häivennyksiä, mutta ei paljon mitään. Kyllä minä vielä menen oikein repäsevästi.
K: Mites kuulo ja näkö sitten?
V: Näkö on aika hyvä, oikein hyvä. En minä tarvitte laseja ollenkaan, kun lääkäri sano, että koita pitää laseja vaan, että pysyy näkö tarkkana. Kyllä mää nään ihan kauheen hyvin. Kuulo, tuppaa korvat meneen vähän lukkoon. Välillä kuulee ihan liiankin hyvin. Ikä painaa jo sillai näitä, veltostuttaa. Se vaikuttaa aika paljon, kun mulla on aina ollu täälä veto, kylpyhuoneessa on ikkuna auki ja ovi auki parvekkeelle. Mutta mää aattelen, että raitis ilma, kun ei enää uskalla niin kovin lähtee ulos, kyllä mää vielä ulkona käyn.
K: Käyttekö te ihan joka päivä?
V: Kyllä minä käyn joka päivä, menen hissillä alas ja sitten tulen ylös portaat kävellen. Sitten menen taas hissillä alas ja tulen taas kävellen portaat ylös, se on semmosta hyvää treenausta. Mutta kun en uskalla mennä alaspäin, kun saattaa astua pahasti, niin putoo sitten portaita alas, ettei tuu mitään vahinkoo. Sillä minä menen hissillä alas ja kävelen ylös. Ne ihmettelivät, että kylläpä sinä osasit keksiä. Se antaa niin tyrnää oloo toi käveleminen. Se on harva joka sanoo, että sinä et oo vielä yhdeksääkymmentä. Mää sanon, että kyllä mää olen jo vähän yli.
(poisjätetty puhe)
K: Minkälainen elämän asenne teillä on ollut yleensä, miten te tähän elämiseen suhtaudutte?
V: No kyllä minä oon suhtautunu ihan normaalisti. Ei mitään erikoisia. Aamullakin nousen jo seittemän aikaan ja väliin puoli seittemän. Sitten minä tuuletan sänkyvaatteet ja petaan petini, panen kaikki kuntoon. Se on joka-aamuinen työ. Sitten päivällä lähden viemään roskapussia roskalaatikkoon ulos. Sitten kävelen pikkusen pihalla, että en minä oo vielä keppiin tarttunu. Ja täälä menee toiset kahden kepin kanssa ja menee kärryjen kanssa.

No. 004 W92
V: Että, tämmöstä on elämä ollut, ja sitä on saanu sitten tämän suvun keskellä olla semmonen keskenen henkilö, joka, johonka sitten soitetaan ja kysytään, mitenkä minä nyt teen ja noin poispäin. Ja nyt niillä on sitte semmonen pelko, että jos minä kuolen. Soitetaan yhtämittaa, että ooks vaan syöny ja ooks vaan syöny. Minä sanon, että jottahan minä joutasin pois. Et sinä jouda, me tarvitsemme sinua. Minä sanon, että eihän minusta mittään apua oo, ennää. Vanha oon tässä ja en aina sitä puhukkaan.
K: Miltäs se vanheneminen on tuntunu?

V: No kun, en minä tunne ollenkaan, että minä vanhenen, en ollenkaan.
K: Ei tunne itseensä vanhaksi?
V: Ei, ei. Niin, ja sitte kun minä joka päivä minä ulkoilen, että minä en oo ollut kun neljänä päivänä tämän vuoden aikaan sisällä. Sillon kun ne kaks myrskypäivää oli ja mitähän mulla sitte kahtena muuna oli, että neljä päivää oon ollu sisällä. Mulle niin kun joku sanoo, että nouse ylös ja lenkille. Sillon täytyy lähtee. Ja minä käyn asemallakin asti edestakasin. Ja noinpoispäin.
K: Siitähän tulee jo monta kilometriä.
V: Niin tekkee. Minä teen semmoset lenkit. Sen tuntee ihan kehossaan kun minä ne neljä päivää olin kotona, että rupes ihan ahdistamaan. Niin sitä täytyy lähtee, lähtee. Sitte vähä viskoa tuossa jalkojaan. Minä joka päivä menen tähän näin, piän sillain tästä kiinni, aattelen että jos vanha horjuu, niin tästä kun minä joka päivä sata kertaa kumpaakin jalkaa heitän.

No.009 W92:
K: Oletteko te mielestänne muuttunu elämän aikana itse?
V: Kyllä olen minä tullu paljon vapaammaksi. Minä muista, että minä olin tavattoman arka ja en minä tahtonu uskaltaa puhuakaan mitään. Silloin kun mä menin naimisiinkin vielä niin mä olin tavattoman semmonen, niin etten minä (epäselvää) keskustella ihmisten kanssa. Mutta nythän minä herätän vaikka (epäselvää) Monta vuotta jo siitä kun minä olen vapautunu sillä tavalla, että minä osaan sanoa mielipiteeni ja sanon vaikka vastaankin jos en jostakin tykkää. Mutta silloin, minä en ymmärrä minkä takia ensin alkuunsa olin niin tavattoman arka ja se oli tietysti sen takia, että mä en, oikeestaan semmonen lapsi vielä mistään tiedäkään. (poisjätetty puhe) Tää on ihan tosiasia. Terveellä järjellä aatellen se on sillä lailla. Ei siitä minkään pääse. Se vois olla lohdutuksena niille nuoremmille, jotka huomaa, ettei he vielä mitään tiedä. Mutta se onkin sillä tavalla, että eihän nuorena tiedä vielä mitään. Eihän sitä ole kerinny millään lailla kokemusta saamaan, eikä sitä tiedä vielä muuta kuin päällimmiten jotakin asioita. Ja mitä on nähny ympärilleen, mutta se on vallan eri asia kun olla itse mukana. Elää sitä asiaa.

Article II

Extract 1.
Liisa: Kyllä mulla raskasta on ollu koko elämäni, mutta kiitollisena minä olen vastaanottanu, kun mää olen saanu terve olla, se on suuri lahja, eikös oo. Kun moni sairasti sieläkin (työpaikka), että aina sairaslomaa (poisjätetty puhe) Kun en mää yhtään sairastanu, toiset oli aina, emmää tiedä oliko ne niin sairaita, mutta ei ne halunnu tehdä. Voimaa mulla on ollu tehdä. Ja (nimi) mun veljeni tytär, hän voi todistaa, kun mää siivoon täälä kaikki, mää vien nää mattonikin tonne parvekkeelle ja sänkyvaatteet ja kaikki, pesen pienen pyykkini, että kyllä mulla niin paljon voimaa on ollu nytkin. (Veljentyttären nimi) voi todistaa sen, että mää en valehtele yhtä sanaa tässä, se on kyllä totta.
Mitä minä siihen vielä lisäisin, en mää osaa sanoo. Paitsi se on minulla, että minulla on kolesteroli ja verenpaine, mutta nekän ei vaivaa.

Extract 2.
Haastattelija: Mites sitten nykyään, käyttekö te missään piireissä tääl?
Liisa: No en mää, kyllä mää joskus käyn noissa piireissä, kerran viikossa käyn kaupungissa, kun toi (veljentytär) tulee mun kanssani sinne, kun se pelkää, että mää kaadun sielä ja kantaa mun ostoslaukkuni sielä. En minä oon käyny, mää tykkään täälä olla ja harrastan täälä ja pysyn terveenä. En mää jaksa näillä jaloillani enää kauheesti mennä, mutta kyllä mää kotini kunnossa vielä pidän. Joka päivä minä täälä hyssyttelen ja teen, vähän aikaa istun, en mää nuku päivällä koskaan, istun vähän aikaa ja taas tulee mieleen joku ja taas mää hyökkään meneen.

Extract 3.
Haastattelija: Liikutteko te tuola ulkona joka päivä?
Liisa: No kyllä minä sielä vähän liikun, mutta en paljon, kun on aina satanutkin ja noin, kyllä mää eilenkin kävin tuola ruokalassa hain maitoo ja kaurahiutaleita. Mutta ei mun parane sieltä paljon ruokaa tuoda, kun sielä on semmonen ruoka, kun mun täytyy itse laittaa, kun on toi kolesteroli. Joka aamu keitän kaurapuuron, sitten vähän ajan päästä otan ton lääkkeeni, päivällä laitan päivällisen, iltapäivällä juon joskus kupin kahvia mustana ja ilman sokeria ja kermaa, illalla jotain iltapalaa syön. Kun ei auttais lihoo, mutta tuppaa lihoon, kun istuu aina. Mutta mun oikee polvi sillai kulunu, se luksahtaa usein, niin mää en uskalla paljon tuola kulkee, täytyy olla varovainen. Mää en pääse sitten mihinkään, tulee semmonen, sitten se on monta päivää kipee. Monta kertaa kun sataakin niin mää teen tästä huoneesta tonne huoneeseen kävelen edestakaisin, se on hyvä verenkierrolle. Kyllä mää olen ollu elämääni tyytyväinen ja se olis kauheetakin, jos ei olis tyytyväinen, se olis raskasta elää.

Extract 4.
Anna: (poisjätetty puhe) Mä ruppeen tuleen vanhaks, niin mä tartten jo lepoo. Eikä mulla, niin kun mä sanoin, ei mulla mitään hätää. Nythän mä sain vähän toista vuotta sitten kun mä sain semmosen pienen veren veritulpan. Mutta se meni kyllä ohitte, vaikka mun meni tää jalkani melkein toimettomaks silloin ja oikeastaan koko oikee puoli aika huonoks. (puhetta sairaalakäynnistä) Mutta kyllä mää tällä nyt kävelen ihan noin, etten mää keppiäkään välttämättä tartte, mutta se että väsyyhän se pikemmin, etten mää jaksa sitten sillai, enkä pitkiä matkoja jaksa muutenkaan kävellä. Mutta tää on se käsi vähän semmonen että, se ei kaikkia töitä tee ja rupee ottaan täältä (epäselvää) mutta kuitenkin liikkuu ja noin. Näkö menee sitten pikku hiljaa.

Extract 5.
Anna: Mutta noin, niin mitä mun piti puhua siitä. Juur siitä, että menee sillä tavalla aistit. Että kyllähän mää nyt vielä tunnen, mutta ei ei se ole ollenkaan sillai että, että mää olisin entisellään. En mää muista ihmisiä. Kasvot minä voin tuntee, toiset minä voin muistaakkin jollakin lailla, mutta harvaa se on kun mää muistan nimeä (poisjätetty puhe) Mää juuri eilen illalla ittekseni harmittelin sitä, kun oltiin yhden sisareni kahdeksankymmenvuotisjuhlilla Tampereella ja siellä oli sitten niitä tuttuja jokka oli jo lapsestakin ollu. Minä sanoin, että älkää nyt kuulkaa ihmetelkö, minä en muista teitin nimeä. Mutta silmistä tunsin monenkin että kyllä tää on tuttu, mutta mikä se nimi nyt oli (poisjätetty puhe) Kyllä tää elämä on ollu mutkikasta mutta, kaippa se loppupäässä sentään on. Täytän 91 marraskuussa, jos nyt elän siihen asti.

Extract 6.
Haastattelija: Miten se teidän oma terveys nyt sitten on?
Anna: No, se on kohtuullisen hyvä. Että kyllä minä tähän tyytyväinen olen, ei mulla yhtään sitä. Kyllähän mua talutella saavat jo tuolla sitten sakissakin kun en mää aina kykene pysyyn oikein hollilla, että mää horjahtelen ja noin. Mutta kyllä mää nyt olen aika hyvin pärjänny.
Haastattelija: No mites te ootte hoitanu sitä terveyttänne?
Anna: No ei tätä erikoisemmin. Olen koittanu vaan pikkusen tehdä, että aika kuluu ja sitten niin paljon kuin mahdollista niin ihmisten kanssa tekemisissä. Jos minä olen kauan aikaa, niin mulle tulee se matalapaine, kun minä olen luonteeltani ollu aina semmonen ilonen ja liikkuvainen. Nuorempanakaan en minä kauan pysynyt paikallani kyllä mää menin ja tulin, silloin kun mulla oli vaan mahdollisuutta. Kyllä sitä pakosta on ollu oltava.

Article III

Litterointimerkinnät:
päällekkäispuhunta alkaa ja päättyy: / /
erityisen hiljainen puhe: * *
selvä tauko: ( )
kommentit, epäselvä puhe tai mahdollinen tulkinta suluissa: (epäselvää)
painokas puhe: <u>alleviivattu</u>

Quotations of group 2. (p. 52)
Sofia: "no, mää oon viä pärjänny, pärjänny mielestäni <u>kauhian</u> hyvin (naurahtaa), mutta noin en tiedä mitä sitten on tulossa"
Henrik: "ikävuosiin nähden hyvä"
Taisto: "ikävuosiin nähden tyydyttävä"
Henrik: "sisäisiä sairauksia" "pieniä flunssia ja semmosia" "kulumia"
Taisto: "tyydyttävä"
Rauha: "omasta puolestani" "mitään vaivoja " pystyn liikkumaan" "mutta koskaanhan ei tiedä mitä tulee"

Extract 1. Group 2.
OJ: …No onko siinä, onko sitten, voiko itse tehdä jotain jos ajattelee, että vanhemmiten tulee kaikenlaisia vaivoja, niin voiko itse mitenkään sitten vaikuttaa ( ) siihen omaan terveyteensä?
Henrik: ainakin henkiseen terveyteen (OJ: mmm) ruumiilliseen ei paljon voi vaikuttaa. Ne tulee ja menee (OJ: niin)
Liisa: no kyllä niihinkin jonkun verran niin kun mää tässä ajattelin juuri, että ois mukava heittää tota jalkaa tohon päälle, mutta <u>voi auta armias</u> jos mää paan vahingossa tän jalan (naurahtaa) niin sillon mulla, mun täytyy toinen vetää sieltä alta pois (naurahtaa). Siis täytyy muistaa, mikkä on ne mun <u>heikot</u> kohtani (OJ: joo)
(yleistä myöntelyä)
Henrik: ja sitten mun tuli mieleeni vielä se, että sen verran voi toki auttaa, että niin kun helposti sanoo, että ei tämmösestä pikku vaivasta kannata mennä lääkäriin ja muuta
(OJ: mm) mutta menee lääkäriin vaikka pienemmästäkin (OJ:joo) ammatti-ihmisen puheille, niin sieltä voi saada semmosta apua, jota ei itte ymmärräkään (OJ: niin)
Liisa: ja sitten tuommonen niin kun liikunta. Jos kerran on terveet raajat niin kun yrittää liikkua, niin kyllä se varmasti edesauttaa. Lihakset pysyy paremmin kunnossa (OJ: joo) mutta se on sitten ilman muuta semmonen tekijä (*epäselvää*) (OJ: niin) sillon ei voi vain, jos mää niin kun itseäni aattelen, niin kun talvi oli ja oli liukasta eikä saanu liikkua, niin nyt

tuntuu, että ei (naurahtaa) pääse liikkeelle. Mutta kun kevät tuli ja pääsi kävelemään, niin okei, taas kaikki luistaa ( ) ihan eri tavalla (OJ: niin) eli kyllä sitä aika äkkiä kyllä rappeutuu vanhemmiten, ei nuorena, mut vanhempana (yleistä myöntelyä), jos ei liiku niin siis ainakin minä, /minä niin henkilökohtasesti/
Sofia: /mulla / kyllä on monta tuttavaa jokka on siihen sitten, kun niitä on ruvennu vaivaan nää kolotukset ja muut niin ne on lössähtäny istuun, "voi kun särkee tätä käsivartta, voi, voi, voi, voi". Mää joskus sitä sanon, mää sanon että kuule koitapas nostaa sitä käsivarttas vähä ylös niin se voi, että se helpottas. "En mää saa sitä mihkään, en mää saa sitä mihkään". Niin siihen jäät (OJ: mmm), kyllä jos tämmöseen alat, että, että jokaikiseen vaivaan vaan, että en mää pääse tästä mihinkään (OJ: joo) tulee semmonenkin aika varmasti ettei pääsekään, mutta se on sitten joskus.

Extract 2. Group 2.
OJ: niin. Mites sitte tämmönen ( ) oma ( ) asennoituminen ja tämmöset henkiset tekijät ( ) vaikuttaa terveyteen? Mää ajattelin vaan, että jos te käytte siellä kirjallisuuspiirissä ja näin, niin se on
Lea: kyllä mää uskon siihen että tota semmonen henkinen puoli, niin,
Aira: henkinen vireys pysyy ( )
Lea: niin että tota se paljo vaikuttaa terveyteen, ainakin ton luulis korvien väliin vaikuttavan
(puhuu kirjoittamisestaan erilaisiin lehtiin)
Aira: että kyllä siihen ittekin voi vaikuttaa
Sylvia: niin
Aira: siihen omaan oloonsa, siihen hyvään oloon
Lea: niin ettei lysähdä vaan ihan /vaan /
Aira: /joo, ettei jää siihen ihan /
Lea: ni, eikä ota kehenkään /kontaktia /
Aira: /joo kyllä se on /, se vie ihmisen
Lea: masentaa
Aira: alta aikayksikön
Esteri: niin ja mulle tulee aina aika-ajoin semmonen masennus, niin mää tiedän, et se menee ohi, mää tajuan sen ja mää huomaan koska se (naurahtaa) alkaa kyllä tuleen (naurahtaa), niin sillon on kyllä kaikki aika mustaa, mutta sillon mää
/alan tekeen jotain /
Lea: /mää en kyllä / sitä ihmettele sun asemassas
Esteri: mm
Lea: kun sää oot aina siä kotona
Esteri: /niin juu/

Lea: /samalla/ paikalla syntyny ja kasvanu / eikä noin käy missään /
Esteri: /juu mutta noin ei, ei mun/_
se, ei mun se yhtään koska mun on hyvä olla siellä
Aira: /niin sää /
Esteri: /mulla on hyvä olla/ en mää kaipaa
Lea: eiks sun aika tuu pitkäks?
Esteri: ei, katto kun mää en oo semmonen *menevä*
Lea: niin
Esteri: ja toi, mää ( ) löydän sitten sen avun siihen aina ( ) en mää osaa sanoo, mutta se vaan menee ohitte sitte, kun mää sen koko ajan tajuan, että se menee, se ei kestä, päivän pari. Mut se tulee kyllä ja se on aika *voimakas*
OJ: joo, mikähän sen mahtaa sit /aiheuttaa?/
Esteri: / en tiedä / mikä, mikä se on, mutta se kaikki tuntuu synkältä, mutta sit taas on niin hyviä, aurinkoisia päiviä että
OJ: niin, niin että joskus on paremmin /ja joskus/ vähä huonommin?
Esteri: /joo, joo /
Aira: kyllä se kaikilla jos yksin on
Taimi: ainakin toi jos on huonot ilmat, niin sillon masentaa

Extract 3. Group 2.
OJ: mites tuota semmonen asia kun ( ) te ootte varmaan luette ( ) seuraatte televisiota, niin on paljon ( ) tämmösiä terveysjuttuja ( ) pitäs hoitaa terveyttä eri tavalla kaikkia kun on siis liikunnasta, ruokavaliosta näin, niin mitä te aattelette, että kuinka paljon ihminen on sitten itse vastuussa terveydestään?
Rauha ja Sofia: aika paljon
Liisa: aika paljon mun mielestäni kanssa niin
Rauha: minä nyt aattelen häntä, että niin kun lääkäri sano, jos hän olis tupakoinut (OJ: mmm) sen leukemian aikaan, ne hoidothan on aina järkyttävät (OJ: niin) niin ( ) et jos keuhkot ei olleet niin puhtaat (OJ: niin) niin hän olis tukehtunu siihen tulehdukseen varmaankin (OJ: joo)

Henrik: kyllä mun mielestäni siis ruoka ( ) liikunta, liikunnalla ruokavaliolla ja ( ) mitä nyt yleensä meikäläiset laskee terveeseen elämään, niin se auttaa kyllä varmaan
OJ: niin. Mikä kaikki siihen kuuluu siihen terveeseen elämään?
Henrik: kyllä mulla, mulla on ihan henkilökohtanen kokemus, että säännölliset elämäntavat
Sofia: niin (yleistä myöntelyä)
Henrik: niin ne auttaa kyllä (OJ: joo) mää uskon että mää oon näin terve kun mää oon ( ) mää oon tota eläny suhteellisen säännöllisesti

ihan sanotaan nuoruu, melkein nuoruudesta lähtien. Ja en, enkä ota alkoholia ja en, en tupakoi ja tarpeellisessa määrin, tosin aika vähän, niin kuntoilen (OJ: mmm) täällä lenkkejä teen ja niin kun sanottu, noissa veteraanitouhuissa oon kuntoillu ja, ja tota tällä tavalla voi kyllä vaikuttaa
Rauha: joo /tavallinen suomalainen/
Henrik: / kyllä esimerkiks / ryyppymies on huonokuntonen viiskymmentä vuotiaana
(yleistä myöntelyä) puhumattakaan sitten, ei ne eläkään kahdeksaankymmeneen vuoteen
(yleistä myöntelyä) kyllä määkin alkoholia oon ottanu reilustikin aikalailla nuorena mutta onneks lopetin (naurahtaa) sen, että. Ja sen jälkeen on ollu ihan ( ) hyvä olo sekä ruumiillisesti että henkisesti
OJ: niin joo

Extract 4. Group 1.
OJ: niin ( ) mites sitten voiko aatella tuota niin että ( ) siis nythän on tämmöstä julkisessa keskustelussa tuotu tämmösiä keskustelunaiheita, että kun rahat loppuu ja mietitään kaikkee tämmöstä priorisointia että ( ) mitä maksetaan ja mitä yhteiskunta kustantaa ja niin ( ) voiks sanoa niin että ihminen on itse vastuussa terveydestään että missä määrin ihminen on vastuussa on sit että et et ( ) että jos ei puhuta siitä, että, että pelkästään vaikuttaa mutta onks ihminen vastuussa sitte siitä ja mikä on yhteiskunnan rooli siinä?
Paavo: niin jos sä tarkotat sitä, että tunnenko mä pahaa mieltä siitä, että mä en käy lenkillä niin tunnen(vaimeaa naurua)
OJ: niin, kun et käy, niinkö?
Paavi: niin kun en käy
OJ: niin
(.)
Paavo: näin se on kyllä, kyllä siis tuntuu, että terveytensä eteen vois tehdä enemmän ja vois tehdä enemmän
Kalle: aika paljon (yleistä myöntelyä)
Toivo: kyllä se omalla vastuulla suurimmaksi osaksi on suurimmalta osalta
/on/
Yleistä myöntelyä: /on/
Kalle: on se varmasti joo (OJ: niin)
Toivo: ja mutta se että sitä valistusta sais olla enemmän jo ihan kansakoulusta asti enemmän sitä terveyden ( ) ylläpitämisen ja justiin niinkun tommoset tupakat pois ja alkoholit pois (yleistä myöntelyä) ja semmoset kun niihin saatas semmonen konsti, että, että niihin ei sorruttais niin sehän olis
Akseli: nykyään kun vähennentään kaikkia liikuntatunteja

Toivo: joo ja se on huono
( )
Akseli: /kyllä mä toisaalta /
Paavo: /tää on tää on nuorison asia / ja sieltä saakka että ( ) mutta me jokka tässä iässä, meidän iässä polttaa niin eipä sitä saa lopettamaan
Akseli: mä oon kyllä sen verran fatalisti, että mun mielestä täytyy yhteiskunnan ottaa vastuu sitte jos ei niillä henkilöillä ole eväitä sen vertaa (OJ: niin), että ne pystyis ottaan aloitteita omaan, omiin käsiinsä ja harrastaan jotain ja tekeen jotain terveytensä eteen, niin kyllä yhteiskunnan, jotka on saanu enemmän eväitä tälle matkalle, niin kyllä niitä täytyis hoivata
Toivo: niin kyllä
Akseli: ja huolehtia
OJ: niin jos kaikilla ei oo /edellytyksiä /
Akseli: /niin kaikilla/ ei oo edes niin paljon, että ne kertakaikkiaan ne halu tahto taidot puuttuu niin kyllä, ei me kaikki olla samanlaisia ( )
Paavo: ei olla samanlaisia (yleistä myöntelyä)

Article IV

Litterointimerkinnät:
päällekkäispuhunta alkaa ja päättyy: / /
erityisen hiljainen puhe: * *
selvä tauko: ( )
kommentit, epäselvä puhe tai mahdollinen tulkinta suluissa: (epäselvää)
painokas puhe: alleviivattu

Extract 1. Group 2.
Aaro: mut sitten, ei malta olla tässä toteematta, sitten sen kääntöpuolen, että kun nyt tässä me ollaan kaikki ainakin henkisesti hyvässä kunnossa ja muutenkin, sitten tulee se raja ( ) ettei pystykään enää, on kaikki menny jo. Ja sen jälkeen täytyy monenkin vielä elää pitkään (OJ: niin). Mulla on sisar tuolla (name of geriatric hospital) sairaalassa. Sai viis vuotta sitten aivohalvauksen ja sen jälkeen on ollu suurin piirtein maailmasta pois (OJ: joo), ei voi vaikuttaa enää millään lailla (OJ: niin)
Eeva: niin sitten se on eri asia
Aaro: että kuinka sen voi hyväksyä, niin se on se
Eeva: se on (OJ: niin, niin)
Aaro: kuitenkin hälläkin on järki tallella vielä, pystyy ajattelemaan ja (OJ: joo) tietää sen, muttei paljon pysty puhumaan
OJ: ei pysty siis?
Aaro: ei. Kyllä se jotakin sanoo vähä, puhuu hyvin huonosti ja vuodepotilaana on ollu jo pitkään

Extract 2. Group 3.
Anna: mutta kaikilla on varmaan lääkitys, paitsi sulla ei (puhuu Marialle)
Bertta: mulla on ja justiin kävin /ja sain /
Anna: / sää oot/ kyllä harvinainen
Maria: mää oon harvinainen
OJ: ai jaa te /ootte niin kun/
Anna: /on niin kuin / yksvuotias (general laughter)
Maria: mulla ei oo oikeestaan mitään. Kävelen vaan paljon ja (OJ: ahaa) ratkasen ristisanatehtäviä, että pysys järki päässä (naurahtaa)

Extract 3. Group 1.
Oiva: ootteks te ajatellut sitä, että, nykyään kun on niin huono toi hoito tuolla, niin mie käyn ainakin sen takia kuntosalilla, et (naurahtaa) sais olla kotona pitempään ennen kuin joutus sinne toisten passattavaks kun ei siä kuitenkaan passata
Eino: näinhän, näinhän

Niilo: joo

Extract 4. Group 3.
Bertta: me ollaan niin erilaisia. Sää et koskaan riehunu missään tua etkä kulkenu
Vieno: en, ei, ei, ei
Anna: etkä harrastanu mitään tanssia etkä mitään voimistelua
Vieno: en mää tanssia, kyllä mulla harrastuksia on, mutta ei mulla oo
Bertta: ne on ollu semmosia /hiljasia harrastuksia/
Vieno: /toisenlaisia / nii en mää. En mää semmonen ollu, että mää oon halunnu mennä
Anna: mää oon taas riehunu kauheesti
Bertta: ja sen näkee ja kuulee (yleistä naurua) Älä välitä, kyllä sää niin oot reipas ja semmonen, että nyt se, vähän ne sun jalkas leikkaukset on tehny sulle vähä sitä takapotkua, mutta kyllähän toi on muuten (jää kesken)
Anna: mutta tota nyt kun mää kävin sillä ortopedillä, niin kun mää sanon, että kun en mää pysty enää ees kilometriä käveleen, niin kuinka paljon teidän pitäs sitten viä kävellä, sano (yleistä naurua) mää sanoin, että mun pitäis mennä viä tanssiinkin, mää näytin näin. No niin no, hiljasia kappaleita sitten (yleistä naurua)

Extract 5. Group 4.
Tauno: kun minä sitä hoitoo, no mitä tämmöset vanhat miehet, tuosson pallo, tuosson pallo, se on terapiaa, sanottiin (OJ: niin) se oli puoli tuntia (OJ: joo) ja tätäkin tervettä koipee rimputettiin semmosessa konneessa niin en minä kahteen viikkoon meinannu syömmään päästä. Minä sanoin, toista kertaa minä en tu tänne (OJ: ai jaa joo) minä sain kuntoutuksesta kylläkseni (OJ: niin, niin). Mää tunnen täältä, niin teijän ylhäällä se assuu (viittaa toisen osallistujan ystävään) se naisveteraani. Minä sanoin, mennään ens kerralla naisveteraani (epäselvää). Se olis Helsingissä kuntoutus

Extract 6. Group 3.
Anna: on mulla yks tyttö, mutta ei me, niin ja sillä, sillä on sitte poika ja sillä on taas kolme lasta. Muttei me niin kanssakäymisissä yhtämittaa olla ( ) eeei
Bertta: mää oon kyllä ihan niin että
Anna: eeei (OJ: niin)
Bertta: kyllä ainakin kerran viikossa jossei enemmänkin, mutta
Anna: soitellaan vaan, se jää siihen
OJ: mutta se sanoitte että teillä on ystäviä sitten, jotka on hyvin tärkeitä
Anna: on on on on, ne on kauheen tärkeitä (OJ: joo)
Anna: en mää voi ny vaatiakaan, laps yks tytär, se jäi just leskeks ja, ja tota sitten sillä on kauhee suruaika ollu ja noin (OJ: joo)

Bertta: ja /vaikeeta oli/ /
Anna: /ja nyt /
Bertta: sillon kun se /sairasti/
Anna: /oli / viis vuotta sairasti syöpää (OJ: joo)
Bertta: niin
Anna: mutta tota noin nyt on työelämässä niin ei sitä voi millään vaatiakaan
Bertta: en määkän vaadi, en missään tapauksessa vaadi (OJ: mmm) en ollenkaan, että monta kertaa kun ne soittaa, mää sanon, että olkaa ny keskenänne, /en mää välitä/
Anna: /joo
se on /
Bertta: enkä /tollai/
Vieno: /mää /en oo koskaan vaatinu, että ihan saa omassa / rauhassaan olla/
Anna: /tulee
sitten niin/ kun kauheeks rasitukseks (OJ: niin)
B: joo jos, jos sillai rupee että
Siiri: sitä /määkin jos niin huonoksi tulee, että ei pysty niin se on lapsille kauhee rasitus/
Bertta: /sehän on niille lapsillekin kamalaa, jos mää rupeisin vaatiin
/ Ne tulee ihan omia ( ) kun ne haluaa
Anna: /niin kyllä se on /
Bertta: /ja nykkin justiin/ ihan äsken soitti Maija, että kai sää nyt jo ens pyhänä, en mää oo kertaakaan niitten mukana ollu tänä kesänä. Tuuks sää ny varmaan ens pyhänä, ja mää älkää nyt älkää nyt
Anna: sullon päin vastoin kun mulla. Mää menisin kauheen mielelläni ny jo, mutta kun ei käsketä
(yleistä naurua)
Bertta: ja sitte tulee juhannus, niin kysyttiin, että haluaks sää mennä, että tota noin, haluaisiks sää mennä sen toisen mummun kans, sen miniän äitin kanssa noin juhannuksena, pojat menis sinne. Mää sanon, antaa sitte poikien mennä. Se on niitten vuoro ny. Mitä me vanhat muorit siä tehdään, kyllä se on sama missä me ollaan (OJ: mmm) mää oon joko täällä tai meen sisko, siskolle mun pitäs mennä, mutta mua houkuttelis olla täälläkin kun täällä noi muorit on kans täällä

Extract 8.Group 2.
Aaro: yks asia on mulle ainakin tärkee on se, että mää oon hakeutunut semmosiin harrastuksiin ( ) joissa mää, mullon mahdollisuus vähän niin kun tuntee itsessäni, että musta on hyötyä jotain (OJ: joo) mää voin siinä veteraanityössä, mää oon hyvin paljon mukana sotaveteraanityössä (OJ: joo

niin) ja seurakuntatyössä ja (OJ: joo) eräissä muissakin semmosissa asioissa (OJ: niin). Mää luulen, että ihminen on kyllä (itsekäs), jos se huomaa, että hän pystyy auttaan jotain toista (OJ: niin)
Tuula: niin
Aaro: se tuo semmosta sisältöö (OJ: joo) ettei tässä vieläkään ihan hyödyttömiä olla.

Extract 9. Group 2.
Aaro: mää, mun mielestäni, kun meitä on tässä tuttavia ja tota meillä ikää kaikilla on ( ) aika paljon jo, niin tota mää luulen, että kun meillä on yhteinen harrastus muun muassa tää kirjallisuuspiiri, niin se kyllä auttaa tohon henkiseen terveyteen. Ja jos on vielä muita, niin ei oo niin paljon, ei tarvitse ajatella sitä vanhenemisen pel, vanhenemisen pelkoo eikä sairauksia jos on (OJ: joo) ja se auttaa (OJ: niin)
Eeva: tässä juur, kun mulla on tullu semmonen tapa, en tiä, mää itte sanon, et se on paha tapa, mutta kai se voi olla hyväkin tapa ( ) että kun tulee, esimerkiksi uudissanojahan tulee esimerkiksi hirveesti televisiosta ja, ja kaikkee tämmöstä, jota ei oo ikinä kuullukkaan, niin mää ryntään heti mun tietosanakirjalle, että mitähän toi oikein tarkoittaa (OJ: joo). Ja nää mun tuttavat tietää, että ne voi soittaa mulle, että kuule tiäks sää tämmöstä asiaa. Mää sanon, etten mää oo koskaan kuullu. No, kato ny sieltä tietosanakirjastas (naurahtaa). Niin tota mua ihme(sana jää kesken), joku ihmetteli, että mitä sää sillä tiedolla teet. Sehän on vanha ihminen ( ) ollu iän kaiken jo pois työelämästä ja kaikkee tämmöstä, mitä se, mitä sen on väliä mitä se sana tarkoittaa. Mää sanon, kun en mää voi, en mää saa unta jos mää mietin vaan, että mitähän se tarkottaa

Extract 10. Group 1.
Eino: uutiset kiinnostaa siis myöskin tässä iässä vielä
OJ: niin, vieläkö kiinnostaa tässä iässä siinä iässä?
Eino: hhnn (nyökkäilee)
Niilo: kyyllä kiinnostaa
Oiva: ja yhteiskunnan asiat kyllä kiinnostaa, mutta niin laiskaks tulee, ettei viitti enää kantaa ottaa
Eino: se, joo
OJ: ai laiskuuttako se on?
Oiva: laiskuutta se on ja sitä ettei viitti enää istua ja mähän kirjoittelin yleisönosastoihin aika paljon niin tota ei viitti enää istua kun selkä tulee araksi siinä ja tota kun ei halua olla mikään besserwisseri kun niillä ei kuitenkaan ole mitään merkitystä (Niilo: niin) mitä kirjoittaa.

ORIGINAL PUBLICATIONS

OLD AGE AS A CHOICE AND AS A NECESSITY
Two Interpretative Repertoires

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ABSTRACT: *This article applies the method of discourse analysis to look at how older people talk about age and getting old. The data come from biographical interviews with people aged 90 years or over. The picture that emerges from these interviewees is one of ambivalence: old age is constructed through two contrasting repertoires that are described as the choice repertoire and the necessity repertoire. Talk about old age as a necessity produces it as a self-evident fact that the essence of old age is deterioration. Talk about old age as a choice is used to undermine the necessity repertoire and to argue for various and more positive definitions of old age among which one can make a choice. It is important to note that the contrast is not between cultural views and individual experience, but the ambivalence is rooted in people's minds. Both repertoires are reasonable and justifiable, which turns old age into a dilemma. Our thinking about old age is dilemmatic by nature.*

INTRODUCTION

Life in modern Western society routinely takes certain paths that vary according to our age. With increasing age, we move from one status and one role to another. Our age influences perceptions of our obligations and rights as well as the way in which we are expected to behave to meet the expectations of others and ourselves. In everyday talk, age is used to explain a wide range of different things. In this

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sense, age is at once visible and paradoxically invisible (because it is taken as a natural fact) in our lives.

The conventional approach adopted in academic research to studying old age is for the researcher to set out the conceptual framework for the research and then for the subjects to answer, as correctly as they can, the questions presented to them. Age may be treated as an independent variable, serving in its own right as a sufficient explanation for certain phenomena, or the accent is on the losses and decrement that follow with advancing age (Coupland, Coupland, and Giles 1991). Old age has also been studied by using analytic concepts that, in themselves, are cultural constructions (Luborsky and Sankar 1993) that need to be challenged.

In this article, we adopt a different approach. We take it that age is constructed and transformed in social practices (Bourdieu 1985; Coupland et al. 1991) and should be studied accordingly. More specifically, our study is grounded in the theoretical approach of social constructionism: We start out from the view that old age is constructed in social interaction and bound up with a certain culture and a certain historical era (Berger and Luckmann 1966). Social constructionism implies a certain view of language and its role in the construction of reality. The analytical starting point for our research is that language is not a transparent medium in the description of reality, but it is used by people to construct different versions of the social world (Potter and Wetherell 1987), or in the words of Gubrium, Holstein, and Buckholdt (1994:42), "analytically, reality is nothing more or less than what members [of society] make of it" (see also Silverman 1989; Lee 1992). Consequently, definitions of old age are also produced, reproduced, and/or redefined in talk; hence, our concern with talk about old age.

In this study, we focus on the talk of older people themselves; it is not only researchers but also ordinary people who conceptualize their lives and build theories of their lives (Gubrium and Wallace 1990). We examine how the oldest-old (i.e., people 90 years old or over) talk about aging and old age. All human beings, including researchers, grow older but the oldest-old are those who have the most direct first-hand experience of the situation that is known as old age. These are the people who are directly affected by old age welfare policies and who are defined by younger people as old. That is why their versions of old age deserve our attention.

Our research questions were generated by the material itself. In the framework of the life-story and narrative interviews in the Vitality 90+ project, people aged 90 years or over were asked, among other questions, what they thought about getting old. Many of them said they weren't old at all; however, our interviewees had reached an exceptionally old age, so we had to assume they were not referring to their chronological age. What exactly were they referring to, then? What, in their talk, is old age? What does it mean to be old?

MATERIAL

This study forms part of the Vitality 90+ project that is concerned to study the oldest-old in the city of Tampere in southern Finland (Jylhä and Hervonen 1999). The data analyzed here come from biographical interviews (N = 250) that were

carried out in 1995–96 with respondents who, on the basis of postal questionnaires, were healthy enough to take part. The interviews were conducted by young and middle-aged female interviewers with an education in health care or the social sciences. Most of the respondents lived in their own homes; some were in service housing or in nursing homes.

The interviews began with the respondents being asked to tell their life story; any details were probed when necessary. They were also asked the following directly age-related questions: What do you think about growing old? What is the secret of old age in your view? What would you like to say to younger generations? However, the issue of age also surfaced in connection with other issues. Rather than following a strict preset schedule, the interviews were quite loosely structured and, in fact, resembled everyday conversation situations more than interviews. For this reason, the questions asked and the wordings of different questions were not identical in different interviews. All the interviews were tape recorded and transcribed, running from a few pages to dozens of pages each.

In this article, we were specifically interested in elements that could be described as "age talk"; although, to identify these elements in the interview material was not an easy or straightforward task. We decided to focus on those parts of the interviews in which the interviewees (1) answered questions about age, or (2) spontaneously talked about their experiences and visions of age and growing old.

For the purposes of qualitative analysis, it was necessary for us to take steps to reduce the exceptionally extensive material. We developed a special application of content analysis in order to make sure that the remaining material covered the variation in the talk. To this end, the interviews were read through and general remarks were made on the central themes concerning age, and these were then condensed into the following keywords: deterioration, independence, dependence, liberation, outsider, useless, needless, sickness, frailty, senility, participating, life experience, and wisdom. Each interview was characterized by one or more keywords, and on the basis of this categorization, we selected 50 interviews for more detailed characterization. In this way, we were able to single out 20 interviews that, in our opinion, covered the variation observed in the age talk and represented both the most common ways and also the rarest ways to talk about old age. We analyzed these 20 interviews in great detail, looking specifically at the content and construction of age, that is, what was said about age and how. This kind of selection process was itself part of the analysis, though the final method on which we based our analysis and findings was that of discourse analysis.

METHOD

In this study, we applied the method of discourse analysis. Discourse analysis is not, in the strictest sense of the word, a research method proper, but rather, a theoretical frame of reference within which we can design various kinds of research applications. The following ideas of discourse analysis are particularly important to our research: (1) Discourse analysis shares, in common with social constructionism, the idea of the constructivity of language; this was already discussed above.

What needs to be added here is that the term construction implies active selection: some linguistic resources are included; others are omitted (Potter and Wetherell 1987); (2) discourse analysis has it that language and talk must be studied in their social contexts (Potter and Wetherell 1987; Billig 1987). It is important to bear in mind that our interviewees were addressed as a specific group (see Material section), as people who hold the key to "successful aging." In this sense, the research setting implies a certain identity for the interviewees.

One of the key concepts of discourse analysis is that of "interpretative repertoire." Wetherell and Potter (1992:90) define interpretative repertoires as "broadly discernible clusters of terms, descriptions and figures of speech often assembled around metaphors and vivid images. They are some of the resources for making evaluations, constructing factual versions and performing particular actions." The idea of an interpretative repertoire is intended to accommodate following considerations: There are resources available that have an "off-the-shelf" character, referring to cultural images of aging, and that can be used in a range of different settings to carry out particular tasks. However, these resources do not determine the way in which age is talked about but they are selectively drawn upon and reworked according to the setting (Potter 1996a). Participants will accordingly often draw on a number of different repertoires, flitting between them as they construct the sense of a particular phenomenon or as they perform different actions (Potter 1996a). In our study, this means that the same speakers use different repertoires to produce alternative interpretations of old age and older people.

The focal concern in our analysis, as implied earlier, is with the content of the interview talk about age, with the kind of expressions that speakers use in constructing age, and with how they use these expressions. The transcriptions of the interviews do not, therefore, go into such detail as is seen in conversational analysis.

The following excerpts demonstrate the variation and the situated use of the notion of old age. Some of the excerpts are rather long; this is because we wanted to highlight the variation of the accounts in the talk of one and the same person. However, we did not want to flood the text with too much detail and therefore, in our analysis, we have decided to focus on those features that we have found most relevant. At the beginning of each excerpt we give the number of the interview and the sex and age of the interviewee (W = woman, M = man).

ANALYSIS

Old Age As a Choice and As a Necessity

We identified in our interview material two different ways of talking about old age: two interpretative repertoires that we call the choice repertoire and the necessity repertoire.

The distinguishing characteristic of the necessity repertoire is that old age consists necessarily and unavoidably of deterioration; this has a central presence in the interviews. Illnesses and frailty are seen not only as inevitable signs of old age, but also as very the essence of old age to which there is no alternative. The rhetorical

design of the following excerpts clearly highlights the self-evidence of the necessity repertoire.

> No. 1089 W90: Old age doesn't come all by itself, you do always get these [illnesses].
>
> No. 1199 W91: I've now lost my eyesight but the doctor told me that at this age, it happens to just about everyone, so you can't really help it any more. . . .
>
> No. 025 W94: . . . you won't be getting the sort of answers that are perhaps expected of me. I'm well aware of that but there's nothing I can do about it. I'm old so I'm old.

It emerges clearly from all the excerpts how age is used as category-based, stable, uncontrollable, and external attribution (Giles and Coupland 1991); this is a matter of "category entitlement" (Potter 1996b) of old age. In the first excerpt, the notion of old age as illness is crystallized in a common phrase. In the second excerpt, the speaker refers to a reliable witness, that is, a doctor (Edwards and Potter 1992) to corroborate her version. In the last excerpt, the statement, "I'm old so I'm old" may at first glance seem tautological, but the context of the sentence does, in fact, make it quite understandable: Old age is produced as a time of unavoidably declining mental capacity that, in turn, justifies the speaker's inability to fulfil social expectations.

The main characteristic of the choice repertoire is that old age can be defined in various different ways and that one can choose from among a range of definitions the one that best fits in with the situation. The choice repertoire is used to undermine the necessity repertoire and to argue for a more "positive" picture of old age. Accordingly, older people can also be seen as self-reliant, independent, and needed members of the community, and on the other hand, as emancipated individuals who, by virtue of their old age, have the right to think for themselves and to refuse to fulfill social expectations. Furthermore, older people should be respected because they have, through their life experience, gained wisdom that young inexperienced people cannot have.

In the next excerpt, the interviewee skillfully uses both repertoires. She uses her neighbor's talk to produce a contrast to her own talk, but she also balances between different interpretations within her own talk.

> No. 1370 W90
>
> Q: What sort of things have been the happiest moments in your life?
>
> A: I would say that since retirement, really. No worries.
>
> Q: Right. The carefree days of retirement.
>
> A: Yes, better carefree, but I mean because I'm that sort of person that I really don't know how to just sit down. I try to do whatever I can all by myself. I've only had the windows cleaned twice. This autumn was the second time. I had this person come round to do them. I've done all my own jobs. . . .
>
> . . .
>
> A: Well you do get this thing here; there are people here I know and that, I mean, they think that I know nothing. Just because I'm so old, that really makes me angry. They're always telling me what to do. Why won't they let me ask,

> and not always, now you do this and you do that, darling. As if I was out of my mind. That I don't know myself well enough that I'm not quite out of my mind yet. Honestly, I mean, I don't know, and they're always telling me this is what you have to do.
>
> . . .
>
> A: I've made six of these tablecloths. And my granddaughter, she said to me, now she wants me to make her a tablecloth. And I said to her, I'm not going to make a single tablecloth any more. I've got 20 of them already. If none of them's good enough, then I'm not going to learn it all over how to crochet. It was just the other day I counted them: 20. There's this size and there's this size. And no more tablecloths. Only what I want to do. A potholder or something. I'm not going to learn tablecloths. It's an awfully big job.
>
> . . .
>
> Q: Well what about, is it good to live to be ninety?
>
> A: Well it was quite good until now, before this [falling accident where she hurt her back] happened. When you could do everything yourself. And could do it quickly. Now, you always have to put the brakes on, will I get up or won't I? Yes, so far it was pretty good, when you could do everything yourself. That's really important; it's hard really to appreciate it. Don't do so much. Why bother with that. Get someone to help you. Why bother when you don't have to. Do whatever you please. On Thursday, I took two rugs out to air them. Took them down in the lift, one at a time. I tell you, my back was aching terribly. . . . And the room was so clean and fresh. And I mopped the floor. And on Friday, I had another big job. The laundry. And I have plenty of that. I mean I'm really on for cleanliness. . . . I've had many people telling me what to do. There's [name of neighbor]. Don't you work so hard. Don't do so much. I said there's nothing you can do if you're born that way, that as long you can do it, you have to try.

The interviewee joins the interviewer in agreeing that old age means carefree days in retirement; that is, old age is defined as a time of emancipation. This is one formulation of category entitlement: It is acceptable for a person who has retired to get help and to do what one pleases; in fact, the oldest-old are not expected to do their own domestic chores, as expressed in the neighbor's talk.

However, the interviewee also creates an alternative version of herself as an independent self-reliant agent who chooses to try and to not give in. Not to be heard as praising herself and blaming other older people for being lazy, she constructs herself as being "born that way"; in other words, this is an external natural fact. Through a detailed description of her everyday domestic chores that she calls "work," she connects herself to the world of "normal" adults who are expected to take care of themselves. This implies an implicit argumentation against the commonsensical understanding of old age, which says that it is not normal for a person aged 90 to do her own work. Associating herself with a certain kind of activity (job), she conveys a picture of the kind of person she is in relation to the expectations of other people (Radley 1993). On the one hand, through her statement "as long you can do it," she portrays herself as a realist who knows her limitations and who is aware of "the expected reality" of old age. On the other hand, when she says "you have to try," she creates herself as a person who tries to live up to the cultural ideal of coping on one's own and not giving in "too easily."

In saying that she will not do what her granddaughter wants her to, the interviewee is again using category entitlement; an old person is entitled to turn down social expectations. She can use very strong and exceptional formulations ("only what I want to do. . . . I'm not going to learn. . . . It's an awfully big job") because she has already constructed herself as a hardworking person.

Through the talk of others ("people she knows"), she claims that older people are considered to be senile and in need of guidance. In her own talk, she argues for a different picture of herself. She legitimizes her claim by using extreme formulations ("I know nothing," "always telling" repeated twice), by quoting the words of others, implying that she is well aware her account may be contested.

Outsider or Needed Member of Community?

One of the key themes in the major theories of social gerontology (Cumming and Henry 1961) is whether or not old age means physical and mental withdrawal from society. This theme is also present in our interviews. Within the necessity repertoire, a fact is produced that old age means being useless and an outsider in the community. In the next excerpt, it is the interviewer who produces a contrast to this view with her question, but the fatalistic talk of the interviewee makes it clear that it is no real alternative.

> No. 103 W90
>
> Q: But you are still outward-going and socially oriented; you want to have friends and see your relatives.
>
> A: Well, I wouldn't want to be forgotten altogether, but I understand that if you're not going to die, then I suppose that it really is the fate of all of us when we get older. Younger people still have so much life around them and their thoughts are all on that.
>
> . . .
>
> A: When my daughter's children were small—they're mothers now themselves—they so enjoyed coming to see Grandma. You're not going to leave us, you're not old, they said. That's how it goes, but it's just life. This happens to all of us, except to those who happen to get out a bit earlier.

The interviewee is dealing here with a sensitive matter; she might come across as complaining and accusing her relatives of abandoning her. She therefore resorts to quantification ("all of us," which she repeats) and normalization ("fate of all," "that's how it goes," "it's just life," "this happens") and in this way, creates as a natural inevitable fact that she is an outsider and useless in society, and it is nobody's fault. Furthermore, in explaining the behavior of her relatives, she uses the categories of young and old to produce young people as having life around them and older people as not; that is, they are outsiders who have no right to make claims on the time of younger people.

In the next excerpt of dialogue, the contrast lies implicitly within the interaction between interviewer and interviewee, but also inside the talk of the interviewee. In the interviewer's questions, old age is repeatedly constructed as deterioration, but the interviewee questions this formulation and constructs various alternative

interpretations of old age and of herself, flitting herself between repertoires inside her own talk.

No. 1046 W91

Q: What about this aging; how have you experienced your aging? Have you noticed anything?

A: No, I haven't noticed anything, that I'm getting older.

Q: There haven't been any adverse effects?

A: None whatsoever. Everything is fine. It was not long ago that we went over to the war veterans' club. They were playing the accordion, or I'm not quite sure what it was. We were doing this ring dance. I've always been one for a dance, I have.

Q: What about the mental side? Do you feel like there have been changes in that respect; for instance, in your memory?

A: Well, yes, I suppose there have been some small changes memory-wise, but nothing really. I still go racing around.

Q: And what about your hearing and your eyesight?

A: My eyesight's pretty good, very good. I don't need glasses at all. The doctor said that try to wear your glasses: It keeps your eyesight nice and sharp. But I do see extremely well. My hearing, my ears tend to get blocked. Sometimes I hear a bit too well. My age is beginning to weigh on these, they're all slack. That's been a major factor that I've always had a draft in here; the window open in the bathroom and the door open to the balcony. But I think that fresh air, because I don't really dare go outside a lot, I do still go out.

Q: Do you go out every day?

A: Yes, I do go out every day, I take the lift down and then I take the stairs back up, that's good exercise. But I don't dare walk the stairs down: You might miss your step and fall down the stairs; I don't want any accidents happening. That's why I take the lift down and walk up. They're all quite amazed. It makes you feel super this walking. It's not many who say you can't be ninety yet. And I say I am, I'm a bit over ninety.

...

Q: What sort of attitude have you generally had to life?

A: Well, I would say quite normal. Nothing special, really. I get up in the morning at seven, sometimes half past six. Then I air the bed and make my bed, get everything fixed. That's a job I do every morning. Then in the daytime I take the rubbish out. Then I walk around in the yard for a while; I haven't taken to a walking stick yet. And there are others here who go around with a stick and a walker.

The self-evidence of the view of old age as a time of illness and frailty is apparent in the interviewee's response to the negatively loaded questions ("experienced your aging," "there haven't been any adverse effects?"); she has no difficulty understanding their implicit assumptions. As an alternative, talking about dancing and going "racing around," she produces herself as an independent self-reliant agent who has an active social life. Following Radley and Billig (1996), we may say that this excerpt shows how a person who is approached as "old," in order to evade this kind of restrictive definition, associates herself with activities that are generally associated with young people.

In her account of her senses and physical abilities, the interviewee is walking a tightrope between the two repertoires. She explains her hearing problems as an inevitable consequence of aging ("my age is beginning to . . ."), but she also has an alternative explanation that, in fact, is the "major factor" and a consequence of her own actions. Providing a detailed description of how she gets around physical obstacles by means of her ingenuity, she creates herself as someone very special to her age ("they're all amazed," "you can't be ninety yet"); talk that, in fact, reproduces the negative stereotype of an old person. She creates the factuality of her account by referring to various details and the talk of other people.

However, later on, when she says that there is nothing special about her life and when she defines her everyday chores as a "job," she constructs an identity for herself as a "normal" person and implicitly argues against the commonsensical view of older people (cf. Excerpt 1370) and, in this way, makes the unusual usual (Radley and Billig 1996).

Another frequent contrast structure in the interviews is the definition of oneself in terms of a negation vis-à-vis "other" older people. In this excerpt, when the interviewee says she has not "taken to a walking stick yet" as others have done, she distances herself from "ordinary" older people and translates physical deterioration into a matter of personal willpower.

In the next excerpt, the interviewee skillfully uses the talk of her relatives as a contrast to her own talk.

> No. 004 W92: So this is what life's been and I've really been, in our family, a sort of center figure who, who's always telephoned and asked what should I do now and you know. And now they're all worried that if I'm going to die. They keep calling me all the time that have I been eating and have I been eating. And I say to them that surely it's time for me to go now. No it isn't, we still need you. And I say that I'm no help to you, not any more. I'm old and I don't always talk about it.
>
> Q: Well, how have you felt about growing old?
>
> A: Well, it's really I don't feel like I'm getting older at all, not at all.
>
> Q: You don't feel old?
>
> A: No, no. Yes, and I mean I go out every day. I haven't stayed in except for 4 days all this year. That was these 2 days when we had these storms and I can't remember what the other 2 days were, but 4 days I've been inside. Like someone said to me, get up and get out. You have to get up and out. I even go all the way to the station, back and forth. And all sorts.
>
> Q: That's quite a distance.
>
> A: Yes, it is. That's the sort of distance I do. You really feel it when I had these 4 days inside; it really gets on top of you. So you have to get out, get out. And then shuffle your feet around. Every day, I get up right here, hold on to this here, and think that oh dear, these stumbling old people, if I do this exercise one hundred times with each leg, that should do it.

The situated variation of the concept of "old" is seen in the way the interviewee balances between two repertoires. She skillfully uses talk of her relatives to argue her case of being a center figure in her family. In her own talk, she produces the

uselessness of an old person as a self-evident fact without further explanation, saying that "I'm no help to you, not any more. I'm old" (cf. Exerpt 025). The factuality of the necessity repertoire is very prominent here; old age itself serves as an explanation.

However, in response to the question as to what it feels like growing old, she says she does not feel she is "getting older," nor does she "feel old." On the reverse side of this kind of talk is the negative image of old age. The interviewee links up old age with physical inactivity and inability and creates herself as another kind of person when she says "I go out every day" and "I haven't stayed in." The emphasis on the amount of exercise the interviewee gets and the interviewer's amazement at the length of her walks both convey the same message: A person of her age is not supposed to go on long walks all alone. Thus, the interviewee's talk makes an implicit reference to other older people. The way in which the interviewee's talk is rhetorically designed highlights the asymmetrical relationship of the two repertoires. When she constructs herself as someone needed and as physically active and self-reliant, she uses various rhetorical devices to legitimize her claim such as talk of her relatives, detailed description, repeat, and quantification.

Wise Old (Wo)Men?

In the next excerpt, contrast is implicit; the interviewee is arguing against the cultural common sense of old age, which equates old age with senility.

> No. 009 W92
>
> Q: Do you think you have changed during your lifetime?
>
> A: Yes, I suppose I have become less constrained. I remember that I was terribly shy and hardly dared to say anything. Even when I got married, I was terribly like, I couldn't [unclear] talk with people. But now I can wake [unclear] it's many years now since I've been less constrained in the sense that I can speak my mind and even answer back if there is something I don't like. But at that time, I do not understand why at first I was so awfully shy and of course it was because I did not, really a child like doesn't know anything really. . . . This is a fact. Common sense says it's like that. There's no two ways about it. That could comfort younger people who notice that they don't yet know anything. But that's how it is; you don't know anything when you're young. You haven't been able to pick up the experience; all you know is some things quite superficially. And what you've seen around, but that's entirely different from being there, being involved. To live it.

This interviewee constructs old age as a time of positive change from "constrained" youth to emancipated old age, and thus implicitly argues against the more common view that has it that older people are senile and tend to become more so with increasing age. She might come across as praising herself if she said straight out that older people are wiser than younger people. Instead, she creates this as an obvious external fact by using contrasting category entitlement (young–old), which she backs up with naturalization ("common sense," "this is a fact," "that's how it is," "of course," "there's no two ways about it"). It is not an easy task for

the interviewee to undermine the self-evident view of older people as senile, which is seen in the way she uses various argumentative devices to legitimize her claim. One way to create a factual version is through detailed description and narrative (Potter 1996b, Edwards and Potter 1992). The interviewee constructs her present "wisdom" through a development narrative from childhood to marriage to old age, which has brought her life experience. She further legitimizes her talk by repeating various extreme formulations ("terribly," "awfully," "anything really," "entirely different").

DISCUSSION

Talk about old age and aging in our interviews is clearly ambivalent. There are two different repertoires in use; we have chosen to call them the choice repertoire and the necessity repertoire. Talk about old age as a necessity produces it as an inescapable law-like fact that old age means physical and mental deterioration that, in turn, leads to dependence and helplessness and makes older people useless/needless outsiders in society. Talk about old age as a choice is used to undermine the necessity repertoire and to argue that old age can be defined differently (and one can choose one's definition). Furthermore, the choice repertoire is used to argue for a more positive view of old age. Accordingly, the older person can also be seen as an independent and self-reliant agent, a needed member of the community, and as someone who is entitled to think about him- or herself and who does not need to meet social expectations. Old age also brings along wisdom, on account of one's long life experience; therefore, older people should be respected.

These alternative versions of old age were largely constructed through contrasts, which is one rhetorical form of constructing factual talk (Wooffitt 1993). However, these versions were not constructed only to make an argument, but they were also constructed against alternatives (Wooffitt 1993; Billig et al. 1988). Rhetorical contrasts were built implicitly and explicitly. The interviewer and interviewee could implicitly present competing descriptions of the same action or event (Potter 1996a). The contrast could also be hidden within the talk of the interviewee so that other speakers were not necessarily present in the talk. In these cases, the interviewees built up contrasts to the cultural common sense (Billig 1987) of old age. Arguments and versions of reality were also constructed explicitly against versions expressed as talk of others; others being other older people, doctors, friends, acquaintances, children, and so forth. Defining oneself through a negation in terms of being different from other older people was a way of taking distance from the definition of old as represented in the necessity repertoire.

It is important to note that these competing descriptions or repertoires stand in an asymmetrical relationship to one another. In the case of the necessity repertoire, there is much less argumentation in the first place; the views put forward are presented as self-explanatory and self-evident; therefore, they seem commonly sensible and consequently, will be accepted without argument (Billig 1987). On the other hand, when the choice repertoire is used, various arguments and rhetorical devices are needed to justify arguments, which indicates that interviewees are well aware that their arguments may be contested.

The ambivalence of age-talk is seen in the fact that although the necessity version of old age has gained the status of fact in the talk of the respondents—it seems literal and not version at all (Wetherell and Potter 1992)—it is nonetheless challenged by the very same people using the choice repertoire. Interviewees argued against what may be called a "negative image of aging" and produced an alternative picture of old age and themselves as old. We claim that the interviewees are, in this way, trying to establish new meanings and definitions for old age and for older people. In the words of Shotter, they are "attempting to make new forms of human being possible" (1993:14). Accordingly, when the interviewees and interviewers talked about old age, they were also having an argumentation battle for control over the interpretation of "what voice should be allowed to speak for, and about" (Gubrium and Holstein 1990:159) older people and define old age. As we saw, language can be used to justify and liberate, but also to constrain, infantilize, and patronize. Discursive and societal power are thus intertwined.

The most important thing to remember is that this argumentation battle is not between the cultural and individual view of old age but the ambivalence is rooted in people's own mind (Billig et al. 1988). In our culture, people have access to different ways of talking about old age. These ways can be partly contrasting, even conflicting, but both repertoires are reasonable and justifiable in the same way. This makes old age a dilemma. As stated by Billig et al., "to experience dilemma is to live out an opposition, so that one is divided upon it in the failure to achieve a resolution" (1988:91). Our thinking about old age is dilemmatic by nature.

What does this dilemma consist of? Through the necessity repertoire, old age is constructed as an external inevitable fact; that is, it is considered nobody's fault that old age means deterioration. The interviewees are, in this way, able to provide an explanation for why they no longer do as much as they used to do, why older people, in general, are dependent on others and entitled to get help, and why they have a social right to be ill or frail (Giles and Coupland 1991). However, acceptance of these kinds of social privileges does involve certain social risks such as being categorized as helpless and dependent, losing full authority, and being defined as a person solely through one characteristic (i.e., that of physical competence).

When one defines oneself as independent and self-reliant, it is possible to preserve or restore full authority and to demand that one is treated as "accountable" (Shotter 1993). However, to be able to do that, one has to take distance from the other old—the sick and the frail—otherwise, one has no credibility. But this also involves the risk of losing the right to expect and demand help from others and to appeal to physical incompetence. Furthermore, it might sound unrealistic to totally deny physical impairment. According to Billig (1987), the speaker may meet with resistance if the common ground—the view of old age as deterioration—is not established. In addition, to emphasize independence and self-reliance places a moral burden on the individual to take care of oneself and to cope on one's own, and makes failure to do so a failure of the individual. Accordingly, being forced to rely on the help of other people may raise doubts that perhaps one has not tried "hard enough."

As we saw in our data, the interviewees also had to admit that they were not as "fit" as they used to be and were therefore at risk of losing their full authority.

One way in which they proved they were "worthy individuals" (Radley and Billig 1996:221) and accountable persons was to connect themselves with "work" and thus to the sphere of "normal" adults. It has been suggested that both working and coping on one's own have been highly esteemed in Finnish culture, at least among older generations (Roos 1987; Kukkonen 1993; Kortteinen 1992). Similar features may be seen in other cultures as well (e.g., Williams 1990). Our interviewees sought to preserve their accountability by describing their everyday chores as work or demonstrating how they had overcome their difficulties, even in the face of physical impairment. Stories of walking down to the pharmacist's or cleaning the house in spite of all the pain and all the difficulties demonstrated that one can cope on one's own and/or that one is at least trying and not giving in "too easily."

In conclusion, old age is an ideological dilemma. It is important to consider the dilemmatic nature of the experience of old age because it frees us from the hopeless task of trying to find the "right" definition of old age. However, to talk about old age in terms of a dilemma does not mean that we cannot discuss and challenge the prevailing cultural picture of older people.

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II

Moral argumentation in talk about health and old age

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ABSTRACT This study examines the ways in which people aged 90 or over construct and negotiate meanings of health in research interviews. Detailed analyses of two interview cases illustrate the flow of these negotiations within interviews, and how the interviewees balance different moral arguments. First, the interviewees try to manage the face-threat posed by the questioning about health. Second, their health accounts move on the axis of advocating good health and activity and conceding impaired health and diminished activity. They apply various rhetorical devices to challenge the traditional discourse of old age as decline. On the other hand, aligning oneself with the category of 'old' makes ill-health and inactivity legitimate, but brings along other kinds of moral obligations. Finally, the results are discussed in relation to cultural discourses of old age and health, and their moral implications.

KEYWORDS *discourse analysis; health; morality; old age; social constructionism*

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Introduction

The major demographic trend in western societies is the ageing of the population; in particular, the number of the oldest-old is growing very rapidly. Old age does not equate to illness, but chronic disease and frailty do increase with advancing age. At the same time, a strong body of research speaks for the increasing importance of health, bodily being and performance in contemporary western societies (Crawford, 1994; Radley, 1994; Turner, 1995). Indeed, one might argue that health has become something

of a 'key word' that is used for defining not only well-being, but the 'goodness' of individuals and society (Crawford, 1994: 1349). The traditional discourse of old age which makes ill-health in old age legitimate and expected is still strong, but it has been suggested that, in western cultures, this discourse is now giving way to the discourses of activity (Herzlich and Pierret, 1987; Featherstone and Hepworth, 1995; Katz, 2000) and 'healthism' (Crawford, 1980) which emphasize individual responsibility and effort. Furthermore, in popular representations the ideal of 'positive ageing' represents people who live long without visible signs of old age (Featherstone and Hepworth, 1995). All this means that ill-health in old age can, paradoxically, be seen at once as normal and natural, pathological and even as a sign of lacking will-power or having a wrong lifestyle.

Several studies of so-called lay beliefs have shown the interconnectedness of morality and health in the talk of 'ordinary' people (see, for example, Cornwell, 1984; Herzlich and Pierret, 1987; Backett, 1992; Blaxter, 1997). In Rory Williams' (1990) influential research on Aberdonian older people, good health was seen as a reward for a modest and virtuous life. Williams traced the ideological roots of this view to the meta-narrative of Protestant ethics. In his case study of 64-year-old women suffering from rheumatoid arthritis, Gareth Williams (1993) showed how coping with chronic illness and ageing could be seen as one way of pursuing the virtues of independence in self-care, cleanliness and solvency. Although people do not necessarily consider themselves responsible for serious illnesses, their failure to recover or to resist the adverse effects of illnesses may be 'attributed to either lack of motivation or a defective will' (Pollock, 1993: 53).

The present article differs from many earlier studies of lay health beliefs and health surveys through its emphasis on interaction and context. Situated and interactional factors of health talk are often neglected in studies of lay health beliefs; in health surveys they remain excluded by necessity (for a criticism, see Blaxter, 1997). This study applies a constructionist and discursive perspective for purposes of examining health talk in the context of research interviews. The constructionist perspective adopted here implies a reflexive view of cultural imagery and interpretive activity. Cultural images or discourses do not determine people's thinking, but offer a 'vocabulary' of concepts and images with which to think about ageing and health. In discussing their everyday life, people use cultural discourses and negotiate their meanings (Gubrium et al., 1994). The practical task of this article is to try to find out how people who have reached extreme old age talk about health in research interviews, what meanings health and old age receive in their own talk and how these two relate to each other.

Discursive perspective on health and old age

The growing body of discursive studies in ageing research has shown that the relation between old age and ill-health is routinely evoked in people's

talk. However, detailed studies of *how* age-related arguments are used in talk have also revealed *both* the ambiguous and the contextual nature of this relation. In the talk of old people themselves, disclosures of chronological age were used in accounts of ill-health as an adequate explanation of frailty, and on the other hand the association between old age and ill-health was invoked in order to dissociate oneself from it (Coupland et al., 1989; see also Jolanki et al., 2000). Not only old people, but younger people as well use age disclosures to align themselves with a certain age category, but also to dissociate themselves from normative age categories. In a study of the ways that people in their 50s discussed age categories (Nikander, 2002), the idea of ageing as self-evident physical decay appeared more or less routinely, as did the idea of the need to act one's age, but also to remain youthful and resist ageing. Nikander's study explicitly addressed the morality of age order, and showed how aligning oneself with an age group, or dissociating oneself from what others may consider the 'proper' age group, is moral activity (Nikander, 2002).

The research interview presents a special context for health talk (Backett, 1992; Blaxter, 1997). Talking about one's own health in such a context may be particularly challenging, since a truthful account is expected, but on the other hand unloading personal medical troubles can be face-threatening to both parties (Coupland et al., 1992). In discussions between doctors and elderly patients (Coupland et al., 1994), even the simple opening question '*How are you?*' was interpreted in many ways. Respondents had to prioritize disparate considerations: the need to present a version of 'how they are', which is adequately truthful and disclosive for the moment; but also the need to respect the current relationship and minimize threats and intrusiveness (Coupland et al., 1994: 119). Thus talk about health can be seen as one form of facework.

The idea of health talk as facework raises two important issues. First, people's health status can be seen as negotiated interactional achievement. Second, the attention in researching health focuses on the morality of health talk. Both these perspectives are highlighted in the study by Coupland and Coupland on ageism and anti-ageism in the talk of doctors and elderly patients (1999). Doctors balanced between conveying the anti-ageist ideology of modern geriatrics and the idea that patients can and perhaps should take responsibility for the maintenance of their good health and well-being. In order to do that, doctors had to challenge the 'self-disenfranchising' statements of elderly patients and argue that better health is achievable in spite of advancing age. However, this required entering the arena of patients' own control and experience, which may constitute a face-threat for both parties. Patients, for their part, used age-disclosures to legitimize ill-health, or to resist the need to change their behaviour and 'normative regimens for good health' (Coupland and Coupland, 1999: 202). Accordingly, both doctors and patients engaged in a balancing act between different moral arguments and negotiating their relevance and value.

Research questions

The approach to health adopted here is grounded in the view that,

> accounts of health and illness are . . . more than descriptions of one's physical condition and more than views about what people in society should do to avoid disease. They also articulate a person's situation in the world and, indeed articulate that world, in which the individual will be held accountable to others. (Radley and Billig, 1996: 221)

In contrast to more common ways of studying morality, the focus here is on the practical interaction in which moral arguments are used. The central idea of this approach is to gain access to the actual practices in which morality comes to life (Jayuusi, 1991), which here meant studying whether and how notions of health and old age are constructed as moral matters, and what kind of arguments could be interpreted as moral.

This article aims to look more closely at the research interview as a context for health talk, and health talk as interactional achievement. More specifically, the main concern in the narrative interviews with people aged 90 or over is with the questions of (a) how the interviewees responded to the interviewers' questions about their present health status, and on the other hand talked about it spontaneously; (b) how the interviewees talked about old age when giving accounts of their own health; and (c) what kind of moral arguments they used in health talk. Two interview cases are analysed in closer detail in order to illustrate the interaction between interviewer and interviewee, the flow of the interpretive processes within interviews and how the respondents balance between different moral arguments.

Data context

The data come from 250 narrative interviews (184 women, 66 men) carried out in Tampere, southern Finland, as part of the Vitality 90+ project in 1995–6 (Jylhä and Hervonen, 1999). The respondents were recruited by mailing a questionnaire to all community-dwelling people aged 90+ in the area, and contacting those who gave their consent to take part in a personal interview. The interviews were conducted by young and middle-aged female interviewers with a training in health care or the social sciences. Most respondents lived more or less independently in their own homes; some were in service housing or in nursing homes. All interviews were tape-recorded and transcribed, running from a few pages to dozens of pages each. Most interviewees were asked to begin by telling their life story, from their childhood onwards; follow-up questions on predefined topics, one of which was health, were asked later on. However, the course of the interviews varied and, in most interviews, sections of free biographical narration alternate with questions; hence their heterogeneity. Health talk was both self-initiated in biographical narration and prompted by the interviewer's questions concerning the respondent's present health. The interviewer

would usually ask: 'What is your health like?', and then proceed to more specific questions about illnesses and bodily symptoms, reasons for good health, exercise, diet and daily routines. Often, these issues would be discussed in the context of the respondent's life history as a whole.

For the purposes of qualitative analysis, it was necessary to reduce the amount of data generated by the interviews. The first step was to identify different themes concerning factors affecting one's health. These themes were divided into two categories: those concerning action taken by oneself (such as diet, exercise, mental stance), and those concerning external factors (such as old age, constitution and genes, environmental and transcendental factors, modern medicine). Earlier studies of lay health beliefs have shown that these themes occur frequently in lay health talk. Here this procedure was aimed at gaining as broad coverage as possible of the variation of health talk. Because of the amount of data involved, the analysis at this level remained rather crude.

In total, 40 interviews were singled out (20 women, 20 men) for more detailed analysis. There were marked differences between the respondents in terms of how much emphasis they placed upon depicting themselves as basically 'healthy' or as having problems with their health. The interviews were selected with a specific view to covering this variation. In addition, they were to include disclosures of old age. The respondents both dissociated themselves from old age, and used it as an explanation for their ill-health. This selection process is part of the analysis itself. Finally, two interview cases were chosen for more detailed presentation here. These two cases exemplify the variation between depicting oneself as healthy and competent vs. conceding that one has health troubles and defining oneself as old. These cases cannot provide an exhaustive analysis of the respondents' arguments (moral or otherwise), but they do highlight some key elements of health talk and moral argumentation as they appear in these interviews.

Analysis

Radley and Billig remind us about the limitations of focusing upon the discourse alone, pointing out that interview talk 'proceeds as part of a relationship that is situated in time and place' (1996: 235). Health in old people is most typically approached in what may be described as 'trouble-oriented' contexts (medical or other health care settings), but the context here is somewhat different. In this dataset, the life story frames health talk, and the respondents were included in the analysis specifically by virtue of their exceptionally high age. The original mailed survey (see Jylhä and Hervonen, 1999) approached all people aged 90 or over in the region concerned, whereas most of the respondents in the biographical interviews were a rather select group of people and exceptional even in the context of their own age group: most of them still lived alone and were relatively

independent. In other words, age and health were made salient issues about the respondents in advance, before the interview situations. Old age is traditionally equated with illness, and the interviews were conducted by interviewers who were considerably younger (in their 30s and 40s) than the interviewees, and doing their work as interviewers, and questioning the health of the interviewees. In other words, the research interviews involved dilemmatic ideological elements (Radley and Billig, 1996).

The constructionistic perspective as outlined by Gubrium et al. (1994) leans towards rhetorical analysis and has the idea that alternative versions of reality constructed in talk compete with one another, which means that interpretive activity must be persuasive if a particular version is to be validated. Regardless of whether persuasion is consciously intended, descriptions of reality are implicitly rhetorical because 'words advocate as much as convey particular versions of reality' (Gubrium et al., 1994: 48). Consequently, some ideas deriving from argumentation analysis (Billig, 1987) are also applied in the analysis. A key notion is that of the 'common-places' of a certain language. This implies that not just anything can be said about old age, health or oneself in a certain culture. This is because some things are considered accountable, natural and self-evident, while others are not. Also, this perspective emphasizes the two-sidedness of thinking; that is, different versions of reality are not only constructed to argue for something, but they are always also explicitly or implicitly against alternatives (Billig, 1987).

Health talk is not only about rendering factual accounts of one's physical condition but also about explaining and justifying one's behaviour, defining oneself and proving that one is a 'worthy' person, which makes health talk a potentially delicate issue. Interactionist research has found that some rhetorical devices signal that the issue at hand is somehow delicate and controversial. One way to convince others of the truthfulness of speakers' claims is to show that the account given is based on a factual depiction of what 'really happened'. Extreme-case formulations (Pomerantz, 1986) and detailed accounts are both used commonly for purposes of constructing the factuality of talk (Edwards and Potter, 1992). According to Antaki and Wetherell (1999), conversational three-part position–concession–reprise structure is used in talk to bolster the speaker's claims against counter-arguments and to achieve a certain kind of rhetorical effect. The central idea of this structure is that by conceding something in the counter-argument, the speaker is able to enforce the original proposition, which others may see as disputable or challengeable. These rhetorical devices appeared very frequently in my data, and I was specifically interested to find out how they were used for purposes of advocating one's own arguments, and how through these arguments health talk became constructed as a moral matter.

All names and other potentially identifying information have been changed. Where the three-part concessionary structure is used, the beginning of the propositions and reprises are marked with italics, and

concessionary markers are shown in bold. Omitted talk is indicated with three dots.

'I never sleep during the daytime'

Liisa Mattila, 92, described herself as someone who was *born* strong and strong-minded, and told how these inborn qualities of strength were further reinforced by her early years of hard work in the countryside. She then proceeded to talk about her past and present illnesses, but stressed that she had now overcome them or had learned to cope with them; she was now 'fit as a fiddle'. The interviewer therefore did not ask the question about health status at all, which was not uncommon since the interviewees often began to talk about their health spontaneously. After her account of life in the countryside, Liisa went on to talk about her later life and factory work.

Extract 1

1 L: It's been a hard life all through really, but I've thankfully accepted all of it, I
2 mean *I've been healthy* and it's a great gift, isn't it? I mean even there (in the
3 workplace) so many of them were always on sick leave . . . I was never ill and the
4 others were always, I don't know if they were all that sick but they didn't want to
5 work. *I've had the strength to work*. And Taina, my brother's daughter, she can testify
6 to this, I do all the cleaning here, I even take the rugs out to be aired and the linen and
7 everything, I wash my own clothes so *I mean even now I have strength*. Taina can
8 testify that I'm not lying one bit here, it's all true. What else can I add? I don't know
9 really. **Except that** I have this cholesterol and blood pressure, *but even they don't*
10 *bother me*.

This extract provides an illustration of the way health talk becomes intertwined with talk about past and present everyday life. Liisa's claim '*I've been healthy*' (line 2) is the initial proposition, which is followed by the concession of problems with her cholesterol level and blood pressure (lines 9–10). The closure for the whole section of talk comes with the reprise of the initial proposition, 'but even they don't bother me' (line 9). In addition to this structure, at least two reformulations of the initial proposition (line 5 'I've had . . .' and line 7 'I mean . . .') can be distinguished. The rhetorical effect of Liisa's talk is that she is still healthy, active and is managing on her own. Being healthy is reformulated as having had the strength to work, and still having enough strength to do the chores at home.

Liisa's concession that she has some health problems serves to make her

argument of her overall health and ability more plausible. But she also uses other devices to support her claim. She introduces into her talk an outside witness in the shape of her brother's daughter (who is also present), gives a detailed account of her daily activities and uses various extreme-case formulations (all the cleaning, even, everything). Especially with the extreme formulation 'Taina can testify that I'm not lying one bit here, it's all true', Liisa is making a very strong statement indeed, as if she were a witness in court. Implicitly, Liisa is conceding that her being so healthy and so able is legitimately in doubt and that she needs to make a strong case to ward off any doubts. The temporal modifier 'even now' marks her talk as age-relevant, and the small word 'even' constructs Liisa's action as extraordinary when set against her age. Thus the 'testimony' is age-related. This kind of 'good for one's age' talk allows Liisa to claim credit *against* normative expectations of frailty (Coupland et al., 1989). However, the extract shows how much argumentation work is required to challenge this 'common-place' of old age (Billig, 1987).

An important dimension of morality here is that Liisa's talk about 'testifying' and truth points at the importance of telling the truth. Liisa is clearly oriented to the situation as something particular, that is as a research interview characterized by asymmetrical power relations between the participants and by specific requirements for interaction.

Another moral dimension concerns the origin of good health. Liisa dissociates herself from other people who do not have her good health, strength and will to work; this could be heard as self-praising and judgemental talk. The voice of an outside witness and the detailed account of her day serve as ways of demonstrating that her talk is not in fact self-praising, but rather depicts a factual state of affairs. Condemnatory talk about other people's behaviour is also alleviated here by the explanation that her own health is a gift and a matter of personal constitution, not something of her own doing.

The following excerpt illustrates how Liisa answers the question about social activities, which in these interviews was often interpreted as a health issue: the respondents' ability to participate in activities outside the home emerged as a central element in defining health.

Extract 2

1 I: So what about nowadays, do you go out at all?
2 L: Well, not really, I do sometimes go to these clubs. Once a week I go to town when
3 Taina comes along. She's afraid that I may fall over so she carries my shopping bag. I
4 haven't gone out, *I like to be out here and do what I do here and stay healthy.* **What**
5 with my legs I can't really move around all that much anymore, *but I can still keep*

6 *my home nice and tidy*. Every day I go around and do things, I sit down only for a
7 short while, I never sleep during the daytime, I sit down only for a short while and
8 then I think of something again and then I'm off again.

In the previous extract, Liisa made a point of emphasizing her health and activity, but here she gives a negative answer to the question of going out. This could threaten her 'face' and undermine everything she said previously of herself, especially when she admitted that there is a risk she might fall. Liisa postpones her answer (line 2 'Well'), which indicates that her answer is going to be negative. However, she softens her answer by concessions (line 2): 'I do sometimes' . . . 'once a week . . .'. Here, concessions have the rhetorical effect of agreeing with the interviewer, and looking for a 'positive' answer to the question (Antaki and Wetherell, 1999: 11), even though the answer in the end is in the negative.

My interpretation is that Liisa took the question to imply the interrelatedness of health, going out and participating in social activities, in which case a negative answer would undermine her earlier talk. However, her proposition (line 4) 'I like to be out here . . .' reformulates the central issue of the question: the reason why she has retained her health is precisely that she stays at home. Liisa concedes (lines 4 and 5 'What with my legs . . .') that she is restricted in what she can do on account of her legs, but only in the world outside. The contrasting marker 'but' (line 5) marks the beginning of her reprise in which the initial proposition is now reformulated as the ability to look after one's home, and further elaborated.

The rhetorical effect of her talk is that in spite of her difficulties, Liisa is capable of looking after her home and is an active and 'mobile' person. The use of various extreme formulations (temporal modifiers: every day, never sleep, repeated temporal modifier: only for a short while, referral to repeated action: off again) and the detailed account further support her claims against doubts. If we consider the claim that talk is always used to undermine contrasting (implicit or explicit) views as well as to argue for something (Billig, 1987), then the detailed depiction of Liisa's activities both here and in Extract 1 gives by contrast a picture of what is considered a normal day for ordinary old people. Furthermore, Liisa becomes constructed as different from those ordinary people. Liisa's body is indeed a 'busy body' (Katz, 2000), and thus she is implicitly claiming that she has the moral high ground over 'inactive' others.

Keeping oneself occupied, being an active and outgoing person was often contrasted in these interviews with being idle, sitting around or sleeping during the daytime. 'Activity' was considered both to generate health and to indicate it, and presented implicitly or explicitly as the preferable option. In Liisa's case this activity ideal was reformulated to mean being able to do her home chores. Her argument can be seen as a gender-specific moral

argument. Being *still* able to look after one's home is perhaps a special standard of ability and activity for women, but also indicative of women's duties. Liisa's talk here, as well as in Extract 1, can be seen as an attempt to give evidence that she can still fulfil the standards as well as her duties. By providing a detailed list of her daily activities, I suggest, Liisa is both demonstrating her ability to the interviewer and constructing herself as a worthy person in society (Radley and Billig, 1996: 221).

When the interviewer asked Liisa whether she goes out every day, she once again produced a detailed account in reply. It is important to note here that, in the original Finnish question (*liikutteko* te tuolla ulkona joka päivä?) the verb *liikutteko* refers to both *going out* and *exercising*.

Extract 3

1 I: Do you go out every day then?
2 L: Well, *I do go out to some extent* **but not a lot**. **I mean** with all the rain there's been,
3 *but I mean I did go out yesterday to the canteen*, to pick up some milk and oat flakes.
4 But I shouldn't really bring in too much food, because of the kind of food they've got
5 there. I'm supposed to do my own cooking, what with my cholesterol levels. I make
6 my own porridge every morning and then after a while I take my pills, in the daytime
7 I make lunch, in the afternoon I sometimes have a cup of coffee black and without
8 sugar and cream, and then in the evening a light snack. Because I'm not allowed to
9 put on any weight, you tend to put on weight when you just sit around. But my right
10 knee has gone. It often seizes up on me and I don't really dare to go out all that much.
11 I have to be careful. I can't get anywhere then, it's sore for days on end. *Often when*
12 *it's raining and I walk from this room to that room over there*, that's good for the
13 circulation.

The question is so worded that it can be interpreted as age-related, as implying that the interviewer is expecting the opposite will be more likely, but also as including a moral imperative that Liisa should be going out every day. A seemingly neutral question is not in fact neutral at all, but prompts Liisa to give a detailed account of her day and detailed explanations as to why she no longer can go out very much. After some hesitation (line 2 'Well'), Liisa makes the proposition that she does go out to some extent, even though she immediately concedes *but not a lot* (line 2), which again is immediately qualified with the referral to bad weather as a legitimate excuse. The initial proposition is reprised (line 3 'but I mean . . .')

through an example that describes her going out the previous day. Another reprise is the closing remark about how she often walks in the house when it is raining (lines 11–13).

Rhetorically, Liisa's talk depicts her as someone who conscientiously looks after her health, and is keen to do 'the right thing': to exercise, to follow her diet and control her weight, in spite of various constraints, the damp weather or her bad knee. Detailed information on her daily routines (lines 3–9) lends evidence to the idea of her as a person who leads an orderly life and who by following a strict diet tries to regulate her body as well. It has been suggested that the rationalization of life and the regulation of body by means of dietary restrictions are among the key elements of life in modern western societies (Turner, 1987, 1991), and Liisa's talk certainly echoes these discourses. Furthermore, Liisa's talk about her 'cholesterol level' and 'circulation' provides a clear illustration of how medical concepts have penetrated everyday language and how the body is now increasingly conceptualized through medical categories (Turner, 1987).

Liisa's remark '*Because I'm not allowed to put on any weight*' (lines 8–9) sets off a chain of argumentation in which Liisa justifies her behaviour against the silent doubt that she has put on weight because of what she has been eating and because she has not taken enough exercise. Liisa had raised her cholesterol level (Extract 1) and also weight as a topic of conversation earlier on in the interview (omitted here). She said that she had been 'too fat' and described how after retiring she had lost 20 kg in one year, after being told to do so by her doctor. Here, indirectly, she concedes that she has gained weight, but the use of the third person (line 9 'you tend to' . . . 'you just sit around') distances the matter at hand from her personally and implies that it is normal for anyone in that situation to put on weight. However, the same sentence indirectly implies that Liisa 'just sits around' as opposed to her earlier talk. Clearly, this calls for an explanation. The subsequent talk is full of extreme formulations (line 10 'my . . . knee has gone . . . often seizes up . . . don't really dare . . . all that much', line 11 'can't get anywhere . . . sore for days on end'), which serve to prove that the problems with her right knee are real and severe.

We can also hear that Liisa is balancing between different risks, and is keen to show that instead of being lazy or unable to control her weight, she is only being *careful* (line 11) in trying to avoid unnecessary risks. Therefore, she is only being rational. To say *I can't get anywhere then; it's sore for days on end*, is obviously a powerful argument against the foolishness of putting herself under too much strain. Thus, morality and rationality are closely intertwined here, and in order to prove one is morally accountable, one had to prove one's rationality (Jayuusi, 1991). In addition, Liisa again limits the scope of her health problems when she creates the contrast between the risky outer world (line 10 'don't really dare to go out', line 12 'raining') and her own home (line 12 'I walk from this room to that room . . .') where she stays healthy.

'I'm beginning to get old; I need my rest'

In the following interview the emphasis of health talk was not so much on testifying for one's ability than on 'conceding change' in one's health (Nikander, 2002). The talk of Anna Nieminen, 91, was largely about making a distinction between her past and present identity, which she did by constructing herself as a good worker and active outgoing person, but by locating all that to the past and saying that she no longer is 'the same'. When Anna talked about her present life, she explicitly aligned herself with the category of the old. After her description of what her childhood was like, Anna moves on to talk about her present life and about the day hospital she visits once a week.

Extract 4

1 A: But what I've been doing there is a rhythm that I've been sleeping there, because
2 they've got these rooms there, I've slept in the daytime maybe an hour or something.
3 I'm beginning to get old; I need my rest. *And I'm not, like I said, I'm in no trouble*. **It**
4 **was** just over 12 months ago that I had this small blood clot. *But* it passed, **although** I
5 almost lost this leg and really most of the right side is pretty bad [talk about hospital
6 visit]. *But* I can walk alright, I don't necessarily need my cane, **but of course** it tires
7 more easily. I don't have the energy and I can't walk long distances anyway. But this
8 hand it's a bit sort of, it can't cope with all these jobs, and it begins to hurt up here
9 and then [unclear] *but nevertheless* it does move, and **my eyesight, that's slowly**
10 **going now**.

Anna's talk about sleeping in the daytime is marked as delicate and potentially blameworthy by her mitigating the duration of her daytime nap (maybe an hour or something). In addition, her statement 'I'm beginning to get old' (line 3) serves as a self-evident reason for Anna's need for rest and no further warrant is needed. This is a good example of how 'commonplaces' operate in talk (Billig, 1987). Thus sleeping during the daytime is constructed as a normal and *necessary* part of the day of old people, i.e. justified, in sharp contrast to the talk in Liisa Mattila's interview.

The claim that 'I'm in no trouble' (line 3) can be seen as a proposition Anna wants to make to qualify the seriousness of her health problems, and it can be seen also as corrective face-work. Anna's talk can be compared to what Radley and Billig have called 'being all right-talk', which they see as a strategy of retaining privacy after revealing health troubles (1996). It is followed by an argumentation chain in which Anna moves back and forth,

conceding that her health has deteriorated (lines 3–4 'It was . . .', lines 4–5 'although I almost lost this leg . . .', line 6 'but of course it tires . . .') and qualifying its effects on her life (line 4 'but it passed', line 6 'but I can walk alright . . .', line 9 'but nevertheless it does move . . .'). Concessions of the effects of the stroke she had suffered, difficulties with her hand and worsening eyesight depict the process of ageing. However the rhetorical effect of Anna's talk is that *she* is in no trouble, even though her body suffers from ailments. This could be seen as one version of the idea that old people may depict the ageing body as a mask that hides their youthful mind (Featherstone and Hepworth, 1991), an idea that reproduces the ancient mind/body dichotomy. The important point is to note that through this kind of talk, Anna is able to alleviate the face-threat posed by talking about her health. Anna's emphasis that she does not necessarily need her cane (line 6), is another way to mitigate the face-threat. Since the cane is one of the physical objects that outwardly symbolizes old age, this serves to distance her from old age.

As in Liisa's case, being able and willing to work was often depicted in these interviews as a measure of health as well as an outward indication of health. When Anna says her hand 'can't cope with all these jobs' (line 8), she is implicitly saying that it is not her fault that she cannot do all jobs. This also serves to reproduce the old mind/body dichotomy, which allows her to dissociate herself from her 'failed' body (Turner, 1991). Earlier research has shown the interconnectedness of health, work and morality (Turner, 1987; Williams, 1990; Radley and Billig, 1996) in western Protestant societies. The data analysed here also echo the ideas that to be healthy is to be able to work, while not working, and especially not wanting to work, seriously questions a person's social worth.

Disclosures of old age are a common way to legitimize ill-health (Coupland et al., 1989; Jolanki et al., 2000), and also to resist the need to change one's behaviour in the talk of old people themselves (Coupland and Coupland, 1999). In Anna's talk we see how illnesses and the gradual loss of the senses are depicted as external facts that just happen, for no other reason than advancing age. The reference to old age overrides all possibilities of choosing one's behaviour or action, and thus removes any moral blame.

Anna then proceeds to elaborate on the issue of her deteriorating eyesight and hearing and other 'effects' of old age.

Extract 5

1 A: But uhm, yes what I was going to say about that was that my senses, they're
2 beginning to, I mean I do still recognize people, but it's not at all as if I were the
3 same. I can't remember people. Faces I may recognize, some I may even remember
4 some way, but it's rarely I remember a name. Even though they've been like close

5 friends. We were at the 80th birthday party of one of my sisters, and there were these
6 people there who'd been since childhood. I said don't you be too surprised if I can't
7 remember all your names. But I knew from their eyes many of them that I know this
8 person, but what was that name now? . . . Oh, I mean, this life has been quite a complex
9 thing, but I suppose it's getting towards the end of it. I'll be 91 in November, if I live
10 that long.

Here Anna concedes again that ageing has had effects on her body. Her talk that moves back and forth between concessions, evaluations and qualifications (marked with the contrasting marker 'but'), and extreme-case formulations show how delicate an issue it is to confess to having trouble with one's cognitive skills, i.e. with memory. Failure to recognize other people, especially in public, threatens one's face in several ways. Politeness requires remembering people's names, especially if they are old friends. Confessing to difficulties with one's memory will easily cast doubts on the cognitive capacities of old people, since the suspicion of dementia is always there looming in the background. Interestingly enough, Anna still uses extreme-case formulations to emphasize the seriousness of her memory problems (few, even good friends, even from childhood). However, these doubts are mitigated by admitting she has trouble only remembering *names*, not *people*.

Anna's story about her failing body does two things here. It shows, first, that bodily performance is indeed a social action, which defines Anna's position among her social circles. Paradoxically, however, by showing that she is aware of her problems, she is also proving her competence to assess her own condition and mitigating the seriousness of her problems. This is shown at the very beginning (lines 2–3) by saying that she is not *the same* as she used to be. What I am suggesting is that to say that someone is not herself/himself any more is a way of exempting that person of moral blame. Through a disclosure of chronological age (line 9) and temporal framing (line 6 'since childhood . . .', line 5 'at the 80th birthday . . .'), Anna 'makes age salient' (Coupland et al., 1991) in relation to her health. She aligns herself with the group of old people whose life is coming to an end, which provides a self-evident reason for her condition.

Once Anna had told about her family life and the death of her husband, the interviewer proceeded to ask about her own health.

Extract 6

1 I: So what about your own health at the moment then?
2 A: Well *it's pretty good*. I have to say I'm reasonably happy, nothing really. **I mean**

3 they do have to keep me steady when we're out and about, I tend to be a bit unsteady
4 when I'm out. *But I mean* I think I've managed pretty well really.
5 I: Well, how have you looked after this health of yours?
6 A: Well, nothing special really. I've just tried to do the odd job, just to keep myself
7 occupied and then kept in touch with people as much as possible. If it continues too
8 long, I tend to get down. I mean I've always been the kind of nature that's happy and
9 mobile. When I was younger, I could never stay still for very long and I was always
10 coming and going whenever possible. You have had to I'm not saying that, but
11 you've had to. [Anna goes on to talk about injuring her knee]

The propositionary material consists of Anna's claim that her health is *pretty good* (line 2). The following evaluation and especially the extreme-case formulation *nothing really* might be contested as unrealistic on the basis of all that has been said before. However, the concession (line 2 'I mean . . .') that she needs help when she's 'out and about', goes to show that she was being realistic. The concession none the less supports her claim since the need for help is limited to certain situations, and is further alleviated by the mitigating expression 'tend to . . . a bit unsteady' (line 3). Rhetorically, Anna's talk creates the effect that 'health' is an issue that has to do with more than just bodily state, and the standard of health is the inner mental state of being *happy* with one's life, and *managing well*, as the reprise of the initial proposition (line 4) argues.

Anna's 'message' needs to be interpreted in the context of her concession. She concedes that she has lost control of her body, at least to the extent that she needs other people to keep her steady. In the previous extract she spoke of her memory troubles. As Featherstone and Hepworth (1991) have stated, being able to control oneself cognitively, bodily and emotionally is required to achieve the status of adult, and losing bodily control and cognitive skills produces the danger of social unacceptability, and losing that status. As a result, old people may not receive moral reprehension, but might be assigned a child-like patronized status. Both Anna, and Liisa (lines 3–5 in Liisa's Extract 2) are balancing between conceding some changes in their health status and mitigating the threat to their adult status, and advocating a positive self-image.

The interviewer's second question (Extract 6, line 5) includes both a moral imperative to look after one's health and the assumption that this is clearly what Anna has been doing. It was very rarely that the worth of self-care was openly denied, even though the interviewees did sometimes evade the question or postpone their answer, as Anna does here. In the subsequent utterance, Anna redefines the question to mean whether she has kept herself occupied, and whether she has taken part in social activities (lines

6–7). Anna's confession that she tends 'to get down' (line 8) implies trouble with her mental well-being. Mental health issues were rarely mentioned in these interviews, and when they were it was usually in a veiled and vague manner and qualified later on, as Anna does by referring to her 'happy and mobile' nature (lines 8–10). We can hear Anna defending herself against the implicit doubt that she may not have kept herself occupied enough, nor been socially active, which has caused her to 'get down'. To be 'active' socially and physically is clearly presented as the preferable option. Thus an implicit moral argument is present here: one should be 'happy, mobile, and socially active', since that is conducive to good health and provides protection against depression. Extreme formulations (line 7 'as much as possible', line 8 'always', line 9 'never stay', lines 9–10 ' always coming and going whenever possible') lend evidence to Anna's argument that she has been as active as possible. Temporal framing, i.e. the distinction between her younger (line 9) and present self, and the use of the second person (line 10 'you have had to'), once again creates her situation as a self-evident result of old age, and as a legitimate part of the normal life course.

Discussion

The aim of this study was to examine the ways in which people aged 90 or over constructed and negotiated meanings of health during the course of research interviews. The main focus was on dimensions of morality in health talk. Instead of one morality, it is indeed more appropriate to talk about different dimensions of morality. The themes discussed through the two interview cases selected for closer analysis here were also central to the original dataset of 40 interviews. These two cases were selected with a view to highlighting the nature of health as a processual and contextual issue rather than something fixed and unambiguous. Different and partly overlapping meanings evolved for health in the course of one and the same interview. The definition that one was entirely healthy could be followed by accounts of health troubles, and accounts of health troubles did not prevent the respondents from defining themselves as healthy. Detailed analysis also revealed the rhetorical nature of health talk, in which the respondents not only depicted factual states, but advocated arguments and managed the face-threat posed by questioning health. The following discussion outlines the main elements of moral argumentation and examines the results in relation to research and cultural representations of old age and health.

When asked about health, the interviewees indeed 'articulated their situation in the world, and in fact the world' (Radley and Billig, 1996: 221). The respondents constructed and negotiated meanings of health in relation to the context of the research interview, social identity, bodily experiences and past and present lives. They oriented themselves to the interview

situation, as one that involved asymmetrical power relations and that required them to give honest and truthful accounts of their health.

Physical and social activity and the ability to do things were constructed in the interviews as constitutive of good health and as an outward indication of good health. This kind of 'activity talk' concerned not only keeping oneself busy by doing home chores, engaging in leisure activities, meeting other people and participating in social activities outside the home, but in general showing an active and positive stance to life. Avowals of activity and ability were often related to, and partly overlapped with 'self-care talk'. Yet, self-care talk was more about caring and controlling the corporeal body, which refers to exercising and having a balanced diet, but also controlling one's mind and adopting a positive stance to adversities. There are various different moral dimensions to activity and self-care talk. Being active clearly emerged as preferable to the option of being 'inactive'. If the respondents made confessions, for instance said that they slept during the daytime or remained mainly indoors, they clearly felt that this called for some justification.

When asked whether and how they looked after their health, the interviewees hardly ever openly questioned the relevance of the question, or denied the importance of looking after one's health. Instead, they might try to evade the question or reformulate its contents. If they were not in the position to give a positive answer, the respondents would go to some lengths to prove that they were trying or had tried to look after their health to the best of their abilities. Activity and self-care talk can be seen to echo western cultural ideals of activity and keeping oneself busy (Katz, 2000), and the preference for regulated life/body in contrast to body and life without order (Turner, 1991, 1995).

In short, health talk was about whether or not one can do something about one's health. Activity and self-care talk was very much built around the idea of health as a matter of choice. By advocating the idea of choice, it is possible to regain one's agency and construct oneself as an agent rather than a victim of fate. But this also means that health becomes a matter of individual decision making and responsibility. In other words, even if one cannot choose to be healthy, one can choose to strive to be active, preserve one's ability and look after one's health. This way of thinking does not do away with idea of old age as decline, but advocates that one can choose not to give in to old age. In this sense inactivity, inability and ill-health become the signs of old age, which can become constructed as a sign of moral laxitude (Featherstone, 1991).

The idea of health as a result of individual choices may also lead to 'moralizing' talk concerning the rightness of one's own behaviour, and claiming the moral high ground over inactive others whose stance to life or lifestyle is wrong. This kind of potentially judgemental talk can also be turned against the speaker, however. In this dataset the respondents downplayed any potential self-praising or judgemental talk by constructing

themselves as a special case and as different from ordinary old people, or their own health as a gift or a matter of constitution.

When arguing for their ability, activity and being healthy, the respondents backed up these arguments by detailed accounts, different extreme-case formulations and three-part concessionary structure. The former two are devices commonly used by speakers who are trying to prove that they are merely depicting what 'really happened', i.e. giving an impartial factual account of the issue at hand. Three-part concessionary structure was employed by the interviewees when they were testifying their ability and activity and being healthy, and by conceding some impairments and limitations they managed to make their accounts of ability more convincing. These rhetorical tools did two things here: they signalled that arguments were somehow disputable, and constituted them as such. All this goes to show that the traditional discourse of old age as decline is still going strong: extensive and detailed evidence is required if the speaker wishes to argue otherwise, particularly if that speaker has reached extreme old age.

When the respondents conceded that they had trouble with their health and that they were less able (to do home chores, 'jobs') and active (going out, social activities), disclosures of old age served as a self-evident explanation, as a 'common-place', which required no further argument. The notion of old age as its own explanation for health ailments is often found in the talk of old people themselves (Coupland et al., 1989, 1991; Coupland and Coupland, 1994; Jolanki et al., 2000) Here the idea of a collective fate that all people face at a certain age helped to ward off individual responsibility for ill-health and 'inactivity', and allowed the respondents to retain their social worth and depict themselves as morally virtuous persons. However, aligning oneself with the category of old people entails other expectations and responsibilities of a moral nature. Old age may serve as an explanation for health troubles, but it does not necessarily exempt people from responsibility to try to resist the adverse effects of illnesses (see Pollock, 1993: 53; see also Williams, 1990). Managing moral blame was done in several different ways. Detailed accounts of difficulties and ailments supported by extreme-case formulations served to prove that health troubles were real and severe. In a similar vein, extreme formulations and detailed accounts lent evidence to interviewees' claims that they were trying to keep on the move and be socially active in spite of their difficulties.

It is risky for people in extreme old age to concede problems with health, particularly with cognitive abilities. Senility after all is an integral part of the traditional discourse of decline in old age, so such concessions may easily call into question the individual's right to autonomy and independent decision making. Somewhat paradoxically, it was possible to retain one's agency and to prove one's competence by conceding deficiencies, whether physical or cognitive. In other words, by demonstrating awareness of one's condition, it was possible to show one was capable of making a rational assessment. Rationality, in turn, is closely related to access to full

personhood, which implies entitlement to independent decision making. This shows just how closely the notions of morality and rationality are interwoven with each other (Jayuusi, 1991). In addition, when respondents gave accounts of ill-health, they also made qualifying remarks of 'being in no trouble'. This kind of 'being alright really' talk alleviated the face-threat and helped people regain their privacy from the gaze of research and the society around (Radley and Billig, 1996).

Bodily being is indicative of the individual's ability to work and to cope independently, and in this way relates to one's social identity and social worth (Radley and Billig, 1996). In societies where these kinds of thing are highly valued, failure of the body poses a threat to prestigious social identity (Featherstone and Hepworth, 1995). As we saw in the earlier analyses, the respondents apologized for their loss of memory and qualified and legitimized the threat of their falling, their need for support in walking and their being unable to do their jobs (home chores) by reference to old age. Furthermore, by rhetorically externalizing 'failing' body parts, the respondents distanced themselves from their 'failing' body, thus alleviating their moral responsibility and the threat to their social position.

Duty to be healthy and active – at any age?

Modern gerontological research has questioned the notion that there is an inevitable link between old age and ill-health and is now calling for alternative ways of defining old age; one such attempt being research advocating active and positive ageing (Featherstone and Hepworth, 1991). Much of this research is no doubt motivated by the commitment to fight ageist discrimination and to promote the health and well-being of old people. Critics, however, have drawn attention to the dangers involved in the implicit representation of an active 'busy body' as the ultimate ideal of the ageing body (Katz, 1996, 2000) and in the imposition of such a moral responsibility upon the individual whose life choices will determine whether or not they are 'active' and age 'successfully'.

'Successful', 'positive' and 'active' still remain the catchwords of much of modern ageing research. This, in itself, is hardly surprising in view of the fact that research is always an integral part of the culture it studies. Improving the health and well-being of old people by means of research requires, first of all, acknowledging the threat that questions about health may pose for the respondents, and appreciating that when they are talking about their health, respondents are also 'performing their identities' as worthy members of society. Therefore, second, researchers need to situate research into the cultural context in which it is practised, take into account the moral nature of health and age categories and recognize that the research interview is not an innocent and neutral tool that produces objective facts. Discursive research on old age offers one way of doing context-sensitive research that addresses these issues. However, there still remain much

broader questions concerning the cultural imagery of old age and health. We cannot step outside our own culture, but can we develop ways of thinking otherwise within it? Is it possible to broaden 'the vocabulary' of old age, and is it possible to unravel the link between health and morality?

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III

Discussing responsibility and ways of influencing health

By Outi Jolanki

Abstract

In this discursive study of four group discussions, I examine how the study participants respond to questions about the possibilities of individuals to influence their own health and their responsibility for health, and what is the role of old age in this context. One key finding was that the participants balanced between seeing health as a do-it-yourself matter and on the other hand as a matter of fate or chance. The participants did not question the idea that they could influence their health or assume responsibility for their own health, but they did raise several factors that limit individual influence. Focus groups proved to be an appropriate data collection method for studying morally laden and potentially sensitive issues. It is suggested that the findings of this small-scale study echo broader western discourses on health and old age and contemporary cultural and social developments.

Keywords: health, ageing, old age, responsibility, culture, qualitative study, focus group discussions, discourse.

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Introduction

Health and information about different health risks and ways to minimise them and enhance one's own well-being are frequent topics in public discourse, in the media and in everyday conversation. As Robert Crawford (2006) has argued, ''health may be reasonably described as social cynosure . . . both a goal and a source of anxiety, a value for self and others, integral to identity, a state of being that is continually assessed and the organising concept for a vast organisation of social action'' (Crawford 2006: 404).

Health also provides a common conceptual framework for views about ageing, old age and the lives of old people (Featherstone & Hepworth 1995; Katz 2000). Health discourses are not, nor have ever been, unitary or unambiguous. However, a distinctive feature of contemporary thinking about health is that this is a matter that every individual *can and should* ''do something about'', by means of their own actions and lifestyle choices. Accordingly, health talk has become talk about individual responsibility (Crawford 2006).

In today's social and cultural climate, which stresses individual effort and responsibility for health, seeing old age as a health issue easily leads to seeing it in terms of individual life choices and decisions. This view challenges the traditional discourse of decline, which has it that ageing is a common fate for all people and inevitably means physical and mental deterioration. Within this discourse, there is little room for individual action. The idea that health in old age can be influenced by one's own actions is not a new idea, either. For centuries, a healthy diet, exercise and moderation have belonged to the ''toolbox'' of anti-ageing strategies (Katz 1996). However, the modern version of this line of thinking, which can be called activity discourse, advocates the idea that, as with health in general, ageing and health in old age can and should be influenced through one's own actions and lifestyle choices (Featherstone & Hepworth 1995; Gilleard & Higgs 2000; Hepworth 1995; Katz 1996, 2000). It has been argued that activity representations of ageing and old age have increased in contemporary culture, in the media and in public discourse (Featherstone & Hepworth 1995; Gilleard & Higgs 2000; Katz 2000; Lee et al. 2007; Rozanova 2006; Williams et al. 2007). The growth of activity

representations does not mean that decline discourse has altogether disappeared. Instead, activity is offered as a remedy for all sorts of ills of old age.

At the individual level, remaining active is offered as a strategy to fight illnesses, maintain functional ability, minimise health problems, resolve loneliness and enhance individual well-being; and on the level of society as a strategy to prevent dependency and to minimise the costs of health and social care provision for the ageing population (Hepworth 1995; Katz 2000). Even though activity discourse promises a more positive view of old age, it also constructs ageing as a matter of individual responsibility, and thus ageing has also become a matter of moral evaluation (Hepworth 1995). The responsibility and the ability to influence one's own health even in old age have become part of the scientific discourse, talk in the media, and everyday conversations (Hepworth 1995; Katz 2000).

Cultural discourses are important in that they offer ''vocabularies'' with which individuals can think about their own ageing and construct their own identity as old people. However, cultural modalities (discourses), dominant codes, values or categories should not be understood in a unitary fashion, or as forces that dictate our concepts of health: as well as being internalised, these discourses are also resisted and transformed, and their meanings ruptured (Crawford 1984). In this research cultural discourses are seen as resources that may enable but also limit people's own thinking. Less attention has been paid to how people use these discourses in their own thinking, apply them to their own lives and own ageing, or on what basis people adopt or discharge certain views.

In this study, I have analysed group discussions in which Finnish people aged 70 or over talk about their health. My aims were, firstly, to analyse in detail how the participants discussed their ability to influence their own health and their responsibility for their own health; and secondly, in more general terms, to explore the role of old age in discussions of health. In doing this, I wanted to study how different views were developed in interaction between the participants and how these views were evinced, supported or refuted. Following the ideas of the discursive approach, my research therefore comprised both the content of different arguments and how they were used in talk.

Data and Methods

The data consist of four group discussions with six participants each, including myself in the capacity of moderator of these discussions. The research participants were recruited by convenience and purposeful sampling. First, I recruited participants to whom I had easy access (members of an art club that I attended) and asked them to recommend other suitable participants. On the basis of my experiences with the first group, I contacted the manager of a local service facility and with her help recruited more participants. The discussions were held in the city of Tampere in southern Finland in 2000. Lasting from 60 to 90 minutes, the discussions were audio-recorded with the consent of each participant and transcribed verbatim (~130 pages). Altogether there were 20 participants (eleven women, nine men), and their age ranged from 71 to 86 years. Background information (age in years, education and occupation at the time of retirement, marital status, housing, health status) was collected after the discussions by self-report questionnaires. Group 1 had five male participants, all of whom attended the same art group, and the discussion was held at the place where that group used to meet. The participants for the other three groups were resident and non-resident clients of one of the service facilities run by the city of Tampere, and these groups met on the premises of these facilities. Group 2 consisted of two married couples and one single woman, all of whom belonged to the same literature circle. Group 3 consisted of five women, two of whom lived at the service centre. Group 4 consisted of two men and three women, all of whom lived at the service centre in question. Groups 1 and 2 represent pre-existing groups, but in groups 3 and 4, too, the participants knew one another at least by sight, some of them were friends. The groups were thus rather heterogenous, since one aim of the study was to trace different perspectives and variation in experiences. All discussants took part voluntarily.

To initiate the discussions, I introduced myself and described the research project. I said I was interested in the participants' own views about health in general and their own health in particular, and also in what health means to them in their everyday lives. The discussions then proceeded according to a set agenda, although largely on each group's own terms. This procedure provided a common basis for the discussions, but allowed different views to emerge within and between the groups.

The discussions focused on the following topics:

- definitions of health, personal and general;
- the individual's own responsibility for health;
- to what extent can health be influenced by individual action;
- the most important things in one's own health, and possible future concerns about one's own health; and
- the relationship between age and health.

These topics were covered in all groups, although the weight they received differed from group to group. The exact wordings of the questions varied slightly between the different groups, because I adjusted the questions to best suit the interaction and the atmosphere in each group. Age was on the list of topics, but the participants brought up age and old age even without prompting. As a result, the discussions in each group were framed by ageing and old age. In the flow of their discussions, the participants also introduced and developed new topics. The transcribed text was loaded into Atlas.ti 5, a qualitative data analysis programme. The programme was used as a tool for organising and coding the data. The speech was transcribed word by word (see Appendix 1 for transcription conventions).

The study draws on the ideas of social constructionism (Gubrium & Holstein 2008; Gubrium et al. 1994), emphasising ''the dynamic contours of reality and the processes by which social reality is put together and assigned meaning'' (Gubrium & Holstein 2008: 3) and of discursive psychology (Potter 1996; Wetherell & Potter 1992), pointing out the importance of language as a means of constructing versions of reality, oneself and others. The discourse analysis perspective offers tools for exploring the different, sometimes conflicting meanings attached to health and old age, and how these meanings are brought forward, substantiated or refuted (Potter 1996; Wetherell & Potter 1992). More specifically, my approach combines ideas from situated and action-oriented discursive constructionism (Potter & Hepburn 2008) with Foucauldian-influenced discourse analysis (Wetherell & Edley 1999). In short, the view adopted here is that people's talk is about the local pragmatics of a particular conversational context, but also part of broader or more global patterns of collective sense-making (Wetherell & Edley 1999: 338). My approach to the data and my own role within that data was guided by the idea of ''active

interviewing'' (Holstein & Gubrium 1995). Active interviewing starts out from the idea that the researcher is never an impartial or neutral person, but the research data are produced jointly, in a collective exercise of meaning-making. My own role was a dual one. On the one hand, I was a moderator whose job it was to make sure that all participants got a say. On the other hand, I was an active participant in the discussions, encouraging and even provoking discussion. In this study, the notion of active interviewing was combined with focus groups as the method of data collection. The reason I chose to collect my data in the form of group discussions was that they offer an effective way of exploring the formation of shared beliefs and values and people's experiences, opinions, wishes and concerns (Barbour & Kitzinger 1999; Waterton & Wynne 1999). As Barbour and Kitzinger (1999) point out, the main idea of group discussions or focus groups is to address the group as a whole instead of asking questions of each person in turn and to make explicit use of group interaction to generate data. In this sense they differ from simple group interviews (Barbour & Kitzinger 1999: 4–5). The advantage of focus groups in comparison to some other data collection methods is that focus groups also constitute a contextual method. The participants are not approached as individuals acting in isolation from the social context, but as members of a social group interacting with each other. The social context of group discussion provides an opportunity to examine the process of meaning-making and how different views are formed, expressed, modified and debated with others (Wilkinson 1999: 67; see also Myers & Macnaghten 1999). In addition, focus groups have a potential to be a non-hierarchical method since the group situation reduces the researcher's influence and leads into a greater emphasis on participants' views (Wilkinson 1999: 70), allowing participants to generate their own questions, frames and concepts and to pursue their own priorities in their own terms (Barbour & Kitzinger 1999: 5). A special challenge in the context of group discussions is how to analyse interaction and talk of the group as a whole and the individual voices within the group (Barbour & Kitzinger 1999).

The questions concerning responsibility and the possibilities of influencing one's own health offered a morally loaded perspective for discussion. One key concern in the analysis was to see whether the participants accepted the interpretation I evinced, or whether they challenged it and

proposed other interpretations. Conventionally, morality refers to shared notions of good and bad, or right and wrong, which can be used to define both people and their behaviour. In philosophical discussions morality is also related to questions of individual agency and the nature and possibility of free will. These questions go beyond the scope of this article. However, the group discussion data and the discursive perspective adopted here present a useful opportunity to look at ''morality-in-use'' (Jayyusi 1991; Nikander 2002), which here means analysing the participants' talk in detail to see whether they construct the issue at hand as moral.

The findings of this study are based on an analysis of the whole dataset. The extracts presented were chosen to illustrate the commonalities and variation of meanings in talk, and on the other hand to show how the participants developed their views and joined or challenged others' views. Identifying names have been replaced with fictional names and R refers to researcher.

Is Health Fate or One's Own Doing?

The first extract comes from Group 2, which consisted of two couples (husband Henrik and wife Liisa, husband Taisto and wife Rauha) and one single woman (Sofia). Before the discussion reproduced below, I asked the participants to define health in general. The emphasis in these definitions (in all groups) was very much on the functional aspect of health, i.e. being able to cope in everyday life. Sofia then began to talk about her own health: ''well for the time being I've managed, I think I've managed *really* well (laughs), but then I don't know what's coming''. After asking the other participants how they assessed their own health, Henrik replied ''good for my age'', and Taisto ''satisfactory for my age''. Henrik explained his good health by saying that he had no ''internal diseases'', only ''the odd flu and things like that'' and ''wear and tear''. Taisto's ''satisfactory'' health status was explained (by his wife) by his cancer, for which he was still receiving treatment. His wife Rauha then went on to say ''for her own part'' that she had no ailments, no medication and that she had good mobility, but added that ''you never know what's around the corner''.

In summary, health was here defined broadly in terms of being able to function and having no real diseases, but only minor aches and pains. In this health context, old age was constructed as a time of deteriorating health, as was visible in the expressions ''good for my age'' and ''satisfactory for my age''. In the other groups this kind of talk was also common, and in earlier studies, too, ''good for one's age'' talk has emerged as a common discursive strategy that explains good health in old age but does not question the conventional view of old age as decline (Coupland & Coupland 1994; Coupland & Coupland 1999; Coupland et al, 1989; Jolanki et al. 2000). Sofia's and Rauha's remarks ''I don't know what's coming'' and ''you never know what's around the corner'' can be interpreted as being related to ageing, but also to illnesses in general. In this kind of talk health was constructed as a precarious state, and its

Extract 1. Group 2

1	R:	. . . Can you, is there something you can do yourself if you think that with
2		increasing age you get all sorts of ailments, is there any way you can influence ( )
3		your own health then?
4	Henrik:	at least your mental health (R: mm) you can't do much about your
5		physical health. They come and go (R: yes).
6	Liisa:	well I suppose you can actually to some extent I mean I was just thinking
7		that it would be nice to put my foot up on here, but *heaven above* if I accidentally
8		put this foot up (laughs) then I will, I have to take my other foot out (laughs). I
9		mean you have to remember what your *weak* points are (R: yeah).
10		(murmurs of approval)
11	Henrik:	and then I also thought that you can of course help yourself if you think
12		that they easily say that there's no point going to see a doctor with a minor
13		complaint like this and (R: mm) but if you go to the doctor even if it's just
14		something minor (R: yeah) to see a professional, you may well get help with
15		things that you don't understand (R: right).
16	Liisa:	and then there's like physical exercise. I mean if you've got healthy limbs
17		and you try to exercise, I'm sure that that will help. Helps your muscles stay fit
18		(R: yeah) but then this is definitely a factor (*unclear*) (R: right) you can't just, if

19 I think of myself, like in the wintertime when it was so slippery and I wasn't
20 allowed to move around, now I feel that (laughs) I can't get out and about any
21 more. But in the spring when I got out on my walks again, I mean everything was
22 all back on track again () in a completely different way (R: right) so I mean you
23 do begin to deteriorate *pretty* soon when you're older, not when you're *younger*,
24 but when you're older (murmurs of approval), if you don't get any exercise that at
25 least I,/I personally/
26 Sofia: /I/ know lots of people who when they've started to have these
27 problems with their aches and pains and what have you, they've just slumped
28 down in their armchairs, ''oh dear the pain in my arms, oh dear or dear oh dear''.
29 Sometimes I say, ''I say listen, try to lift your arm a bit, you know it could help. I
30 can't move it at all, I can't move it at all.'' *You really won't get anywhere* (R:
31 mm), I mean if you start going down this road, I mean with each and every
32 complaint you say that I can't get anywhere (R: yes). One day you *will* no doubt
33 get to the point that you *really can't* move, but that's *sometime* in the future.

alterations seemed to be beyond the individual's control. Next, I moved on to ask how the participants saw their chances of influencing their own health.

In this extract health was jointly constructed as something that can be influenced, but different explanations were evinced for the origins of good health as well as for the role of individual action. Firstly, Henrik's talk constructed mental and physical health as distinct areas, and the latter as something beyond the individual's control. However, I have interpreted his reference to ''they come and go'' (line 5) to mean diseases rather than health in general. In her response Liisa contrasted with Henrik's view, but her talk implied a more general view of health, that is, health as functional ability. Disagreeing with the former speaker, as she did, is often a delicate matter. She delayed her comment (line 6 ''well I suppose'') and toned it down in advance (''to some extent''), which in itself suggests that her talk will take a critical stance on what was said earlier. ''Influencing'' was also given a different interpretation in which it was related to individual differences and to the need to adjust oneself to one's limitations (''weak points''), which helps to avoid health problems. ''Weak points'' refers to inherited qualities, which in Liisa's talk serve as a self-evident cause constraining individual action.

After his wife's turn, Henrik also modified his view (lines 11–15) and suggested that one could try to enhance one's health by seeking medical advice, but received no support from the others. This topic was initiated by him on several occasions, but received little support. In his talk, Henrik implicitly contrasted ordinary people and their limited understanding (''you don't understand'') with ''professional people'', ''who know better''. His talk diminished the role of individuals as agents, and this social position was not perhaps one that the others were prepared to support. Liisa's talk, on the other hand, emphasising the importance of individual actions, received more support, and was followed by similar talk by other participants. In these discussion groups the view that seeking medical help might have beneficial effects was quite rare, and was only mentioned in the context of ''serious'' diseases (such as cancer) and their treatment.

Liisa continued the theme of physical exercise, which was then supported by the others and remained one pervading issue in the discussion. Liisa's first turn (lines 16–25) in which she advocated the beneficial effects of exercise, implicitly again mitigated her husband's view that there is nothing one can do to influence one's physical health. The laughter and the point she made that she was only talking about herself (''if I think of myself'', and ''at least I, I personally'' lines 19, 25), can be seen as a way of mitigating the implied criticism. Her talk could be heard not only as a criticism of her husband, but also as veiled criticism of other people who did not try hard enough to exercise. It is a delicate matter to accuse and blame others because that may be seen as a violation of the rules of interaction and the speaker may him/herself be blamed for praising him/herself and for being too judgemental about others. Liisa's emphasis on the personal aspect can therefore be interpreted as a move to try and avoid these interactional hazards.

On lines 22–23, her factual statement ''so I mean you do begin to deteriorate...'' marked Liisa's talk as a closure to the earlier theme of old age. Both weather problems, inherited qualities (''weak points'') and old age served here as external forces that were beyond individual influence. However, she modified this view by referring to the possibility of alleviating health problems and slowing down the ageing process by exercise (line 24).

Sofia's turn (lines 26–33) continued the exercise theme. Her talk contrasts herself with unnamed others who are harming themselves, refusing or lacking the willpower to try and resist the health problems brought about by ageing (''when they've started to have these problems'' lines 26–27). As a linguistic strategy, extreme case formulations (''I can't move it at all'', ''with each and every complaint'') (Pomerantz 1986; Potter 1996: 87–188) and vivid quotations of others' talk (Drew 1998: 319–322; Potter 1996: 160–162) serve to demonstrate others' exaggerated reaction to their health complaints. Sofia's talk constructs these complaints as common, minor and somewhat vague (''their aches and pains'', ''each and every complaint'' lines 27, 31–32) rather than as specific diseases. The expression ''if you start going down this road'' indicates that the unnamed others have (at least partly) chosen their lot, and also given in to indolence (''slumped down in their armchairs'' lines 27–28).

Sofia's talk has a judgemental tone and as was previously stated, it is risky to judge others' behaviour. However, the linguistic strategies mentioned and the description of health complaints as minor ones serve to justify her disapproval of others' behaviour. Also, she qualified her judgemental tone by referring to future effects of old age (lines 32–33 ''one day you will no doubt get to the point'', ''really can't move''), which in this context served to show that she was not being unreasonable. In summary, the participants' talk constructed serious diseases as a matter beyond individual control, but views about ageing and old age were more ambiguous. On the one hand, in this health context, old age was constructed as a process of inevitable deterioration accompanied by related health problems. On the other hand, individual decision-making and action was given an important role in enhancing one's own well-being and fighting the ''effects'' of old age in everyday life.

In Group 3 one of the participants talked about the literature circle in which she was involved and in that context raised the role of mental alertness in health (cognitive skills, social activity). I saw this as a chance to try and find out how the discussants would tackle question about mental aspects and their influence on health. My question was very loosely

Extract 2. Group 3

1	R:	yes. What about then () one's own () attitude and these kinds of *mental* factors
2		() how do they affect one's health? I was just thinking that if you take part in this
3		literature circle and, you know that this.
4	Lea:	well yes *I certainly* believe that this kind of mental side it, I'm sure.
5	Aira:	keeps up your mental agility ().
6	Lea:	yes and that it has a major influence on your health, at least you would *think*
7		it has some effect between your ears.
8		(talks about the pieces she writes for different magazines)
9		(. . .)
10	Aira:	so that you can make a difference by what you do.
11	Sylvia:	yes.
12	Aira:	to how you feel, to feeling good.
13	Lea:	yes so that you *don't just lie down/just/*
14	Aira:	/yes, that you *don't just stay there/*
15	Lea:	right and don't get in/touch with anyone/
16	Aira:	/yes that really is/, that gets you down.
17	Lea:	depressed.
18	Aira:	in no time at all.
19	Esteri:	yes and when I get this depressed feeling and I know it will go away, I
20		realise that and I notice it when it (laughs) starts to come (laughs), everything's
21		pretty dark when it creeps up on you, but at that point /I'll start to do something/
22	Lea:	/well I'm not/
23		*at all surprised* in your position.
24	Esteri:	mm
25	Lea:	when you're always there at home.
26	Esteri:	/yes right/
27	Lea:	/born and bred/in the same place/and never go anywhere/
28	Esteri:	/yes but it doesn't really, for me/*it*, it
29		doesn't for me *at all* because I'm comfortable there.
30	Aira:	/yes you/
31	Esteri:	/I'm comfortable / I don't miss.
32	Lea:	don't you get *bored*?
33	Esteri:	*no,* you see I'm not really the *outgoing* type.
34	Lea:	yes.

35 Esteri: and erm, I ( ) I do then *always* find *the help* () I don't know, but *it just*
36 *goes away*, I know it will, it only lasts a day or two. But it always comes and its
37 pretty *strong*
38 R: yes, I wonder what it is that /causes it? /
39 Esteri: /I don't know /what, what it is, but it all seems so
40 dark, but then again there are these good, sunny days that.
41 R: yes, yes so sometimes it's better/and sometimes/a bit worse?
42 Esteri: /yes, yes/
43 Aira: that goes for everyone if you're alone.
44 Taimi: and at least I mean if the weather's bad, then you do get depressed.

formulated in order to give the participants the chance to address those dimensions that they considered most relevant.

In theory, the loosely formulated question might have received different interpretations, and the participants could have interpreted my reference to ''mental factors'' as meaning something other than the individual's own outlook and attitude. One might imagine that belonging to a literature circle would produce all sorts of pleasant experiences that enhance well-being. Instead, mental activities receive a rather instrumental meaning here as a means of improving one's mental agility.

At first, Lea took to this issue very eagerly, and began to talk before I had time to finish my questions. She voiced the view that her writing had helped her retain her cognitive skills (lines 4, 6–7). Lea and Aira together constructed the view that mental activities and the preservation of mental agility have an effect on health, and secondly that mental well-being (''feeling good'') and mental agility are a result of one's own outlook and decision to be active. In this way, elements of everyday existence were converted into activities (Katz 2000: 140–141) that promote health in old age. Lea's and Aira's talk is rhetorically very effective, creating a vivid image of the unfortunate stagnation into which people may fall if they fail to lead an active lifestyle. Clearly, this kind of metaphorical expressions (lines 13–14 ''don't just lie down'', ''don't just stay there'') were ''doing far more than designating physical positions'', as Williams has stated (1993: 104). Lea's and Aira's talk carries the implicit message that mental

problems may be induced or avoided by one's own actions, and people can choose how to behave, i.e. whether to ''just lie down'' or be socially active. The view that social and physical activity and being ''positive'' somehow generates health was very common in these discussions. Similar findings have been made in earlier research as well. Crossley (2002) found that discussants in her focus group data linked good health with being extrovert, taking exercise and having a positive mental attitude to life (ibid: 1471).

Esteri joined the conversation (line 19) and began talking about her own depressive mood. Apparently, she was trying to show that she agreed with the former speakers by saying, ''yes and when I get'', and explaining then, ''but at that point I'll start to do something'' (lines 19–21). However, she was interrupted by Lea, who burst into the talk which constructed Esteri's sentiments as a natural and inevitable consequence of her own actions, namely staying indoors and avoiding social contact. The extreme formulations in Lea's talk (''not at all surprised'', ''always there at home'', ''never go anywhere'') underline the idea that Esteri is one of those people who has chosen to be socially inactive, and her conduct was in fact constructed as a lifetime habit (line 27 ''born and bred in the same place...''). Lea's interruption could be seen as offending, but it was not received as such by Esteri, who defended herself very calmly. Here, as in the earlier extracts, the fact that the participants knew one another, and the friendly atmosphere in the group, apparently made it possible for strong disagreements to be voiced and resolved.

Yet Esteri's response was defensive, which indicates that she interpreted Lea's talk as condemnatory. Her response was to define herself as someone who does not need social contacts to the same extent as a more ''outgoing type'' (line 33) might. Her talk introduced the idea that people are different, and what is good for one person is not necessarily so for another. In this way she rebutted any doubts that her situation might have been caused by her social inactivity. At a more abstract level, this whole episode can be heard as everyday theorising about what counts as activity, and whether social activity which is largely accepted as an important element in promoting older people's health can be taken as the standard applicable to all people (Katz 2000: 143). Furthermore, in Esteri's talk depression appeared as an active agent which comes and goes with

great predictability (line 36 ''it always comes''), and all she could do was to try to adapt. But by pointing out that ''I do then *always* find *the help*'' (line 35) she also constructed herself as an agent, not only as a victim of disease. It is potentially face threatening to confess that one suffers from mental problems, and Esteri's laughter can be seen as one way of reducing the seriousness of her revelation. However, the extreme case formulations ''everything's pretty dark'' and ''pretty strong'' (lines 20–21, 36–37) do construct her symptoms as serious, which can be interpreted as an interactional move to prove that she was not complaining for nothing. Towards the end of the excerpt, Aira and Taimi joined the discussion. Aira's talk mitigated her earlier strong view and constructed depressive feelings as natural for all people (''that goes for everyone''), but still as result of being alone (line 43). Taimi then continued the weather theme introduced by Esteri (line 40 ''sunny days'') and offered bad weather as an obvious cause for feeling depressed. Consequently, in their talk depression and depressive feelings are equated with natural forces, and as changeable as the weather. Aira and Lea did not seem to abandon their view that individual action has an influence on health, but they did soften it. As the conversation unfolded, the group moved towards a more moderate view, that is, that health may be a matter of individual action, but the same rules do not apply to all people and some things are beyond individual control.

Responsible or Not?

Questions of responsibility were often followed by lengthy accounts of appropriate or inappropriate conduct. Another very common feature of these discussions was that the participants talked at one and the same time about their own health and health in general, as happened in the following extract.

Extract 3. Group 2

1	R:	what about I mean () you must have you read () you watch television and
2		there's a lot about () these health matters () you should look after your health in
3		different ways I mean there's physical exercise, diet and things like this, what do
4		you think, to what extent are people responsible for their own health?

5 Rauha and Sofia: quite a lot.
6 Liisa: yes I agree quite a lot.
7 Rauha: I'm now thinking of him (refers to her husband), I mean like the doctor
8 said, if he'd been a smoker (R: mm) at the time he had the leukemia, I mean the
9 treatments they're always a shock to the (R: right) then () that if his lungs
10 hadn't been as clean as they were (R: right) then he would have suffocated with
11 the inflammation he had I think (R: yes).
12 Sofia: yes, I mean in my opinion food () physical exercise, physical exercise,
13 diet and () all these things that people like us consider part of a healthy life, I'm
14 sure it helps.
15 R: yes. So what do you count as part of a healthy life?
16 Henrik: well I, for me the personal experience is that a regular way of life.
17 Sofia: yes (murmurs of approval).
18 Henrik: that does help (R: yeah) I believe that I'm as healthy as I am () I mean
19 I've led a reasonably regular way of life since I mean since I was young, almost
20 since I was young. And I don't, I do not drink and I don't smoke and I do enough
21 physical exercise, although not very much, go for walks here and as I said I've
22 done some exercise with the war veterans and, and in this way you *can* make a
23 difference.
24 Rauha: yes/the average Finnish/
25 Henrik: /yes say if you're/a heavy drinker by fifty you're in a pretty bad
26 shape (murmurs of approval) let alone, I mean they don't even live to eighty
27 (murmurs of approval) I mean I used to drink sometimes quite a lot when I was
28 younger but fortunately I stopped (laughs) drinking, so that. And since then I've
29 felt absolutely () fine both physically and mentally.
30 R: yes right.

In the earlier extract from this same discussion, exercise was discussed at some length as a way of improving one's health (physical fitness). Here, my introduction offered exercise and diet as means of taking care of one's health, and connected them with individual responsibility. The introduction clearly stated that looking after one's health is the appropriate thing to do (line 2 ''you should look after your health...''), but by embedding these demands in a wider social context I tried to keep the floor open to different views. The participants did not challenge the interpretation

offered, but they did qualify it during the discussion. At first, in response to my question, Sofia and Rauha replied in the affirmative, laying a heavy burden of responsibility on the individual's shoulders (lines 5–6 "quite a lot"). Rauha's example was quite extreme, quoting her husband's non-smoking as the factor that saved his life. A doctor is called upon as an "outside witness", an authority whose words proved that what Rauha was saying was true. Later on, she moderated her rather extreme causal statement with the expression "I think" (line 11) that ends her turn. These extreme views about responsibility were also mitigated by Sofia and Henrik, who used the word "help" (lines 14, 18) to describe people's own influence. In their talk then, people's own actions do make a difference, but they are not the causes of good or poor health.

The participants talk constructed a division between we ("people like us"), who lead a healthy life and other, unnamed people ("smokers", "boozers") whose lifestyle is healthy and even life-threatening. However, to talk about a "regular way of life" (line 16) and the "average Finnish" life (line 24) constructs a *moderate* lifestyle as preferable to extreme behaviour. The participants' talk here reiterates the findings of earlier research. This kind of talk can be called "a harmony" principle in health beliefs (Herzlich 1973). Backett (1992), too, said her respondents condemned excess in health-seeking behaviour and actually denounced it as unhealthy (ibid: 261–264). In this respect, Henrik's turn (16, 18–23, 25–29) is interesting in many ways. He introduced the idea of "a regular way of life" and pointed out that he did not overdo a healthy lifestyle, but took "enough physical exercise". He balances between confessing that he does not go very often for walks, but still takes enough exercise. In this way he shows that while he does assume responsibility for his health, he does not overdo things. In this extract then, as I see it, the participants constructed a morally grounded division between different factors that influence the individual's health, of which smoking and alcohol use are considered the most reprehensible. This division was constructed in other groups as well.

Henrik's confession of his earlier, sometimes heavy alcohol consumption (lines 27–28) is particularly interesting in this context. Earlier, he had made it clear that he is aware of what a healthy lifestyle implies (lines 16–23 and extract 1) and that he tried to lead his life accordingly. I construed that in this context, his admission did not threaten his image as a "pro-health

person''. Also, it is more acceptable for a man than for a woman to admit to excessive drinking, especially if this is something that happened in one's youth (cf. Backett 1992: 260). The mention of personal experience softened the moralising tone, and strengthened Henrik's claim in two ways: it showed that he was not trying to set himself above the others; and also that he had first-hand knowledge of what he was talking about, lending added credence to his words (Potter 1996: 112–113).

Not all the participants claimed that they tried to lead a healthy life, understood as taking exercise and having a healthy diet. However, anyone who admitted to leading a not-so-healthy life always expressed the view that one should try to look after one's health. The following extract sheds light on this kind of talk. In Group 1, the discussion had revolved very much around social issues, and I framed my question of responsibility accordingly.

My question suggested that there is a contrast between the individual and the society, and offered social development and public expenditure as a

Extract 4. Group 1

1	R:	yes() so what about could you think then that () I mean there's been a lot of
2		talk in the media now that with money running out and with these questions of
3		priorities that() what costs should be covered and what society should pay for ()
4		is it fair to say that people are responsible for their own health I mean to what
5		extent are people responsible for being for () I mean if we talk not only about
6		being able to influence one's health but are people responsible for their health
7		and what is society's role in all this?
8	Paavo:	yes well if you mean that do I feel guilty for not going out for walks then
9		yes (muted laughter).
10	R:	yes, I mean for not going out, is that what you're saying?
11	Paavo:	yes because I don't go out.
12	R:	right.
13		(.)
14	Paavo:	yes it's true, I mean you do feel that you could do more for your own
15		health, you could do more.

16 Kalle: quite a lot (murmurs of approval).
17 Toivo: *yes it is your* own responsibility *for the most part* it is *for the most part*.
18 Others in unison: yes.
19 Kalle: yes I'm sure it is (R: right).
20 Toivo: and but there should be *more education* really from primary school
21 onwards about the maintenance of health () and like getting rid of smoking and
22 alcohol and all these (murmurs of approval) and like if somehow it would be
23 possible to find a way that people didn't fall into temptation and I mean that
24 would be.
25 Akseli: nowadays they're cutting physical exercise classes at school.
26 Toivo: yes and that's really *bad*.
27 ()
28 Akseli: /though on the other hand/
29 Paavo: /this thing with young people/and going back all that way () but those of
30 us who at this age, who are smoking at our age you can't get them to stop.
31 Akseli: I have to say that the fatalist in me thinks that society has to take over
32 and assume responsibility if these people don't have enough resources to (R:
33 right) to take the initiative, to take over and engage in some sort of activity and
34 work for their own health, then I do think that society, the people who are better
35 equipped for our journey here, they should take care.
36 Toivo: yes that's right.
37 Akseli: and look after.
38 R: yes if not everyone has the /resources/
39 Akseli: /yes not everyone/ they don't even have enough to
40 I mean the will the desire the skills they're just not there, we're not all the same
41 (murmurs of approval).
42 Paavo: we're not the same (murmurs of approval).

frame for discussing the question of personal responsibility. As the discussion shows, society was accepted as a key notion and vantage point for the discussants' definitions of responsibility, but different meanings of responsibility still emerged in the discussion.

Paavo answered (lines 8, 11) my question with a personal confession of not going out for walks. It is interesting that he formulated his answer to my question as a counter question, ''translating'' mine to contain an

explicit moral message of good individual behaviour. His concluding comment that one should and could do more for one's own health met with the approval of the others (line 16). With this talk, the participants constructed themselves as people who understand the value of looking after one's own health in spite of admitting to not doing enough. The discussion that follows (lines 17–19) confirms that they accept personal responsibility for their health. This is evident in Toivo's heavily stressed talk and repeated expression ''for the most part'' (line 17), which is joined by others and Paavo's closure ''yes I'm sure it is''. In spite their assertiveness Toivo's words (''for the most part'') leave some room for factors other than personal responsibility. These other factors were addressed when he raised the perspective that changed the course of the discussion altogether. Toivo's talk about the need for ''education'' (lines 20–24) reduced the demand for individual responsibility in that it constructed a healthy lifestyle as a matter of knowledge and appropriate education. Physical exercise and the avoidance of alcohol and tobacco were raised as self-evident issues in a healthy way of life, as in other groups.

Toivo's expression ''to find a way that people didn't fall into temptation'' and Akseli's remark about ''they'' who are cutting exercise classes at school implicitly constructed two kinds of actors in health, i.e. authorities and ordinary people. In the participant's talk ordinary people's responsibility and chances to look after their own health were dependent on the actions of some unnamed authorities. However, it is clear from the comments about school education, and from Paavo's comment on the futility of trying to change one's habits in old age, that the participants were talking about the health of young people. The participants' own talk seemed to implicitly confirm the view that ''old dogs don't learn new tricks''; attempts at lifestyle changes are best left to young people.

Akseli's turn (lines 29, 31–35, 37) shifted the emphasis to talk about people in general. His talk constructed a distinction between people who do not have the means or the resources to look after their health, and those who do (''people who are better equipped''). Differences in health were constructed as a matter of education, different resources and inherent qualities, which was confirmed later on (lines 40–42) in unison: ''we're not all the same''. Initially, the responsibility was mainly laid on the

individual's shoulders, but this view was qualified in Toivo's turn; and eventually Akseli's turn and the subsequent talk shifted much of the responsibility to society and to those individuals who were better ''equipped'' than others. In this extract I asked the participants to express their views on society's and individual's responsibilities. However, collective responsibility for people's health was raised in other groups too without prompting, even though the discussions of responsibility revolved mainly on individual responsibility.

Discussion

In this study the aim was to find out how the participants would respond to questions about the possibilities of individuals to influence their own health and their responsibility for health, what would be the role of old age in this context, and how these topics would be discussed in a group situation. Some participants agreed more strongly than others with the idea that people can influence their health and that they can and should bear individual responsibility for their health, while other participants offered more moderate views. However, during the discussions both oriented to each others' talk, and qualified and developed their views jointly.

It has been suggested that group pressure in group discussions tends to steer talk towards unified ''public'' views and to inhibit the voicing of sensitive issues or individual disagreement. My experiences do not fully support this view since in these discussions, disagreements were indeed expressed and delicate personal issues raised. The findings presented here concur with Kitzinger and Farquhar (1999) views that the composition of the group, the topic and the overall sentiments of the group and the role of the moderator play a decisive role in enabling or prohibiting discussion on sensitive issues. I conclude that the atmosphere of the discussions had a major role in enabling or impeding multidimensional talk, and this is something the researcher (or interviewer or moderator) can influence. In the present data the participants in each group knew one another at least to some extent, which may be one crucial factor (Barbour & Kitzinger 1999: 8–9). Instead of group pressure, I would be inclined to talk about interactional courtesy rules that people follow in order not to offend other discussants, and yet manage to express opposing views by subtle verbal and non-verbal means.

Even though the health talk in this data was ambivalent, it was clear from the analysis that the participants in these group discussions did not question the individuals' ability to influence their own health, or their responsibility for their own health *in principle*. This finding could be attributed to asymmetrical power relations in interaction. By this I mean that the participants may have seen me, the researcher and the questions I asked, as representing the voice of authority and shared cultural norms. For example, the discussion in group 1 (18) about responsibility in which the participants expressed their sense of guilt for not doing enough for their health, indicates that this is how the participants saw the situation. However, in reporting her experiences of data collection, Backett (1992) has argued that in spite of her attempts to be non-judgemental, the majority of the respondents "felt the need to apologise for and justify aspects of their life which they thought might seem unhealthy" (ibid: 261). This indicates that the subject of health may engender moral talk, irrespective of the conduct of the interviewer. These findings are only logical, given that health is one of the central values in Western societies today and, that people define themselves and others at least in part by their "healthy" or "unhealthy" behaviour (Crawford 2006: 402). Dissenting voices do not easily surface in a research situation where respondents would have to challenge shared beliefs or values (Billig 1996 [1987]), but as the data showed, qualifying and contrasting views may be voiced. Apparently, the questions (even as strongly formulated as mine) directed but did not determine the content and course of the discussion, and did not prevent the participants from expressing opposing views *in the end*.

Group discussions indeed offered a site where different and contrasting and even conflicting voices could be expressed. The findings here support the idea that focus groups can work as a non-hierarchical method to reduce the researcher's influence and to gain insight into participants' conceptual worlds (Wilkinson 1999: 70). The findings also suggest focus groups can be used to study how people discuss morally laden and potentially sensitive issues of healthy lifestyles and responsibility for one's own health, and also as a site for the participants to "confess" and elaborate on what would conventionally be seen as unhealthy lifestyles or inactivity, both of which go against contemporary ideas of "healthism"

and beneficiary effects of activity evident in public discussion and policy programmes. As Kitzinger and Farquhar (1999) argue, studying sensitive moments and topics in and with focus groups would help to ''map out the boundaries and transitions between public/private, acceptable/unacceptable and routine/non-routine discourses among diverse groups in different situations'' (ibid: 171). On the basis of this and other research (Cunningham-Burley et al. 1999; Waterton & Wynne 1999), I would suggest that focus groups could be even used to inform theorising and policy-making, and to involve lay people into public debates and policy discussions. Also, focus groups and detailed analysis of talk and interaction could be employed to illuminate and deepen the findings of quantitative research, e.g. to construct questionnaires and to develop understanding of key issues or in a latter phase of research to ''tease out the reasons for surprising or anomalous findings'' (Barbour & Kitzinger 1999: 6).

However, the challenge of focus groups is that they can end up bringing forward the voices of the most articulate and dominating participants, or suppressing contrasting and conflicting voices. The moderator's interactional skills are therefore crucial in enabling everyone to have a say without curtailing or forcing the discussion. Also, there may be various barriers to the participants' willingness or ability to acquire information and engage in discussion about health issues in general or their personal issues. Lay views therefore cannot simply be used to replace professional or scientific expertise or focus group data cannot be said to unproblematically represent the views of the whole community (Cunningham-Burley et al. 1999; Waterton & Wynne 1999). The analysis still represents the analyst's interpretation of the discussions, and it is up to researcher to theoretically argue for the transferability of the findings. Focus groups also easily generate large amounts of data, which presents a challenge for the analysis. During the last years qualitative software programmes, such as Atlas.ti used in this study, have entered the field and greatly facilitate organising large volumes of data and for example checking both prominence and rareness of different topics and the broader context of data extracts, thus improving the rigour of the analysis. The challenge of catching the group effect while analysing individual voices within

discussions requires special attention but detailed methods of text analysis such as discourse analysis help to meet this challenge.

On the basis of the findings here it was evident that both activity and decline discourses with their moral implications were part of the participants' thinking. The participants often explained and justified their conduct in response to questions, or they evinced reasons for other people's behaviour. However, these accounts about personal experiences brought abstract discourses of health and old age to the level of everyday life and everyday decision-making. To summarise the content of the discussions in regard to the ideas of influencing and assuming responsibility for health, the participants' talk can be seen as a balancing act between two lines of argument; namely health as ''do-it-yourself'' versus health as a fate or chance. These situated and contrasting arguments themselves embody and draw on broader controversial health and old age discourses and reflect the ambiguous expectations of older people in contemporary societies.

The participants argued that it is possible to influence one's health, which in this context means taking steps to enhance one's well-being or even to prevent illness by means of certain lifestyle choices, that is physical exercise, non-drinking, non-smoking and a healthy diet, actively maintaining social relations, being involved in all sorts of activities, and taking a positive attitude to adversities. Within this line of argument, messages from epidemiological research of ''risky'' behaviour intertwine with recent messages from gerontological studies on the beneficiary effect of ''positive'' thinking and active lifestyle on health in old age (Gilleard & Higgs 2000; Katz 1996). The participants in this study gave accounts of their own attempts to live a healthy life, but also expressed self-judgments of not doing enough for their health. As the findings showed, judgments could also be directed towards other people. Judgment of others and self-blame reflect the general moralisation of health (Crawford 1984: 70), a phenomenon that has been documented repeatedly in earlier studies. The pursuit of health has become not only a moral obligation and a sign of virtuous citizenship but a means to control and discipline individual lives. The findings here and elsewhere indicate that ''healthism'' is part of the older people's own thinking even if contrasting discourses persist too.

"Healthism" (Crawford 1984) can be seen as a cultural discourse that partly overlaps and strengthens the messages of epidemiological and recent gerontological discourses on old age. Thus, if health is one of the "key words" in contemporary western cultures, "activity" is the key word in discussions of old age, describing much of today's public and policy discourses (Katz 2000). As a result, individualistic and activist discourses – with their moralistic repercussions – that emphasize individual choices and activity as solution to the ills of old age are gaining recognition in the thinking of ordinary people themselves. In the talk of these participants, activity was constructed as a strategy with which it is possible to alleviate age-related health complaints, and sometimes binary oppositions were constructed between active and passive people. Metaphoric expressions such as "just lie down", "just stay there" or "slump down in their armchairs", were used to describe the unfortunate state of those people who chose not to fight adversity, but remained inactive and as a result harmed themselves. Even though the activity discourse can be seen as an empowering discourse that allows older people themselves to question ageistic views of their abilities and competency (Jolanki et al. 2000), it does problematise older bodies and lives as dependency prone and "at risk" (Katz 2000: 147). Activity discourse is also essentially individualistic, putting individuals under pressure to lead active self-caring lives (Jolanki 2004), which was visible in this data. The participants put forward the idea that it was possible to influence health in old age in a similar way as health in general. The idea that not only physical but social activities and a positive outlook on life may enhance one's own well-being and even improve health is not new (Herzlich 1973; Williams 1993). More recent and more directly age-related idea is that social participation and different mental activities can assume instrumental meaning as "activities" that can improve cognitive functioning and even postpone or prevent dementia (Gilleard & Higgs 2000; Katz 1996). This theme is currently prominent in the media and various self-help books, and the findings here suggest that older people are now picking up on these ideas. The problem here is obviously not the maintenance of good health, but the tendency to reduce older people's social positions and lives into a health concern, which means that different aspects of older people's everyday lives are seen more and more as part of instrumental techniques to manage health (Katz 1996: 127; Katz 2000: 140–141).

However, the participants also qualified the role of individual action and raised factors that in their mind limit people's chances or even prevent them from influencing their own health, and in this way also detract from individual responsibility. Within fate discourse individual health was constructed as a matter of chance or fate and old age was constructed as a period of inevitable health problems which limit the individual's influence and for which the individual cannot therefore be held responsible. So, the discourse of decline or fate was also present in the participant's talk and it was used to qualify the expectations and demands inherent in activity discourse. Invoking good health in old age as more unlikely than ill-health (''good for my age'') and describing poor health as inevitable in the future served to explain and justify the participants' health complaints. Serious diseases were identified as one of the factors that limit the individual's possibilities to influence their health. Diseases were constructed as external forces that ''come and go'' more or less unpredictably, and therefore they are beyond individual control. Different individual qualities and social resources were also constructed as factors that can either improve or undermine the individual's possibilities and abilities to look after their own health. The participants evoked the idea that people ''are not the same'' or do not have the same resources. This version of the fate discourse draws from and reproduces spiritual and philosophical considerations of human beings at the mercy of destiny (or god in religious discourses). Yet, perhaps paradoxically another underlying stream within the fate discourse comes from the messages of modern epidemiological research. While arguing for various actions the individual can take to improve his or her own health, epidemiological research also points out the areas beyond individual influence such as genetic propensities and probabilities.

Within fate discourse the task of society and more fortunate people was to level the differences and help out less fortunate people. So, even though discussions on responsibility for health revolved mainly around individual responsibility and individual actions, the participants qualified individual influence and also advocated the idea of collective responsibility for health as an alternative for individual responsibility. At the individual level then, the participants' talk touched upon similar issues of collective responsibility, the role of communities in people's lives and the division of obligations and rights which are becoming more and more crucial in

wider debates about the course of development of modern welfare societies (Phillipson 2006: 206). In the participants' talk, the different factors served to legitimise one's own health complaints and evict the moralising view that people in ill-health have brought about their own situation.

Thinking of old age and health furnishes ambiguous elements whose origin lies in wider social and cultural discourses and developments of western, or to be exact, European–American societies. Scientific inquiry and growing gerontological and epidemiological knowledge has helped to question and challenge overly determinist views of health in old age and to argue for more positive views of old age as a matter that can be influenced with one's own choices and actions (Katz 1996). Research results then have served as a tool for empowerment and questioning ageist thinking and practices. Yet, scientific inquiry can be seen as part of an even broader development of modernity and "consumerist late modern environment" (Blaikie 2006: 15, see also Gilleard & Higgs 2000: 170) within which individual choice and agency are advocated as a means of well-being and better health. Crawford (2006) sees "healthism" in somewhat similar terms as born out of tensions of consumer capitalism.

In addition, according to Blaikie, modernity's devaluation of older people as unproductive has been replaced by older people's potentially productive roles as "purchasers of goods signifying particular lifestyles", and the pursuit of health serves as a tool for positive ageing and for preserving youthfulness (Blaikie 2006: 15; see also Featherstone & Hepworth 1995; Katz 2000). Advocating individual activity and choices and individual responsibility for one's own life and health has been further fuelled by alarmist views of population ageing and financial troubles allegedly awaiting advanced economies in response to the ageing of populations (Blaikie 2006: 13–14; Katz 1996: 128; Tulle 2004: 176). As part of the attempt to better manage ageing of populations, neoliberal goverment policies in different countries aim to strengthen the role of individuals as consumers making choices and seek to shift the responsibility for health and social care costs to individual consumers and their choices (Gilleard & Higgs 2005: 57; Phillipson 2006: 203). These trends offer different interpretive possibilities and lifestyle choices for individuals. They can be seen to work to liberate people from overly deterministic thinking of

old age to pursue their individual goals and interests and empower older people to take their lives and well-being and health into their own hands. The other side of the coin is that ''activist'' and ''healthist'' discourses can work as emotional and symbolic ''straitjackets'' compelling people to direct their activities and interests to pursue active and healthy lifestyles in accordance with normative expectations. Furthermore, within these discourses inactivity and ill-health even in old age can be seen in individualistic terms as responsibility and failure of the individual (Featherstone 1991). In this respect, the decline or fate discourse with its appeal to collective human fate offers liberation from individual blame.

The findings here are based on a small-scale study whose participants represent a group of elderly Finns. In view of the size of the population they therefore represent a small group of people. Qualitative studies do not usually aim or claim to provide generalisable knowledge in the same sense as quantitative research; instead we can consider transferability of the findings beyond the study context and whether the findings of qualitative research can feed and give ideas for discussing contemporary development of societies. On the basis of the findings and the references quoted, similar health and old age discourses are in circulation in different societies and have become part of the older people's own thinking. In this regard, the findings here are transferable to a broader context and echo ambiguous cultural discourses of old age and expectations addressed to older people in contemporary western societies. Health programmes, the media and numerous self-help books circulate ideas from scientific inquiry to a wider audience. Yet, these scientific and cultural discourses do not determine people's thinking. In their mundane decision-making people draw from broader discourses, but also from biographical particulars and practices of everyday life. Studies of older people's own meaning-making activities can show whether cultural discourses became lived reality. In summary, the participants constructed health and even health in old age as matters that the individual ''can do something about'', and to a certain extent should act upon. In the end, however, old age, serious diseases, individual differences and social factors represented either the unpredictable or common fate of all people or belonged to realm of collective responsibility, and in any case challenged the belief that the autonomous

individual has the capacity "to re-make self and world" (Crawford 2006: 403).

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Appendix 1: Transcription conventions

- overlapping speech starts and ends: //
- particularly quiet speech: * *
- clear pause: ()
- comment, unclear speech or possible interpretation in brackets: (unclear)
- heavy stress underlined: *weak*

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IV

Agency in talk about old age and health

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ABSTRACT

There is a strong drive in ageing research, policy programmes and the media today to promote the agency of older people. In this paper, agency is approached as a discursive and interactional phenomenon. The data consist of group discussions with people aged 70 or over. Although the interviews were designed to focus on questions of health, the participants also raised other topics, including their interests, social activities and social relations. The main focus of the analysis was on the participants' descriptions of themselves and on their scope of action in health issues. The aim was to establish whether being old was constructed as an agentic position and to identify the meanings attached to agency in age-talk. The participants described themselves in agentic terms and agency was assigned diverse meanings, but whenever the category of old was mobilized, agency became problematic.
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Introduction

One of the major focuses of ageing research and ageing policies today is to promote the agency of older people. With older people, it seems, agency is a more ambiguous and problematic issue than it is with younger people. Cultural discourses feature dualistic notions of agency in old age, with the images of older people ranging from needy and dependent objects of others' actions to self-sufficient and active senior citizens who take charge of their own lives. There is a growing body of ageing research and media reporting that represents a 'new ageing' discourse (Katz, 2005: 140–141). The new ageing discourse underlines the meaning and importance of individual choices and actions in the way that the individual grows old, or manages to postpone ageing. This discourse promises that retirement and old age can offer opportunities for self-realization and involvement in social activities, and provide release from previous social obligations, and on the other hand the possibility to be an active and productive member of society. Individual agency, then, is brought into the focus of interest as a way of challenging what is seen as an overly deterministic discourse of decline. (Gilleard & Higgs, 2000; Featherstone & Hepworth, 1995; Hepworth, 1995; Katz, 2005).

Yet, as has been made clear in studies on the lives of older people in institutions (Gubrium, 1997; Paterniti, 2003), interactions between nursing staff and older people (Hockey & James, 1993; Kontos, 1998; Morgan, Eckert, Piggee, & Frankowski, 2006), doctor–patient interaction (Coupland & Coupland, 1994; Coupland, Coupland, & Giles, 1991) and familial relations (Hockey & James, 2003), people who are assigned to the category of old run the risk of losing their agentic position. Older people are addressed as if they were children, and most of their decisions are made by other, younger people. Older people are constructed as objects of others' actions, reducing their prospects of being seen as actors entitled to making their own decisions.

The concept of agency is a slippery one and its definitions vary. Human agency can simply refer to the idea that 'people are the authors of their own thoughts and actions' (Burr, 2003: 121), which brings forth the human ability to ascribe meaning to objects and events and to act on those meanings. However, the efficacy or ability of individuals to engender change in themselves and in social order is seen as an essential requirement of true agency (Burr, 2003: 182; see also Barker & Galasiński, 2001: 45), as is the availability of choices and the individual's capabilities to make and enact those choices (Morgan et al., 2006).

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Much of the earlier research on old age and agency has been concerned to explore how older people's agency may be inhibited or promoted by their social or physical environment, health status or by other people. Agency itself is taken as a matter of course. Wray (2004) criticizes the assumption that 'experiences of agency are somehow fixed and unmarked by diversity' (p.24), and calls for conceptualizing agency as creative, generative and relational (p.26). Also, even if we accept the principle that human beings are inherently agents, this does not mean that people necessarily see themselves as agents or as having the possibility to enact their agency. It is important to study people's self-descriptions and their accounts of everyday life situations to see if they themselves cast their own actions and decisions as enactment of agency (Gubrium & Holstein, 1995).

In this study I approached agency as a discursive and interactional phenomenon by analysing a set of group discussions focusing on health issues. I was interested to find out how the participants talked about themselves and others as old people and about their potential and chances to act in health issues or other areas. My aim was to see whether they constructed being old as an agentic position and to identify the meanings ascribed to agency in talk.

The interactional perspective on agency adopted here meant that once the different aspects of agency had been acknowledged, they were 'bracketed out' (Holstein & Gubrium, 2000: 41–43), and the analysis concentrated on 'the way in which 'doing things' was represented in discourse, including who was positioned as doing what kind of things, in relation to what, or whom' (Barker & Galasiński, 2001: 144). In addition, efficacy here referred to the way that causality of action was represented in talk, while the agent was 'the participant that causes things to happen' (p.144). In this study I was particularly interested in explicit or implicit self-descriptions and group descriptions concerning decisions, choices and action or wishes and aspirations to act, in whether the participants would considered themselves to have influence over their own health or over other matters discussed, and what meanings they would give to age and old age in this context. The study participants were not explicitly asked about agency, but the concept of agency serves instead as a heuristic tool with which the researcher can address the data. As a result, following Holstein and Gubrium (2000) I took agency to have no absolute or concrete standing in the participants' lives and instead treated agency as a practical outcome of the interpretive work done by study participants as they presented their decisions, choices and actions as a topic for discussion (p. 42).

Data and analysis

The data consist of four group discussions with six participants each, including myself. The discussions took place in the city of Tampere, southern Finland, in 2000. The participants were recruited by convenience and purposeful sampling. The groups were thus rather heterogeneous, since the aim was to trace different perspectives and experiences. I started out by recruiting participants from amongst people to whom I had easy access (they were members of the same art club that I go to) and asked them to recommend other suitable participants. Based on my experiences with the first group, I contacted the manager of a local service facility and asked her to help me with recruiting further participants. This service facility is a municipal service centre that provides services for retired people aged 60 or over. Service users pay a small service fee, but most of the funding comes from the local council. The services include meals, physiotherapy, barbering and hairdressing, library and internet access, as well as various free time and recreational activities. In addition, the service centre provides housing services for older people who are unable to cope with everyday activities in their own homes, but who do not require care in a nursing home or hospital.

The participants ranged in age from 71 to 86 years. Each group had five discussants (11 women, 9 men). Lasting from 60 to 90 min, the discussions were audio-recorded with the participants' consent and transcribed verbatim (~130 pages; see Appendix A for transcription notation). Background information (age in years, education and occupation at the time of retirement, marital status, housing, health status) was collected after the discussions by self-report questionnaires.

Group 1 had five male participants, all of whom attended the same art group, and the discussion was held at the place where that group used to meet. The participants of the three other groups were resident and non-resident clients of the service facility, and these groups met on the premises of the facility. Group 2 consisted of two married couples and one single woman, all of whom belonged to the service centre's literature circle. Group 3 consisted of five women, two of whom were residents. Group 4 consisted of two men and three women, all of whom were residents. Groups 1 and 2 represent pre-existing groups, but in groups 3 and 4, too, the participants knew one another at least by sight, some of them were friends. All of them took part voluntarily.

To initiate the discussions, I introduced myself and described the research project. I said I was interested in the participants' own views about health in general and their own health in particular, and also in what health means to them in their everyday lives. The discussions then proceeded according to a set agenda, although largely on each group's own terms. This procedure provided a common basis for the discussions, but allowed different views to emerge within and between the groups. The topics focused on definitions of health, the individual's own responsibility for health, to what extent health can be influenced by individual action, the most important things in one's own health, and possible future concerns about one's own health. Another topic was the relationship between age and health, but that was raised in the discussions without prompting. As a result, the discussions in each group were framed by ageing and old age. These topics were covered in all groups, although the weight they received differed from group to group. Although the main concern was with issues of health, other topics also evolved in the flow of the discussions. The exact wordings of the questions varied slightly between the different groups (see Appendix B Interview Guide), because I adjusted the questions according to the interaction and the atmosphere in each group. Questions were not addressed to individual discussants, but to the group. The transcribed text was loaded into Atlas.ti, a qualitative data software package that was used in the preliminary stage of analysis to help organize the data and to gain an overall view of the content. This stage included

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formulating coding categories such as definitions of age and old age, definitions of I or other people (as a particular kind of person, e.g. 'writer'), definitions of oneself or other people as old, health talk (concerning one's own or others' health), talk about different activities and interests (other than health) and relations with other people. In order to explore *how* talk about these different categories, definitions and activities were *used* to position oneself or other people as a particular kind of person or persons, I then moved on to analyze the talk in more detail by means of discourse analysis, as exemplified in the extracts.

There are several different variants of discourse analysis, but this study draws on the ideas of social constructionism (Burr, 2003; Holstein & Gubrium, 2000) and discursive psychology (Potter 1996; Wetherell & Potter 1992). Both of these emphasize the importance of language and interpretive practice as situationally sensitive interactional process through with people construe and represent reality (Holstein & Gubrium, 2000: 41). Also, as Holstein and Gubrium (2000) state, 'from this perspective, social life is continuously being constructed by its members' and 'whatever is real about life world is made so through the interpretive work that members do to constitute it' (p.42). Each construct invites a different kind of action from human beings, and therefore sustains some pattern of social action and excludes others (Burr, 2003: 4–5). In the context of this study, the discourse analysis perspective offers tools for exploring different 'versions' of older people's agency in the participants' talk and the different, sometimes conflicting meanings attached to health and old age, and how these meanings are brought forward, substantiated or refuted in talk (Potter, 1996; Wetherell & Potter, 1992). The concept of subject position as an analytical tool enabled me to study how the participants in practice defined themselves or other people as certain kinds of people. Positions in discourse provide us with the content of our subjectivity. They bring with them 'a structure of rights and obligations; they legislate for what 'that kind of person' may or may not reasonably do or say' (Burr, 2003: 124), but they also 'provide us with our sense of self, the ideas and metaphors with which we think, and the self-narratives we use to talk and think about ourselves' (p.124). The concept of subject position also entails that we all can define ourselves in many ways, we can adopt or reject offered positions, and our self-definitions may vary between different settings or within different situations (Wetherell & Edley, 1999: 337). In practice, the analysis concentrated on accounts of everyday life situations and the shared features of self-positioning in these accounts, including moments of self-descriptions or constructing positions as 'we', i.e. group identities (Wetherell & Edley, 1999: 335–337).

Talking about agency and old age

The participants' self-descriptions and their evoking of the category of old concerned different aspects of their lives, not just health. I have clustered these aspects together under three themes: body and health, social relationships, and personal interests and activities. This is for analytical purposes only; in the participants' talk these themes often overlapped. The extracts below are chosen to illustrate commonalities in age-talk and in positioning oneself and others. If the extract represents a rare case, that is mentioned separately. The participants' names have been changed and R refers to researcher.

Body and health

Old age as the end of agency

The participants' talk about old age and health and the body contained ambiguous elements. Old age was often constructed as a period of predictable, inevitable deterioration and health problems, which had many and profound consequences. Remarks about "the ailments of old age" appeared frequently in the middle of talk about one's life and everyday activities. The cause of these health problems was the ageing body, which had forced one to give up exercise, to take part in fewer social activities, to ask home help to do the cleaning, etc. In this kind of talk, the ability to enact wishes, decisions and actions was self-evidently dependent on and limited by the physical body. When I asked the participants in group 2 about what they thought they themselves could do to influence their own health, a long discussion ensued in which it was concluded that taking exercise helps to maintain health and bodily competence. However Aaro's turn then changed the direction of the conversation.

Extract 1. Group 2

Aaro: But then, I just have to point out in this connection the reverse side of the coin, that I mean we're all here at least mentally in good shape and otherwise but then you get to the limit ( ) that you can't any more, everything's gone. And after that many of us still have to live for quite some while (R: right). I have a sister at (name of geriatric hospital). She had a stroke five years ago and ever since then she's been more or less out of this world (R: yeah), there is absolutely nothing she can do to influence things any more

Kerttu: Yes that's a different matter then

Aaro: you know how can you accept it, it's

Eeva: It's (R: right, right)

Aaro: And still I mean she still has her senses about her, she can think and (R: yes) knows it, but can hardly speak

R: so she can't?

Aaro: No. She does say the occasional word, speaks very badly and she's been bedridden for some time now.

In this extract Aaro's talk positioned the participants as we: a group of people in relatively good health who have not yet reached the borderline beyond which there is nothing one can do to influence one's own health. His factual statement "but then you get to" constructed it as self-evident that this borderline lies ahead, beyond which there is no more agency because "everything's gone". The other participants concurred. Even though the de facto cause for the inability of

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Aaros sister was the stroke she had suffered, talk about the geriatric hospital and the age-related temporal framing ("any more", "still has her senses") constructed this episode as age-related. The extreme expression "out of this world" symbolically located Aaro's sister outside of social life and the community of able people. In all these groups, expressions such as "lie there and being turned" or "so that you wouldn't have to just lie there in bed and be turned over" pictured the worst imaginable future scenario. From this perspective the core idea of agency is to be able not only to make decisions and to express one's own will, but to act independently without needing help from other people.

To become physically impaired and dependent on other people was constructed as a matter of chance or bad luck, not as a consequence of the individual's actions. However, Aaro's rhetorical question "how can you accept it" suggested that even this situation might involve individual action and choice—even if that were limited to accepting or refusing to accept the situation where one's own actions were reduced to thinking, as physical mobility and communicating one's own thoughts were virtually impossible. The rhetorical formulation implied that this acceptance was by no means to be taken for granted, although it might be expected.

Managing health and ageing by means of individual actions

Even though physical and mental impairments were constructed in the participants' talk as an integral part of the ageing process, this process was not considered to be the same for all. Furthermore, the participants seemed to have adopted the idea that it is possible by certain means and actions to influence one's own health and in this way to postpone deterioration. Similar findings with regard to older people's own thinking of health in old age have been reported elsewhere (Berman & Iris, 1998: 228–30).

The following extract illustrates how the participants positioned one another as people with different qualities. In these discussions good health was attributed equally often to the qualities that the individual had inherited as to their conscious choices and actions. However, as the following extract goes to show, these two views were often intertwined. Before this episode I had asked the participants of group 3 (all female) about their own health and here, as in the other groups, they talked about how ageing and declining health had limited their lives and their possibility to take exercise. Still, the participants defined themselves as relatively healthy on grounds that they had no serious illnesses and that they felt healthier than most other people. A small number of prescribed medications were often considered an indicator of good health, and here too one of the participants began to talk about her medication.

Extract 2. Group 3.

Anna: But I'm sure we all have some medication, except you (talks to Maria)

Bertta: I do and I just went /and I was given/

Anna: /yes but you're/an exception

Maria: I'm an exception

R: Oh I see/you're like/

Anna: /she's like/a one-year-old (general laughter)

Maria: I really don't have anything. I just walk a lot and (R: a-haa) do crosswords, I want to keep my senses about me (laughs).

Here the word "exception" and "like a one-year-old" clearly positioned Maria as different from the other participants and old people in general. In earlier studies, too, 'good for one's age' talk has emerged as a common discursive strategy that explains good health in old age but does not question the conventional view of old age as decline (Coupland, Coupland & Giles, 1989; Jolanki, Jylhä, & Hervonen, 2000). In addition, as Hurd (1999) has stated, "the greater the distinction between one's chronological age and one's appearance, the more an individual is revered as a hero or heroin of the 'not old'" (p. 425). Here, however, the important point is that Maria's talk about her activities drew attention to the idea that an individual can indeed influence her own health through her own actions. This might be heard as an implicit accusation towards other participants, but this impression was alleviated by her extraordinary nature. And yet Maria was constructed as an admirable example of a healthy and active person who chooses to look after her health.

I see this extract as an example of how ideas circulating in public language are adopted as part of one's own thinking and conduct. Public discourse today is replete with information about different ways (such as crosswords or mental activities in general) in which it is possible to maintain one's mental and physical ability in old age, or at least to postpone impairment. In this kind of talk different activities receive instrumental meaning as potentially health improving activities. At the same time, good health becomes a matter of individual choice.

In most cases the participants talked about their activities in general terms as a way of managing the adverse effects of ageing, but the following extract is the one exception in which the speaker gave a very specific reason for attending a gym club. Before this extract, the participants in group 1 (all male) had been talking about their social and physical activities. An example they mentioned was a hiking trip a few years earlier (three of the participants in this group had joined in). One of the participants called Eino described the daily programme by saying 'every day we headed out somewhere and were knee-deep in something and riding on our bikes and climbing up the fells'. In this account the participants were positioned as fit and active people. I saw this discussion as a good opportunity to throw in the question of whether it is possible to influence one's own health in any way. A long discussion ensued in which the participants negotiated the range of options available. In the middle of this discussion, one participant who had previously said he attended a gym club made the following remark.

Extract 3. Group 1

Oiva: Have you thought about this that nowadays with the treatment that's so poor over there, that's the reason that I go to the gym so that (laughs) I can stay at home

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longer before they take me away to be looked after by others because they don't really do that do they

Eino: Right, right

Niilo: Yes.

Oiva's talk was received with murmurs of concurrence. The reason for this, as for his laughter, may lie in the sensitive subject. In contrast to earlier talk, the participants here were positioned as old people with gloomy future prospects, and physical activity took on the meaning of a means to postpone that future. There was no explicit reference to old age, but the contemporary expression "I could stay at home longer before I'm taken away to be looked after by others" clearly constructed this as an age topic. Oiva positioned himself as someone who has chosen to try and keep fit so that he could stay on longer in his own home—and this as an agent with the ability to influence his own future. On the other hand, moving away from home was constructed as a necessity. Also, the decision to take exercise was constructed as consequential to fact that the care provided would be inadequate and of poor quality.

Oiva's talk is another version of the 'border-talk' introduced in extract 1. In his talk activity assumed the meaning of a means to manage the difficulties of old age and to postpone institutionalization. Although this was the only case where a participant so bluntly talked about this matter on a personal level, the poor quality of care and the neglect of older people were also taken up in other groups. I have interpreted this and other similar episodes to indicate that the public discussion about the poor quality of care and the shortage of resources may have influenced the way that older people perceive their future options and chances to influence those options. Oiva's talk expresses implicit critique towards the organization of care of older people (which was softened with a humorous tone and laughter), but it also reproduces the discourse of age which gives primacy to 'the privatization and individualization of the management of risk entailed in potential bodily deterioration' (Tulle, 2004b: 182).

Redefining one's own position and agency

The following extract is an example of how the participants defined their mutual differences as agents and of how old age was then brought into the discussion. Before this episode, the participants of group 3 (all female) had talked about their social activities and personal differences with respect to social contacts and activities.

Extract 4. Group 3

Bertta: We're all so different. You never went tearing around out there and you didn't go

Vieno: No I didn't, no no no

Anna: And you didn't go dancing or do any gymnastics

Vieno: No not dancing but I do have other activities, but I don't have

Bertta: They've been sort of/quieter activities/

Vieno: /different yes I don't. I wasn't like that, that I've wanted to go

Anna: I on the other hand have gone into all sorts

Bertta: And you can see that and hear it (general laughter), never you mind, you're so sprightly and otherwise, that the, these operations you had on your legs they've set you back a little, but I mean otherwise (cuts off)

Anna: But erm now that I went to see this orthopaedist, when I said I can no longer walk even a kilometre, then so how far should you still be able to walk, he said (general laughter) I said that I should still be able to go dancing and all, I showed him like this. Well yes, to slower tunes in that case (general laughter).

In the first part of this episode, Vieno and Anna are introduced as individuals with diverse interests and activities. In this dataset, being socially and physically active was constructed as the preferred style of behavior. However, findings from earlier studies suggest that this is a common phenomenon (Hurd, 1999; Jolanki, 2004). Crossley (2002) found that discussants in her focus group data linked good health with being extrovert, taking exercise and having a positive mental attitude to life (p.1471). In this way, elements of everyday existence were converted into activities (Katz, 2000: 140–141) that promote health in old age. As a rule, those who admitted to being not-so-active adopted a defensive stance in justifying their inactivity. As we see, relying on the support of Bertta, Vieno constructed herself as an introvert, "quiet" person who engages in leisure activities even though they are different from Anna's activities. Anna was positioned as active and outgoing. "Tearing around" was clearly extreme conduct for Vieno, but for Anna just a sign of her energetic nature, constructing her as an admirable example of activity.

In the latter part of the episode, Anna made skillful use of her doctor's voice to tell two sides of the same story. Quotations of what one's doctor had said recurred frequently in health talk. The doctor was usually constructed as a figure of authority, but sometimes that authority was called into question. Here, the doctor's position was ambiguous: on the one hand the doctor was positioned as a figure of authority, but on the other hand Anna's talk can be heard as a criticism against implicit ageism in the doctor's talk. The rhetorical formulation "so how far should you still be able to walk" assigned Anna to the category of old people and implied that her ambitions for improved physical mobility were not necessarily legitimate. In a way, the doctor was saying that Anna should settle for less. Anna's response can also be seen as a resistance to this kind of positioning and as an attempt to redefine her position and agency. Tulle, (2004b) study on older athletes reports similar findings of older runners who resisted advice given by their friends or a doctor to take up more sedate pursuits or to give up running after turning 50 (p.184). These findings show how the category of old entails expectations of age-appropriate behavior, which can be resisted but still influences the way that

IV

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other people position the person and evaluate her or his actions.

Vieno and Anna were initially both positioned as individuals who enacted their agency in different ways according to their diverse qualities, interests and aspirations. Agency assumed different meanings here with different moral connotations. In the first part of the discussion, being outgoing and socially extrovert was constructed as the preferred style of behavior. Vieno differed from this ideal and attempted to redefine the meaning of activity and her own position as an active person. In Anna's story, the doctor's talk served to demonstrate what is considered age-appropriate activity for older people, and then it was Anna's turn to distance herself from that position and to define herself differently. In line with the earlier results of Coupland and Coupland's (1994) study on doctor–patient interaction, and Tulle's (2004b) studies on both older people's housing decisions and older athletes, the findings here show how age categories are used to evaluate the appropriateness of people's behavior. It seems that older people's involvement in different activities is encouraged provided that they do not transgress social and cultural expectations of 'age-appropriate behavior' (p.184).

The participants were sometimes critical of the discourse that represented old age in terms of decline and that ascribed older people an inferior social position, but that criticism was often vague and toned down by laughter or jokes, as in the previous extract. The following extract represents a rare case of overt criticism. The criticism is presented in group 4, where all the participants lived in sheltered housing and needed assistance with mobility, unlike the participants in the other groups. One of the participants called Tauno (male) explicitly defined himself as a "veteran" (refers to World War II), and this account is about his experience of the rehabilitation services for veterans that he had received.

Extract 5. Group 4

> Tauno: When I was, this treatment, well I mean what do old men like me, there's the ball, there's the ball, they call that therapy (R: right) it was half an hour (R: yeah) and I mean even this good leg of mine they fiddled with it in this machine so that I could hardly get down to eat for a fortnight. I said I won't be coming here again (R: right yes) I've had enough rehabilitation thank you (R: right, right). I know this woman veteran of yours (refers to other participant's friend) who lives here upstairs. I said let's go next time women veterans (refers to rehabilitation organized especially for female war veterans, talk is partly unclear). The rehabilitation would be in (name of another city).

In this account the clients of the rehabilitation centre were positioned as objects of action and the anonymous staff members were constructed as active agents. It is clear from Tauno's talk that he was not willing to accept this positioning. The content of the rehabilitation was also subjected to criticism. Tauno's talk constructed the activity at the rehabilitation centre as a trivial exercise of throwing a ball around, not as proper therapy. I have interpreted Tauno's talk to imply that this kind of activity which is conventionally seen as children's activity ridiculed old men. The message of his talk was that older people should be treated differently and with respect, which was further underlined by his referral to war veterans. Furthermore, Tauno positioned himself as a victim of misplaced treatment since his healthy leg was subjected to "fiddling" that actually made him worse. Surely, the official aim of rehabilitation must be to support clients' agency, but in this account the agency of the client was in fact inhibited, leading to the decision no longer to return.

Social relationships

When the participants spoke about their social relationships, they positioned themselves in relation to other participants or their peers either as equals or in a hierarchic relationship, as was seen in the previous extracts. The previous extract of the participant's rehabilitation experience also serves as an example of hierarchic institutional social relations. That extract and extract 4 represent experiences of being positioned as old and as a subject of others' actions and decision-making. In a similar fashion, when the participants positioned themselves in relation to their children or younger people in general, the recurrent pattern was to construct a hierarchic relationship and difference between the young and the old.

In the group of five women (group 3), the participants talked about their social activities and relationships with other people, including their children. Anna and Maria seemed to have a more distant relationship with their children. Maria spoke mostly about her feelings of loneliness and about how her children have a "life of their own". Bertta, Siiri and Vieno were positioned as mothers with close relationships with their children. Anna's turn then led to a different kind of interpretation of these relationships.

Extract 6. Group 3

> Anna: I have one daughter, but we don't, yes and she, she has a boy who has three children. But we don't see each other all the time ( ) nooo
>
> Bertta: Yes but I do I mean
>
> Anna: Nooo (R: right)
>
> Bertta: At least once a week if not more often (refers to her own children)
>
> Anna: We just phone each other, and that's all
>
> R: But you said you have friends, who are very important to you
>
> Anna: Yes yes yes, they're extremely important (R: yeah), but I can't really insist, my one daughter, she was just widowed and, erm then she's been grieving awfully and like (R: yeah)
>
> Bertta: And /it was hard/
>
> Anna: /and now/
>
> Bertta: when he fell/ill/

Anna: /was/He had cancer for five years (R: yeah) but erm she's now got a job so there is no way you can place any demands on

Bertta: Well I don't place any demands, I certainly don't make any demands *not at all*, I mean often when they phone I say no you spend time together, /I don't mind/

Anna: /yes it's/

Bertta: or /anything/

Vieno: /I've/not placed any demands on them, they can be all on their own

Anna: It sort of becomes such an awful burden (R: right)

Bertta: Yes if, if you sort of start to

Siiri: That's/what I say that if you deteriorate so much that you're no longer capable then it's an awful burden for the children/

Bertta: /I mean it would be awful for them children too if I were to start placing demands/They come out of their own ( ) when they want to

Anna: /Yes it's/

Bertta: /And like/now just a short while ago Maija phoned me and asked that surely next Sunday, I haven't been out with them all summer. Are you sure you'll be coming next Sunday, so I said don't you now, don't start

Anna: Your situation is the complete opposite to mine. I'd love to go now but no one's telling me to (general laughter)

Bertta: And then comes Midsummer's, so they asked do I want to go, erm that do you want to go with the other grandma, the daughter-in-law's mother on Midsummer's, the boys would go there. I said let them boys go. It's their turn now. What would we old grandmas do there, it makes no difference where we are. I'll either stay here or go to my sister's, I ought to go to my sister's place but I'm tempted to stay here as these old ladies are here as well.

Initially, the relationship between Bertta and her son's family was constructed as a close and warm one, but it is then at risk of being constructed in less positive terms through the reference to placing demands on children. The word demand was brought into the discussion by Anna and it was quickly picked up by the other participants. There follows a flurry of overlapping talk in which the participants repeatedly deny that they place any demands on their children. Their arguments are backed by several extreme case formulations ("not at all", "I've never", "an awful burden", "it would be awful if I were to start placing demands"). These extreme formulations serve here to show that the participants acknowledge how inappropriate it would be for them to place any demands on their children.

In this discussion the participants constructed a distinction between younger and older people. Younger people were positioned as those who are in active employment and entitled to their own peace and quiet, an implicit contrast to old people. The statement that it was the boys' turn to go to the Midsummer party (which is one of the most important national holidays) without their old grandmas reproduced common beliefs about the appropriate and normal time for certain events in relation to chronological time (Holstein & Gubrium, 2000: 79). These arguments constructed the young-old division and division into age-appropriate activities as legitimate.

Enacting agency in this case meant giving up one's own needs and wishes and positioning children and younger people as the principal agents who have the right to decide on the frequency and length of encounters. The appropriate way of acting as an 'old granny' in relation to younger people seemed to be to avoid placing demands and becoming a burden to younger people. Through their talk, the participants showed that they understand this and their own position in relation to younger people.

Bertta's final turn "what would we old grandmas do there, it makes no difference where we are", with its double referral to old age ("old grandmas") crystallized the subservient position of older people in relation to younger people. The group position of old received diminishing meaning here, which was highlighted by the fact that in Bertta's subsequent talk, "old ladies" were constructed in more positive terms as a group.

Interests and activities

Individual as agent versus old people as agents

The participants also spoke about their interests and activities, such as attending an art group or literature circle and doing handicrafts and writing stories for local newspapers. These activities were often constructed as a goal in itself, the underlying motivation as an inner desire for self-improvement. When old age was raised as a relevant category, these activities received other meanings as well. The following extracts show how old age was discussed in this context. The physical limitations related to ageing were discussed earlier, so I will here focus on other aspects. Prior to the episode quoted, the participants of group 2 had discussed their activities and hobbies, such as the literature circle to which they all belonged.

Extract 8. Group 2

Aaro: One thing, at least that's important to me, is that I've got involved in leisure activities( ) where I, I have the chance to feel a bit that I'm of some use (R: yeah) I can with these veterans, I'm very much involved in working with veterans (R: yeah right) and in church organizations and other similar things. I do think that people are (selfish), if they realize that they can help someone else (R: right)

Tuula: Yes

Aaro: It creates a sense of purpose (R: yeah) that we're still not completely useless here.

In this account Aaro positioned himself as an active agent who has chosen to contribute to the work of various

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organizations. The motivation, he explained, was the sense of personal satisfaction and purpose that comes from helping other people. By naming these leisure activities as work, he dissolved the distinction between work and leisure and between employed and retired people. The whole account and most clearly his final remark “that we're still not completely useless here” implicitly challenged the view that older people are nothing other than objects of help in society. I have interpreted the implicit message of his talk to mean that older people can indeed be agents in society more generally and contribute to the well-being of other people.

The following extract shows how one and the same participant could ascribe different meanings to personal interests, and how views were developed in the course of interaction. Here Aaro continued on the subject of social activities and positioned the group members as we, i.e. as members of the literature circle.

Extract 9. Group 2

Aaro: I, in my opinion, as we all know each other here and erm we all have some age about us ( ) quite a lot in fact, erm I think that as we share one activity in common like this literature circle, it does help with your mental health. And if there are still others, then there's not so much, you don't have to think about the fear, the fear of ageing and diseases if you're (R: yes) and it helps (R: right)

Eeva: I was just, I mean I've picked up this habit, I don't know, I say myself that it's a bad habit but I suppose it can also be a good habit () that when there are, for instance there are lots of new words that you hear on television and, and all that kind of things, that you've never even heard about, so I go straight over to my encyclopaedia, I wonder what that really means (R: yes). And these friends of mine they know that they can always call me, hey what do you know about this thing. I say I've never heard about it. Well look it up in your encyclopaedia (laughs). Se erm, I do won(word is cut off), somebody once wondered, you know, what do you do with all that information. She's an old woman ( ) hasn't been in working life for ages and all that, what does it matter what the word means. I say the thing is I can't, I can't go to sleep at night if I just keep wondering what it means.

At the beginning of this episode Aaro's talk positioned the participants as members of a certain age group and as members of the literature circle. His talk constructed the literature circle as a way of maintaining one's mental health in old age. Furthermore, being involved in several different leisure activities was constructed as a way of keeping oneself occupied and not having to think about the signs of old age and the fear of ageing. These activities thus took on the instrumental meaning of a means of managing ageing and postponing impairment in the same way as in extracts 2 and 3.

Eeva followed up on the same topic, but framed it in a different way. Here, talk about individual qualities was contrasted with negative images of old people. Eeva positioned herself as a person who was eager to learn new things and as someone whom her friends can rely on as a source of information. She made skilful use of her friends' voice to support her story, but also introduced the voice of an unknown outsider to question the rationale of her actions. This other voice served here to argue for the conventional view that old people who are no longer in gainful employment have no use for new knowledge, therefore Eeva's actions were rendered meaningless. By introducing this dubious voice into her talk, Eeva showed she is aware of this view. However, by insisting on her thirst for knowledge, she positioned herself as a person with an inner drive to know and learn. In this way she undermines the conventional view, but also shows that the motivation for her actions derives from other sources than the desire to postpone the effects of old age.

There was not very much explicit talk among the participants about politics or political agency. This may have been due simply to the focal topic of interest in our discussions, i.e. health. The following extract illustrates one rare occasion where politics was brought into the conversation. In group 1, in response to my question concerning their possible future, the participants eventually ended up discussing death, saying it would be a pity to leave this world without knowing what will happen in international politics, for instance. I decided to wait and see what course their discussion would take and did not intervene except for nodding once in a while. After some time one of the participants suddenly turned to me and said something that surprised me, but that I later on interpreted as a rhetorical return to the research situation. The following extract begins from this remark.

Extract 10. Group 1

Eino: So the news continue to be of interest even at this age

R: Yes, so you're still interested at this age at that age?

Eino: Hhnn (nodding)

Niilo: Yes it does

Oiva: And social issues they are interesting, but you tend to become so lazy that you can't be bothered to express your opinion any more

Eino: It, yeah

R: Is it a matter of laziness?

Oiva: It's laziness and that you can't be bothered to sit any more and I mean I used to write letters to editors quite a lot and you don't want to sit any more because you tend to get a sore back when you do and if you don't want to be a know-all because at the end of the day it really makes no difference (Niilo: right) what you write.

My interpretation is that with his remark, the first speaker Eino ’translated’ the group's talk about politics into age-talk and in that way made politics a relevant topic in the research context. In this way he also positioned the speakers as objects of research and as members of a certain age group. The underlying message of this expression was that old people are

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no longer expected to be interested in social and political issues, but Eino's talk can be heard as an effort to challenge this view. I was somewhat surprised by this sudden remark, as can be seen from my response. The others agreed with Eino and Oiva elaborated on the issue by describing his own interests and letters to editors.

Oiva's self-description here was ambiguous. He said he was still interested in social issues, but no longer contributed to public debate and discussion. Repeated temporal framings ("become", "any more") constructed his talk as age-talk and portrayed ageing as a process of physical and mental deterioration ("tend to get a sore back", "you become lazy"). In other groups, too, the participants talked about getting lazy as a result of ageing. Lazy is conventionally seen as a reproachable attribute, referring to a person who gives in to indolence and difficulties. This is yet another example of the moral meanings of agency in these discussions. So, Oiva's talk can be heard as self-blaming talk, but laziness also implies choice and the possibility to act differently. Following this logic, he could have chosen to fight the tendency of laziness and the sore back to and continue writing, but he didn't. Paradoxically, then, he was constructed as an agent, even though his agency here is morally dubious. In part, his decision to stop writing was constructed as an inevitable result of ageing, in part as a result of his own decision. The denial that he wanted to be "a know-all" and the argument that his writings made no difference anyway may reflect the frustration of an individual citizen, or the belief that older people's opinions are not taken seriously anyway. In summary, being old was constructed as a category that implied reduced interest in social affairs, and the participants needed to argue against this stereotypical view of old people when they argued for their own interest in politics. However, old age also received the meaning of physical and mental decline, which explained the withdrawal from public debate. These examples go to show how the category of old can be used in various ways in talk. Nevertheless the participants' talk showed that they were aware that 'being old' fits in poorly with 'being interested in or participating in politics'. In this respect the category of old conflicted with having an agentic position in social and political issues.

Discussion

One of the aims of this study was to see whether the concept of agency and agency in old age could be unraveled through a detailed analysis of the talk of older people. A further aim was to establish whether being old is constructed as an agentic position and what meanings agency received in the participants' talk. Based on an analysis of their talk, the participants in this study saw themselves as agents who have the opportunity to enact their agency. However, that agency was not taken for granted and it received different and even ambiguous meanings in the participants' talk. As individual actors, the participants positioned themselves as actors in varying ways according their differing individual qualities and interests. The category of old seemed to serve as a homogenizing category, and whenever the participants mobilized that category, agency was challenged.

Below, I summarize and discuss the central findings of this study. The participants' talk about health and bodily competencies involved some ambiguities. On the one hand, enacting agency meant adapting to bodily changes and impaired bodily competencies, as well as lowering one's own expectations and giving up activities. In the participants' talk old age was even equated with the end of agency, if one's health was so impaired that it was impossible to manage on one's own and to lead an independent life. From this point of view the core idea of agency is to be able not only to make decisions and express one's own will, but to act independently and without the help and assistance of other people. People who were bedridden in an institution represented the Other, the frail elderly; this phase of life represented 'the end of the social; a point in life after which further choices are irrelevant' (Gilleard & Higgs, 2000: 4). It seemed that the only way to enact agency beyond this borderline was through the decision on whether or not to accept one's own fate. In fact, one may well question whether we can legitimately talk about agency here at all. The participants did not so much talk about their choices between different alternatives as about adapting to the process which was thought to be beyond individual influence.

We need to ask why does physical incompetence lead to losing one's agentic position, even though it is more difficult in that situation to express one's own wishes or to take action? There are studies that have addressed the problem of how to maintain and support individual autonomy and the right to independent decision-making when it is difficult for individuals to express themselves or when their cognitive abilities are impaired, as in dementia (Kitwood & Bredin, 1992; Kontos, 2004). These studies have raised important questions about some of the presuppositions implicit in the concept of agency. One possible answer is that even if we accept the principle that all human beings are agents, in practice agency implies cognitive competence and rational behavior as determined by the standards of the community or society at large. Furthermore, bodily failure and loss of bodily control usually endanger the adult status, which is also implicitly related to agency (Featherstone & Hepworth, 1995). The findings here indicate that it would be important to study the process of physical impairments and becoming dependent from other people to see whether this process entails giving up the agentic position symbolically and in practice. This process would then mean positioning not only other people but oneself as Other, a frail old and as an object of other people's actions. Earlier studies have shown that some older people with impaired health can forgo their agentic position, i.e. give up decision-making and vest responsibility on others, and some people faced with functional limitations resist being defined as incapable and dependent and insist on making decisions concerning their own life (Morgan et al., 2006: 124). Morgan et al. (2006) suggests that this phenomenon is explained by 'cultural mandates or class variations among families' (p.124), which seems plausible but nevertheless warrants further research. Earlier research has shown that taking a non-agentic position may have positive connotations, since it can serve to legitimate dependency and need for help and to free oneself from needing to be active (Coupland & Coupland, 1994; Jolanki et al., 2000). Yet, as studies on people suffering from dementia have shown, losing the position of agent can easily lead to losing the right to make decisions on one's own life and even to inhuman

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treatment. While there may be many direct practical reasons for the shift of power, it is likely that older people's own internalized negative views of ageing and old age also work to erode self-confidence, reduce expectations and thus possibly lead to poorer physical and mental performance, which are then treated as signs of old age (Gilleard & Higgs, 2000: 137).

The participants in this study also raised the idea that through their own choices and actions, individuals can slow down or even prevent impairment in old age. I argue that in this kind of talk, not only physical exercise but also different interests and social activities assumed instrumental meaning as health activity, i.e. as a means to maintain one's physical and cognitive abilities and to delay or prevent dementia. To put the findings into broader perspective, we can ask whether in modern western societies in general the proper way to enact agency in old age is to try and keep fit and healthy and to keep oneself occupied and entertained (Katz, 1996, 2005; Tulle, 2004b).

Surely it is in everybody's interest to remain healthy, but the problem for me is that old age and older people's agency thus become defined in a rather narrow sense as primarily a health issue. As a result, positioning people as old reduces the multiplicity of their individual interests and goals. The new ageing discourse promises new kinds of identities for older people providing that they decide to pursue an active and healthy lifestyle. But not all people are in the position to pursue this 'new ageing', for which they would need adequate financial, social and cultural and physical resources. Also, many researchers connect new ageing to the political ideologies of consumerism and "neoliberalism, where empowered communities and agentical identities are made to subsidize the de-structuring of the public sphere" (Katz, 2005: 146; see also Gilleard & Higgs, 2000: 197; Polivka & Longino, 2004; Tulle, 2004a,b: 180). It has been argued that health provides a more and more common conceptual framework for views about ageing, old age and the lives of old people (Featherstone and Hepworth 1995; Katz 2000). Foucaultian inspired researchers see this phenomenon as an indication of 'governmental rationality'. To put the idea of governmentality briefly, it is related with 'Foucault's idea of disciplinary society… and refers to mutual interaction between state and self-governance' (Gilleard & Higgs, 2000: 145–146). According to Katz, 'technologies of government describe and make practicable those ideal identities that best express the fit between political and personal goals'…and those 'technologies operate through the practices of the self' (2005: 146, see also Holstein & Gubrium, 2000: 225–226). Consequently, adopting an active and healthy lifestyle can be seen as one such practice, which promises 'liberation from the personal decrements' of old age, while engaging older people into 'fulfilling the goals of neoliberal ideology' (Tulle, 2004b: 181).

Robert Crawford speaks of 'healthism' (Crawford, 1980) to describe the central role of health in contemporary western life as a value, a goal of action, as a measure of virtuous identity and an organizing concept for much of social action (Crawford, 2006). As Crawford argues, a distinctive feature of contemporary thinking about health is that this is a matter that every individual can and should 'do something about', by means of their own actions and lifestyle choices (2006). In his empirical studies Crawford has shown that this line of thinking is an integral part of the everyday language and thinking of ordinary people in contemporary western culture (Crawford, 1980, 1994). Even though Crawford draws from a different theoretical framework than Foucaultian inspired theories and emphasizes more class related factors, the key ideas of healthism fit in well with the 'new ageing' discourse. The 'new ageing' or activity discourse infuse and transport the ideas of healthism into the field of ageing and old age. Old age is seen more and more as a health matter dependent on individual decision making and consequently as a matter of individual responsibility.

In some respects the participants' talk certainly echoed these themes, and "to live risk-aversion and self-caring lives" (Katz, 2005: 146) seemed to be experienced as much as a necessity as a possibility. Even though we take human agency for granted, the social and cultural discourses and development described above gives cause for concern that in the future, the agentic position will be reserved for 'seniors' who live up the expectations of a physically and socially active and healthy life, while physical impairments and dependence condemn people to be labelled as 'old' and to losing their agentic position. However, since these discursive or moral imperatives 'must be played out and through their local and particular applications' they 'virtually require the assertion of individual agency…to deal with the competing demands of that moment and its social circumstances' (Holstein & Gubrium, 2000: 229). In fact, both the concept of 'governmentality' (Tulle, 2004b) and 'healthism' (Crawford, 1994, 2006) leave room for individual agency. Older people are faced with conflicting expectations but, as the findings here also indicate, practices of everyday life leave scope for renegotiation of one's own agentic position (Holstein & Gubrium, 2000: 226–229).

If and when old age and agency in old age are seen mainly as a health issue, that may also overshadow the possibility of seeing older people as collective agents, participants and decision-makers in other issues than those concerning personal coping and management of health (Katz, 1996: 126–27). In the words of Emmanuelle Tulle (2004a), 'older people are either denied agency because they are engaged in an inexorable process of decline, or if agency does indeed manifest itself, it is used as a way of pushing back decline' (p. ix). In this study the participants' talk indicated they realized that older people are not normally seen as people who are interested in self-development and learning new things, or as political actors and useful members of society. As far as I can see their accounts of their own personal interest in politics, working in organizations and their eagerness to learn new things were attempts to redefine their position as 'old'. At the same time, these 'local narratives of identity' (Holstein & Gubrium, 2000: 229) served to challenge stereotypical views of older people in general, and to advocate the idea that older people are also collective agents and contributors in society. The knowledge and awareness of alternative ways to position oneself, not only 'soften the moral imperatives of self construction, but the alternatives can be weighed and worked against each other' (Holstein & Gubrium, 2000: 228) as participants talk showed.

In relation to other participants and peers, the participants constructed their position as equals or as sources of help for one another. A hierarchic difference was constructed between

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old and young people. Younger people were positioned as having a busy family and working life, while older people were outside that area and 'past it'. The notion that younger people were entitled to lead their own life gave further legitimacy to the idea that younger people are the principal agents in intergenerational relationships. In this context, enacting one's own agency meant accepting the situation and refraining from placing any demands on younger people so as not to become a burden to them. Older people's agency was conditional on younger people's wishes and needs. As was shown once again in this data, patients are usually positioned as subordinate to professionals in social and health care. Yet the assignment to the category of old seemed to further enhance that subordination. These findings can be explained in at least two ways. To give priority to young people may be seen as an altruistic act, as an admission that older people have had their turn (Holstein & Gubrium, 2000: 79). On the other hand, this may be seen as reproducing a deep-rooted western preference for youth and a relative undervaluing of everything that is old—accompanied here by self-deprecation. As was discussed earlier, another explanation can be sought from internalized negative views of ageing, which reduce expectations and lead the individual to accept subservient position 'as old' (Gilleard & Higgs, 2000, 137). These two explanations are not at variance with each other, but operate at different levels—and indeed in this case they both apply. As the analysis showed, in some cases this subservient position in relation to younger people or as a social actor was resisted and in some cases accepted. In any case mobilizing the category of old in talk leads to a questioning of one's own or others' agentic position. The findings here support Wray's (2004) argument that the investigation of agency needs to adopt a more culture sensitive approach, which sees agency as a relational and generative concept.

A broader dataset could have revealed more and different aspects of positioning as well as more variation in ways of defining oneself as old. However, as it stands the analysis shows that it is indeed possible to open up different meanings of agency by looking closely at people's accounts of their own life and at how they position themselves vis-à-vis other people. Studying agency as part of everyday decision-making and the meanings that older people ascribe to agency deserves more attention in research and in various programmes aimed at improving older people's chances to enact their agency. The findings suggest that older people's agency and enacting one's agentic potential involve a balancing act between contrasting and even conflicting experiences and expectations. Studies of agency in old age also need to address both embodied aspects of agency, that is, the sensed reality of a declining body and cultural constructions of body and dependence in the thinking of older people themselves (Hockey & James, 2003; Tulle, 2004b: 181). It is equally important to consider the role of language and cultural images of old as a symbolic hindrance to seeing older people as agents or their role as promoters of certain kinds of activities and interests as preferable for older people. Cultural representations of age are also representations of age-appropriate agency, which are internalized as part of self-identity (Gilleard & Higgs 2000; Hockey & James, 2003; Wray, 2004). However, since cultural discourses do not determine our thinking, as the findings here indicate, it is equally important to study those local practices in which meanings of old age and agency are defined, redefined, and put into practice (Holstein & Gubrium, 2000: 161–65). Studies of cultural images of old age combined with studies of encounters in homes, clubs, service centres and institutions and detailed analysis of the social positions and social practices that are taken for granted could shed useful light on how older people themselves see their possibilities and limitations for agency as individuals when they are defined as old.

IV

Appendix A

Transcription conventions

- overlapping speech starts and ends: / /
- particularly quiet speech: * *
- clear pause: ( )
- comment, unclear speech or possible interpretation in brackets: (unclear)
- heavy stress underlined: weak

Appendix B

Interview guide

The topics and questions explored in this study included (not necessarily in this order and with appropriate individual adjustment):

1) Definitions of health, personal and general
   What does health mean in your opinion? What does it mean to you personally?
   Tell me about your own health, what is it like?
2) Responsibility for health
   Do you think that people are responsible for their own health, or not?
   Do you think that people should look after their own health?
3) Personal influence
   Do you think it is possible for people to influence their own health? How? Have you yourself done something for the good of your own health?
4) Future concerns
   How about the future? What do you think about your own future? Do you have any concerns about the future and your health?
5) Age and health
   Have you noticed any changes in your health? Do you think that ageing has affected your health?

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