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Extending the Critical Gerontology Perspective: Cultural Dimensions:

Introduction

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Our first advances in gerontology were founded on empirical studies of common myths about the elderly at home and abroad. For example, the seminal NIMH Human Aging Study that identified undiagnosed disease conditions among elderly persons led to differentiating healthy aging from disease related impairments formerly attributed to “normal” aging. Similarly, the putative high esteem of aged people in technologically simple societies was shown by actual fieldwork to be an inaccurate idealization (Glascok, 1990; Maxwell, Silverman, & Maxwell, 1982).

Today, gerontology has advanced to the point where it can benefit by applying this same critical gaze in ward to examine its main topics of attention and the development of research and policy agendas. For example, research shows that the definitions of variables such as health, illness, ethnicity, family, and self are not universal. Instead, each culture provides its own definition of these constructs (Sankar, 1984). Even within cultures, there is diversity in how various subgroups define those constructs. Further, previously unrecognized ethnic and social class differences in health, morbidity, and mortality have shaped our knowledge of what constitutes “normal” aging; these factors are only now coming to be understood (Dannefer, 1988; House, Kessler, & Herzog, 1990; Longino, 1991). We propose that a modest increase in awareness of how gerontology is practiced will provide benefits by broadening our knowledge base and perhaps identifying unrecognized avenues for research and for policy options.

This introduction and the following articles by Ann Dill and Mark Luborsky suggest ways to extend the critical gerontology framework (Moody, 1988) to include such issues. They do so by developing insights into how wider American culture influences the conduct of gerontology. To understand and appreciate how cultural and historical factors pattern analytic constructs and the topics of study, we need to examine shifts in the nature of the definition of problems and the range of conceivable solutions. Such pursuits are a gap in the gerontological perspective which is gradually receiving wider recognition as a part of the rehabilitation and the aging enterprises (Gritzer & Arluke, 1985; Minkler & Estes, 1991; Moody, 1988).

Extending the Critical Gerontology Perspective

While the myths and realities approach in gerontology (e.g., Hendricks, 1986) continues to be productive, the time is ripe for more critical and cultural perspectives. We suggest the concepts and methods of critical studies be more widely introduced. The main goal of the critical gerontology (CG) approach is to identify wider societal influences on the problems that are examined, to explore how theorizing is done, and to analyze the consequences of different patterns of research and theory building. The CG approach is useful to other disciplines in that it shows how cultural categories enter into the world view of gerontology as well as the people it studies.

Critical Theory

Critical theory provides a starting point for critical gerontology. Contemporary critical theory is associated with the Continental philosophical and political movements of the Frankfurt school (Habermas, 1988; Slater, 1977) that rose to influence at mid-century. They argued from the stance that scientific and philosophical constructs are enmeshed in and serve to recreate the wider socio-historical settings. In gerontology, the moral and political economy paradigm builds from this perspective. Cogent reviews of the limitations of critical theory are offered by Hammersley (1992) and by Honneth (1987). The challenges it poses for gerontology are described by Moody (1988). More general versions of such a critical theory program have been described as “critical research” (Mishler, 1986) or “analytic induction” (Strauss, 1990; Denzin, 1989). The critical theorists primary concern with social structure and order did not provide a clear view of the ways that dynamic interactions and competition among social groups lead to social change and shifts in cultural world views. Nor was the individual conceptualized as a willful autonomous person. Instead, individuals were viewed as social norm or “rule-bound zombies” (Stuchlik & Holy, 1981) and were defined simply as the sum of their family, work, and community roles. Critical theory lacked models for important diversities in families and communities at the local level of knowledge (Geertz, 1983), for the nature of personal experience, or for individuals as proactive agents within social systems (Ortner, 1984). These lacunae are being addressed by qualitative researchers in gerontology. However, the inquiry developed here has not yet been made: the coupling of empirical studies of key constructs with culturally informed inquiry into the formation and consequences of the sense of what is problematic for study.

Cultural Dimensions

Culture patterns our knowledge by way of the basic building blocks of science. Two examples may clarify this view. From an anthropological view, sparse attention is devoted to asking how the growing body of knowledge embodies our cultural world-views. We are accustomed to treating variables and scientific procedures as value-free, a point contested by critical theorists. Yet even the language of science expresses basic cultural values. A critical gerontology points out the deep moral vein in our work: we are instructed to construct and carefully protect “independent” and “dependent” variables, the statistical “power” of our designs, we “control” variables and enhance people’s sense of control. We judge if constructs and data are right and “valid” or “in valid” (the latter word also denotes disability). Further, we share with the subjects the search for “themes” in our life and in the

data. Second, it can be suggested that the prevailing negative attitude toward “medicalization as a form of social control is not shared at all levels of society. The medical attention may be welcomed by people whose life long poverty excluded them from full participation in mainstream society including adequate healthcare. The universal entitlements provided by Medicare may serve as a welcome avenue to greater social equality.

Basic analytic constructs (e.g., independence, stress, family, frailty, self) are also cultural concepts, not value-free absolute variables. The constructs bring shared cultural assumptions about the world into the research process and the course of the discipline (Achenbaum, 1978; Cole, 1986; Estes & Binney, 1990; Rubinstein, 1990) as Moss and Moss (1989) document in the case of the disenfranchisement of death and grief from mainstream gerontology. Less explicitly, the constructs carry with them an implicit script or teleology for maintaining society and for individual development that replicates current values or social roles and inter group structures. Cohen and Sokolovsky (1989) describe how the dire conditions faced by aged men in the Bowery get defined in terms of individual adjustment problems, and not in terms of the wider societal and political factors that create the problems for individuals.

Briefly, we propose that the CG perspective can be enhanced by greater attention to the cultural components in the routine practice of gerontology and in the definition of problems for study. Following critical theory’s concern with sociocultural values immanent in analytic constructs, CG aims to show how conventional formulations of problems and constructs lead to expectable kinds of findings. The latter, in effect, directs us to seek out the implicit teleology or blueprints (e.g., the acorn is destined to be an oak tree) that replicate the vision for future society that is coded into traditional sociopolitical and scientific paradigms.

We argue that the field of gerontology is a particularly apt demonstration of these processes of cultural patterning by virtue of its multidisciplinary approach. It is important to clarify such cultural and historical processes as gerontologists assume a greater advocacy and policy role for a public that wrestles with the emerging “aging society,” and are called upon to propose new visions for aging individuals, society, and political-economic institutions.

Extending Critical Gerontology Concepts and Methods

A culturally informed critical gerontology may begin as follows. The extended CG engages in two modes of analyses. In the one, it examines the cultural contexts of the conduct of contemporary gerontology. In the other, it examines the nature of contextualization itself.

In one mode, culturally informed CG engages in contextualization of gerontology. First, perhaps most familiar to all gerontologists, CG asks about how the routine practice and basic constructs in our field are situated in and respond to particular historical, demographic, and sociocultural contexts. For example, family caregiving studies became ascendant (Abel, 1991a) in the context of a Conservative political ideology oriented to family responsibility and the divestiture of government from individual lives. In a second mode, CC engages in examining the very method of “contextualization,” that is, the wider settings within which an event or process occurs (cf., Ochs, 1990; Crapanzano, 1991). We recognize that

contextualization is a pervasive feature of qualitative research but observe that it has not received the same careful study as other analytic techniques or concepts. Specifically, we see a need to formulate explicit criteria for the conduct of contextualization, its goals, methods, and standards for evaluating its adequacy. These proposed developments will be directly relevant by specifying guidelines to help evaluate the adequacy and caliber of qualitative-quantitative publications, research, and program evaluations.

Outline for CG Studies

The generalized approaches for conducting CG studies can be briefly outlined. We begin with an overview and then describe some studies that applied the CG framework. The CG method rests upon the systematic pursuit of a set of clearly articulated questions. Quantitative and qualitative methods are used as dictated by the kind of problem being investigated. CG is characteristically based upon the hermeneutic style of a continuing dialogue between the theoretical and empirical approaches to a problem within each study.

CG studies include four general components. First, a clear definition of a key concept or problem formulation in gerontology is presented. Second, a description of how the construct is currently conceptualized is stated, and that formulation's place in the continuing (past to present) thought about the issue is summarized. Third, the current definition is critiqued to reveal several gaps and limitations in the concept/problem formulation's ability to explain the phenomena it focuses on, and other problems that it does not highlight. In particular, we ask in what ways are the problems defined for study consonant with the wider sociopolitical climate of that time, and in what ways do they implicitly embody visions for future social organization and values in human life. Fourth, the researcher conducts the empirical research and presents the data that is now informed by the analytical and historical critique. CG results are in the form of new data as well as new questions and analytic frames for thought.

Examples of Findings and Issues

Results and new questions developed from the extended CG framework were discussed during symposia chaired by the authors at the 1990 and 1991 meetings of The Gerontological Society of America. Several basic concepts were examined using data from ongoing research. Jaber Gubrium (1991) draws data from his study of caregivers of dementia patients to question the assumption that survey respondents are the passive vessels of answers to which researchers pose the questions. Instead, he shows how respondents create their answers through a process of questioning the question. That is, they actively examine and reexamine their lives in light of the posed question and consciously create their response. Using ethnographic work with dementia patients residing in nursing homes, Karen Lyman (1991) probes the construction of caregiving problems as disease based. Lyman's participant observation study suggests, in contrast, that caregiving should be analyzed as a power relationship and that care settings be seen as institutions invested in both care and social control. Based on research with caregivers of the dying and of dementia patients, Andrea Sankar (1991) argues for a rethinking of the dyadic formula in social support theories. Instead of the stimulus-response dynamic which favors a dyadic model, she suggests a systemic approach to understanding the dynamics and effects of positive and

negative support. In her analysis of the diaries and letters of 19th Century women caregivers, the historian Emily Abel (1991b) reconsiders the assumption that caregivers require professional support and guidance. She attributes the present need to historical shifts in local availability of support for women and in the legitimacy for women's knowledge of caregiving. This later development she links with the increased professionalism of the medical establishment. Similarly, Tamara Hareven and Kathleen Adams (1991) used data from their multi-generational study of a New England industrial town to question the a historical tendency of gerontology to focus its analysis on the present. This is particularly the case in its examination of patterns of intergenerational assistance. Instead, they suggest an evolutionary model in which patterns of assistance change over the life course and evolve with conditions in historical time. Linda Mitteness and Judith Barker (1991) described findings from a study of the management of chronic disease and argued that elderly people manage health problems by setting up hierarchies of relative disorder, placing any single health problem in the context of their life environment and other illnesses. The difference in hierarchies of priorities between patients and physicians leads to considerable conflict and miscommunication. Full articles presenting culturally informed critical gerontology studies of life themes by Mark Luborsky and of needs assessment by Ann Dill are presented in this symposium.

Initial results of applying the culturally extended CG perspective have revealed major domains of problems to grapple with in future studies. The issues represent what we believe to be several cutting-edge concerns for gerontology. The issues are formulated as questions or needs for future work. What theory and practice guidelines direct the technique of contextualization? How do we conceptualize the impetuses or motive power for change, at the level of individual action or agency, or of macrosocial structures? What criteria need to be applied to evaluate the claims of qualitative and critical gerontology? What are the implicit scripts for sociopolitical life in critical studies themselves? In multidisciplinary work, what are the implicit logical and theoretical incongruities created by the "creative" blending of conceptual categories and frameworks drawn from differing assumptions and traditions, and what are the implications for theory building and implementation of findings? Answers to these and other questions emerging from CC studies may offer vital new insights to advance gerontology.

In each study reported, contextualization is an important analytic method but is conducted differently. Studies of macro-level institutional processes and phenomena (e.g., systems of health care) are asking how to make sense of these higher order things in terms of individual lives and in concrete social settings. Conversely, the studies of individual phenomena (e.g., life histories) move toward asking how to make sense of the individual life enterprise as a phenomenon of general cultural and historical settings. Contextualization emerges as a continuing challenge as well as an analytic technique. Thus, another contribution is to clarify the problematic nature of contextualization; solutions remain elusive.

Final Remarks

We are not proposing that scientific progress in gerontology is dictated by cultural or historical facts. Clearly, there are many internal and external sources of change and insights

into aging in our discipline. Scientific advancements are provided by the cumulative weight of new scientific knowledge and by the emergence of competing scientific paradigms that open new areas of description, study, and hypotheses testing. Also, as a civilization there is stream of economic and political processes altering the landscape of social life within which concerns about aging are formulated and applied. These processes are fueled by a conceptualization of aging issues in terms of concerns about the shifting profile of age demographics, the social systems costs, and an evolving morality in post-industrial economies. Further, fashions and fads in intellectual perspectives, some transient and others enduring, enter into the discourse of gerontology. So, too, as one multidisciplinary cluster among many American scientific and political interest groups, gerontology works to position itself and to legitimate claims to a political-economic and intellectual territory. It acts as the “town-crier” on aging. Charismatic individuals or special interest groups contribute to progress, as do shifts in developmental and life-stage specific concerns among leaders in the field (Riley, 1988; Lawton, 1990).

In historical view, the early decades in gerontology attended to technical and data analytic concerns. It is now time to help in the maturing and future planning of the field by developing critical insights into the habituated modes of gerontological thought and practice. Future directions for a more culturally informed critical gerontology include studies of other topic areas, of the concepts guiding critical studies, and refinement of the current first generation of methodologies. It is vital to consider the “taken-for-granted” aspect of our sense of problems for gerontological study and how we practice theory building and application if we are to invigorate gerontological practice in the pursuit of basic and applied knowledge. The extended view of CG we propose suggests that gerontology develop a rigorous view of the cultural constructing of the field’s orienting questions and concepts. Should we as a field demure from this task, we may miss opportunities to develop new perspectives and modes of practice, thereby serving as exponents for cultural and historical processes rather than proponents of new directions and knowledge.

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