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Relation between medical sociology and sociology of ageing or later life. A new challenges, social expectations and dilemmas

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Abstract: Medical sociology has not paid special attention to observed demographic changes associated with the "greying of societies". Lack of interest in ageing has resulted in the necessity to develop a new subdiscipline – sociology of aging. The evolution of this subdiscipline has been described in relation to social gerontology. Theories of aging (healthy, successful) have been presented in relation to new changes. Dilemmas and intractable problems focus on prejudices concerning the older persons, gender-related differences in the quality of life in older age, elderly abuse, and quality of life in mentally ill old people as well as other issues.

Key words: medical sociology, sociology of aging – later life

Introduction

The number of people older than 60–65 years is expected to rise worldwide in the next decade, and the proportion of the world's population over 60 years is expected to double, while the global population over 85 years ("oldest old") is projected to increase by 351% between 2010 and 2050, compared with a 188% increase for the population aged over 65 years during the same time period (NIA, NIH, WHO 2011). Statistical data confirmed a demographic revolution associated with "the greying of societies" and increasing number of baby boomer cohorts entering into the Third Age as well as the old-old (85 years and over) entering into Fourth Age.

In his paper "Medical sociology at the millennium", W.C. Cockerham stresses that many of the current studies reflect problems or developments associated with postmodern social changes, the increasing proportion of the elderly is one of them, but these studies do not generally dispute within the subdiscipline concerning the interpretation of particu-

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lar social phenomenon, rather, they are typically efforts by medical sociologists to account for the effects of changing social conditions in a variety of areas".

It is necessary to mention that an increasing interest in sociology of ageing has been observed but researchers involved in this area come from disciplines other than medical sociology.

Anne Foner (2011) describing her personal half century as a sociologist of ageing and society experiences concluded: "the sociology of age and ageing as a field of study was relatively underdeveloped in the 1960s at the theoretical level sociologists had written about the problem of generations and had analyzed age as element of social structure. Later on many interdisciplinary studies had been performed focus on relation between ageing and society, Age stratification perspective called attention to the age structure, which consists of society-wide age strata and exploring the age as a basic of social stratification".

Some sociologists, even if they were involved in the teaching programs focused on what they define today as "sociology of ageing", in the previous stages of their academic career showed professional interest in social gerontology (Cutler 2011).

Unfortunately, medical sociology has not paid special attention to observed rapid demographic transformation in the context of second modernity and longevity. The growth of medical sociology (especially sociology of illness, disability and illness behaviors as a core of this subdiscipline) ignored the topics associated with ageing, and later life tended to be marginalized. Current medical sociology has continued to treat old age as a separate, often peripheral category. Conventional medical sociology has perceived the later life as a period of the lifecourse (retirement) or with illness states and showed a static understanding of what old age and ageing represent (Higgs and Jones 2009). These authors criticized the text book of sociology of health published by Germov (2005) who addresses ageing by linking it to death and dying in chapter "Ageing, dying and death in the twenty-first century" (Higgs and Jones 2009).

Lack of interest in the ageing and older stages of life has resulted in the necessity to develop new areas of research on ageing, as well as build new paradigms and concepts which could be useful to explain the role of sociological interpretation of different multidimensional problems affected by ageing.

Sociology of ageing has been developed separately in the Unites States (Settersten and Angel 2011) and in Great Britain (Higgs and Jones 2009). The Polish input to developing the "Sociology of ageing" focuses on the challenge of ageing societies in Central and Eastern Europe (Perek-Białas and Hoff, 2012). Among important issues explained were those associated with ageing as an image of the typical elderly Poles, elderly people in residential environment, typology of family care for dependent seniors , as well as different types of maltreatment and health –related quality of life in older age.

Victor W. Marshall and Vern L. Bengtson (2011) describing the evolution of sociology of ageing divided it into three phases: first phase – perceived the ageing as "role less roles" – withdrawing older citizen from social roles and social interactions, in relation to biological, psychological and social dimensions of life, waiting on dying and death; second phase – the concept of withdrawal was

replaced by a new approach to the ageing, focused on continuation of activity in older stage of life (at the same level as had been performed in the middle stage of life): such approach has developed a concept of successful ageing; and third phase – focused on developing a new idea of promoting older stage of life as an active approach (activity theory), concentrated on social participation of older citizens, physical activity, diet and other behaviors promoting health and reducing the risk of disease.

Age Stratification Model of Ageing developed by Riley (1972) focuses on the perspective of poverty in old age, different socio-economic positions in older age (Settersten and Angel 2011).

In the mid 1980s, the prevailing concept in the American sociology of ageing was that ageing (both on an individual and population level) was a process of cumulative experiences and risks coming from the earlier stages of life.

Using a "life approach perspective", based mainly on family sociology theoretical framework, focused on the connection between the life experiences and most important life decisions coming from the past and social situation of older people. From the perspective of life span, relations between the generation of grandparents and grandchildren, as well changes in the role of family in care-giving, have been analyzed in relation to "grey time bomb" and increasing risk of intergenerational conflicts (Connidis and McMullin 2002).

Classical theoretical framework used in development of sociology of ageing are based on E. Durkheim and M. Weber theories as well on T. Parsons and R. Merton (functionalism), G. Lenski and R. Dahrendorf (conflict theory) G. Homans and P Blue (interactionism, exchange theory), G.H. Mead, Ch. Cooley and E. Goffman (symbolic interactionism) and A. Schutz, P. Berger, T. Luckman (social constructionism) (cited after Settersten and Angel 2011).

The same theoretical framework such as structural functionalism, symbolic interactionism and conflict theory, which have a significant influence on the development of medical sociology, plays identical role in relation to sociology of ageing.

Connections between medical sociology and sociology of ageing are closely related to sociology of illness, sociology of health and sociology of body.

Sociology of ageing should show the social scenario for the significantly improved life expectancy – how to organize post retirement life as healthy ageing and active ageing in the context of understanding the impact of social changes.

Sociology of ageing, like medical sociology, focuses on the development of more holistic understanding of existing social inequalities in health, but also on the way the natural scenario of life span has been supported by cultural and social scenario, based on social participation and social expectations. Although Siegrist and Marmot (2004) mentioned that the "steepest social gradients in health are observed at two stages of life course: early childhood and midlife", this thesis has not been supported by data characterizing social inequalities in later life – on the contrary, to Siegrist and Marmot (2004), social inequalities in health remain significant. It is necessary to mention that studies on the role of the social pattern of health and disease (like socio-economic status) in relation to age groups focus only on the young and middle-aged; the age group of 65 yrs. and

above has usually been excluded from different analyses (Marmot, 1996).

Theories of ageing have a very short history in comparison to others (Bengtson and Roberts 1991) and currently focus on "successful ageing" – characterized by high satisfaction with life, high level of activity and social engagement (active theory). Period from 1965 to 1980 was very innovative in the sociology of ageing; different social concepts were developed, social interactionism significantly influenced perspectives on ageing, such as subculture of ageing theory or devaluated status of the elderly – ageism, the social breakdown theory – older people dealing with personal crisis at the micro-social level, experienced the victimization of ageing (Bengtson and Roberts 1991).

In their book "Medical Sociology and Old Age, Towards a Sociology of Health in Later Life", Paul Higgs and Ian R. Jones (2009) mentioned that "medical sociology has underplayed the issue of ageing within the main stream of its thinking while at the same time social gerontology has, with a few notable exceptions, avoided a direct engagement with the knowledge bases on medical sociology".

In parallel, the development of social gerontology in the last decades of the 20th century was based on bio-medicine, although social dimensions of ageing were involved in this concept. Social gerontology following the policy aim presented by WHO, is not only to prolong the duration of later life, but also to improve the quality of life of older people (Hung et al. 2010).

Gerontology and social gerontology based on the "disease model" of ageing, and in the medical model healthy ageing means the absence of chronic illness, the ability to overcome chronic illness, or the elimination of risk factors that lead to chronic illness (Hansen-Kyle 2005).

Healthy and successful ageing

Definitions of healthy ageing based on subjective assessment of older people have shown that older people's norms, perception and self-awareness of the reality of ageing vary among different cultures (Hung et al., 2010). These differences are mostly based on traditions, religious beliefs and the system of values. Cross-cultural studies on ageing showed different perception of ageing as well as different definition of successful ageing by elders coming from different cultures. For example, for older Japanese main components of successful aging were: remaining in good health, being able to take care of oneself, having family and friends, good genes, being free of chronic diseases, satisfied with life, and adjusted to age-related changes. For older Americans, apart from all the above mentioned factors (excluding genes) of importance were also social involvement, being able to make choices, to meet all needs, to act accordingly to own inner standards and values, and to cope with challenges of later years, as well as not feeling lonely or isolated (Matsubayashi, Ishine, Wada, & Okumiya 2006). For older Australians, successful aging means: 1) remaining in good health, 2) being able to take care of oneself, 3) remaining free of chronic disease, 4) feeling good about oneself, 5) feeling satisfied with life the majority of the time, 6) being able to make choices about things that affect aging, and 7) staying involved with the world and people, 8) being able to act according to own inner standards and values, 9) having friends and family, 10) not feeling lonely or isolated, 11) adjusting to changes

that are related to aging, 12) being able to cope with the challenges of later years, 13) being able to meet all of own needs (Tan, Ward, & Ziaian 2011).

Schulz and Heckhausen (1999) focused on a "normal ageing process" and described the healthy ageing as the process of decreasing morbidity and increasing the age of mortality.

Healthy ageing has been perceived as a successful ageing, and most definitions stress its multidimensional characteristics using physiological, psychological, societal and personal perspectives. Most of developed gerontological definitions involved the "social aspects of ageing" – such as the ability to continue social functions, personal accommodation, autonomy, supportive environment.

Sociological perspective focus on healthy ageing including the psychological interpretation (attitudes, resilience and personal- subjective definitions of healthy ageing) and adds social interactions and social support structures. Other authors focused on psychosocial perspectives of healthy/successful ageing, mentioned the role of openness to change, individual autonomy, and equated autonomy to healthy, successful ageing social support and social interactions. The cultural ideas and role expectations play also a part in the successful ageing (Hansen-Kyle 2005).

Several definitions of healthy or successful aging stressed the role of health independence, family, financial security, life adaptation, personal growth, friends/relatives relationship, emotional care from family and friends, satisfaction with life, regular social activities, high level of psychological and social well-being, learning new things, physical appearance, sense of humor and spirituality, leisure activity, happiness, independence.

Contrary to the conclusion given by Hung and colleagues (2010) that healthy ageing is a more appropriate term which is clearer and more widely understood than "successful ageing", from sociological perspective successful ageing, especially assessment based on subjective opinions presented by older people, have given more significant information about social status of older people in society, level of social integration, intergenerational interactions, and life satisfaction.

In spite of the above mentioned definitions of healthy and successful ageing, also other concepts have been presented, for example positive aging as a state characterized by feelings of control, social relationships, quality of environmental settings, mental health, cognitive efficacy, social competence and productivity, personal control, life satisfaction, and ability to cope with stressful situations, the maintenance of a strong social support system, integration in the community, high morale and life satisfaction, psychological well-being and level of physical fitness and physical health or as a functional ability or role functioning (domestic), quality of social and community interaction, psychological well-being, somatic sensations (pain), life satisfaction.

Concept of health related quality of life has been developed in the 1970s, based on a general quality of life defined as a possession of resources necessary to the satisfaction of individual needs, wants, and desires; participation in activities enabling personal development, self-actualization and satisfactory comparison between oneself and others (Crowther et al. 2002, Young et al. 2009).

Social dimensions of the quality of life

Perception of intergenerational relationships and family solidarity, generational bias – parents usually rated their relationship as warmer and more cohesive than children did. The generational stake theory focuses on the explanation of differences in the perception of one group by another and how to explain the perception of age groups.

Model of intergenerational solidarity in ageing families (identifies six dimensions of solidarity: affectual, associational, structural, consensual, functional and normative) developed by Bengtson and Roberts (1991), Silverstein and Bengtson (1997) as well as conflict, ambivalence in family relationships and the role of stress have been used to provide a multidimensional theoretical explanation for the mistreatment of older adults. A phenomenological approach has been helpful to develop a domestic violence paradigm (Biggs and Goergen 2010). Dependency caused by health status and disability (somatic and mental) of seniors associated with the necessity of expected help, care and social support, like a "hospital at home" triggers problems related to issues such as abusive behaviours performed by carers.

Relation between social network characteristic and health outcomes in older age has been well documented by many studies in relation to structural aspects: number of close friends and relatives, marital status, affiliation or membership in religious or voluntary association.

Convey theory showed that "an individual is seen in a life course perspective as travelling through life surrounded by members of his/her cohort who share experiences and life histories and who provide support to one another reciprocally over time" (Antonucci and Akiyama 1987, Kahn and Antonucci 1980 cited by Berkman and Glass 2000).

Especially in older stage of life, social support coming from social network influences significantly mental health, psychological and social well-being.

Sociological concept associated with later life focuses especially on social networks encompassing interrelations among individuals; defined as a set of nodes that are tied to one another by types of relations between them (Moren-Cross, Lin 2000). Social relationships surrounding an old person, refer to the structural aspects – they are the channels through which pragmatic help as well as emotional and support can be exchanged between individuals (Victor, 2000, Achat et al 1998).

Life course perspective has been concentrated on conveying dynamic and lifelong changes in some ways, but remaining stable in others, across time and situation (Antonucci 1985, Kahn, Antonucci 1980, cited by Ajrouch, Blandon, Antonucci 2005). Social networks in older adults have been defined as a combination of indicators of the networks' structure (number and proximity of ties and reciprocity of helping) as well as network function (frequency of visual and non-visual contacts) and feelings of intimacy and closeness. Social relations of older persons are usually evaluated by contacts with children, grandchildren, other family members, contacts with friends, neighbours and participation in religious community, as well as in voluntary groups and associations.

Dilemmas and intractable problems

Observed rapid demographic, economic, cultural and social changes as well as medical success in the treatment of several chronic conditions, has developed various dilemmas concerning the definition of a beginning of older age and necessity of modification of existing stages of the older part of life in relation to systematically increased life expectances (especially among women). It is also important to stress the shortage of real sociological definition of older age, based on social indicators. Existing definitions based on the medical model of ageing, mostly concentrated on healthy ageing tend to, overlook the psychosocial conditions experienced by the predominant part of older citizens suffering from characteristic chronic conditions or different levels of disability and limitation in everyday activities.

Stereotypical perception of older people based on prejudice and several manifestations of ageism related to intergenerational relationships determined the level of social integration or disintegration. Sociology of ageing or sociology focusing on later life should develop successful strategies to cope with obstacles responsible for negative attitudes toward the older part of society; these strategies should follow the changes in the family life models, a new approach to traditional role of care-giving and support given to older parents and grandparents, especially with limitations in everyday activities caused by chronic conditions and disability, significantly determined by occupational activity performed by younger relatives of senior's families, migrations, as well as by their material and psychosocial resources.

Gender differences in health in later life supported the well known paradox that men are likely to die earlier than women but women suffer from a higher level of chronic health conditions and disability (Arber and Cooper 1999, Jefferys 1996).

Gender and ageing (Arber et al. 2003) concentrated on changes in social roles and relationships, especially in relation to feminization of the older part of society. Older women account for a majority in the later age group, mostly widowed or divorced (only about 35% married women in the age group 65 years and over), they live single and suffer from loneliness. Gender–related differences in social networks have been noticed. Feminization of older age has been observed over many generations of older people, but current data from the European countries confirm that later life become less numerically dominated by women (Arber 2003). The significant role of older women as a care-givers in comparison to men has been well documented in several studies.

Cecilia Tomassini et al. (2003) mentioned well documented gender differences in the structure of families and social networks. A significant transition for many older people (mostly women) begins when they are widowed, in the consequences of the loss of a partner (husband/wife) perceived as the main source of companionship and instrumental and emotional support (Aber, 2003).

Sara Arber (2003) cited the results of Davidson study (2001) who showed gender-related differences associated with widowhood: for older women widowhood may be associated with a newly found sense of freedom and autonomy, whereas widowers can see no advantage at all of being widowed compared to be-

ing married. It is necessary to mention that the current generation of older women have had a very different life course from the oldest generation of women but also from older men. Data showed that older women more frequently than men are victims of different forms of domestic violence (Tobiasz-Adamczyk 2009). Most of well-documented studies confirmed a poorer quality of life in older women in comparison to men (Tobiasz-Adamczyk 2003).

Traditional social inequalities based on socio-economic status and family status in the older stage of life have been additionally influenced by gender, social networks and material resources.

Abuse against older people, recognized in the middle of the 1970th symbolized by the case of "Granny Battering" (Baker 1975) has developed a new area of psychological and social research focused on description of this "taboo" phenomena in relation to social theories of aggression as well deviant behaviours presented by perpetrators in different social environments, social groups and social classes. International Network for the Prevention of Elder Abuse, World Elder Abuse Awareness Day, Abuse and Neglect of the Elderly discussion on abuse showed that only 15–16% of domestic abuse as well as other forms of aggressive behaviours have been recognized – majority of older victims are still unknown. Critical assessment of the spread of awareness of mistreatment depends on understanding of what constitutes elder mistreatment (Tobiasz-Adamczyk 2009, Penhale 2010).

Connection between sociology and mental disorders in older age based on ethnomethodology and symbolic interactionism as well as on theory of social deviance and social control confirmed poor quality of life of older people with mental disorders, and continuation of previous inequalities coming from earlier stages of life.

New social dilemmas associated with active ageing, such as elderly drivers, but also inequalities in the participation in the University of Third Age. Ageing has also been characterized by the problem of institutionalization of older people or homes for the aged, as well as self-damage behaviours, for example senior suicide.

In conclusion it should be stated that it is necessary to expect that the future will bring successful development of sociology of ageing also in Poland (Tobiasz-Adamczyk 2012), because most of the sociologists interested in ageing participate in the gerontological studies and only some of them try to perform pure sociological studies on this topic.

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