UC Berkeley

UC Berkeley Electronic Theses and Dissertations

Title

"This is How We Live, This is How We Die:" Social Stratification, Aging, and Health in Urban America

Permalink

https://escholarship.org/uc/item/6831m48q

Author

Abramson, Corey Michael

Publication Date

2012

Peer reviewed|Thesis/dissertation

eScholarship.org Powered by the California Digital Library
University of California

"This is How We Live, This is How We Die:" Social Stratification, Aging, and Health in Urban America

By

Corey Michael Abramson

A dissertation submitted in partial satisfaction of the

requirements for the degree of

Doctor of Philosophy

in

Sociology

in the

Graduate Division

of the

University of California, Berkeley

Committee in Charge:

Professor Martín Sánchez-Jankowski, Chair
Professor Claude S. Fischer
Professor Ann Swidler
Professor Michael Hout
Professor Daniel Dohan (UCSF)
Professor David Montejano

Fall 2012

“This is How We Live, This is How We Die:”
Social Stratification, Aging, and Health in Urban America

Copyright © 2012

by

Corey Michael Abramson

Abstract

"This is How We Live, This is How We Die:"
Social Stratification, Aging, and Health in Urban America

by

Corey Michael Abramson

Doctor of Philosophy in Sociology

University of California, Berkeley

Professor Martín Sánchez-Jankowski, Chair

From our first breath in the hospital to the day we die, we live in a society characterized by unequal opportunities for maintaining health and taking care of ourselves when ill. These disparities reflect persistent racial, socio-economic, and gender-based inequalities and contribute to their persistence over time. Social scientists have established that gaps in access to information, uneven material resources, unequal treatment in medical institutions, and differences in interpersonal networks link social inequalities to disparities in morbidity, mortality, and health behaviors. However, we know less about how these links operate in everyday life. This dissertation uses findings from three years of comparative ethnographic research in four urban neighborhoods and 60 in-depth interviews with seniors from different race, class, and gender groups, to show how inequality shapes seniors' responses to the health and illness demands of growing old. The findings show how spatial disparities, resource differences, and social networks profoundly affect the way seniors respond to the challenges of aging. However, explaining how these inequalities operate in everyday life requires understanding how culture links past inequality, present experiences, and behavior in the unequal contexts of the American city.

Although the poor and marginalized have to deal with the problems of growing old at a younger age, all those who live through "old age" face shared predicaments (chapter 2). In old age, seniors across socioeconomic and racial lines confront new challenges grounded in the degeneration of their bodies. As people grew older, they often face pain, a loss of energy, declining mobility, cognitive slowing, and sensory changes. They must confront increased health problems, the deaths of loved ones, and the erosion of prized characteristics like beauty, stamina and wit. Ultimately, they must deal with their own mortality. The problems of their foundering bodies come to profoundly limit what they can do in the world. In facing these predicaments, many seniors from across the social spectrum come to a shared realization that "old age" becomes a primary force in shaping their everyday lives. As they interact with the physical and social world, the dwindling capacities and physical uncertainties of their aging bodies create persistent problems of social action that require a response—the aging body becomes a "structural dilemma."

While they face a shared set of problems, what different groups of seniors see as the most desirable, reasonable, and plausible responses to this dilemma reflect different "cultures of aging" (Chapter 3). These responses reflect both past inequalities and present circumstances.

Different combinations of motivations (i.e. protecting the body or maximizing enjoyment before it breaks) and orientations (i.e. the body is self-regulating or the body needs to be regulated) acquired over the life course lead seniors to pursue different strategies in old age— some spend all day at the doctor's, others spend the day at the bar or other social settings. Some go to the farmers' market for produce, others get sugary drinks at Starbucks. Some wait until a physical problem lands them in the emergency department, others check in with the doctor every time they develop a cough. These differences often break down along the lines of ethnicity and past socioeconomic status. However, they continue to affect how people act even when they have similar resources, access to health care, and information in the present.

Social networks, which also reflect past and present inequality, matter a great deal in old age. Friends, families, neighbors, and acquaintances affect how seniors respond to the everyday challenges of aging (chapter 4). However, how these "social ties" operate depends on shared cultural norms and understandings that differ between groups. For instance, for some helping neighbors is an obligation whereas for others it is an economic exchange. Being in contact with friends can mean lunch and a ride to the doctor or it can mean skipping an appointment to go to the pool hall. While being together matters, what "being together" means is different for different groups of seniors.

The persistent material, organizational, and spatial inequalities that shape individuals' lives over the working years also profoundly affect how they can respond to aging (chapter 5). Seniors from both middle-class and poor neighborhoods rely extensively on a social "safety net" to secure access to basic resources like food, housing, and medical care. However, middle-class seniors have access to substantially more services and services of a higher quality. Further, seniors confront old age with substantially different individual resources that reflect past inequality. Those who enter old age with homes, pensions, and supplementary insurance have more options for responding to problems both large (e.g. a major illness) and small (e.g. getting food they desire). In contrast, poor seniors must rely on referrals from "street level bureaucrats" like social workers and clinicians who maintain substantial control over their lives. The entrepreneurial structure of grant funding compounds this problem by funneling competitive resources to the most affluent areas. At the same time, ongoing funding cuts and other austerity measures threaten to erode funding on a local, state, and federal level and consequently diminish services that poor seniors most depended on.

These findings show that attempts to explain how inequality, health, and behavior affect one another over the life course cannot ignore the interplay between structural inequality and culture. First, culture provides a fundamental mechanism that links past structural inequality and present behavior. People's understandings, motivations, shared strategies, and repertoires are not just an interesting addendum to material inequality, but a reflection of it. They limit which behaviors are desirable, reasonable, and plausible, and consequently are key to the reproduction of stratified social systems. Second, while social ties matter immensely, discussing "social capital" without reference to the socio-historical and cultural contexts in which these ties exist is misleading. Culture ultimately shapes what "being together" means. Third, which cultural categories most profoundly structure behavior in a given context reflect unequal resources— and in old age, the aging body becomes a fundamental category and stratifying resource. Explaining how people respond to complex bio-social dilemmas like growing old requires us to move beyond models of disembodied actors towards a deeper understanding of situated bodily cultures that reflect inequalities both past and present. For more information on the author and related projects please visit: http://cmabramson.com/

Table of Contents

Contents …….. i

Acknowledgements ……..... ii

Chapter 1: Introduction..…...…… 1

Chapter 2: "Wearing Out" and "Breaking Down": The Convergent Predicaments of the Aging Body ……..……... 15

Chapter 3: The "Desirable," "Reasonable," and "Plausible": Cultures of Aging ……. 34

Chapter 4: The Meaning of "Who You Know": Networks, Norms and Health in Old Age … 50

Chapter 5: "It's Money": Unequal Contexts and Resources for Aging in the American City . 62

Chapter 6: Conclusion…...…… 82

Bibliography ….……. 88

Appendix 1: Sample Interview Schedule ……...……... 100

Acknowledgements

The notion that a dissertation manuscript is the work of a single individual, rather than a collective effort that takes place in a larger community of scholars, friends, and family, is misguided. The "lone scholar" framing not only obscures the nature of the research enterprise (doubly so for ethnographic research), but it robs credit from those who deserve it most. This section is a cursory nod to this fact; an opportunity to briefly thank people who deserve more credit and praise than I can put into a preface.

Foremost among them is my longtime advisor and mentor Martín Sánchez-Jankowski. It was his work that convinced me of both the viability and the necessity of conducting participant observation in a systematic comparative manner. Since meeting him as an undergraduate, Martín has invested an incredible amount of time and energy in my intellectual, professional, and personal development. He has always pushed me to do my best, given me feedback on myriad projects, treated me with great respect, and shown remarkable patience in the process. I hope to one day make his immense investment worthwhile. Claude Fischer has been a mentor to me since the very beginning of my sociology career as well. His work and writings have profoundly influenced how I approach social networks, the American context, and sociology more generally. Claude has continually worked with me to improve my writing and hone my analytical skills and has provided candid feedback on nearly all my projects, both large and small, and read more rough drafts than anyone ought to be subjected.

Ann Swidler has been a formative intellectual influence on me. Her work on culture provided inspiration for a number of my projects, this one included. Over the past eight years she has provided me with intellectual feedback, encouragement, and often needed professional advice. Mike Hout has been essential in the development of my interest in inequality and methodology. He has been there since I began at Berkeley, provided me feedback and mentorship, and helped me clarify many half-baked tables in my quantitative projects. Although I have known Dan Dohan for a shorter amount of time, during the past two years he has invested a great deal of time and energy in mentoring me. Intellectually, working with Dan has forced me to expand my understandings of what sociologists can do with their methodological tools and provided a model of how to conduct ambitious collaborative projects. Finally, David Montejano has been involved in all the milestones of my graduate career, from my qualifying exams onward, and in the process provided useful feedback, skepticism, and commentary that helped this project take form.

Outside of my dissertation committee, Aaron Cicourel has encouraged me to think critically about the role of ethnographic research in social science and has helped me hone my ideas as a methodologist. Aaron has also continually pushed me to consider the role of cognitive structures in my understandings and models of social action. Steve Vaisey's work has not only helped shape my understanding of culture, but he has provided useful advice on a number of my projects, as well as candid mentoring, professionalization help, and perspective. Trond Petersen chaired my qualifying exam committee, helped train me in quantitative methods, and provided me with feedback on many of the statistical projects that were the essential precursors to this dissertation.

The Institute for the Study of Societal Issues (ISSI), the Center for Research on Social Change (CRSC), and the Center for Urban Ethnography (CUE) each provided me with physical and intellectual homes during my research. At CRSC, Christine Trost, Deborah Lustig, and David Minkus provided feedback, encouragement, and mentorship on many of my endeavors in

the past three years, this dissertation included. Their excellent training program also exposed me to interdisciplinary approaches to social research and public engagement that have helped broaden my views of social science and its possibilities. Eva Seto and Christine Trost have been immensely helpful in both encouraging community at ISSI generally, and helping me specifically. The Jacob K. Javits program, the Center for the Study of Social Change, the Center for Latino Policy Research, the Department of Sociology at UCB, and the University of California Berkeley more generally, each provided funds during my time in graduate school.

The graduate fellows at CUE have served as a primary source of support, feedback, and intellectual development since I entered graduate school. Phillip Fucella has not only been a friend, but has provided commentary on many iterations of my projects. Darren Modzelewski has worked with and encouraged me on various projects, and also has the dubious distinction of being the only person on this list to have given me a concussion. Greggor Mattson, Katie Marker, Manata Hashemi, and Silvia Pasquetti have been friends and long time members of the CUE writing group— providing invaluable feedback on nearly all of my articles, projects, and professional materials. Chris Herring, Alisa Szatrowski, Siri Colom, and Susan Miller are newer members who have provided useful comments on the final stages of this dissertation. Neil Gong has been not only an engaging student and a talented research assistant who contributed to this project, but also a friend and colleague. The other graduate students at CRSC provided me with valuable feedback, friendship, and support during my final years at Berkeley, particularly my writing group: Yolanda Anyon, Jose Arias, Trevor Gardner, Anne Martin Sara Anne Minkin, Keramet Reiter, and Alex Schafran. Kelsey Hoff invested an immense amount of time and energy in this project as a research assistant. Her work was key to maintaining momentum in data collection and analysis during the final phases of this project. Several other research assistants and interns, including Katherine Hood, Johanna Lee, Tiffany Abramson, and Shira Saperstein helped with vital tasks on this dissertation. My family has provided more support and inspiration than I can ever put into words both during this project and over the course of my life, so rather than try and fail, I can only hope to eventually "make good" on their support and sacrifices.

Finally, although confidentiality requires that they not be named, I would like to thank the many seniors who participated in this project and allowed me to be part of their world, as well as the leaders and members of the organizations I observed. Their insights and friendship have profoundly altered the way I approach the world, and it is my sincerest hope that something in this manuscript will be useful for addressing the challenges they face in their everyday lives.

Introduction

All would live long, but none would be old.
Benjamin Franklin

Social scientists have repeatedly demonstrated that racial, economic, and gender based disparities in health both result from persistent social inequalities and contribute to their persistence over time.[1] Being poor and marginalized contributes to stress and illness. Being ill limits already scarce opportunities for socio-economic mobility.[2] Myriad studies have established that gaps in access to information, uneven material resources, unequal treatment in medical institutions, and differences in social networks, constitute mechanisms[3] that link social inequalities to disparities in morbidity, mortality, and health behaviors.[4] However, despite knowing that structural and institutional factors predict inequalities in health, we know less about how key mechanisms operate in everyday life for different groups.[5] This dissertation uses findings from three years of comparative ethnographic research in four urban neighborhoods and 60 in-depth interviews with seniors from different race, class, and gender groups, to show how spatial inequalities, resource disparities, culture, and social networks lead seniors to manage the health and illness demands of growing old in different ways. In doing so, it shows how the key categories and resources that define inequality change in the "end game" of old age and in the process provides new perspectives on the relationship between persistent social inequality, culture, and the human body.

---

[1] See Alberto Palloni and Carolina Milesi."Economic achievement, inequalities and health disparities: The intervening role of early health status *" Research in Social Stratification and Mobility* 24(2006):21-40; David R. Williams, "The Health of U.S. Racial and Ethnic Populations" *Journal of Gerontology* 60(2005):S53-S62; David R. Williams and Chiquita Collins, "US Socioeconomic and Racial Differences in Health: Patterns and Explanations." *Annual Review of Sociology* 21(1995): 349-386.

[2] For a review see Adler and Newman (2002). Nancy E. Adler and Katherine Newman. "Socioeconomic Disparities In Health: Pathways And Policies". *Health Affairs* 21.2 (2002): 60-76.

[3] I use the term mechanisms to refer to the intermediary pathways that connect explanatory variables to observable outcomes. As Richard Swedberg and Peter Hedström note, "This style [of theorizing] can roughly be characterized by a focus on middle-range puzzles or paradoxes for which precise, action-based, abstract, and fine-grained explanations are sought." See also Sánchez-Jankowski and Abramson (2012) and Hedström and Ylikoski (2010). Peter Hedström, and Petri Ylikoski. "Causal Mechanisms in the Social Sciences". *Annual Review of Sociology* 36 (2010): 49-67; Peter Hedstrom and Richard Swedberg. "Social Mechanisms: an Introductory Essay." *Social Mechanisms: An Analytical Approach to Social Theory*. Ed. Peter Hedstrom and Richard Swedberg. Cambridge: Cambridge University Press, 1998. 25; Martín Sánchez-Jankowski and Corey M. Abramson. "Direct Observation and Causal Inference: The Function and Practice of Participant Observation in The Positivist-Behavioral Tradition." *AJS Causal Thinking and Ethnographic Research*. Ed. M. Small. Chicago: American Journal of Sociology. 2012.

[4] For a review of this literature see Williams (2005), Williams and Collins (1995), Spalter-Roth, et. al. (2005) and Roth and Mirowsky (2008). Catherine E. Ross and John Mirowsky. "Neighborhood Socioeconomic Status and Health: Context or Composition?" *City and Community* 7(2008): 163-179; Roberta Spalter-Roth, Terri Ann Lowenthal, and Mercedes Rubio. "Race Ethnicity, and the Health of Americans." *ASA Series on How Race and Ethnicity Matter*. Ed. Roberta Spalter-Roth: American Sociological Association. 2005.

[5] For a review of this problem see Fred C. Pampel, Patrick M. Krueger, and Justin T. Denney. "Socioeconomic Disparities in Health Behaviors." *Annual Review of Sociology* 36(2010): 349–70.

An Aging America

Studying the elderly, how they live, how they die, and how we as a society treat them, is more important than ever. Americans are living longer than ever before. In 1900, the average life expectancy for an American child coming into the world was just over 47 years.[6] In contrast, a newborn in the United States in 2010 can expect to live to be almost 78, and fewer than 7 out of every 1000 children die in infancy.[7] This is part of a larger historical trend towards a longer, more secure, and more predictable life course has drastically altered the American social landscape.[8] Compared to children born a century or more ago, children today can expect their lives to be comparatively free of fatal accidents in the factory and on the farm, debilitating diseases, disruptions from war and famine, and early violent deaths.[9] Consequently, the elderly now make up a larger portion of the US population than at any time previously.[10] Between 1950 and 2000 alone, the percentage of Americans over 65 years of age rose dramatically from 8% to 12.4%. Although racial minorities and those subject to socioeconomic disadvantage have shorter lives than their peers on average, these groups have increasingly benefited from expanded life expectancy as well.[11] Accordingly, the people who live until old age in America are more racially and economically diverse than ever before. For the first time in our history, it is not only plausible, but likely, that many Americans will spend a larger portion of their lives caring for elderly parents or ill spouses than for small children.[12] More of us will live to be old. As medical technologies advance and the baby boomers transition into old age, these trends are expected to accelerate.

Studying seniors is not only essential practically to deal with the new demographic demands of coming years, but essential theoretically for those interested in the form and content of social stratification in America. While life is more stable than in past epochs, the reality is that America remains a deeply unequal place.[13] The race, class, and gender inequalities that permeate American society shape the length, trajectory, and content of individual lives, past and present.[14]

---

[6] From CRS compilation of National Center for Health Statistics (NCHS) data. Laura B. Shrestha. *Life Expectancy in the United States*. Ed. Congressional Research Service: Library of Congress, 2006.

[7] Centers for Disease Control and Prevention, National Center for Health Statistics. *Deaths and Mortality*, http://www.cdc.gov/nchs/fastats/deaths.htm (2011)

[8] Claude S. Fischer. *Made in America: A Social History of American Culture and Character*. Chicago: The University of Chicago Press, 2010.

[9] See Fischer (2010). Steven Mintz. *Huck's Raft: A History of American Childhood*. Cambridge: Belknap Press of Harvard University Press, 2004.

[10] I use the terms elderly, aged, and seniors interchangeably to refer to individuals of 65 years of age or older.

[11] U.S. Administration on Aging. *A Profile of Older Americans*. Washington, D.C, 2009.

[12] See Emily K. Abel and Margaret K. Nelson. *Circles of Care: Work and Identity in Women's Lives*. New York: State University of New York Press, 1990. As Hochschild notes, these "recent trends in the United States have expanded the need for care while contracting the supply of it, creating a 'care deficit' in both private and public life" (214). Arlie Russell Hochschild. *The Commercialization of Intimate Life: Notes from Home and Work*. Berkeley: University of California Press, 2003.

[13] For evidence that substantial inequalities in income, race, and education persist in America, see Massey (2007). For a review of the changing historical form of persistent inequalities in American society see Fischer and Hout (2006). Claude S. Fischer and Mike Hout. *Century of Difference: How America Changed in the Last One Hundred Years*. New York: Russell Sage, 2006; Douglas S. Massey. *Categorically Unequal: The American Stratification System*. New York: Russell Sage Foundation, 2007.

[14] For instance, most African American men born in 1900 would die before they reached age 33, more than a decade before their white counterparts. In 2010 newborn African American males fared better. They could expect to live to

The poor and members of racial minority groups are more likely to die young,[15] become geographically uprooted,[16] or suffer from debilitating illness.[17] Childhood and old age are the only moments in the life course where there is a major state intervention aimed at addressing these persistent inequalities. In childhood, the state intervenes by holding out the promise of universal education. In old age, the state intervenes by offering the promise of "entitlements" like Social Security and Medicare. Sociologists have produced an immense body of literature examining the relationship between educational interventions, mobility, and social stratification.[18] We know much about how inequality works in the early and middle years of life.[19] We know comparatively less about how it works at the end. Studying the elderly offers us a particularly useful and surprisingly underutilized lens for understanding the inner workings of these persistent American inequalities. They show us how social stratification works out in the end game—old age and death. They allow us to see if and how the categories and resources that structure our experiences change over the life course. Looking at the aged offers the potential for new insights and perspectives on American inequality, yet how and why particular forms of inequality operate (or cease to operate) in old age is unclear.

The "Leveling" Versus "Cumulative Disadvantage" Debate

The underdevelopment of the mechanisms linking aging, health, and inequality are evident in the debates around whether old age should be understood as a time of "leveling" or "cumulative disadvantage." Social scientists have extensively documented the ways that inequalities translate into differences in who lives and who dies. They have shown that much of the effect of inequality on health plays out through "selective mortality." We know that those with fewer resources, and those from marginalized racial groups, tend to be less healthy and die younger.[20] The truly disadvantaged die before they ever have the chance to grow old. This begs the question, if inequality plays out largely via who dies before they get old, what happens to the pool of "survivors" that reaches old age? Some argue that old age becomes a time of leveling. According to this line of argument, members of disadvantaged groups who survive into old age are biologically and socially "robust." This robustness combined with social insurance programs

---

around 70. Still, this is over 5 years less than a white male. Likewise, women today tend to live about 5 years longer than men. National Center for Health Statistics (NCHS) data. See Shrestha (2006).

[15] See George Howard et al. "Race, Socioeconomic Status, and Cause-Specific Mortality." *Annals of Epidemiology* 10.4 (May 2000): 214-223.

[16] For an example of recent work on home foreclosures, see Carolina Reid and Elizabeth Laderman. "The Untold Costs of Subprime Lending: Examining the Links Among Higher-Priced Lending, Foreclosures and Race in California." *Community Development Investment Center Working Paper, Federal Reserve Bank of San Francisco*. 09(2009). Regarding displacement in the wake of natural disasters, see A. Fothergill, E. G. M. Maestas, and J. D. Darlington. "Race, Ethnicity and Disasters in the United States: A Review of the Literature." *Disasters* 23(1999): 156–173.

[17] See Williams and Collins (1995)

[18] See for instance Richard Breen and Jan O. Jonsson. "Inequality of Opportunity in Comparative Perspective: Recent Research on Educational Attainment and Social Mobility." *Annual Review of Sociology.* 221(2005): 223-43.

[19] For a general review of the sources and effects of social inequality see Kathryn M. Neckerman, ed. *Social Inequality*. New York: Russell Sage, 2004.

[20] CJL Murray et al. "Eight Americas: Investigating Mortality Disparities across Races, Counties, and Race-Counties in the United States". *PLOS Med* 3.9(2006): 1513-1524.

like Medicare make old age a time when the inequalities that structure the earlier part of the life course are mitigated.[21]

A competing body of research suggests that old age is a time of "cumulative disadvantage," where multiple interlocking inequalities tend to gain momentum and converge, making the poor and members of minority groups more vulnerable than ever.[22] In this framework, inequalities in material, bodily, and cultural resources accumulate over time, despite the interventions of social service programs and the mortality differential. Recently social scientists have begun to show that, at least on a demographic level, both process are at play. They argue that while "selective mortality" can give the illusion of leveling, examinations of individuals over the life-course often show that among those who do survive, disadvantages still accumulate. Poor seniors, those with less education, and members of many racial minority groups are still worse off than their surviving peers.[23] While this line of argument offers a useful starting point for understanding the relationship between aging and stratification, we know comparatively little about how "leveling" and "cumulative disadvantage" matter in the everyday lives of seniors and the communities they form. In order to advance the debate around "leveling" and "cumulative disadvantage" outlined above, as well as enhance understandings of the relationship between social inequality and health generally, it is necessary to look at key pathways linking health and social stratification. Past research has linked unequal health outcomes and behavioral differences across racial, socioeconomic, and gender groups to three non-exclusive factors which I examine briefly below: structural disparities, culture, and social connectedness. I now turn to what social scientists know about these mechanisms and explain why comparative observational data of the type provided in this study is necessary.

Structural Factors

Social scientists have repeatedly shown that structural inequalities (e.g. unequal material resources and institutional treatment) affect the health and health behaviors of individuals and communities.[24] Inequality along socioeconomic and racial lines is often cast as a "fundamental

---

[21] See James S House, Paula M. Lantz and Pamela Herd. "Continuity and Change in the Social Stratification of Aging and Health over the Life Course: Evidence from a Nationally Representative Longitudinal Study from 1986 to 2001/2002 (Americans' Changing Lives Study)." *Journal of Gerontology B Psychological Sciences. 60(2005) Special issue 2: 15-26;* Diane S. Lauderdale. "Education and Survival: Birth Cohort, Period, and Age Effects." *Demography.* 38.4 (2001): 551-561; Pamela Herd. "Do Functional Health Inequalities Decrease in Old Age?: Educational Status and Functional Decline Among the 1931-1941 Birth Cohort". *Research on Aging.* 28.3 (2006): 375-392; Jinyoung Kim, and Richard Miech. "The Black White Difference in Age Trajectories of Functional Health Over the Life Course". *Social Science and Medicine.* 68(2009):717-725.

[22] See Andrea E.Wilson and Kim M. Shuey. "Cumulative Advantage Processes as Mechanisms of Inequality in Life Course Health". *American Journal of Sociology*. 112.6 (2007):1886-1924; Scott M. Lynch. "Explaining Life Course and Cohort Variation in the Relationship between Education and Health: The Role of Income." *Journal of Health and Social Behavior.* 47(2006): 324-338; Kim M. Shuey, and Andrea E. Willson. "Cumulative Disadvantage and Black-White Disparities in Life-Course Health Trajectories". *Research on Aging.* 30.2 (2008): 200-225.

[23] See Matthew E. Dupre. "Educational Differences in Age-Related Patterns of Disease: Reconsidering the Cumulative Disadvantage and Age-As-Leveler Hypotheses." *Journal of Health and Social Behavior.* 48(2007): 1-15; Scott M Lynch. "Cohort and Life-Course Patterns in the Relationship Between Education and Health: a Hierarchical Approach." *Demography*. 40(2003): 309-331.

[24] See for instance Paul Farmer. *Infections and Inequalities: The Modern Plague*. Berkeley: University of California Press, 1999. Amartya Sen. *Resources, Values, and Development*. Cambridge: Harvard University Press, 1984; Brian D. Smedley, Adrienne Y. Stith, and Alan R. Nelson, eds. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Edited by I. o. Medicine. Washington, D.C.: National Academies Press, 2002.

cause" of health disparities.[25] Specifically, a lack of access to money, poor health care and institutional discrimination limit opportunities for maintaining health and dealing with illness.[26] Regardless of the beliefs and psychosocial processes at play, access to resources and external controls on behavior affect health and illness behaviors.[27]

In the American case, structural issues associated with patterns of physical isolation and racial segregation are well documented. Research has demonstrated that there is an unequal spatial distribution of hospitals and other health resources, with these resources being clustered in more affluent white areas.[28] Limited opportunities in the housing market have concentrated families with lower incomes in the same locale, creating a situation in which there is limited access to medical professionals and facilities because these resources are located in more affluent areas a considerable distance from the lower-income neighborhoods.[29] Further, racially segregated neighborhoods with concentrations of lower-income populations tend to be plagued by high levels of violence that may discourage people, particularly older people, from leaving their places of residence.[30] This is a structural condition that can lead to increased isolation and potentially inhibit them from seeking medical care.[31] There is some evidence that living in this type of environment increases mental health problems.[32] The available data also suggest that while a significant portion of the effect of neighborhoods on health can be accounted for by the "composition" or individual characteristics of their members, the "context" of the neighborhood itself is still important.[33] While social scientists have used quantitative methods to show that structural factors are key for understanding the relationship between health and inequality, there is a dearth of systematic qualitative data showing the mechanisms by which these factors affect the everyday experiences and health behaviors of different groups, particularly at the end of the life course.

---

[25] For a general overview of this perspective see Bruce G. Link and Jo Phelan. "Social Conditions as Fundamental Causes of Disease." *Journal of Health and Social Behavior.* 35(1995): 80-94; For an examination, Jo C. Phelan and Bruce G. Link. "Controlling Disease and Creating Disparities: A Fundamental Cause Perspective." *Journal of Gerontology.* 60(2005): S27-S33.

[26] For a few examples see M. Bartley. *Health Inequality*. Cambridge: Polity Press, 2004; Kevin Fiscella, Peter Franks, Mark P. Doescher and Barry G. Saver. "Disparities in Health Care by Race, Ethnicity, and Language Among the Insured- Findings from a National Sample". *Medical Care.* 40.1 (2002): 52-59; as well as Farmer (1999), Sen (1984), Smedley et. al (2002); Spalter-Roth (2005) which are cited above.

[27] See Icek Ajzen. "The Theory of Planned Behavior". *Organizational Behavior and Human Decision Processes.* 50(1991): 179-211; Ronald M. Anderson. "Revisiting the Behavioral Model and Access to Medical Care: Does it Matter?" *Journal of Health and Social Behavior*. 36.1(1995): 1-10; Seth M. Noar and Rick S. Zimmerman. "Health Behavior Theory and Cumulative Knowledge Regarding Health Behaviors: Are We Moving in the Right Direction?" *Health Education Research.* 20.3(2005): 275-90.

[28] See Spalter-Roth et al. (2005) and David R. Williams, and Chiquita Collins. "Racial Residential Segregation: a Fundamental Cause of Racial Disparities in Health". *Public Health Report*. 116.5(2001): 404-417.

[29] See Kirby and Kaneda (2005).

[30] See Williams and Collins (2001).

[31] See Eric Klinenberg. *Heat Wave: A Social Autopsy of Disaster in Chicago*. Chicago: University of Chicago Press, 2002; G.W. Evans and S. Saegert. "Residential Crowding in the Context of Inner City Poverty in Theoretical Perspectives". *Environment-Behavior Research*. Ed. S. Wapner, J. Demick and T. Yamamoto. New York: Kluwer Academic/Plenum, 2000.

[32] See Catherine E Ross and John Mirowsky. "Neighborhood Disadvantage, Disorder, and Health". *Journal of Health and Social Behavior.* 42(2001): 258-276; Robert Sampson. "Neighborhood-level Context and Health: Lessons from Sociology". *Neighborhoods and Health*. I. Kawachi and L. F. Berkman. Eds. New York: Oxford University Press, 2000.

[33] See Catherine E. Ross, and John Mirowsky (2008).

Cultural Context

"Cultural explanations" of inequality are politically contentious in contemporary social science and public debate. Since the popular misappropriation of Oscar Lewis' work on the "Culture of Poverty,"[34] looking at the collective meanings and motivations of the poor and marginalized has been seen (in varying degrees) as "blaming the victim." "Cultural" explanations are often represented as being in direct competition with "structural" explanations. While these representations hold political cachet both within and outside of the academy, they are philosophically and empirically problematic. Most contemporary scholars of culture agree that although there are important analytical distinctions between the material resources and institutions that are at the core of social structures and the collective meanings, understandings, and motivations that constitute "culture," it is impossible to understand one without the other. [35] Institutions and social systems are produced by the meaningful actions of people who inhabit specific cultural milieus. They embody specific ideas and logics. Further, the wider historical contexts determine the specific content of the valued meanings, motivations, and strategies available to any individual at any given point in time. In other words, culture and social structure are necessarily and fundamentally intertwined.[36]

Empirically, researchers have demonstrated that even within similar structural contexts it is necessary to look at the values, beliefs, and motivations that drive people towards particular ends to understand differences in their behaviors.[37] Further, differences in collectively available cultural tools and strategies affect the ability of different groups to interact with important structures like medical institutions, labor markets, or schools.[38] Fully understanding the individual and communal responses to concrete everyday health issues (including how resources are mobilized differently by different individuals within and across social strata) requires an examination of the shared meanings, motivations, and strategies that constitute "culture." Although ethnographers have long argued that culture matters for understanding behavior, scholarship that takes culture seriously in the arena of health and inequality has only recently begun to take hold.[39] Consequently, quantitative studies of health and health care use have done

---

[34] Oscar Lewis. *Five Families: Mexican Case Studies in the Culture of Poverty*. New York: Basic Books, 1959.

[35] In this dissertation I use the term "culture" to refer to three intertwined components: *shared meanings* that make the world comprehensible, *inputs* that direct action towards particular ends (e.g. values, cognitive orientations, motivations, etc.), and *collective tools and strategies* that influence, in conjunction with larger social structures, whether particular ends can be reached. For a fuller treatment of my use of the term culture, and a model of the structural contingencies under which different elements most strongly influence action and outcomes, see Corey M. Abramson. "From "Either-Or" to "When and How": A Context-Dependent Model of Culture in Action." *Journal for the Theory of Social Behaviour.* 42(2012): 155-180.

[36] For some examples see Pierre Bourdieu. *The Logic of Practice.* Stanford: Stanford University Press, 1990.; William H. Sewell Jr. "A Theory of Structure: Duality, Agency, and Transformation." *American Journal of Sociology.* 98(1992): 1-29; Ann Swidler. *Talk of Love: How Culture Matters*. London and Chicago: University of Chicago Press, 2001.; Stephen Vaisey. "Motivation and Justification: Towards a Dual-Process Theory of Culture in Action." *American Journal of Sociology.* 114(2009): 1975-1715. See also Abramson (forthcoming).

[37] Stephen Vaisey (2009); Martin Sánchez-Jankowski*, Cracks in the Pavement: Social Change and Resilience in Poor Neighborhoods* Berkeley: University of California Press, 2008.

[38] Daniel Dohan. *The Price of Poverty: Money, Work, and Culture in the Mexican American Barrio*. Berkeley: University of California Press, 2003; Annette Lareau. *Unequal Childhoods: Class, Race, and Ramily Life.* Berkeley: University of California Press, 2003; See also Bourdieu 1984, Friedenberg 2000, and Swidler 2001.

[39] See for instance Pescosolido and Olafsdottir (2010) and Shim (2012). Bernice A. Pescosolido and Sigrum Olafsdottir. "The Cultural Turn in Sociology: Can it Help Us Resolve and Age-Old Problem in Understanding Decision Making for Health Care?" *Sociological Forum.* 25.4(2010): 655-676; Janet K. Shim. 2010. "Cultural

a poor job of operationalizing culture in a sociologically reasonable way.[40] Likewise, as in other arenas of social scientific research, past ethnographic inquires have focused on providing rich "narrative" rather than leveraging the direct observation of human behavior in comparative contexts as a means for charting the operation of social mechanisms. [41]

Social Connectedness

Much of the current social scientific research linking social connectedness to stratification in general (and heath specifically) describes deeply complex, interpersonal relationships in numeric terms: as either a dichotomous measure (people are connected or isolated) or a continuous measure (some people are more connected than others). Scholars frequently invoke the term "social capital"[42] to highlight the way these interpersonal ties function as a resource that varies between people and groups, and that this resource can affect concrete outcomes ranging from the ability to secure health care to whether one gets a job.[43] "Social capital" is often presented as unequivocally positive for the possessor, and differences in social capital are seen as differences in quantiy, without considering the possibility that social capital differs in its qualities and effects. Further, the relative levels of "social capital" possessed by individuals are often conflated with differing degrees of "social organization" in the communities they occupy. That is to say, those who reside in organized areas are believed to have more connections to others, to be more integrated into social systems, more subject to norms of social control, are more likely to be efficacious both individually and communally in securing outcomes. We are warned the United States has become a society with dangerously shrinking realms of sociability, where people are becoming more disconnected from each other and from their communities. Pundits argue that these processes are accelerated by new technologies which encourage, perhaps even coerce, face to face disengagement. The net consequence, we are told, is a loosening of the fabric that holds our social system together—the classic problem of modern alienation come to Middletown, USA. Work on aging and health has also continually pointed to the importance of social connectedness, which is contrasted to disengagement and isolation. Klinenberg's (2002) well-known work explains the life and death outcomes of the 1995 Chicago heat wave in these terms.[44] Klinenberg showed that those seniors

---

Health Capital : A Theoretical Approach to Understanding Health Care Interactions and the Dynamics of Unequal Treatment". *Journal of Health and Social Behavior*. 51.1(2010): 1-15.

[40] For more on this point see Pescosolido and Olafsdottir (2010) as well as Abramson and Sánchez-Jankowski (2012).

[41] This is the case with most past ethnographies looking at aging communities e.g. Hochschild (1977); Friedenberg (2000); Myerhoff (1980), Portacolone (2011). See Judith Noemí Freidenberg, *Growing Old in El Barrio*. New York: New York University Press, 2005; Arlie Russell Hochschild. *The Unexpected Community*. Englewood Cliffs: Prentice-Hall, 1973; Barbara Myerhoff. *Number Our Days*. New York: Touchstone, 1980; Elena Portacolone. "The Myth of Independence for Older Americans Living Alone in the Bay Area of San Francisco: A Critical Reflection." *Ageing and Society*. 31(2011): 803-828.

[42] For more on the various definitions and invocations of this term see Alejandro Portes. "Social Capital: Its Origins and Applications in Modern Sociology". *Annual Review of Sociology*. 24(1998): 1-24.

[43] While this term has a strong following in the social sciences, it has also been criticized for being overly broad and ill-defined in practical terms, as well as thin and marketizing in its ability to strip key subjective characteristics from interpersonal relationships. See Claude S. Fischer. "Bowling Alone: What's the Score?" *Social Networks*. 27(2005): 155-67.

[44] Eric Klinenberg. *Heat Wave: A Social Autopsy of Disaster in Chicago*. Chicago: University of Chicago Press, 2002.

who lived alone, socially isolated from the community and networks outside, were more likely to die—and they died alone in droves. Compared to Latino elders, a disproportionate number of African Americans died, because even though their circumstances were otherwise quite similar, the African Americans seniors were more isolated.[45]

What many of the current accounts underestimate is that the actual functioning and net effects of social connectedness are contingent on other cultural and structural factors. That is, social connectedness does not universally produce positive or negative outcomes— even among the aged. Social connectedness does not mean the same thing for rich and poor. Social connectedness does not necessarily work the same way for different racial and ethnic groups.[46] "Seeing friends within the last week," one common measure used on surveys, can mean very different things for a senior. It can mean friends drove one to the doctor, or discouraged going to the doctor in favor of drinking alcohol at the local pub. Similarly, noting whether or not a senior "visits with family members," says nothing about whether that visit was one that provided food, an emotionally supportive encounter, or a stressful and aggressive exchange regarding finances. In short, these accounts neglect the importance of the quality and realization of social ties.[47]

While the authors above demonstrate with varying degrees of success that interpersonal ties affect people's life-chances, they fail to show how the mechanisms through which this happens are linked to concrete contexts.[48] "Social capital" is not just about networks, but about how they are deployed and to what end.[49] Many existing accounts are artificially universalistic and thin in their inattentiveness to the variable cultural meanings, motivations, and strategies that give these ties force in real world social contexts. With a few notable exceptions, there is a vast literature showing that "social capital" matters for understanding the relationship between health and social stratification,[50] but our understanding of how this happens in concrete social and cultural contexts is substantially more limited.

---

[45]For the precariousness of seniors living alone see also Portacolone (2011).

[46] For more on this see Sandra Smith. "A Test of Sincerity: How Black and Latino Service Workers Make Decisions about Making Referrals." *The Annals of the American Academy of Political and Social Sciences*. 629(2010): 30-52.

[47] For more on this point see Fischer's (2011) book, which shows that although the quantity of some forms of social ties may have declined during the last 30 years, the quality has improved in several arenas, and statements about the decline of American community are overblown. Claude S. Fischer. *Still Connected: Family and Friends in America Since 1970*. New York: Russell Sage Foundation, 2011.

[48] Mario Small's ethnographic work provides a notable exception in highlighting the importance of context in looking at the development and implementation of social ties. See Mario Luis Small. *Villa Victoria: The Transformation of Social Capital in a Boston Barrio*. Chicago: University of Chicago Press, 2004. And Mario Luis Small. *Unanticipated Gains: Origins of Network Inequality in Everyday Life*. New York: Oxford University Press, 2009.

[49] The relationship between context and network structure is also made by Entwisle et al. (2007), albeit in a more structural sense. Klinenberg's (2002) work makes this point as well. Specifically he shows how different contexts were related to different levels of social connectedness, and consequently different patterns of life and death among Chicago residents. Still, his "social autopsy" was necessarily conducted after the event. We can infer the way the higher level and type of connectedness held by Latinos influenced their behaviors during that heat wave, but we do not have direct observations. My data complement these findings by showing how social connectedness influences everyday life across a variety of settings. Barbara Entwisle,Katherine Faust, Ronal R. Rindfuss, and Toshiko Kaneda. "Networks and Contexts: Variation in the Structure of Social Ties". *American Journal of Sociology*. 112.5(2007): 1495-1533.

[50] For a recent review see Peggy A. Thoits. Mechanisms Linking Social Ties and Support to Physical and Mental Health". *Journal of Health and Social Behavior*. 52.2(2011): 145-161.

Methodology

The research presented in this dissertation is founded on two interrelated empirical questions: 1) How do the mechanisms known to link social inequality to health and illness (i.e. structural inequalities, culture, and social connectedness) operate in everyday life among the elderly? 2) How do women and men of different racial, ethnic, and socio-economic groups collectively and individually manage the health and illness demands associated with aging?

To answer these questions, I conducted three years of comparative ethnographic research in four urban communities and collected 60 in-depth interviews to reveal the ways seniors and the communities they form make sense of and manage the health and illness needs of their aging bodies. Two of the communities were primarily poor and two were primarily middle-class. The communities contained racial, ethnic, and gender variation, which was mirrored in my interview sample. Comparative ethnography was well suited for this project since it allowed me to observe individuals as they went about their everyday activities in various social and organizational contexts. By combining my observations with in-depth interviews as well as informal conversations, I was able to catalog how people understood the predicaments they faced, examine how they made health choices and justified their actions, and observe both the process and results. This combination of methods allowed me to see the dynamics through which different individuals came to address the same health issues in different ways, the forces that shaped their range of options and understandings, and how this affected specific outcomes.

Sample of Neighborhoods

This study includes four urban neighborhoods. Two of the neighborhoods were predominantly poor, and two were predominantly middle class.[51] Within each socio-economic grouping, one community was more racially mixed, while another was largely homogenous—although there was some racial and ethnic variation even in the more homogenous settings. All neighborhoods were in, or connected to, major metropolitan areas in Northern California. Although neighborhoods were initially screened using tract-level census data to ensure they met the above inclusion criteria, neighborhood boundaries were not simply imputed based on census tracts but were grounded in "socially recognized and ecologically reinforced," local boundaries (Small 2002: 9).[52] These communities are described briefly below:

Poor Community 1 (racially mixed): Rockport [53]

Rockport (pseudonym) was located in the center of a poor urban area and contained many African Americans and Latinos, as well some whites. Many of the seniors lived in public or subsidized senior housing units and the majority had been poor for most of their lives.

Poor Community 2 (more racially homogenous): Elm Flats

[51] I define a poor, urban neighborhood as a social and geographical unit, located within a larger metropolitan setting, where the percentage of households with incomes below the federal poverty line adjusted for family size (e.g. the standard poverty index) is 30% or higher.

[52] See Mario Luis Small. "Culture, Cohorts, and Social Organization Theory: Understanding Local Participation in a Latino Housing Project." *American Journal of Sociology.* 108.1 (2002): 1-54.

[53] I follow the standard practice of using pseudonyms for all individuals, organizations, and communities to protect the identities of those involved in this study.

Elm Flats (pseudonym), was also in a poor urban area. Most of the residents were African Americans who had been poor for most of their lives. Some lived in public or subsidized housing.

Middle-Class Community 1 (racially mixed): Cedar Hills

Cedar Hills (pseudonym) was primarily middle-class. The majority of its residents were white, but there was substantial racial and ethnic diversity. The seniors in this area generally did not live in public housing, though some received assistance or government subsidies. Most had been middle-class for the majority of their lives, although some were now on a fixed income.

Middle-Class Community 2 (more racially homogenous): Baygardens

Baygardens (pseudonym) was in a middle-class urban district. Most of the seniors were on a fixed income, but had been middle-class for most of their lives. Like Rockport, many lived in public or subsidized senior-housing. Most of Baygardens' seniors were white, but there were also smaller numbers of African Americans, Latinos, and Asian-Pacific Islanders living there.

The diversity of individuals from different class, racial, and ethnic groups within the four communities in this study, while not exhaustive, allowed me to examine when, and how, race-, class-, and gender-based inequalities in health work out in old age. While this comparative sampling strategy (including seniors from different social strata occupying different social contexts) does not directly tell us how they came to be in their present condition, it does provide the ability to study how they make sense of their situation and behave once there. As noted below, I also attempted to address this issue by collecting life-history data in interviews. A summary of key neighborhood characteristics can be found in table 1.1 below.

Table 1.1: Key Neighborhood Characteristics

	Poor	Middle-Class
Racially Mixed	Rockport	Cedar Hills
More Racially Homogeneous	Elm Flats	Baygardens

Observational Strategy

Within each neighborhood, my observational strategy was two-tiered, including both general observations of communal settings and organizations, and closer observations of individuals as they went about their daily lives. For my general observations, I spent time in organizations and public spaces frequented by the elderly. Initially, I observed senior centers and housing units that had primarily senior residents. I also regularly visited nursing facilities in Rockport and Bayview. By the end of the project, I expanded my pool of general observations to include various settings frequented by seniors: apartment building common rooms, doctors' offices, emergency rooms, pharmacies, senior centers, bars, parks, corner stores, shopping centers, pool halls, hair salons, coffee shops, and discount stores. Over the course of the three years of fieldwork, I observed hundreds of elders, and developed close relationships with a number of them. After meeting and developing rapport with specific elders, I would ask permission to follow them around in their daily lives and talk with them. When speaking to them for the first time, I informed people that I was a sociologist working on a book about aging in different communities. Since I was an obvious outsider, often the only person under sixty at many sites, new seniors would frequently ask me why I was at that location—which allowed me

to explain my project. I also typically wore a hat with the Cal Berkeley insignia, which served as both a conversation starter and a declaration of my affiliation. Although I was not employed by any senior agency, I informed, and was granted permission by, authorities to observe organizational activities at various senior centers, housing units, and nursing facilities.[54] This provided me with a great deal of freedom to strategically position myself to see social processes at work.[55]

While I was in the field, I spent between 20 and 40 hours per week with the elders in my study as they went about their daily routines. I listened to them as they discussed the issues involved with their aging bodies (such as the loss of mobility, pain, or attempting to follow a complicated pharmaceutical regimen) through complaints, jokes, and the formulation of earnest strategies for managing their problems. I talked with them about their many concerns. I followed them as they went to the doctor and saw how they interacted with different people in medical settings. I listened to their accounts of what went on when I was not there. I observed the environment in which they lived, the food they ate, whether and how they took their medicines (and why), and seemingly mundane processes such as how often they bathed. I observed the way they interacted (or avoided interacting) with other people. I watched what they did when they became ill. I saw to whom they turned , what remedies they took, and at what point they sought out medical professionals or healers (Western or otherwise). I watched what they did when they were feeling well, and examined what "feeling well" meant to different groups. I watched them interact with friends and family. I listened to them talk about their hopes and concerns, sources of joy and sadness. I spent time with elders after they were placed in total institutions such as skilled-nursing wings of hospitals or assisted living facilities. I visited seniors in these facilities. I observed how sick elders managed their dying bodies as well as their dying friends, and how they approached the social and psychological stresses this entailed. By doing so, I was able to chart how seniors dealt with growing old, how this varied within and between social groups, how individuals and organizations responded to them, and how seniors made sense of the process. I staggered the day and time of my observations in an attempt to minimize the chance of missing some key time- or day-dependent variation in behavior. I took notes by hand while in the field.[56] I typed full field-notes immediately upon returning from my research sites each day.

Interview Methods

The second method I employed was semi-structured in-depth interviews. With the help of two research assistants, I collected 60 interviews ranging from twenty minutes to over two hours in length. Most interviews took around one hour. [57] The interviews contained eight topical

---

[54] This was in addition to gaining the consent of the specific seniors with whom I interacted.

[55] I did, however, occasionally help out as a volunteer. Although this limited my ability to move around particular sites, it was advantageous in signaling my respectability and institutional legitimacy to the seniors who were often concerned about being taken advantage of.

[56] I generally did this out of sight of the seniors. This is not to say the ethnographic component of this study was covert—rather, many of the seniors simply seemed more at ease when I did not write the notes in front of them. Although I assured subjects of confidentiality, and over the years I became a trusted friend for many, the seniors in this study were accustomed to interacting with social workers, doctors, and other institutional representatives who hold some degree of direct power over their lives. These people often take overt notes that could affect the services at seniors' disposal or alter their living situation in a profound matter. By not taking notes in the manner they did, I wanted to signal that I was not one of these people; that I wanted to understand rather than "evaluate" their lives.

[57] These research assistants, whom I trained and mentored over a period of two years, assisted in the collection, transcription, and coding of these interviews. Having additional interviewers allowed me to collect more data than would have been possible on my own, at the potential cost of introducing response variation due to researcher

domains: background/life-history, thoughts on aging, navigating everyday life, social connectedness, health behaviors, attitudes towards the body, medical vignettes (i.e. what should a senior do if he or she has had a lump on the back for one month), and general demographics.[58] Although there were some standardized questions, such as the demographics and vignettes, seniors were given the opportunity to discuss topics they felt were not addressed. The interviews provided additional data about how the elders in this study think about and represent the world. Further, they complemented the ethnographic data in identifying behavioral norms, shared meanings, and collective representations that proved essential to understanding responses to health and illness. By comparing interviews with my participant observation data among seniors, I examined what people say others "should do" when presented with a physical dilemma, what they consider "reasonable" for themselves and others given their social location, and what they ultimately do. Examining both the points of congruence and discord between interview and observational data provided leverage for understanding how various aspects of culture, grounded in inequalities both past and present, affected seniors' responses to health problems in social context. Additionally, these interviews allowed me to collect more systematic life history data. Thirty two of the 60 interviewees were female (53%). The median age of interviewees was 69.4. 26 were white (43%), 21 were African American (35%), 10 were Asian Pacific islanders (17%), two were unspecified (3%), and one was Latino (<2%).

Analysis

I entered all fieldnotes and transcripts into ATLAS.ti, current generation computer assisted qualitative data analysis software (CAQDAS) package that facilitated the systematic organization, coding, and analysis of the voluminous data.[59] I conducted an iterative analysis that used both deductively and inductively generated concepts, codes, and themes to evaluate and expand existing models of the relationship between inequality, health, and culture.[60] Table 2.1 below summarizes what each type of data contributes to my analysis.

Table 2.1: Methods and Evidence

Method	Participant Observation	Interviews
Evidence Provided	***What subjects do in everyday life*** 1. Health and illness issues faced 2. How those issues manifest	***What subjects say in an interview*** 1. Which issues seniors identify as salient 2. How seniors describe/frame

characteristics. However, since this strategy allowed me to collect more perspectives than would have been possible otherwise, and the interviews were always triangulated with observation, in my estimation the potential breadth added by the introduction of these auxiliary interviews was worth the risk. For this reason, having multiple interviewers is increasingly commonplace in large sociological studies. For a similar strategy involving interviews and observation see Lareau (2003).

[58] See appendix 1 for a sample interview schedule.

[59] For more on the topic of CAQDAS and its contribution to ethnographic work see Dohan, Abramson and Miller (2012) and Dohan and Sanchez-Jankowski (1998). Daniel Dohan, Corey M. Abramson, and Susan Miller. "Beyond Text: Using Arrays of Ethnographic Data to Identify Causes and Construct Narratives." *AJS Causal Thinking and Ethnographic Research.* Ed. Mario Smalls, American Journal of Sociology, 2012; Daniel Dohan and Martin Sanchez-Jankowski. "Using Computers to Analyze Ethnographic Field Data: Theoretical and Practical Considerations." *Annual Review of Sociology* 24 (1998): 477-98.

[60] For further explanation and a more detailed example of this approach see Abramson (2009) p. 71-73. For a discussion of the ontological, epistemic, and axiological underpinnings of this approach see Sanchez-Jankowski and Abramson 2012.

	and are negotiated in concrete contexts 3. How seniors make sense of issues together 4. How seniors explain behavior in context	issues 3. How seniors describe appropriate responses to issues 4. How seniors justify behavior 5. Life history data

Goals and Overview

In examining the everyday lives of seniors, this dissertation provides insight into how key mechanisms linking social inequality, culture, and the human body operate. In addition to this scholarly contribution, it is my hope that my findings will also provide practical insights that will be of use to the medical practitioners, service providers, and policy makers who are in a position to address these problems. Put another way, this dissertation has both scientific and practical goals. The scientific goal is to use systematic observations of the world to improve existing models of human action and social systems.[61] It does this by concretely showing how the relationships between inequality and health work out in everyday life for the aged in America, and why.

The ethnographic research presented here is *not* a collection of "anecdotes" or "stories" meant to supplement the trends cataloged by demographers and statisticians. Rather it is a systematic inquiry into the inner workings of crucial *mechanisms* which are necessary to explain larger social processes and categories that can only be seen in the context of daily life. The more practical goal of this dissertation is to provide a better framework for explaining the workings of these mechanisms to the world outside the academy, so policy makers and practitioners can better understand where and how to help the rapidly growing population of elders in America.[62] In order to understand how the mechanisms linking social inequality to health operate, this dissertation examines four facets of everyday life for seniors in America: (1) the shared *dilemmas,* both biological and social, faced by people as they reach old age, (2) the way these dilemmas *manifest* differently depending on the relative position of these people within stratified social-systems, (3) differences in the individual and communal *resources* brought to bear in addressing these dilemmas, and (4) the resulting *responses* and the subsequent *outcomes* for individuals. To do this, I proceed as follows:

Chapter two shows that although the poor and marginalized often have to deal with the problems of growing old at a younger chronological age, all those who live through "old age" face shared predicaments. Rich or poor, black or white, in old age seniors confront new challenges grounded in the degeneration of their bodies. As people grow older, they often face pain, a loss of energy, declining mobility, cognitive slowing, and sensory changes. They must

[61] This follows a classic tradition of sociological inquiry, articulated by Max Weber: "Sociology is a science concerning itself with the interpretive understanding of social action and thereby with a causal explanation of its course and consequences" Max Weber. *Economy and Society.* Berkeley: University of California Press, 1978. p.4.

[62] This aim follows a classic tradition in sociology, as well. Sociologists historically have been, and should be, concerned with the lives of the people they study. Emile Durkheim stated this point well, "Yet because what we propose to study is above all reality, it does not follow that we should give up the idea of improving it. We would esteem our research not worth the labor of a single hour if its interests were merely speculative. If we distinguish carefully between theoretical and practical problems it is not in order to neglect the latter category. On the contrary, it is in order to put ourselves in a position where we can better resolve them." Emile Durkheim. *The Division of Labor in Society.* 1893. New York: The Free Press, 1984. P. xxvii

confront increased health problems, the deaths of loved ones, and the erosion of prized characteristics like beauty, stamina and wit. Ultimately, they must deal with their own mortality. The problems of their foundering bodies come to profoundly limit what they can do in the world. In facing these predicaments, many seniors from across the social spectrum come to a shared realization that "old age" becomes a primary force in shaping their everyday lives. As they interact with the physical and social world, the dwindling capacities and physical uncertainties of their aging bodies create "structural dilemmas" – persistent problems of social action that require a response.

Chapter three explains that while seniors face a shared set of problems, what different groups see as the most desirable, reasonable, and plausible responses to this dilemma reflect different "cultures of aging." These responses reflect both past inequalities and present contexts. Different combinations of motivations (i.e. protecting the body or maximizing enjoyment before it breaks) and orientations (i.e. the body is self-regulating or the body needs to be regulated) acquired over the life course lead seniors to pursue different strategies in old age— some spend all day at the doctors, others spend the day at the bar. Some go to the farmers market for produce, others get sugary drinks at Starbucks. Some wait until a problem lands them in the emergency department, others check in with the doctor every time they develop a cough. These differences often break down along the lines of ethnicity and past socioeconomic status. However, they continue to affect how people act even when they have similar resources, "access," and information in the present.

Chapter four shows that social networks, which also reflect past and present inequality, matter a great deal for seniors' abilities to respond to problems in old age. Friends, families, neighbors, and acquaintances can shape seniors' lives. However, what these "social ties" mean depends on shared cultural norms and understandings that differ between groups. For instance, for some, helping neighbors is an obligation, whereas for others it is an economic exchange. Being in contact with friends can mean lunch and a ride to the doctor or it can mean skipping an appointment to go to the pool hall. The effects of networks depend on context.

Chapter five returns to the issue of material inequality in the present. This chapter demonstrates that despite leveling processes, persistent material, organizational, and spatial inequalities profoundly affect how people can respond to aging. Seniors from both middle-class and poor neighborhoods rely extensively on a social "safety net" provided by government and non-governmental services, but this net is both thin and tenuous. While most seniors are able to secure access to basic resources like food, housing, and medical care, the quality of these resources varies greatly between middle-class and poor seniors. The entrepreneurial structure of grant funding compounds this problem by funneling competitive resources to the most affluent areas. Further, seniors confront old age with substantially different individual resources that reflect past inequality. Those who enter old age with homes, pensions, and insurance have more options for responding to problems both large (e.g. a major illness) and small (e.g. getting food they desire). While poor seniors may meet their everyday needs, they must rely on referrals from "street level bureaucrats," like social workers and clinicians, who maintain substantial control over their lives. Middle-class seniors have resources that allow them alternatives.

Finally, chapter six summarizes the empirical and theoretical contributions of this dissertation.

Chapter 2
"Wearing out" and "Breaking Down": The Convergent Predicaments of the Aging Body

I. Introduction

Conventional wisdom in the scientific community explains biological aging, or senescence, "as the eventual failure of maintenance" in the cells, tissues, and organs that allow an organism to stay alive.[1] Put more simply, aging is the process whereby living beings "wear out" and "break-down" over time.[2] When the organisms being studied are modern human bodies operating within modern societies, the effects and experiences of "wearing out" and "breaking-down" become sociological topics. This chapter explains what common aspects of the socially-mediated (but biologically rooted) processes of "wearing out" and "breaking down" entail for seniors living in urban America and the continuities in how these seniors make sense of them across communities. The sections below focus specifically on the convergent problems of everyday life created by the aging body. The issues described below traverse the four communities in this study[3] and form shared predicaments to which seniors had to respond. Rich or poor, male or female, black or white, the individuals in this study found the phenomena detailed below an integral part of growing old. While ample resources, good fortune, strong social networks, and robust genes can delay and soften the onslaught of these processes, all who lived long enough had to face these issues. Examining these convergent predicaments provides an essential starting point for the dissertation's larger task of unraveling the relationship between social stratification, aging, and health in the context of urban America.[4]

In order to move towards this goal, section 2 of this chapter examines a number of concrete everyday issues rooted in the breakdown of the human body such as decreasing energy, pain, mobility problems, cognitive changes, increased health needs, the loss of physical capacities, and the deaths of friends and loved ones. In section 3, I examine those cultural understandings of these issues that were widely shared across the communities in this study and show how they emphasize the centrality of the body in the experience of "growing old." We will see that the everyday problems created by the breakdown of the human body funnel seniors from different social groups towards a shared experience and common insight that the body is a fundamental resource for experiencing and acting in the world. In section 4, I show that although seniors do not necessarily grasp the connections, their fragmented insights about the centrality of

---

[1] See Robin Holliday. "Aging is No Longer an Unsolved Problem in Biology". *Annals of the New York Academy of Sciences* 1067.1 (2006) :1-9. Page 1. See also Suresh I.S. Rattan. "Theories of Biological Aging: Genes, Proteins, and Free Radicals". *Free Radical Research*. 40.12(2006): 1230-1238.

[2] As Holiday notes, on a biological level senesces is complex and multi-causal process. As in any element of science, there is no absolute consensus about how all aspects of aging work. However, the statement above, is a point of much more commonality than contention.

[3] The reader will recall that two of the communities are poor (Rockport and Elm Flats) and two are middle class (Baygardens and Cedar Hills).

[4] As I will show in later chapters, the timing, severity, subjective experience, and concrete manifestation of physical problems are a function of differences in the cultural and material resources available to specific individuals and the social groups they constitute (i.e. a part of larger processes of cumulative disadvantage).

the body point to longstanding issues in theories of human action. The importance of the biological unit in social systems must be an empirical and theoretical focal point for sociological attempts to explain the relationship between social stratification and health.

II. The Biological and Social Predicaments of the Aging Body

Myriad physical problems increase with or are compounded by old age. Consequently, public health researchers often refer to the elderly as a medically engaged population, subject to increased health needs and consequently a "biological imperative" to seek care.[5] As the human body ages individuals undergo numerous physiological changes. Tissues break down. The cardiovascular system and heart become less efficient and blood vessels become less elastic. Bones shrink and muscles atrophy. Digestive problems increase. Sexual dysfunction becomes more common. Genito-urinary problems become common and can lead to incontinence. The immune system weakens and the ability to fight off disease decreases. Changes on the genetic level make the elderly more vulnerable to diseases such as cancer. People eventually die. These statements are not simply the assessment of public health researchers and physicians or a categorical extension of bio-medical models for the management of populations, but physiological facts rooted in the biological process of aging (which is known as senescence).[6] They are also a vivid part of the daily experience of aging seniors. While these phenomena were imbued with various meanings in social interactions between seniors, medical organizations, and social services, they created concrete issues that affected the everyday lives of seniors in the four communities in this study.[7]

The degeneration of the aging body creates two basic categories of problems for the everyday lives of seniors. The first category involves aspects of bodily *breakdown* which required direct behavioral responses. This category includes the presence of increased health problems, decreased mobility, pain, fatigue, sensory changes, and cognitive slowing. The second category involves the secondary *losses* degeneration and slowing engender, and the practical issues these create in social interaction. This category includes the social ramifications of losing valued traits and capacities that are grounded in the body (strength, agility, memory, intelligence), dealing with proximity to death (of the self and others), and the strains these losses entails.

[5] Barbara Hulka and John R. Wheat. "Patterns of Utilization: The Patient Perspective". *Medical Care*. 23(1985): 438-460.

[6] My point here is not to refute the notion that the expansion of western models of medical categorization are important avenues of inquiry, or even the notion that they represent a fundamentally new form of power and social control (e.g. Foucault 1980). My point is simply that regardless of the labels applied, these terms refer to real processes that exist outside our systems of categorization, even if we can only understand them in terms of cultural-cognitive systems. Michel Foucault. *The History of Sexuality- Volume 1: An Introduction*. New York: Vintage Books, 1980.

[7] In examining these commonalities, it is important to not lose sight of the fact that racial minorities and those subject to socio-economic disadvantage tend to be less healthy and receive a poorer quality of care than their peers. I examine the source and consequences of this variability in chapters 3-5.

Problems of the Breakdown

Decreased Energy

As people grow older, they have less available energy.[8] For some seniors fatigue deeply limits what they can do and becomes a structuring aspect of everyday life. For others, it is simply an annoyance. But in both cases, decreased energy requires a behavioral response. Even the most active seniors in my study admitted that they do not have the stamina they did when they were younger. A 76 year-old woman who worked full time (and whose identity was deeply invested in her job) noted, as you get old "you're a little more tired. You're just a little more tired, that's all. I do everything that I did when I was younger." Later she added that she worked fewer days, and needed to take more time off because she was tired. When asked if she had as much energy as she used to she simply said "no." In a similar vein a seventy three year old retired woman described the process of physical slowing, and declining energy. She commented:

> *Well, the main part [of getting old] is that you're actually surprised that **you're physically not able to do what you could do before**. Before it's, well, 8 hours on end that I could do things, you know, if I had a big task in the yard that I wanted to do, then I love gardening. I could spend 3, 4 hours without stopping and do it. When you're older it's part of the immobility that's bothering you. And uh, you know, **you compensate for it, but in the main, it's either aches or pains, or not having the stamina.** [Emphasis added]*

Although the timing, severity, and response of losing stamina varied across the groups in my study, it was something with which all of them eventually had to come to terms.

In more extreme cases fatigue became a structuring force in everyday life for seniors. The experience of Dave, a poor white man in his early sixties living in Elm Flats, provides an example of how decreased energy can become a predicament which organizes behavioral possibilities.

> *Dave prides himself on his mental acuity, but physical problems from numerous diseases and a general lack of energy limit his ability to go out and do things. I usually ask Dave how he is feeling when I visit, to which he often responds "I've so many problems, my problems have problems." Dave is extremely afraid of falling if he overexerts himself. He talks about the risk of falling being related to fatigue, and the necessity of keeping enough "energy in reserve." Dave says he is concerned with falling, because it would result in him losing his independence. Dave says the disjuncture between what his mind wants to do, and what his body and energy levels enable him to do, is upsetting:" I think I'm a Ferrari but I can't get out of third gear... I get about two hours of good energy a day, where it is safe for me to move around and do things." I once commented that the free time of retirement must have provided Dave, who always enjoyed reading, with the opportunity to read many books. He responded, "Well keep in mind this is in the context of having lots of health problems and very little energy. I can't do a lot of*

[8] This is due largely to a combination on neuromuscular and circulatory factors. While there are debates about which levels of fatigue are normal versus pathological, like the other biological changes described in this section this is generally un-contentious among scientists and physicians. For a review see Susan B. Roberts and Irwin Rosenberg. 2006. "Nutrition and Aging: Changes in the Regulation of Energy Metabolism With Aging." *American Physiological Review.* 86.2(2006): 651-667.

things." On the occasions when we would go out, simply walking down the stairs to the car placed a noticeable strain on Dave. [9]

For Dave, the predicament created by the convergence of a lack of energy and various health problems became a structuring force around which he had to organize his everyday life. Meals, visits with friends, and doctors' appointments had to be scheduled around his two-hour energy window. Likewise, what he could eat, with whom he visited, and where he went--mostly to doctors and the pharmacy across the street-- were determined in large part by his physical limitations.

Specific health problems and medications can also affect energy levels. Seniors with cancer would often complain that they were tired all the time (due in part to the treatment regimens). Seniors on narcotic pain medications would talk about having less energy and being less alert than they used to be. Stimulants and diuretics used to treat other problems made sleeping difficult and although they provided an immediate energy boost, lead to a lack of overall energy. The problem of fatigue was there for even comparatively healthy seniors. Sandy, an 89 year-old former nurse who occupies an apartment for independently living seniors in Baygardens stated the problem clearly in one of our many informal conversations noting "Your body just doesn't do what you want it to do. You are tired all the time and you get confused." Jane, a 65 year old breast cancer patient, lamented the effect declining energy had on her social life. "I can't do the things I want to do. I am tired and depressed. I did manage to go to [the local pub] the other night and dance to [local musician], but I was in bed the whole next day. I couldn't even get dressed." She said she was trying to learn about football which was less active, "since I still like bars and men, so I should be able to carry on a conversation."

Pain

Issues of pain and how to manage were omnipresent among the seniors in my study. Even for younger participants (i.e. those 74 and under),[10] many of whom were active and had experienced comparatively minor physical problems, the issue of managing "aches and pains" was constant. Pain was a common issue for seniors from each of the gender, racial, and socioeconomic groups represented in this study. The subjective meaning of pain varied greatly for different groups, a topic to which I return in chapter 3. For some pain was portrayed as a source of focus, for others a natural part of the life course, and for some an injustice. Likewise the behavioral responses, even those within a demographic category, varied substantially. Some seniors took narcotic pain pills, others did yoga, many adapted their daily activities to minimize discomfort, some wrote poems, some went to doctors, others avoided doctors, and some spent time drinking alcohol in bars. The point here is that the increased presence of (often constant and sometimes excruciating) pain, and the corresponding need to address it in some way, formed a shared predicament of everyday life for seniors across all of the communities I studied. The following quotes from elders going about their everyday lives indicate both the commonalities and variability of this experience:

Pharmacy teller: "How're you doing?" Elderly African American Man: "*Could be better, this weather makes me hurt."* (African American Man in his 70's from Elm Flats)

[9] These field notes and observations were collected over a six month period during which I visited Dave weekly. The excerpt above is from a memo on Dave.

[10] The seniors in my study ranged in age from 61 to 99. The majority were in their seventies and early eighties.

"[My Arthritis] Hurts like hell boy. I am stuck to this goddamn bed. I can't stand up because it is unbearable. It is ok when I lie down, just uncomfortable. No-one told me arthritis would hurt this bad."
(77 year-old white man in Baygardens)

"It's all the little things with your body. My eyesight is getting' bad. I got arthritis. All my joints ache. When the weather changes, like when it rains, I know it."
(65 year-old African American Man from Rockport)

"Everything hurts. I want to go out and have all these new experiences, but my body just won't let me. "
(White woman in her early 80's from Cedar Hills)

Interactions like those above were ubiquitous. While the level of pain experienced, attitudes towards it, and behavioral responses vary tremendously among seniors, dealing with pain was an issue for seniors in all of the communities I studied.

Mobility Issues and Falls

The confluence of pain, fatigue, and injury affected the physical mobility of many of the seniors I observed. Seniors consistently noted that they could not walk as far, stand as long, or navigate the same sorts of physical environments (e.g. buildings with steps or sidewalks with lots of cracks) as when they were younger. Many seniors had trouble engaging in physical activities they once enjoyed (e.g. playing pool, dancing, bowling) because they lacked the ability to coordinate their movements or stay standing for a long time. As people aged, most experienced a decline in the physical mobility that allowed them to participate in activities they found meaningful. Sandy (the 89 year old former nurse), articulated common problems faced by even comparatively healthy seniors when she noted "Luckily my heart is good, but my legs and arms hurt, and are tired. I can't walk very far anymore. My legs get tired, and I have to sit down. That happens to a lot of people." In another instance, upon introducing my project as a study of aging in communities a retired dentist in Cedar hills noted, "That is interesting. One of the key issues is whether they are ambulatory or not." Mobility issues varied not only among seniors, but for a given senior over time. While shopping, one senior noted "I hurt, but you have good days and bad days. I have arthritis." I said she seemed to be moving well. She said, "Yeah, it is in my shoulders today, so my legs are holding up."

General mobility issues were closely related to the problem of falls. Many seniors feared falls, which were one category of potentially catastrophic physical events that could substantially change their everyday lives. Seniors in public spaces constantly joked about being "one fall away from the home," although one senior commented to me in an aside "we joke about that, but it's true." Even under the best circumstances, a fall typically resulted in increased pain and problems navigating the physical environment. This is demonstrated clearly in my interactions with Donald, a Chinese senior living with children in Baygardens.

> *Donald used a walker and had experienced several falls in the last year. Since his last fall, he began to move more slowly and exhibit pain while walking. While having coffee at the Baygardens senior center, Donald remarked to me "I broke my wrist last year. They didn't call it broke though, something else." I said fractured? He said "yes. I was*

walking for too long, maybe an hour, and I got tired and fell." I asked why he was walking. He said, "for managing my medical condition."

As his physical problems progressed after the fall, and his energy levels decreased, the distance Donald could walk shrank. He had to rely increasingly on his family to transport him.

Often, among those seniors who were older (i.e. 75 or over), did not have extensive social networks, or sustained serious damage during a falling episode, the end result was hospitalization. Even if the senior recovered, the fall typically resulted in prolonged rehabilitation in a nursing home, which was generally regarded as undesirable across communities. Of course falls occur in real world physical locations like homes, streets, doctors' offices, nursing facilities, and senior centers. These physical environments often reflect social inequalities in surprising ways, a topic I to which I return in chapter 4. Likewise, how seniors deal with falls is a function of the cultural tools, material resources, and understandings about the body that influence their actions, a topic examined in chapter 3. Still, the point of commonality for seniors across social and geographical terrains is that the potential of having to deal with falls and the consequences they produced was a real issue. Even when falls were not catastrophic, they had ramifications.

Cognitive Slowing

Issues of cognitive degeneration and memory loss affected seniors as well. As individuals age, all must contend with changes in memory even if these changes do not become a structuring force in their daily lives.[11] For some, memory lapses were an occasional annoyance. For others, severe cognitive degeneration made living alone unviable, in some cases resulting in placements in total institutions like nursing homes and hospitals. Even in more innocuous cases, memory issues translated into problems managing medications, keeping track of doctors' appointments, finding important documents, paying bills, and even remembering to eat and drink. In the extreme institutional cases, a loss of memory could be tantamount to a loss of identity.

Jokes about "senior moments" and "dementia" were common in the public places where independent seniors congregate like barbershops, beauty salons, senior centers, diners, and clinics.

While seniors often make jokes about issues like memory loss and reaction time publically, many also acknowledge that these are a real source of concern. Seniors from all communities, even those who kept a generally positive attitude about aging, exhibited frustration with forgetting things, the need to rely on others, and the way forgetting reminded them of growing old. When describing her problems in a visit to her home, Sandy commented that when you get old "you get confused." During an interview, a sixty-seven year-old Chinese man from Elm Flats noted even more bluntly "The thing about getting older is your memory is fucked!" Memory problems were often exacerbated by medication or treatment for other health problems. In a typical example, when I went to visit her home at a time we had arranged, a woman from Baygardens seemed both surprised and flustered. She explained, "I am having a hard time with

[11] Again, there is a massive empirical literature in psychology, biology, and clinical sciences, suggesting that the cognitive and memory declines associated with old age are observable and biologically based (rather than simply being an artifact of projected stereotypes). These literatures also show however, that the extent to which aging affects focused versus general tasks may vary. See Shu-Chen Li. "Connecting the Many Levels and Facets of Cognitive Aging". *Current Directions in Psychological Science.* 11.1(2002): 38-43; Timothy A. Salthouse. "What and When of Cognitive Aging". *Current Directions in Psychological Science.* 13.4(2004): 140-144.

scheduling now because of chemo brain."[12] The extent to which her cancer treatment led to her forgetfulness, versus her age, is impossible to discern. In all likelihood, both contributed.

Sensory Changes

In addition to problems with memory, as people age they experience a host of sensory changes. Hearing, taste, smell, and touch become less acute.[13] Many seniors talked about getting "a sweet tooth" as their sense of taste dulled. Others talked about numbness and neuropathy in touch which led to accidents around the house and difficulties with basic tasks such as opening jars. Many complained that they can no longer smell as well. In some cases, the degeneration of the senses had profound ramifications for everyday life. Degeneration of hearing and loss of eyesight had the greatest overall effect. Hearing problems created difficulties in communication often requiring special equipment like hearing aids and modified phones. Problems with sight affected seniors' ability to read, recognize other people at a distance, and drive. The older seniors in my study frequently talked about how their decreased vision required them to give up driving, which was generally experienced as a loss. In some cases the family convinced them they were a danger, in other cases the DMV intervened. The decline of hearing and sight were doubly difficult as they not only eroded a seniors' capacity to act, but signaled the loss of this capacity to others and perhaps themselves. Many seniors talked about getting depressed when they had to give up their cars as once again this was experienced as both a loss of independence and a reminder of becoming old.

When the seniors in my study talked about the dulling of the senses, they never did so in a positive way. Regardless of seniors' assessments, the biological changes associated with the aging body alter how people experience the world outside. These changes often create issues in everyday life. Some of these seem comparatively minor (e.g. having to ask people to speak up) while others carry existential weight because of their implications for personhood and independence (e.g. when to give up driving). The various implications for seniors' experiences of the world are discussed in chapter 3. The point here is that for seniors having to deal with the concrete issues created by declining, sight, touch, hearing, and smell was a shared problem across communities.

Health Problems

As the sections above demonstrate, growing old is often associated with various physical problems created by the "wearing out" and "breaking down" of the body. One of the predicaments that often arose was that seniors came to spend a large portion of their lives dealing with health issues. This is seen in the discussion above of the predicaments seniors face concerning pain, mobility issues, and decreased energy. But the issue of health problems is broader. Seniors who saw medical professionals for their aches, pains, mobility, and cognitive issues could easily spend a good portion of their week, and much of their limited energy, in medical settings. Dave, who is discussed in the section on energy above, often commented that if he went to see medical providers every time he was supposed to, he would spend his entire life in the hospital. For those with conditions requiring ongoing treatment (e.g. cancer, diabetes,

[12] In Nursing homes, the loss of memory is a concern as well but because of the institutional implications of "losing your mind," it is used more frequently as an insult between seniors.

[13] There is an extensive literature that shows how and why this operates on a biological level. For a basic review see Neil J. Nusbaum. "Aging and Sensory Senescence". *Southern Medical Journal.* 92.3(1999): 267-276.

wounds) this effect was magnified. A comment made by Jane (the 65 year old woman discussed above) during one of my visits articulates a typical frustration about the breakdown of a body and its treatment, "I feel like having cancer is a full time job. It has just been a really fucked up week. The house is a wreck, dishes are piled up, I have all these appointments, and my car is broken…I haven't even checked my e-mail in three days. It has been a fucked up week." For Janet, cancer and its management became a structuring force in everyday life. Between the tiredness, constant medical tests, doctor appointments, chemotherapy infusions, trips to the pharmacy, and medication side effects, Jane spent a large portion of her time dealing with physical conditions.

The demands of a "breaking" body are not unique to seniors. Illnesses minor and catastrophic can affect the young as well as the old. However, as people age this becomes a much more common experience. For some seniors in my study, the weekly (or bi-weekly) trip to the doctor was the only time they left their homes. For those in nursing homes, trips to the hospital or another medical institution were the only time they left the facility. But even for seniors who were younger (i.e. aged 74 or below), more socially active, and not institutionalized, issues of health problems came up frequently. In addition to exacerbating the issues of mobility, pain, and energy, mentioned above, and the issues of loss mentioned below, health problems affected the ability of seniors to work and to participate in recreational activities. Health problems led to having to give up physical activities like dancing, hiking, gardening, bowling, or pool. One senior noted that she knew something was wrong because she was not feeling well enough to go to weekly bingo, so she went to the doctor. Health problems also led to some individuals having to give up work. Seniors often described specific health problems such as strokes, injuries, heart attacks, cancers, etc. as turning points in their lives that required them to change how they behaved and engaged with the world in substantial ways. For instance, in one observation Donald was lamenting having lost a warehouse job. I asked if he still worked. He said, "I was forced to retire. Too many surgeries. I had 9 surgeries." I asked what for. He said, "Aneurism, blood clot in my leg. See here [He showed me mismatched skin on his leg]… They had to graft skin from my thigh, which is why it look ugly now. I also have diabetes which complicates things." Donald's health problems made his previous occupation and social role (as a laborer and provider) much less viable. Although many seniors contested or strategically used the "sick role" in interactions with people and organizations, the Parsonian insight that certain roles become less viable when the body breaks down were visible among and acknowledged by the seniors in my study. [14] While they may be seen as politically desirable for some, stories about the robustness of oppressed groups and the infinite contingency of experiential "journeys" of aging miss an important point about the universal predicaments created by the breaking down and wearing out of the human body.[15]

[14] Talcott Parsons. *The Social System*. New York: Free Press, 1951.

[15] This is pronounced in contemporary gerontology, particularly its "critical" variants. A current trend in gerontology is to focus on experiential differences in aging (e.g. Portocolone 2011), the robustness of minority populations (e.g. Hooyman and Kiyak 2005), or how aging is an "individual journey" that can be done well or poorly. Before it is possible to chart these variations and relate them to social inequality, it is necessary to acknowledge (rather than reject) in a neutral social scientific manner, both the biological commonalities and social contexts that produce both commonalities and divergences in aging. Elena Portocolone. "The Myth of Independence for Older Americans Living Alone in the Bay Area of San Francisco: A Critical Reflection". *Ageing and Society.* 31(2011): 803-828; Nancy R. Hooyman and H. Asuman Kiyak. *Social Gerontology : A Multidisciplinary Perspective*. 7th ed. Boston: Allyn and Bacon, 2005.

Problems of Loss

All who live to old age must contend with the problems of the degenerating body. In addition to direct physical issues described above, this involves a secondary loss of *people* and *capacities* that are (or were) central to a sense of self, social identity, and ability to act in the social and physical world.[16] Growing old required the seniors in my study not only to grapple with their own mortality, but to deal with the deaths of others. Aging also involved the loss of other people: friends, loved ones, and acquaintances. Getting older meant watching existing networks shrink (even if new ones were built). Becoming one of the "old people" was associated with losing prized and socially validated characteristics that are grounded in the body: strength, beauty, stamina, and wit. There was great variability in how the elders in my study dealt with these losses. Some said it made them appreciate life and what they still had, some became preoccupied with preventing future losses, some become fatalistic and depressed.[17] All had to respond however, and for this reason, loss is a central predicament of growing old.

Death

One aspect of loss resulted from the death of members of a senior's social network. Medical and legal institutions refer to death as either "irreversible cessation of circulatory and respiratory functions, or (2) irreversible cessation of all functions of the entire brain, including the brain stem."[18] Sociologists and anthropologists have often examined death as a bio-social process affecting the form and function of social systems. As a sociological phenomenon, death's meaning, experience, and effect on others is a function of social and cultural contexts, but it is ultimately rooted in the cessation of biological function.[19]

As people and those in their networks age, they have to contend with the deaths of others with greater frequency.[20] The seniors in the communities I studied were constantly dealing with the deaths of friends, family, acquaintances, neighbors, and pets. For seniors living in institutions like nursing homes this was a common occurrence. During a regular visit to a nursing home in Baygardens, I asked one man what happened to his bedbound roommate who was absent. He nonchalantly added "he died....this is the 4th one to die on me." This pattern is seen in apartment buildings populated mostly by seniors as well. One woman remarked that her social life was less active at present than a few years ago. I asked why? She responded, "I used to have more friends in the building but four died." On a trip to a senior center a man asked another senior I was

[16] Some seniors talk about what they gain as they grow older. This is much rarer, more contingent, and decisively less linked to changes in the human body than loss.

[17] These responses are underwritten by variation in material and cultural resources, meanings, and dispositions (the subject of chapter three). Interestingly, the orientations for dealing with the loss of old age line up closely with the orientations to material scarcity described by urban ethnographers (c.f. Dohan 2003 and Sánchez-Jankowski 2008). Perhaps this is because the structural dilemma of aging involves scarcity, but the resources that become scarce are rooted in the body. See Daniel Dohan. *The Price of Poverty: Money, Work, and Culture in the Mexican American Barrio*. Berkeley: University of California Press, 2003; Martín Sánchez-Jankowski. *Cracks in the Pavement: Social Change and Resilience in Poor Neighborhoods*. Berkeley: University of California Press, 2008.

[18] George C. Keely, et.al. *Uniform Determination of Death Act*. Ed. N. C. o. Commissioners and U. S. Laws, 1981.

[19] For a brief review see Stefan Timmermans. "Resuscitation Technology in the Emergency Department: Towards a Dignified Death". *Sociology of Health & Illness.* 20.2(1998): 144-167.

[20] Once more, this is a trend that is well documented as an aggregate pattern. Psychiatrists and gerontologists often refer to the increasing volume of loss, corresponding strain, and potential desensitization as bereavement overload. Robert J. Kastenbaum. *Death, Society, and Human Experience*. Allyn & Bacon, 2008.

spending the day with, "How is the gang over there [at the apartments]?" She responded "Most died. That's what happens when you get old, you lose all your girlfriends..." Even those whose networks involved large numbers of non-seniors had to confront the deaths of friends, family members, or pets. A middle class white woman in her early 70's summed up a common predicament: "I've had a lot of death in the last few years, so I've lost a lot of people I was very close to." Statements like "all my immediate family is dead," are not uncommon among seniors in both public and private settings. This is particularly true for those in their 80's and beyond.

The loss of people through death or permanent institutionalization produced concrete problems in both the instrumental and psycho-social arenas. One issue for seniors was acknowledging and developing strategies for facing the inevitable prospect of their own death. As seniors watch friends and family die, and recognize that their own bodies are not as strong as they once were, they are presented with the inevitability of death. A 95 year old Chinese man from Elm Flats reflected on this problem and outlined aspects of his response "nobody lives forever. Death's inevitable, right? Sooner or later, so I don't worry about dying, I'm just live[ing] one day at a time and do it best I can. I do something to help people, if I need help I ask for them to help me. So that's my philosophy." While his espoused response to the problem of mortality articulates a particular set of understandings, to which I return in chapter 3, the acknowledgement that growing old meant approaching the end of life was common.

The loss of people that were important to seniors also had a potentially less existential, but still sociologically substantial effect on everyday life. The loss of friends involved having fewer people with whom to recreate and "conversate." Places seniors once enjoyed came to remind them of the friends they had lost. The deaths of others involved the loss of emotional pillars in the form of family, or close friends. The loss of pets often carried a great deal of emotional resonance. The practice of keeping pictures or albums of dead pets was quite common among the seniors in my study. Many otherwise unemotional individuals would break down talking about cats or dogs that had passed away, indicating a substantial sense of loss.

The deaths of others also involved instrumental losses that affected daily activity for the seniors in my study. One senior articulated this, when she noted that she used to get rides with her friend to the grocery store and church, but now she has to take the bus even though she is less mobile from advancing arthritis. As I will show in chapter 4, these sorts of network changes were often repaired over time. However, there was a transition period of disruption which created practical difficulties for seniors. Patterns and routines were often a very important coping strategy for seniors who lacked the energy, physical, and cognitive flexibility of youth. Even seemingly small disruptions could be experienced as powerful or distressing events. The deaths of people in a senior's network often combined this sort of disruption with the implications of losing another person. Death of a key person in a senior's network often resulted in depression and social withdrawal which could compound seniors' other difficulties.

Loss of Capacities

Even when the degeneration of the body did not substantially impede the basic ability to act "independently" in the world (via institutionalization, death, or debilitating illness), the aging body produced losses in physical and cognitive capacities that carried social ramifications. Seniors often talked about not having the strength to lift things, open bottles, or do routine maintenance of their physical environments. Men talked of losing their physical presence. Women talked about developing wrinkles, and how this change in appearance affected the way they were treated. One woman noted that "they [young people] treat you like you are from another planet." Another noted "all they see is wrinkles." Seniors (particularly women)

continually noted the way they were overlooked in interactions with service providers, retailers, and other people, and commented that this was a source of irritation. I saw this in the numerous instances when people would address me instead of the senior I was following. [21] Seniors often commented on this, with the following response being a typical example: "If it's at the restaurant it really bothers me because it almost feels like they don't think I can read the menu and make up my own mind, because they always ask the other person." The issue of a newfound "invisibility" was difficult for many to deal with, particularly those with wealthier backgrounds and those from racial groups unaccustomed to dealing with stigma rooted in their appearance.[22]

Growing old involves not only the loss of people but the physical characteristics that people value and consequently specific capacities for action that are grounded in the body. In other words, as people aged, the resources provided by their bodies dwindled. In extreme cases, this created predicaments where people felt trapped by their bodies. During a visit to a nursing home to see Jason, a seventy six year old white male, he made this clear when he shook his head and said "I'm an action man, and there's no action there. [raises voice] I'm an action man. I raced cars and flew planes." I followed up shortly after and asked how his week was going. He shrugged and said, "I just sit around all week dying, and watching others waiting to die. I'm a fucking cripple, and I can't go out." Here the degeneration of the body, in this case produced by rheumatoid arthritis and a host of other physical problems, was understood as literally taking away his capacity to act. While objectively this may have been an overstatement,[23] the fact remains that Jason could not walk, could not bathe without assistance, and could not dress alone. His modest social security income could not provide a private aide to help him in everyday life. He poignantly noted "you depend on them [the nurses] for everything. They control your biology." Although some actions such as lamenting his lost "independence" were available to Jason, his diminished physical resources limited his capacities for pursuing lines of action he found desirable.[24]

For poor individuals who have fewer material resources, and whose social status is often rooted in aspects of "physical capital," losing the strength, beauty, or stamina that were central to their lives was often particularly difficult.[25] For seniors who prided themselves on their ability to work, the lack of the physical capacity to do so was difficult to deal with. Poor men in particular often talked about how the degenerating body signaled vulnerability in a way they found undesirable. Commenting on his increased need for medical care an elderly African American man from Rockport noted, "a man has a certain image to project. And that image, it don't include doctors." This was often associated with a sense of shame. The decreased physical deterrent and ability to ward off crime and predation were a concern as well.

---

[21] This was true even when I would follow at a distance and/or try to avoid eye contact.

[22] This is seen in Goffman's work on stigma. Here the body is a point of signification that places the individual in a "discredited" category associated with assumptions about competence, proficiency, and morality. Erving Goffman. *Stigma: Notes on the Management of Spoiled Identity*. Englewood Cliffs: Prentice Hall, 1963.

[23] On a technical level, his speech behavior and acknowledgement of his lost capacity to act are in fact actions.

[24] I expand upon these points in the conclusion. Here the physical tools available to seniors are a direct correlate to the cultural tools used to construct lines of action. For an explanation of how cultural tools are used to construct lines of action in various contexts see Ann Swidler. *Talk of Love: How Culture Matters*. London and Chicago: University of Chicago Press, 2001.

[25] Wacquant (2004) and Sanchez Jankowsi (2008) show how poverty is associated with a very physical existence and habitus in urban America. Loïc Wacquant. *Body & Soul: Notebooks of an Apprentice Boxer*. Oxford and New York: Oxford University Press, 2004.

The way the degenerating body created secondary social predicaments is exemplified by the following incident observed during a visit to a senior center event.

> *An elderly Latino man was standing in line for handouts (free food and medical supplies). The line was substantial (about 20 seniors were waiting), and moved slowly. He grimaced then left. An elderly white woman commented, "He has a problem standing up, because of his hips." Upon returning, he commented to me "It is hard for me to stand for a long time. They should have some chairs." An elderly Asian woman told me "Please tell them to have chairs." The man shook his head and said, "I already told [the director]." I asked him "Have you ever thought about one of those folding chairs?" The man responded shaking his head, "I don't want to play the cripple card yet. It's only 6 months since it got bad. Already I can tell my wife doesn't want to go out with me."*

Here, the problem of physical degeneration and mobility problems converged to produce a loss of capacities with substantial social and psychological ramifications.

However, even those who constructed a sense of self around less clearly "physical" attributes were forced to acknowledge how key aspects of their identity (e.g. intellectualism, ability to work, position in the labor market) were affected by their aging bodies. A financier visiting a middle class senior center commented on this as well, noting that not only was his memory worse, but he had less energy, and even though he wanted to work no-one wanted to hire someone who "looked old." In explaining the issue of what age seems to signify to institutions, his comment was representative of a common sentiment, "they just totally think we're all old, feeble people with no brains. And it is very upsetting. It's a really tough way to be treated." A seemingly less physical aspect of identity, the ability to work in a non-manual profession and produce income, was eroded with the changes in the aging body (energy), the capacities dependent on that body (cognition), and what age and the body signify to potential employers (lack of youthfulness/competence etc.). Growing old involved the loss of a body that not only enabled action but signified a competent and energetic person to individuals and groups with which the senior had to interact.

III. Convergent Degeneration: Shared Responses to the Structural Dilemmas of the Aging Body

The sections above showed how the aging of the human body created a set of shared predicaments for seniors across all four communities in my study. This section examines the corresponding congruence in how people across those communities described how they understood these predicaments. The individuals in my study confronted the issues above (e.g. lost mobility, declining energy, and death) with different life histories, material, social, and cultural resources. However, they ultimately were forced to contend with a common set of problems rooted in the "breaking down" and "wearing out" of their bodies. Although rooted in bio-social rather than purely institutional forces, these predicaments formed structural dilemmas.[26] These dilemmas create "tasks or practical difficulties of action, to which the wider culture generates many different, sometimes competing, and always only partially satisfactory solutions."[27] For all of the observable variation in the motivations, behavior, and strategies of the

[26] This term is adapted from Ann Swidler. *Talk of Love: How Culture Matters*. London and Chicago: University of Chicago Press, 2001. p. 201

[27] Ibid. p. 201.

seniors I studied (key topics in chapters 3 and 4), there was a substantial congruence in how they made sense of aging. The main point of convergence, which I turn to now, centered around the importance of the physiological body for everyday life.

The Centrality of the Body in the Experience of Aging

Seniors frequently discussed aging in terms of a breakdown in biological function. Even those who would make public proclamations about "feeling young," like "age is just a number" or "I feel 35," would often privately confide that they were experiencing some physical problems. Many worried about the implications this had for their futures in general, and how this would affect their opportunities for independence (typically defined as living alone without a permanent helper) in particular.[28] Declining health, and growing old, were largely linked in the minds of seniors across all communities. The following excerpt from my field notes provides a representative example:

> *I was driving Jessica, a 92 year-old white woman who lives alone in an apartment in Baygardens, to see her ophthalmologist. She mentioned that her friend, who was recently hospitalized, was having a hard time. I asked what was wrong with her. Jessica laughed then said* ***"She's old. That's what's wrong with her.*** *I can tell you what's wrong with me. [counts on fingers] I've got a slipped disk and a bad back, I got arthritis all over. I have a bad leg on the one side. I have glaucoma, a hurt ankle, and I can't hear too well. If I stand up too long I get dizzy and my legs get tired.* ***That's getting old. You can't see, you can't hear well, you get confused, and you have trouble walking."*** *[Emphasis added]*

In Jessica's account, to grow old is synonymous with bodily breakdown. James, a 77 year old African American man from Rockport expressed the same sentiments about health problems being a key aspect of growing older when he noted

> *You have a tendency when you get older to have a problem with your health, walkin'. You have problems, all problems pertaining to your health. You know, it could be walking, sitting, laying. Those are the things that an old person deals with that's not easy.*

The observations above illustrate an acute recognition of how the predicaments of "getting old," such as the increased health needs, presence of pain, decreasing energy, slowing cognition, and sensory changes described in the previous section, are grounded in the degeneration of the body.

In addition to the two-and-a-half years of participant observation research that forms this study, with the help of a number of research assistants I conducted a supplement of sixty semi-structured in depth interviews with seniors. One question which was always asked was "How would you describe what it is like to grow old to someone who is younger?"[29] Although the question deliberately makes no reference to the body or health specifically, every respondent, without exception, mentioned physical degeneration and the social consequences as part of their response.[30] The comments of Tim, a 67 year-old white male living in Baygardens, are representative of a number of themes that were central focal points for seniors:

---

[28] See Portocolone (2011).

[29] For a complete copy of the interview schedule see the methodological appendix.

[30] These questions also precede any questions about health or the body in the interview schedule. The subjects are not primed that this is an interview on physical issues as they are told simply (and correctly) that this project is about

> *So I'm really **physically** a wreck. And I'm very, very concerned about being able to **live by myself**, because I've lost a lot of the **flexibility** that I used to have, and that's one of the things that I wanted to mention... Seniors are a tough crowd... They're old, by definition, they're cranky, they're often in **bad health**, they're frequently in **mourning** for, you know, family or compatriots, and lastly, they're basically sniffing their own **mortality**, which is, you know, it's a tough, tough, tough crowd. [Emphasis added]*

Tim's answer points to the salience of the problems created by the aging body detailed in the sections above, as well as an acknowledgement that these problems were a source of concern.

Likewise Janice, a 67 year-old upper-middle class white woman living in a large home in Elm Flats, described many of these issues when asked what a young person should expect when growing older:

> *Well, speaking personally, things that I used to enjoy eating, I can't always eat because your digestion changes. Things do slow down. I've had a problem with my back. I used to be a person that walked a lot, but I've had a particular problem with my back and it's slowed me down. It can be frustrating. **Stuff happens. Heart attacks happen. Strokes happen. And falls happen.** And you have to just* be very *careful, and you have aches and pains. Your teeth may have to come out, and your eyes get old, it's called cataracts.*

In addition to acknowledging the physical changes of aging and how they affected her, Janice's account points to a sense of increased risk that is associated with becoming old. This theme was shared across all four communities. The risk seniors acknowledge is often physical: the chance of falling, strokes, or catastrophic medical problems. However, many seniors also constantly described fears of being taken advantage of, "losing their [mental] facilities," and/or being victimized by crime.[31] One senior described the process of aging as "coming to terms with a mindset of frailty," which involved an increased likelihood of catastrophe both in terms of health and crime. Comments like "I feel safe going out during the day, but I never go out at night," were most common among women living in poor areas, but were shared across groups. This is sometimes joked about, as mentioned by a senior in the section above, as the reality of "being one fall away from the home."

Seniors also talked about the way sensory changes, the presence of pain, and physical and cognitive slowing produced a general shift in ways of experiencing and acting in the world. Seniors from all four communities discussed how the general pace of life "slowed down" as they reached old age--often to the chagrin of individuals who built an identity around their ability to "stay active" through work, sports, volunteering, or other forms of social engagement.[32] Many described learning to accept and manage the pain of everyday life as an aspect of a general shift in how they experienced the world. An elderly white woman in Cedar hills conveyed the general sentiment of the experiential shift that comes with aging when she noted to a friend during lunch,

---

what it is like to get older in America. Likewise, the seniors I shadowed in everyday life were not told that the overarching project was about health, but growing older more generally.

[31] For a similar finding on seniors and their reasons for isolation see Klinenberg (2002). Eric Klinenberg. *Heat Wave: A Social Autopsy of Disaster in Chicago*. Chicago: University of Chicago Press, 2002.

[32] For some like Jim, a former financier from Baygardens who was "downsized" at 64, this can be devastating to their sense of identity. For others the ability to enjoy increased leisure time, when combined with general changes in the body and style of life, was "liberating." Still, despite the stark variation in subjective and behavioral responses, "slowing down" was not simply a useful cultural frame, but a dilemma to which seniors had to respond.

"When you get old things change. How you think and feel." [33] James, the 77 year old African American man from Rockport, described several of these points when he commented:

> *What you don't really understand about seniors is the way they feel. You can never understand the way they feel because you from another generation, and with that you have different ideas on the way that older people are supposed to fit into a category. The whole world is in that position.* ***No one understands being old, but old people.*** *That's just an event that happens and it's catastrophic. You can't change it. It's like a tree out there. Uh, when it's young it's growing, when it gets to a certain age, uh, it spreads out, but it don't grow any more. It's just, uh, branches come back and they fall off, but you still the same. And when you get old, everything is a chore. Everything you do is a chore. Just getting up in the morning is a chore. Because you can't sleep the same, you can't eat the same, you can't walk the same. And you don't have the same dreams.* ***Everything changes. Old is a different animal all together.*** *And the only way you can understand it is you have to get there.[Emphasis added]*

Except for the vivid clarity and use of active voice, James could well have been paraphrasing Bourdieu's notion of habitus: socially constituted psycho-social-cognitive dispositions, ingrained through everyday life, that affect how people experience and act in the world.[34] Although the seniors above had different degrees of physical and cognitive changes, and were from different backgrounds, all were responding to the convergent predicaments of the degenerating body and the associated shifts in modes of experiencing and acting in the world that accompanied their responses.

Although seniors' understandings of the aging process were fragmented and at times even contradictory, they shared a degree of coherence around the centrality of the body in everyday life. The observations above illuminate the ways in which the degeneration of the aging body not only creates concrete everyday predicaments that exist across communities, but how they are made sense of in similar ways.

IV. Conclusion

Analyzing the shared predicaments of the aging body and the convergent responses of individuals from communities across socioeconomic and racial groups presents challenges for social scientific models of stratified modern societies. Problems arise in part from the fact that biological and social models of reality are often cast as competing rather than complementary. Sociologists often counterpoise models of agentic behavior to the evolutionary models and genetic determinism of the biological sciences.[35] Biological and clinical science often dismiss

---

[33] Interestingly, various physical, social, and psychological aspects of "slowing down" are often clumped together in seniors' accounts. The fact that their understandings of these processes does not necessarily invoke mind-body dualisms is important and telling. However, for the purposes of charting the concrete problems of everyday life seniors experience, it is useful to (at least briefly) to maintain the analytical (but not ontological) distinction between "physical" and "cognitive" slowing.

[34] Pierre Bourdieu. *In Other Words: Essays Toward a Reflexive Sociology* Stanford: Stanford University Press, 1990a.

———. *The Logic of Practice*. Stanford: Stanford University Press, 1990b.

[35] For a discussion and attempted synthesis within the arena of stratification see Daniel E. Adkins and Steven Vaisey. "Toward a Unified Stratification Theory: Structure, Genome, and Status Across Human Societies". *Sociological Theory.* 2.2(2010): 99-121.

the insight that the mechanics of the human body only matter within, and are subject to, the operations of larger social systems.[36] It does not require much imagination to understand how these artificial antagonisms are grounded in the "structural dilemmas" produced by the practical demands of competing disciplines and the scholars that constitute them. However, even if one were to grant that dividing the biological and social aspects of human behavior is analytically (if not ontologically) reasonable, even the analytical separation breaks down when looking at phenomena that reside precisely in the space between the body and society

The Body as an Instrument, Resource, and Constituent Unit in Social Systems

The biological social divide is most evident in sociological models of "structure," and the difficulties they create. Sociologists most often analyze how both the mundane and existential problems of life form the arrangements of social structures. How to define "social structure," a key concern for sociologists, is a longstanding point of contention. A useful starting point can be found in William Sewell's classic article on the topic.[37] Sewell describes structures as "mutually sustaining schemas [cultural meanings, motivations, and strategies] and resources that empower and constrain social action and that tend to be reproduced by social action." [38] In this framework, structures are ultimately the product of human action, but on a day to day basis, pre-existing institutional arrangements create the conditions that limit the range of possible responses for given individuals in any concrete context.[39] This idea, an adaptation of what Giddens refers to as the "Duality of Structure," is a key theoretical prior for much contemporary sociological theorizing.[40] Sewell contributes to this model by integrating Bourdieusian ideas about the cultural underpinnings of both macro-social and cognitive structures. Swidler's work expands this relationship further by showing how culture and the schemas it forms not only underpin and congeal around institutional relationships, but is something "used" by actors as deployable tool in response to concrete "structural dilemmas" created by existing contexts.[41] However, with a few notable exceptions, the fundamental role of the human body as the underlying bio-social unit that enables and constrains social life is largely neglected.[42] Consequently, notions of structure

[36] In a sense this is similar to a point Durkheim makes when he notes there is no individual without the group that constitutes it. Emile Durkheim. 1893. *The Division of Labor in Society*. New York: The Free Press, 1984.
[37] William H. Sewell Jr. "A Theory of Structure: Duality, Agency, and Transformation". *American Journal of Sociology.* 98.1(1992): 1-29.
[38] Ibid. Pp. 19
[39] Note that Sewell uses the plural form "structures" to indicate that these social configurations are multiple, overlapping, and mutable. See also Swidler 2001
[40] Anthony Giddens. *The Constitution of Society: Outline of the Theory of Structuration*. Berkeley: University of California Press, 1984.
[41] In Swidler's framework, structural dilemmas are shared problems which create "tasks or practical difficulties of action, to which the wider culture generates many different, sometimes competing, and always only partially satisfactory solutions." (Swidler 2001) p. 201.
[42]Turner (1984) makes this point in his classic work arguing for the centrality of the body in social theory. Likewise the body is central to Bourdieu's (1990) understanding of the habitus and Foucault's (1977, 1980) notions of power. See also Wacquant (2004, 2009). Still as Turner points out although the centrality of the body is recognized in a handful of arenas like medical sociology, mainstream American sociology tends to overlook the importance of the body in the analysis of more abstract social forces. Michele Foucault. *Discipline and Punish: The Birth of the Prison*. New York: Random House, 1977; Bryan S. Turner 1984. *The Body and Society*. New York: Sage, 1997; Loïc Wacquant. "Habitus as Topic and Tool: Reflections on Becoming a Prizefighter". *Ethnographies Revisited.* Ed. W. Shaffir, A. Puddephatt and S. Kleinknecht. New York: Routledge, 2009.

are disembodied. They focus on the constitution of social systems, but fail to recognize the reciprocal relationships between these systems, their biological underpinnings, and the physical environments in which interaction takes place.

In order to understand the problems of everyday life faced by different groups of seniors, it is necessary to consider the importance of the body and theoretically reintegrate it into notions of structure. This is a larger theoretical task that will be taken up in the conclusion of this dissertation. However, the everyday difficulties and subjective responses of seniors across communities described above contribute to our empirical understandings of how biology and social structure are intertwined. The data presented in the sections above exemplify three key relationships between the biology of the human body and social structure: (1) how the body is a *fundamental precursor* to social structure, (2) how the body functions as the basic *instrument for action*, and (3) how the body is a *resource* that influences action and outcomes.

On a fundamental level, the body is a necessary *precursor* to social structure, as it provides the raw material for human actions and cultural-cognitive constructs that are the foundations of structures. Shared meanings cannot exist without a biologically grounded cognitive system, and physical action cannot take place without a vehicle. Although physical traces such as artifacts can remain, societies cannot exist without inhabitants.

In a related but more concrete way, the body is also an *instrument for action.* It constitutes the apparatus human beings use to experience, understand, and act in the world. There is no social actor without a human body. As people age, the fundamental character of their apparatus changes. The way they can act changes. The way people treat them changes. This is what James is referring to when he notes "*No one understands being old, but old people….Everything changes. Old is a different animal all together*." Changes in the body are not just about the way people can present themselves. Biological changes, mediated in social interaction, fundamentally structure how people experience and act in the world .

Finally, the body is a *resource* in the sociological sense. A retired teacher at a senior center in Baygardens put this most clearly when she noted "You don't realize how precious your body is until you get old." Appearance, intellect, strength, agility, and endurance are all grounded in the human body, even if their labeling as such, and the associated processes of moral signification, require a social response.[43] Having the right "physical capital" or bodily tools can be essential in securing desired outcomes, and like money or status, the body can be leveraged in attempts to reach particular ends.[44] This is seen in the way a lack of energy limits what Dave can do, where Donald can walk, and whether Sandy can go out. When the biological body dies, social death results and an individual's capacity for action vanishes. However, the resources of the body can substantially dwindle before death.[45] This is what Jason realized when he commented "I just sit around all week dying, and watching others waiting to die. I'm a fucking

[43] For a classic look at labeling and signification see Goffman (1963). For a recent examples within the context of poverty and middle class neighborhoods, see Wacquant (2004) and Sanchez-Jankowski (2008). Erving Goffman. *Stigma: Notes on the Management of Spoiled Identity.* Englewood Cliffs: Prentice Hall, 1963.

[44] See Wacquant.(2004). Loïc Wacquant. "The Pugilistic Point of View: How Boxers Think and Feel About Their Trade." *Theory and Society.* 24.4(1995): 489-535.

[45] This point may seem commonsensical, but it important in understanding how capacities, roles, and social systems are underpinned by a fundamental biological unit. For more on roles and social death see Sudnow (1967), Goffman (1963), Timmermans (1999) and Mulkay and Earnst (1991). Michael Mulkay and John Ernst. "The Changing Position of Social Death". *European Journal of Sociology.* 32(1991): 172-196; David Sudnow. *Passing On: The Social Organization of Dying*. Englewood Cliffs: Prentice Hall, 1967; Stefan Timmermans. "When Death Isn't Dead: Implicit Social Rationing during Resuscitative Efforts". *Sociological Inquiry.* 69.1(1999): 51-75.

cripple, and I can't go out." Without necessary bodily resources, the self-proclaimed "action-man" lacks the capacity to act.

Once these relationships between the body and structure are acknowledged, the notion of a structural dilemma becomes an extremely useful lens for examining the predicaments of growing old. In the case of aging, some physically rooted predicaments are culturally imbued with existential weight (e.g. when to give up driving or move to a nursing facility) while others are seen as more immediate and pragmatic (e.g. how to deal with arthritic knee pain or trouble opening cabinets). In each circumstance however, the degeneration of aging bodies creates concrete problems requiring a choice to be made by actors. In the context of the wider social system, physical predicaments create structural dilemmas that demand a cultural and behavioral response.

On the Sociological Importance of Aches and Pains

It is probably not surprising to the reader that growing old is associated with health problems, aches, pains, changes in cognition, the death of friends and relatives, and declining physical capacities. After all, these phenomena are all well documented in the medical, social scientific, and popular literatures and affirmed by common sense. This fact alone should point to their importance for everyday life among the aged, but the fact that they are "common sense" makes them too easy to ignore. The banal universality of growing old is decidedly un-seductive to a social science that continues to value novel findings—but it is in their universality that aches, pains, and mobility problems among the aged provide an essential location for examining the fundamental mechanisms linking social inequality and health. [46]

The predicaments experienced by seniors who grow old in urban America point to ongoing problems in contemporary social-scientific understandings of the relationship between the human body and social systems. In disciplines like sociology and anthropology, which emphasize the importance of context and interpretation, it is important to remember that contingency is not without limits. Some aspects of life, like coming to terms with "breaking down" and "wearing out," are comparatively universal. Even if the solutions and tools brought to bear by different individuals and groups are different, the root problems are fundamentally the same. For this reason, the aging body ultimately presents a comparatively universal structural dilemma that individuals must address with uneven resources and tools, making it a key location for understanding the relationship between social stratification and health.

Returning to the debates around "leveling" and "cumulative disadvantage" that are a central theme of this dissertation, the common breakdown of the body provides a point of universality—in a way a sense of leveling. Contrary to some popular accounts however, "leveling" is not about entering a life stage where all people have what they want or need. It is not about reaching a shared minimum quality of life. Rather, the point of commonality is being forced to deal with the exigencies of bodily breakdown and the predicaments this creates. To grow old is to possess a degenerating instrument for acting in the world, regardless of one's

[46] Of course some forms of social inquiry such as ethnomethodlogy, linguistic anthropology, and cognitive sociology have long focused on the importance of rules or rule-like invariance in seemingly everyday phenomenon. The point here is not to argue that social science should focus exclusively on these topics, but to acknowledge an often discarded insight that seemingly mundane phenomena are essential for understanding both the universalities and contingencies of the human condition.

social position in it. Leveling is about watching the resources of the body dwindle and experiencing the social consequences. In the next chapter, I turn back to the question of whether and how inequality experienced over the life course is carried forth into old age by examining how one's location in society affects the available behavioral responses, subjective experiences, and ultimate outcomes of seniors from different social strata.

Chapter 3
The "Desirable," "Reasonable," and "Plausible": Cultures of Aging

I. Introduction

As Chapter two shows, the common experiences associated with growing old lead men and women from different racial and socioeconomic backgrounds to the shared realization that their bodies form a fundamental and dwindling resource for acting in the world. Nonetheless, there is great variation in how seniors, both within and across neighborhoods, respond.[1] Understanding this variation requires examining the way culture influences behavior. Social scientists have shown, for a variety of topics, that people with different attitudes, dispositions, and understandings behave in very different ways even in very similar circumstances with similar resources; i.e., culture matters.[2] However, less work has connected elements of culture to behavior in everyday life, particularly health behavior.[3] In this chapter, I examine why seniors adopt certain strategies for dealing with health problems rather than viable alternatives. Certainly, the resources available to seniors determine which behaviors are *possible* (the topic of chapter five). However as, this chapter shows, "cultures of aging" that reflect past experiences with inequality, determine what seniors understand as *desirable (motivations)*, *reasonable*

[1] There is vast social scientific literature that shows that seniors from different racial, socioeconomic, and gender groups respond to health and illness in very different ways. For instance even among the poor with the same level of health and illness whites and women are on average substantially more likely to go to a doctor than African Americans and men. For this last finding and a brief review see Abramson and Sanchez Jankowski (2012). See also Smeedley et al. (2002) and Spalter-Roth et al. (2005). Corey M. Abramson and Martín Sánchez-Jankowski. "Racial Differences in Patterns of Having and Using a Doctor Among the Elderly Poor in The United States." *Research in Social Stratification and Mobility.* 30(2012): 203–217; Brian D. Smedley, Adrienne Y. Stith and Alan R. Nelson. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Ed. I. o. Medicine. Washington, D.C.: National Academies Press, 2002; Roberta Spalter-Roth, Terri Ann Lowenthal, and Mercedes Rubio. "Race Ethnicity, and the Health of Americans." *ASA Series on How Race and Ethnicity Matter*. Ed. R. Spalter-Roth: American Sociological Association, 2005.

[2] For a general review of these literatures see Swidler (2001), Vaisey (2009), and Abramson (2012). For a more specific application to health and health behavior see Shim (2010). Corey M. Abramson. "From "Either-Or" to "When and How": A Context-Dependent Model of Culture in Action." *Journal for the Theory of Social Behaviour*. 42(2012): 155-180; Shim, Janet K. "Cultural Health Capital : A Theoretical Approach to Understanding Health Care Interactions and the Dynamics of Unequal Treatment." *Journal of Health and Social Behaviour.* 51(2010): 1-15; Ann Swidler. *Talk of Love: How Culture Matters*. London and Chicago: University of Chicago Press, 2001; Stephen Vaisey. "Motivation and Justification: Towards a Dual-Process Theory of Culture in Action." *American Journal of Sociology.* 114(2009): 1675-1715.

[3] Although recent sociological inquiries into health and illness have begun to take the relationship between culture and health more seriously (e.g. Shim 2010), as Pescosolido and Olafsdottir (2010) note, these concepts remain poorly measured in quantitative inquiry. Likewise, systematic comparative direct observation studies such as this one are essentially non-existent, and economic models that discount the importance of culture a-priori abound (see Abramson and Sanchez-Jankowski 2012). Bernice A. Pescosolido and Sigrum Olafsdottir. "The Cultural Turn in Sociology: Can it Help Us Resolve and Age-Old Problem in Understanding Decision Making for Health Care?" *Sociological Forum.* 25.4(2010): 655-676.

(orientations), and *plausible (strategies)* given the resources available to them.[4] By combining interviews with my participant observation data among seniors, I describe what people say others "should do" when presented with a health problem, what they consider "reasonable" for themselves, and what they ultimately do. In looking at both the points of congruence and discord between the interview and observational data, I show how aspects of culture, grounded in inequalities both past and present, shape seniors' health decisions and strategies for managing old age.

II. What is Desirable: Motivation, Maximization, and Responses to Scarcity

In recent years, sociological debates about "how culture affects action" have shied away from the term "values," particularly when looking at the relationship between culture and inequality. [5] Although the notion of "values" as employed by Weber and Parsons is problematic as a standalone model of culture, a great deal of empirical research in contemporary social science shows that "what people want" or what they "value" affects behavior both within and across social contexts.[6] This is true of the seniors I studied as well. The effect is most noticeable when seniors are able to pursue various behaviors (such as taking pain medication or not), but consistently chose one over the other. In these cases, differences in what seniors value affect how they manage the predicaments of the aging body. Some seniors feel that the best way to deal with aging is to adopt long term strategies to mitigate loss, conserve health, and maintain independence. Others feel that aging is a reminder that they are nearing their "end," so they might as well have a good time while they can. What seniors prioritize has a profound effect on how they behave.

---

[4] For a sociological explanation of motivations see Vaisey (2009). For orientations see Bourdieu (1984), Geertz (1977), and Laitin (1986). For tools and strategies see Swidler (2001). For a model connecting these three see Abramson (2012). For group cultures and styles see Eliasoph and Lichterman (2003). Pierre Bourdieu. *Distinction: A Social Critique of the Judgment of Taste*. Trans. R. Nice. Cambridge: Harvard University Press, 1984; Nina Eliasoph and Paul Lichterman. "Culture in Interaction." *The American Journal of Sociology.* 108(2003): 735-794; David D Laitin. *Hegemony and Culture: Politics and Religous Change among the Yoruba*. Chicago and London: University of Chicago Press, 1986; Clifford Geertz,. 1977. "Religion as a Cultural System." *The Interpretation of Cultures: Selected Essays.* New York: Basic Books, 2000. 3-30; Ann Swidler. *Talk of Love: How Culture Matters*. London and Chicago: University of Chicago Press, 2001.

[5] For a review of this, and an interesting discussion of the relationship between wants, social inequality, and academic politics after the miss-appropriation of "The Culture of Poverty" see Vaisey (2010). Steve Vaisey. "What People Want: Rethinking Poverty, Culture, and Educational Attainment". *Annals of the American Academy of Political and Social Science.* 629(2010): 75-101.

[6] This is true in fields such as sociology, psychology, cognitive science, psychology, and political science. See Vaisey (2010) for a brief review. For important conceptual critiques of the classical notion of values see Swidler (1986) and Valentine (1967). For more on the criticism that values fail as a standalone model of culture but can be integrated into a more holistic model, see Abramson (2012). For classic descriptions see Weber (1946) and Parsons (1927). Ann Swidler. "Culture in Action: Symbols and Strategies." *American Sociological Review*. 51(1986): 273-286; Talcott Parsons. *The Structure of Social Action*. New York: Free Press, 1937; Charles A. Valentine. *Culture and Poverty: Critique and Counterproposals*. Chicago: University of Chicago Press, 1967; Max Weber. "The Social Psychology of the World Religions." *From* Max *Weber*. Ed H. H. Gerth and C. W. Mills. New York: Oxford University Press, 1946.

Seniors both rich and poor acknowledge that no matter how well off they are, their physical vulnerability means they are "one fall away from the home."[7] As chapter two showed, the fear of bodily calamity is not based in an ungrounded abstraction, but is a reality that seniors encounter on a regular basis. Seniors continually watch friends, family, and acquaintances die or become institutionalized. In both cases, problems associated with the "wearing out" and "breaking down" of the body substantially reduce physical resources for acting in the world.[8] In the case of death, no amount of material or social wealth can prevent this. In other cases, such as declining mobility, wealth and networks may affect the age and circumstances under which seniors face these issues—however, all who live long enough must eventually confront them.

Consequently, the aging body creates a "structural dilemma" grounded in scarcity. The resource that is in short supply is not just money but basic physical resources that provide key tools for acting in the world.[9] This is what the middle-class senior in chapter two was referring to when she said, "As we age, our bodies become more precious."[10] In this light, the fact that the dispositions that shape responses to aging mirror those found in other contexts of scarcity (e.g. urban poverty) is not surprising. [11]

Preserving the Body: "Coming to Terms with the Mindset of Frailty"

The way in which many seniors respond to getting old is guided by principles of "preserving the body."[12] The underlying idea is that the body and consequently the ability to act in the world are perpetually at risk as one grows old—so the responsible thing to do is to maximize functionality, independence, and life as long as possible.[13] This is the espoused goal of

---

[7] This mirrors the sense of potential calamity Sanchez-Jankowski (2008) finds among the very poor. See Martín Sánchez-Jankowski. *Cracks in the Pavement: Social Change and Resilience in Poor Neighborhoods*. Berkeley: University of California Press, 2008.

[8] Jason in chapter two provides a representative example.

[9] Sociologists have sometimes referred to these resources as "bodily capital". Chapter 4 will examine other resources such as money, effective networks, interactional tools, and spatial resources. For more on bodily capital see Wacquant (1995). Loïc J.D Wacquant. "Pugs at Work: Bodily Capital and Bodily Labour Among Professional Boxers". *Body and Society.* 1.1(1995): 65-93.

[10] This is not to say all seniors face this problem on the same terms. As I will show in chapter five, seniors living in poverty often have to face problems of scarcity on not only the physical but material front.

[11] For instance, these findings parallel the ways individuals in poor neighborhoods respond to the circumstances of material scarcity and uncertainty by maximizing "security" or "excitement." See Sanchez-Jankowski (2008) p.21-22. In aging this translates to "preserving the body" and "maximizing enjoyment" while the body still functions.

[12] Points of maximization are best understood as underlying motivations that direct action towards certain ends (see Vaisey 2009). Like values, these motivations produce different understandings of what is desirable. Motivations determine what an actor "values" or "maximizes," but can do so less reflexively and require less semantic coherence than the classic Weberian-Parsonian notion of values. These motivations are a deeper form of cultural "input" that provides an essential starting point for sequences of behaviors (Abramson 2012). They are always directional. They differ from post-hoc justifications (Vaisey 2009), interactional tools which can be invoked ambivalently (Swidler 2001), and cognitive frames that determine what is seen as conceivable (Goffman 1986, Small 2002). This distinction becomes important in explaining seniors' decision making sequences which are guided by various types of cultural inputs (motivations, orientations, and values) at different points in time. Erving Goffman. *Frame Analysis: An Essay on The Organization of Experience*. Boston: Northeastern Press, 1986; Mario Luis Small. "Culture, Cohorts, and Social Organization Theory: Understanding Local Participation in a Latino Housing Project". *American Journal of Sociology*. 108.1(2002): 1-54.

[13] Although the points of maximization are presented as contradictory, and they are often treated as such by seniors, the dichotomy is not hard and fast. Rather, it is more accurate to think of the degree to which excitement or security is maximized as an individual trait that could be represented by a continuous psychometric measure. However, this

myriad programs for seniors which make proclamations like "Our goal is to help keep you safe in your own home."[14] Security maximizing seniors are less likely to go out at night, disregard the advice of medical authorities, drink alcohol or use recreational drugs. They are more likely to carefully track the medication they take, get exercise, research treatments, and verbalize their worries. Seniors who maximize security are often concerned with monitoring their bodies, getting information about health, treating problems as soon as they appear, abstaining from activities that can result in catastrophes (such as walking or driving too far), and making sure they have support systems in place for when something bad (such as a fall) does happen.

Seniors with dispositions towards *preserving the body* emphasize through both speech and physical behavior that the frailty of old age necessitates a careful, conservative, and temperate approach. One senior described this as "coming to terms with the mindset of frailty." Another senior referenced the notion of worrying and monitoring when she quipped, "If I didn't have something to worry about, I'd make up something. That's just me. I worry about everything." She went on to link this to how she dealt with aging by noting that she was constantly researching potential causes and treatments for her health problems large and small, and that she would spend hours on the internet researching both Western medicine and alternative treatments.

The motivation to preserve the body was generally not a new manifestation for seniors but part of general strategies of "security maximization" developed over the life course. Although I could not directly observe their lives during their childhood and middle age, the behaviors and strategies people described during their working years lined up closely with how they behaved in old age, as well as which behaviors they saw as "responsible." Consider the case of Donald, the Chinese senior from Baygardens introduced in chapter two. Over coffee at the senior center, Donald was talking about the importance of saving money. He told me a long story about how he came to America with nothing, and worked in a factory. He would work as many hours as he could in the factory, then sell shoes during his day off. By never spending his money except on investments like property he said he was able to buy homes and support his family. He attributed this to his "old fashioned Chinese values. Very conservative. We had no money, but our sons went to [university]. We saved all money even though we were poor."

Just as Donald explained that the responsible thing to do in middle-age was to work hard and save money, for him the responsible thing to do in old-age was to stay on top of health conditions and seek doctors when something went wrong. When Donald fell after taking an extended walk around town, he immediately went to the doctor to get an x-ray. He went to his regularly scheduled appointments. He adhered to the dietary guidelines that the medical care providers set in response to his diabetes. When there was a health fair at the senior center, he went to check his blood sugar and blood-pressure and speak to consultants, proudly telling other seniors that his numbers were good. He went to great efforts not to overextend himself physically after the fall, such as always using a walker. He sought to protect the physical assets that he had left.

Inclinations towards preserving the body were also seen clearly in my interview data which uses vignettes to probe what seniors say people *should* do when presented with a

---

does not mean that the distribution of the trait is normal among the seniors I observed. Rather, it was clustered around the two types described as "preserving the body" and "maximizing enjoyment."

[14] This line was presented by a member of the Baygardens Fire Department at a special event for "living independently." This phrase was also found in the brochures passed out and is a typical party line for many organizations that provide in home services to seniors.

predicament. Each of the five vignettes I used end with the question "what should this senior do?" A sixth vignette recounts the behaviors of a particular individual I observed early in fieldwork.[15] Security maximizing seniors had the strongest response to this sixth vignette: "There is a senior I know, who has breast cancer and is getting chemotherapy. Her doctors told her she should not drink alcohol, but all her friends are heavy drinkers. After getting chemo-therapy, she would often go out to bars with her friends to drink. What do you think of this?" Here, rather than asking what a senior should do, the question calls for the respondent to evaluate a senior who behaves in a way counter to the ideal of preserving the body. Those who exhibited security maximizing behaviors would often shake their heads and say things like "That's stupid. That's really stupid." An African American man from Elm Flats offered an indignant and telling response, "I think that's asinine. If you are not gonna pay attention when you have a disease like that, and you feel like you have to take it upon yourself to drink when it's not necessary, then you are asking for trouble. You have no one to blame but yourself." This sort of behavior was seen not only as "stupid" but as irresponsible. Some said it was unfair to her loved ones. Security maximizers often made similar statements about not wanting to let down friends or medical professionals. In describing a similar dilemma, a White senior from Elm Flats noted that although he was sick of doctors, "I feel responsible to them, not to do anything stupid, and let all of these caring professionals down." In contrast, seniors who focused on maximizing enjoyment would note that while this behavior was bad for longevity the issue was complicated.

Maximizing Enjoyment: "I'm Going to Have a Party for my 90th"

In contrast, other seniors felt that people should deal with the problems created by aging by trying to enjoy life before it is gone. The guiding notion is that to focus on preventing catastrophes, rather than taking advantage of opportunities, before the inevitable disasters of aging hit is irresponsible. Here, the focus is not so much on seniors letting other people down, but rather letting themselves down. They are quick to make proclamations like, "you only get one go-round." Enjoyment maximizing behavior often translated into a much more laissez-faire attitude towards problems of health and the body. This is seen with Sandy, the 89 year-old nurse introduced in chapter 2:

> *During one of my visits to Sandy's home, I casually mentioned that my mom was diabetic. Sandy noted that she was as well, adding "I eat candy sometimes. I know you are not supposed to but at this age who cares?" In a later visit, she articulated the notion behind this sort of behavior. "Next year is my 90th birthday. I'm going to have a cake and dinner and they [her family] might as well come. This is going to be the last one I celebrate. I don't really care what happens after that. What is there to live for at this age? All my immediate family is dead. My father died at 56, my mother died 2 years later. My sister died at 54. Why did I live so long? [Shrugs] I don't know, but I am going to have a party for my 90th [smiles]."*

Sandy's actions were still oriented towards the future, but the timeline for what constitutes the future was compressed. Seniors who maximize excitement are more likely to deviate from medical advice, drink alcohol, smoke cigarettes, use recreational drugs, engage in casual sexual activity, go out after dark, risk falls, and delay getting care until health problems become a major issue.[16] In explaining why he drank vodka and smoked constantly, Dave articulated a common

[15] The interview schedule and vignettes are provided in the methodological appendix.
[16] Each of these behaviors was observed, or in the case of sexual activity, independently verified verbally.

attitude shared by excitement maximizers, "What am I going to get lung cancer? I've already had it. Liver damage? I already had fifty thousand beers in my lifetime so what's one more." Likewise, Jane disregarded the instructions of her oncologist regarding abstaining from beauty products while on chemotherapy. They told her not to use nail polish, but she showed polished nails to me and said "I think I would rather be sick then have black nails."[17]

As with inclinations towards maximizing security, my data suggest the drive towards maximizing excitement is not newly developed as people reached old age, but the product of dispositions acquired over the life course.[18] Although the image of excitement maximizing seniors bucks common stereotypes, the fact that there is motivational continuity from earlier in life is not surprising given the vast sociological, psychological, and even economic literatures on the importance of socially mediated motivations, values, and dispositions acquired early in life.[19] Further, although one might expect the potentially jarring experience of growing old to produce a fundamental change in motivations (i.e. a "conversion experience")—I did not observe this. People's life histories, general motivations, and reported past responses to dilemmas mapped extremely well onto what they sought to maximize in the present.[20] This finding is also consistent with recent developments in the psychological literature on aging which emphasizes behavioral continuity and declining cognitive and emotive flexibility in old age.[21]

Jane, the 65 year old white woman introduced in chapter two, and the basis of the breast cancer vignette used in my interviews, provides a good example of an excitement-maximizing senior. When I first met her, Jane mentioned:

> *I was diagnosed with Rheumatoid arthritis in my early 20's so I have never really been able to work a regular job, which is hard, because it means I was always dependent on a man even though I had a degree from [University].*

Jane often remarked that she did not like having to depend on people for help but that she was used to it, and that she was also used to not having money, so she would try to have fun when and where she could. Jane described her life in both the past and present as "chaotic." In the time that I knew her, she spent a lot of time with her "group of guys," heavy-drinking younger seniors (mostly in their 60's) whom she dubbed "the lost boys." She met them at local bars and had been in casual sexual relationships with at least three. She said they were all alcoholics, and noted "I don't know if I have a sign over me, or if it is just that I like to go to bars, but I am a magnet for alcoholics." The following example, which is typical of the time I spent with Jane, shows how excitement maximization can relate to behaviors around the body.

I visited Jane in her Baygardens home near Christmas. She said she had intended to make "the lost boys" a Thanksgiving dinner, but ended up not feeling well from the chemo, so she got drunk and called all her friends and family instead. She was having rat problems [her house had lots of trash, empty beer cans, and other debris] but did not want to pay for an exterminator—she said she hoped one of the "lost boys" would take care of it. We spent the day in several

---

[17] She noted that the type of chemotherapy she was undergoing causes people to lose their nails or that they get sickly and black.

[18] I use the term suggest, which implies imputed association rather than direct observation, since I did not directly observe the seniors prior to old age. However, although this link is not directly observed, the claim is grounded in speech behaviors and life history information collected during interviews.

[19] For a review see Vaisey (2009, 2010).

[20] The issue of orientation change was more prevalent. This is discussed in section 2 below.

[21] For a discussion see Mendes (2010). Wendy Berry Mendes. "Weakened Links Between Mind and Body in Older Age: The Case for Maturational Dualism in the Experience of Emotion". *Emotion Review.* 2.3(2010): 240-244.

neighborhood bars, which were populated with other seniors. We stopped at 4:55 to get overdue blood work done at a small clinic on the way to another bar. Jane explained she was behind on her chemo because they needed the blood work, so she should do it while we were there and she remembered. In the evening we were at a liquor store waiting for her new "guy." We were waiting for a long time so I offered Jane a sugar-free candy. She said she had fibromyalgia which makes the sugar substitutes bad for her but then shrugged and started eating them. She ate most of the bag. While waiting, Jane also noted that she had previously been obese and had a gastric bypass. I asked why she had a bypass. She said "I wanted to look better for guys. It was about 7 years ago." She proceeded to tell me stories about how she regularly gets sick when she eats ice cream, a food generally prohibited after gastric bypass surgery. "I love ice-cream, but you can't process it. Instead of eating the three bites, I eat the whole thing then get sick." After about 45 minutes Jane finally got a hold of her "guy," who was dealing with police and accident victims after causing a car wreck—and trying to avoid having the incident labeled a DUI. When she heard this Jane quipped "see what I said about chaos." As I went to drop her off with a friend, Jane asked "can you go to UPS. I forgot, and they are about to close. If I don't get my fax, I lose my health insurance."

Jane was savvy, educated, and articulate. She read books voraciously and spent a great deal of time using the internet. She lived in a middle-class neighborhood with high quality senior services and medical facilities. She was quite aware of the potential ramifications of her behavior for health and longevity. Still, she dealt with the dilemma of growing older and getting sick the way she had earlier in her life—by trying to maximize excitement, which in her case revolved around men, music, food, and alcohol.

Health Behavior and Distinction: The Case of Dope Pills and Pot

In general, seniors enacted one or the other strategy because they felt it was the "right" way to act."[22] This moral weight is seen clearly in how seniors responded to the issue of pain. As chapter 2 demonstrated, although the levels and subjective meaning of pain varied greatly for different groups, managing pain was an issue for seniors from all of the gender, racial, and socioeconomic groups represented in this study. Seniors' behavioral responses, even within a demographic category, varied substantially. Some seniors took narcotic pain pills, some exercised more, others moved less, some wrote poems, some went to doctors constantly, some sought out street drugs, and some like Jane spent more time drinking alcohol in bars.

Which strategies for coping with pain were seen as legitimate was a constant thread of conversation among seniors and a point of distinction that highlights the divide between those who maximized preservation of the body and enjoyment of the body. This visibly played out in discussions concerning whether particular seniors in a community chose to use pain medications, which ones they chose to use, and which ones they felt were acceptable for a given level of pain. Those seniors who did not take pain pills often cast themselves as having greater will, character, and self-control than those who took "dope" from "pill hill." Temperance and self-regulation were valued by these seniors. My field notes from a visit to Jessica's house in Baygardens provide a representative example:

> *This is to keep track of my pills [shows me a notebook]. I can take up to three a day, but I never take that. Sometimes I'll take some other pills. They gave me these for sleeping, and*

[22] This is the same finding presented by Sánchez-Jankowski (2008) in his discussion of value orientations and poverty.

these for pain [hydrocodone]. I used to joke about them being dope pills, but that's what they are. I don't like pills and don't want to be hooked. My daughter says, 'So what if you get hooked.' But I don't want to.

This senior would shake her head and talk about seniors who "got hooked." Even though she was unable to manage without the medication, she would still closely monitor her use to remain temperate. Another senior from Elm Flats noted, "Some people just lie down and take narcotics. That is no life." He went on to reinforce this distinction "If you can work through the pain you have accomplished something and it gives you a sort of clarity…It is *better* than laying down waiting to die." The "moral boundary" around the use of pain medicine echoes the more general distinctions about the desirability of temperate behaviors that conserve the body and prolong "independence."[23] Donald made this point about the importance of temperance more generally when discussing the values he imparted to his children "All I asked was that my children did not go around with women, or do drugs, or drink, or stay out late, and that I would like them to be in the top 10% of their class."

On the other end of the spectrum, "enjoyment maximizing" seniors believed there is no reason to be old and in pain. Sobriety and temperance were not seen as ends in and of themselves, and certainly not markers of higher moral status. At a health event in Baygardens, volunteers were taking the blood pressure and glucose levels of seniors. An African American man walked over from the nearby bus stop and approached me, saying:

"I'd have them take it [blood pressure] but they'd say I'm high. I used to be able to say that all the time [laughs]," walks away. A few minutes later the man came back with a plastic baggie with marijuana remnants and said "I just told you about getting high. Look what I found on the street. Let me tell you though, the Chinese is the ones with the good stuff [there were lots of Asian-American seniors at the event]. They got opium. That's what I use. Good for the pain [smiles]."

Seniors like the man above often deal with their age, pain, and pending mortality through the use of pain pills, recreational drugs, alcohol or whatever else they can find to take their mind off of their predicaments. Dave, who drank at least a six pack of beer a day, smoked marijuana regularly, and used oxycodone, said he was in "constant pain" and that it only made sense to do whatever helped. He said he did not understand why people were so concerned with pain pills, adding "I don't understand. They don't get you high. Maybe if you crush them up and inject them or they can help if you are addicted." He went on to say that he smoked medical marijuana with his landlord most days which he described as a "nice interlude." Dave continued "I have been smoking marijuana since before you were born. It is interesting, that *it actually does help with the pain and appetite. It doesn't stop the pain, but it takes my mind off it,* and the waves [of pain] are not so bad plus I eat more." He went on to tell me that the current marijuana was much better than what he had in his "hippie days," and that as with pain pills, he did not understand why people had such a problem with something that did not affect them. I asked one diabetic woman I visited regularly why she did not follow the doctor's advice regarding avoiding sugary

[23] The term "moral boundary" in contemporary sociology is often associated with the work of Lamont (2000), who articulates the concept and describes how it appears in discourse using interview data. However, the notion of social boundaries separating good people from bad, sacred from profane, etc. has deeper roots in both classical sociology (i.e. Durkheim) and structuralist anthropology (Levi-Strauss). Emile Durkheim. *The Elementary forms of Religious Life*. New York: The Free Press, 1995; Michele Lamont. *The Dignity of Working Men: Morality and the Boundaries of Race, Class, and Immigration*. Cambridge: Harvard University Press, 2000.

foods and pain pills and she laughed, responding, "Why not? I don't want to live forever." Temperance was simply not seen as desirable given the problems of growing old.

III. What is Reasonable: Orientations for Responding to the Aging Body

While these motivations affect how seniors respond to the structural dilemmas of aging there are numerous ways seniors can address a specific health predicament. For instance seniors trying to conserve the body can still pursue different strategies— they can go to an herbalist or doctor for stomach troubles, try to sleep more or go to an emergency room if they are dizzy, check in with a psychiatrist or friends if they feel sad, do yoga or take Aleve for arthritis. Which of these strategies they see as most *reasonable* is influenced by a second set of cultural inputs which I refer to as orientations. Orientations are sets of attitudes relating to a particular subject, in this case the aging body. These inputs orient action towards particular paths and strategies in the world given people's motivations or values, but are not motivations in and of themselves. [24] Orientations are less ingrained and they change more easily over time than values or motivations. For instance, having a bad experience with a hospital is unlikely to change an individual's underlying motivations or psychological makeup, but may very well affect how the individual sees and interacts with doctors. Motivations drive action by determining what is desirable, but orientations point people towards what is *reasonable* given their motivations.[25]

I now examine two competing orientations which frame how seniors can and should relate to their bodies. Like the motivations described above, these orientations have a pronounced effect on how seniors manage the predicaments of their aging bodies. I refer to these two primary orientations as "the natural body" and the "medical body." These are related to a second set of orientations around "active" versus "reactive" engagement with health and illness.

The Natural Body

The "natural body" orientation emphasizes that the body is a "natural," self-regulating, and highly individual object. While motivations differed within demographic groups, orientations often broke down along the lines of race, class, and gender. Within the context of this study, the orientation towards the "natural body" was often held by seniors who were poor, particularly poor African American males.[26] In this orientation, seniors, as opposed to doctors, are seen as experts on their physical and mental state. The body is seen as possessing everything it needs to repair itself. Chemicals and medical interventions are generally framed as counterproductive or harmful to this natural healing process. People with this orientation often distrust doctors and Western medicine in general which they frequently describe as money making schemes, or as one senior from Rockport put it "bullshit systems and programs." Another

[24] The term attitude alone is inadequate. Orientations can only be understood as clusters of ideas which hold a nominal degree of internal coherence that points people towards viewing particular behaviors and outcomes as reasonable. As used here, orientations differ from the more nebulous concept of a "cognitive frame" in that they have a specifically defined object and can operate on a discursive as well as cognitive level.

[25] For a broader discussion of how orientations differ from attitudes, motivations, and values drawing on Geertz and Bourdieu, see Abramson (2012).

[26] This orientation was also held by smaller numbers of middle-class African Americans, some whites (mostly poor), and some Asian-Americans (both poor and non-poor).

senior provided a quote representative of this attitude when he commented, "Doctors bug me, because I know that they're just juicing it for money, I know they are."

The "natural body" orientation is well articulated by Ray, a 68 year old middle-class African American from Elm Flats, in an interview:

> *I don't see doctors and I don't believe in taking medicine basically…Friends of mine at work said at a certain age you need to go in and have a doctor shove his finger up your ass so he can check out your prostrate, so I went in and did that so I can get back to Jamie [his friend] and say "Ok Jamie I did that, I could have done that myself you know. Anyway, the doctors didn't know what that's all about, I don't know…If you get sick you get a lot of rest and then the body heals itself.*

Ray went on to say that he had not seen a doctor since the prostate exam twenty eight years ago. He did however take "herbal concoctions," smoke marijuana, and see a chiropractor to feel better, but noted that he no longer does "real drugs" like LSD or speed. He went to the doctor when he was middle-aged after having chronic migraines, and the medicine that was prescribed helped. When last observed at the Elm Flats senior center, Ray was preparing for his annual "garlic fast," a month long period of not eating solid food—except for garlic. Ray said this helps the body cleanse itself. Later, when asked what he did if he did not feel well he commented:

> *Rest. I see what sort of herbal concoctions sound best, but mostly just rest.* ***The body heals itself. The body has all types of natural healing agents inside of it if you leave it alone instead of loading it up with chemicals.*** *When you get a cut, I don't care how deep it is, all you have to do is stop the bleeding and it patches itself up. It's how nature works.*

This sort of orientation was shared by many of the poor African American men in my sample, but other groups exhibited it as well.

These orientations reflect past experiences, in many cases negative experiences or interactions with medical organizations or authority figures generally. These experiences often, though not always, reflect racial and socioeconomic inequalities that shape how seniors view the world and respond to problems in the present. Still, as experiences vary even within demographic categories, orientations are not uniformly tied to social position. For instance, although Ray's responses are representative of the "natural body" orientation, he was not poor. He had an AA degree, owned a home, and had a car, health insurance, and disposable income.

A 70 year old middle-class Asian-American woman from Baygardens who had thyroid problems frequently reiterated the idea that "the body heals itself." When offered surgery, she refused against the advice of both her doctors and her children, choosing instead to focus on metaphysics.[27] Seniors with this orientation continually emphasized that "doctors aren't god" and that they knew their own bodies better than any outsider. James, the 77 year old African American from Rockport, invoked attitudes in this orientation one day while commenting on how people were dressed around the senior pool hall, and went on to explain why he was not wearing a coat:

> *When you wear a lot of clothes, your body has a tendency to not do its job. In other words the body is designed to make intersections for the weather. But once you try to make intersections for the weather it throws the body out of kilter. And you catch a lot of colds. A lot of things that happen to you that wouldn't normally happen to you if you didn't have the frame of mind. You don't need a whole lot of clothing. Like today, you*

[27] Metaphysics refers to a broad set of philosophies concerned with existence, often without invoking theism, and frequently connected to the "new age" movement.

got 3 or 4 coats on, cause in their mind, they think, the season, that's what you are supposed to do. Rather than the way you feel.

Once again, James emphasizes how the body manages itself and points out how the interventions directed by both convention and Western medical systems discount seniors' tacit knowledge of their own bodies. Often invocations of this orientation were followed by discussions of how western medicine was a "scam" set up to make money. One senior articulated this assessment in explaining his distrust and displeasure at having to go to the doctor to get his prescriptions renewed: "She makes me come back every 90 days. And I'm not different, you know, I'm no different every 90 days. She's just, I'm sure she's got a tremendous income. I mean, I bet she makes a ton of dough." Even though these seniors' visits were covered by Medicare (which removed many financial barriers), this orientation made engaging with doctors more than absolutely necessary seem unreasonable.

While holding the "natural body" orientation affected what was seen as reasonable, it was not wholly determinative of what seniors did.[28] When things got bad enough people still saw medical professionals, but when, and how, they did this was influenced by their orientation towards a "natural body." Even James echoed this point when he reluctantly admitted, "If I don't feel well, then I'll go to a doctor. But I usually don't feel bad enough to have to go to a doctor." Seniors who emphasized the "natural body" would often first try to use holistic or folk strategies for staying healthy or dealing with illness, when something "broke" they would still end up at the hospital. For instance, Jessica, the 92 year old white woman from Baygardens, was adamant that she knew her body and that doctors' offices were places people went to "get sick." She stressed that she could handle things on her own and that her grandmother had lived to 105 without ever seeing a doctor or taking flu shots. Jessica would only go to her regular doctor once a year to placate her daughter. Still, when something major would go wrong, Jessica would fall back on the doctor and emergency department. This had happened several times because of falls which landed her in the ER. Another time she had ended up hospitalized for a week with gastrointestinal problems.

The following example from Jessica involving another trip to the ER is typical of how those with the natural body orientation end up at a doctor or hospital. I went to visit Jessica, who had asked me to take her to the doctor. I asked how she was doing because going to the doctor was a rare occasion for her unless something was very wrong. She told me she had a "little problem." Apparently she was having major issues with constipation for a week, and was concerned because she was previously hospitalized for intense pain at which time she was diagnosed with "tricholitis."[29] As usual, she tried to take care of it herself, by taking lots of Maalox, which she believed was a laxative. She got the Maalox from the drugstore across the street. She emphasized that she thinks it is best to take care of these things yourself. After having a very solid stool and not sleeping for several days however, she became "very worried" and finally went to the hospital so they could "clean me out and make sure it all came out." She said she took the bus to the ER and had to wait a long time but that was fine. She said "I don't like to go to the doctor, so I try not to go unless I can't fix it myself." Jessica explained that she thought

[28] These two orientations bear a resemblance to parenting strategies of "fostering natural growth" among working class children in contrast to middle-class "concerted cultivation" among the middle-class observed by Lareau (2003). Annette Lareau. *Unequal Childhoods: Class, Race, and Ramily Life.* Berkeley: University of California Press, 2003

[29] Diverticulitis is a sometimes painful gastro-intestinal ailment.

the problem with both her bowels and the sleep was related to the "dope pills" she was prescribed. After visiting the doctor, Jessica reiterated that she thought the dope pills were the problem. She said "I don't take pills unless I have to, but I took one so maybe that is what happened." Jessica said she was feeling better so she would stop taking them. She did not schedule a follow-up with the doctor. She also did not stop taking the pain medication, although she continued to carefully monitor it in a notebook.

The above examples demonstrate how those with "natural body" orientations vary in how proactively or reactively they respond to health problems. Although Ray was distrustful of doctors, he was proactive in using alternative strategies to help himself feel better. Jessica used various strategies, Western and otherwise, to "fix herself." James on the other hand was more reactive, usually only addressing problems when he was truly worried about his health. However all three seniors are typical of those with the "natural body" orientation in that (1) they eventually ended up at a Western medical professional when things got "bad enough," (2) this happened only after trying to fix problems themselves, and (3) finally turning to conventional medical care involved an ER or urgent care rather than scheduling an appointment with a primary care provider. The example of Jessica also reveals the way orientations and motivations can be tempered by the demands placed on seniors by their social networks. Although Jessica did not like going to doctors and felt it was largely a waste of time, the insistence of her daughter ensured that she went at least annually (with trips to the ER in between).[30]

The Medical Body

In contrast to those seniors who held the "natural body" orientation, other seniors espoused the familiar Western model of the body as a biological machine that needs to be observed, maintained, and fixed. This orientation was most often held by middle-class seniors, particularly whites and Asian-Americans. Here, doctors and other medical professionals are cast as experts who possess specialized knowledge, although seniors are also responsible for following their instructions to maintain health. An elderly white woman emphasized this last point to a friend at a senior center when commenting about how another senior was absent with gout. Upon hearing the explanation the woman shook her head and noted, "People need to exercise, watch their blood pressure. They can't just eat whatever they desire."[31]

Seniors with this orientation often go to doctors on a regular basis to monitor their conditions, even if they are relatively healthy. A typical response is provided by a Tanya, a 62 year old middle-class African American woman from Cedar-Hills

> *I have to see a nurse practitioner every month for blood work and a checkup. Then I see a doctor about four times a year for a checkup and physical and consultation, and medicine refills, new eyewear, and eye exam, dental work. Whatever I need to do.*

Likewise, Bill a 79 year old middle class Latino man made a similar statement:

> *I have my doctor and we have a regular schedule. We used to see him twice a year. Well I usually see him in January now. They draw my blood and I come home and have a meeting the following week and he and I check on everything.*

[30] The topic of how networks affect seniors' health trajectories, and how this too is premised upon shared cultural understandings is examined in chapter four. Chapter five examines the role of structural barriers.

[31] Although talking about diet and exercise is and of itself can be associated with either natural or medical body orientations, the idea of contrasting desire to regulation, as well as the importance of monitoring medically validated vital signs such as blood pressure, is more commonly associated with orientations towards the "medical body."

The overarching idea was that doctors and medical professionals should be consulted regularly to catch and address problems early. The most *reasonable* thing to do was to go to doctors to fix or minimize problems. Bill explained this when he noted "you just make the best of it. Try and keep healthy enough so you don't need that much attention. I'm 79 and I feel great. Although sometimes I ask myself why am I shuffling? I guess the legs just give out."

Many individuals with orientations towards the "medical body" were also proactive in seeking care when problems would arise. These seniors would go to a doctor, typically a general practitioner or specialist, when they felt they had a health problem. Many would call the provider when they felt something was wrong. Sometimes they would have specific guidelines to avoid being labeled a hypochondriac by the providers. Tanya, the African American woman from Cedar-Hills, provides a typical example:

> *My rule is 48 hours - I mean if you have a fever or if you're going to pass out, or if your heart is racing then naturally you need to call 911 and get to the hospital, but a lot of seniors don't do the right thing. They think that they are keeping their life in their hands when they stay at home and think it's going to be alright, when in fact, you do need to go.*

Tanya's quote illustrates several important components of how seniors with "medical body" orientations think about and respond to health problems. The first point is that when there is a problem, the doctor is the correct place to go for care. The second is that although what constitutes reasonable behavior is a function of severity, the appropriate response is to get professional care. Finally, Tanya notes that this is "the right thing to do." This orientation is conscious (unlike some motivations), but that does not mean it is seen as one equally reasonable response among many.

The orientation that one should go to the doctor whenever a health problem arises, and the corresponding behavior, was more common among the women I observed, but it was shared by (mostly middle class) men as well.[32] In describing how he was dealing with recent health problems that sent him to an emergency room, Walter a 74 year old Asian-American retired dentist commented:

> *I had kind of numbness in my arm and everything else, and I thought oh my god I'm having a stroke, went over there and it turned out to be a pinched nerve (laughs). But at least I found out that it was okay. When I went in with bloody stools [several months prior] they kept me over night because it turned out that I did have the Diverticulitis. So they were able to take care of that.*

Walter went on to explain that when it turned out to be a pinched nerve he "felt really stupid, but again as you say, when things don't seem right we are more likely to go to the ER."

Although orientations towards the "medical body" influenced behavior, as with orientations towards the "natural body," they did not determine it. Consequently there was a great deal of variation in behavior. Some seniors religiously checked vital statistics like pulse, blood pressure, weight, and blood sugar. This was sometimes done publically and turned into a game to see "who had the best numbers." This public ritual is part of a more general process

[32] This finding where women are more likely to seek care at a given level of health and illness generally (Springer and Mouzon 2011) and even among seniors living in poverty (Abramson and Sanchez-Jankwoski 2012) is found in quantitative research as well. The point here is not to make a distributional claim about the prevalence of this attitude or orientation in a wider population, but to describe its content and effect on everyday life. See Corey M. Abramson and Martín Sánchez-Jankowski. "Racial Differences in Patterns of Having and Using a Doctor Among the Elderly Poor in The United States". *Research in Social Stratification and Mobility.* 30.2(2012): 203–217; Kristen W. Springer and Dawne M. Mouzon. "'Macho Men' and Preventative Health Care". *Journal of Health and Social Behavior.* 52.2(2011): 212-227.

where health, and its signifiers, were taken to be an axis of status and distinction among seniors with this orientation.[33] Even among these seniors however, people often behaved in way counter to espoused ideals. A typical example involves the financier described in chapter two. He was a diabetic and touted the fact that he had not had "a real coke for twenty five years." Still, he drank alcohol occasionally even though he knew that it was bad for his diabetes. The typical justification in these scenarios is that maintaining life indefinitely is not worth it if it takes away everything you enjoy. Some "excitement maximizing" middle-class seniors would go so far as to say they visited doctors simply because they "loved life" and wanted to stay healthy to enjoy it. Doctors were seen not as "moral authorities," but facilitators who helped people enjoy life by treating their bodies.

IV. What is Plausible: Strategies for Managing the Aging Body

While motivations point individuals towards what is desirable, and orientations shape what is seen as reasonable, shared cultural strategies and the resources people possess affect which types of action are seen as plausible.[34] I use the term cultural strategies to refer to general ways of managing the health problems and physical predicaments of the aging body over periods of time.[35] There are four basic behavioral strategies seniors adopt to respond to the dilemmas of the aging body, each of which is premised on particular motivations, orientations, and resources (cultural and otherwise). I refer to these as: "better safe than sorry," "be healthy, but get help if sick," "fix for fun," and "damn the torpedoes." The sections below describe the characteristics of these strategies. Table 1 below summarizes how these strategies break down with respect to the cultural motivations and orientations described above. The rows list motivations. The columns list general approaches to health and illness. Each cell charts observed behavioral responses categorized by specific orientations towards the body.

Table 1: Cultural strategies for managing the aging by motivation and orientations to the body

	Active Strategies	Reactive Strategies
Motivation: Preserving the Body	**Better safe than sorry** - "Medical body": Go to the doctor often (Donald/Tanya) - "Natural body": Help body heal itself (Jessica)	**Be healthy, get help if sick** - "Medical body": Minimize harm by doing what *doctor* days (Bill) - "Natural body": Minimize harm by doing what the *body* says (James)
Motivation: Maximizing Enjoyment	**Fix for Fun** - "Medical body": Doctors as facilitator (Jane)	**Damn the Torpedoes (until I am in the ER)** - Whatever *feels* good

[33] I saw this play out numerous times at various senior centers, clinics, health fairs, and apartment common areas.
[34] Their relative efficacy, and dependence on cultural and material resources, is a the theme of chapter 5.
[35] See Swidler (1986: 277; 2001) for a more thorough formulation of strategies of action. Ann Swidler. "Culture in Action: Symbols and Strategies". *American Sociological Review*. 51.2(1986): 273-286.

	- "Natural Body": Whatever *helps* feel good (Ray)	(Sandy/Dave)

Better Safe than Sorry

"Better safe than sorry" is a proactive strategy that involves the motivation to preserve the body. Seniors who adopt this strategy deal pro-actively with health problems that arise and problems that can potentially arise. How they go about this is influenced by orientations towards the medical or natural body. For those who have an orientation towards the medical body, the ideal behavioral strategy is simple: go to the doctor and do what the doctor says. The responses of Tanya and Donald described above are indicative of how this is done in both health and illness. Both monitor their health closely, go to doctors when ill, and have regular checkups when well. Although they do not follow medical advice exactly, they are more likely to follow this advice than any other group. For those who hold a "natural body" orientation the correct way to actively engage with the body is to do everything to help the body heal itself. The responses of Jessica provide an example. She pays attention to her body, assesses what it needs, and attempts to provide it. She is active in that she tries to do this both before and after something becomes a problem. She goes to medical professionals, but she does so only after her initial strategies for helping the body heal itself fail.

Fix for Fun

Those who adopt the "Fix for Fun" strategy are enjoyment maximizers who take a proactive strategy towards the body. Rather than trying to minimize the problems of the body, they try to maximize the enjoyment they can get out of life. How they do this depends on whether they orient towards the "natural" or "medical body." Those who have a "medical body" orientation engage with doctors readily, but do so only instrumentally to maximize enjoyment. This is seen in Jane's behaviors. She would go to doctors, get transfusions, and have surgeries, but these were done to facilitate her ability to enjoy life. She had bariatric surgery to be more desirable to men, never missed blood transfusions which gave her more energy, and interacted with doctors to get medicines that helped her feel good. Those with orientations towards the natural body act in a similar way, but differ in how they interact with medical institutions. They do what they can to help themselves feel good, but believe doctors and Western medicine are typically counter to this goal. This is seen in Ray's behavior. He actively seeks to feel better through the use of marijuana, herbal supplements, garlic fasts, and other "alternatives" to engaging with doctors.[36]

Be Healthy, Get Help if Sick

Those who adopted the "be healthy, get help if sick" strategy aimed to preserve the body, but did so in a more reactive way than those who employed the "better safe than sorry" strategy. Once again, how they did this varied by their orientation toward the "medical" or "natural body."

[36] These people also frequently made use of "complementary and alternative medicine" practitioners, such as herbalists or acupuncturists.

Those who saw the body as a medical object would try to follow the doctor's advice in order to stay healthy, but would still reluctantly go to the doctor for checkups or when something broke down. This strategy is seen in Bill who went to the doctor once a year in addition to when he had a major health problem. Still, he viewed the body in medical terms and consequently tried to achieve security by "staying healthy" in accordance with doctors' advice. For those who adopted the "natural body" orientation this involved "listening" to the body. This is seen in James' discussion of paying attention to the body's demands, as opposed to doctors or social conventions, while still going to see someone when there is a serious problem.

Damn the Torpedoes (Until you end up in the ER)

Those who employ a "damn the torpedoes strategy" aimed only to maximize excitement and dealt with health reactively. The overarching principle is that one should do whatever feels good since death or institutionalization are not far away. This is seen is Sandy's discussion of why she eats candy and Dave's justification of drinking, smoking, and marijuana use. People with this orientation emphasize that they should live one day at a time, and that regardless of if the body is "medical" or "natural," enjoying oneself is the prime directive.

V. Conclusion

Explaining how groups of seniors respond to the shared predicaments of growing old requires understanding how they make decisions regarding their bodies. What people want and how they see the world matter for understanding how they behave, particularly when they have resources to act in different ways. This chapter has shown that the decisions seniors make are ultimately premised upon and linked to motivations, orientations, and strategies that influence what is experienced and understood as *desirable*, *reasonable*, and *plausible.* The specific content of these cultural elements are acquired over the life course and reflect past experiences with inequality. They often mirror models of responding to problems that seniors have employed in the past. The next chapters turn to how options and behaviors are ultimately limited by inequalities in the present. However, why people respond differently to similar problems (particularly with similar resources), requires us to take the role of culture seriously. Culture determines how seniors make sense of the past, relate to the future, and react in the present. It provides a key link between inequality over the life course and health behavior in old age.

Chapter 4
The Meaning of "Who You Know": Networks, Norms, and Health in Old Age

Introduction

A voluminous literature emphasizes the importance of social ties for health.[1] Past chapters have suggested that friends, family, and neighbors play key roles in helping seniors deal with the material, physical, and psychological problems of growing old. Here, I examine the meaning of seniors' connections to friends, family, strangers, and acquaintances more directly, and show how these social ties can function in quite different ways. The data I present show that past scholars are correct in their acknowledgement that social connections continue to matter a great deal in old age. However, exactly how friends, neighbors, and acquaintances support seniors depends on both past and present circumstances, including their experiences with inequality. When, why, and how people provide help cannot be adequately explained without acknowledging how shared cultural understandings and norms shape the meaning and efficacy of social ties— particularly within ethnic groups. Whether helping others is seen as a general responsibility or a more immediate exchange affects what sort of support is available to seniors. Further, in some contexts social ties can help make seniors healthier; in others, friends, family, or neighbors may undermine their health. This chapter explains how seniors operate differently in different contexts, and explains the role of culture in this divergence.

Social science research has often demonstrated that there is more truth to the proverb "it's not what you know, but who you know that counts" than most Americans readily admit. Sociologists have long shown that both strong and weak connections to other people can profoundly affect our lives.[2] These "social ties" to family, friends, neighbors, and acquaintances can help people get jobs, find a mate, maintain health, disseminate ideas to communities, and perhaps even be happier.[3] How to measure and categorize these ties has been a point of more contention.[4] Much of the research on the effects of social connectedness tends to operationalize interpersonal relationships as either a dichotomous measure (people are connected or isolated) or a continuous measure (some people are more connected than others). The term "social capital" is frequently attached to highlight the way these social ties function as a resource, which, like other

[1] For instance see Bartley (2004), Berkman (2004), Berkman et al. (2000), Pescosolodo (1992), and Thoits (2011). M. Bartley. *Health Inequality*. Cambridge: Polity Press, 2004; Lisa F. Berkman. "The Health Divide". *Contexts* 4(2004): 38-51; Lisa F. Berkman, Thomas Glass, Ian Brissette, and Teresa E. Seeman. "From Social Integration to Health: Durkheim in the New Millennium". *Social Science and Medicine* 51(2000): 843-857; Bernice A. Pescosolido. "Beyond Rational Choice: The Social Dynamics of How People Seek Help". *The American Journal of Sociology* 97.4(1992): 1096-1138; Peggy A. Thoits. "Mechanisms Linking Social Ties and Support to Physical and Mental Health". *Journal of Health and Social Behavior* 52.2(2011): 145-161.

[2] See for instance Granovetter (1983), Lin (2001), and Portes (1998). Mark Granovetter. "The Strength of Weak Ties: A Network Theory Revisited". *Sociological Theory.* 1(1983): 201-233; Nan Lin. *Social Capital: A Theory of Social Structure and Action*. Cambridge: Cambridge University Press, 2001; Alejandro Portes. "Social Capital: Its Origins and Applications in Modern Sociology". *Annual Review of Sociology* 24(1998): 1-24.

[3] For a relevant review of the relationship between social ties and health see Thoits (2011).

[4] For a review of some of these issues see Fischer (2005) p. 161-162. Claude S. Fischer. "Bowling Alone: What's the Score?". *Social Networks.* 27(2005):155-67.

forms of wealth, can affect outcomes like health and wellbeing.[5] Social capital is sometimes presented as unequivocally positive for the possessor—that is to say, all else being equal it is better to have "capital" than not.[6] In much of the urban literature, the relative levels of "social capital" possessed by individuals are directly or indirectly connected to differing degrees of social organization in the communities they occupy.[7] Scholars operating in this tradition argue that those who occupy organized (generally non-poor, white) areas have more robust connections to others, are more integrated into social systems, are more accountable to norms of social control, and are more likely to be efficacious both individually and communally in securing outcomes.[8] We are warned about the deleterious effects of declining community and social capital in America and the specter of the social disorganization that lurks in the poor communities.[9]

Work among the elderly has echoed these sentiments—continually pointing to the importance of social connectedness for understanding behavior and outcomes. "Connectedness" is frequently contrasted to disengagement and isolation. In Heat Wave, Klinenberg (2002) explains the life and death outcomes of the 1995 Chicago heat wave in these terms. Specifically, he argues the lack of connectedness, community organization, and social integration were key attributes contributing to the large number of African American seniors who died at home. The social networks and norms of reciprocity that tied Latino elders to their community, on the other hand, reduced their risks of dying alone from heat. Hochschild (1973) provides a more optimistic, but analytically similar case, in The Unexpected Community. In her study, seniors who were more socially connected were more effective and found more meaning in their lives than those with fewer ties. [10] In each of these cases, social connectedness is cast as good. Those who have it benefit. Those who do not, suffer. Although these works provide useful insights,

---

[5] Though the term social capital can be found throughout sociology, the recent resurgence is most closely associated with popular works by Coleman (1988) and Putnam (2000). Also, see Portes (1998) for a review. James Coleman. "Social Capital in the Creation of Human Capital". *American Journal of Sociology Supplement.* 94(1988): S95-S120; Robert D. Putnam. *Bowling Alone: The Collapse and Revival of American Community*. New York: Simon & Schuster, 2000.

[6] While this is a distortion of the idea, it is not uncommon particularly in applied settings.

[7] For a representative example see Sampson and Graif (2009). Robert J. Sampson and Corina Graif. "Neighborhood Social Capital as Differential Social Organization Resident and Leadership Dimensions". *American Behavioral Scientist.* 52.11(2009): 1579-1605.

[8] See for instance Sampson and Graif (2009), Sampson, Morenoff, and Gannon-Rowley (2002), Wilson (1996), Bursik and Gramsick (1993). Robert Bursik and H.G. Grasmick. *Neighborhoods and Crime: The Dimensions of Effective Community Control.* New York, Toronto: Lexington Books , Maxwell Macmillan Canada, Maxwell Macmillan International, 1993; Robert J. Sampson, Jeffrey D. Morenoff, and Thomas Gannon-Rowley. "Assessing 'Neighborhood Effects': Social Processes and New Directions in Research". *Annual Review of Sociology.* 28(2002): 443-478; William Julius Wilson. *When Work Disappears: The World of the New Urban Poor*. New York: Vintage Books, 1996.

[9] While this framing of social capital has a strong following in the social sciences in general, and the literature on health in particular, it has also been criticized for being overly broad, ill-defined in practical terms, an artifact of poor measure selection, thin, marketizing, and inattentive to meaning (e.g. Abramson and Modzelewski 2011; Fischer 2005; Hochschild 2003). Corey M. Abramson, and Darren Modzelewski. "Caged Morality: Moral Worlds, Subculture, and Stratification among Middle-Class Cage-Fighters". *Qualitative Sociology.* 34.1(March 2011): 143-175; Arlie Russell Hochschild. *The Commercialization of Intimate Life: Notes from Home and Work.* Berkeley: University of California Press, 2003.

[10] For a recent discussion see also Portacolone (2011). Arlie Russell Hochschild. *The Unexpected Community*. Englewood Cliffs: Prentice-Hall, 1973; Eric Klinenberg. *Heat Wave: A Social Autopsy of Disaster in Chicago*. Chicago: University of Chicago Press, 2002; Elena Portacolone. "The Myth of Independence for Older Americans Living Alone in the Bay Area of San Francisco: A Critical Reflection". *Ageing and Society* 31(2011): 803-828.

such accounts of "social capital" are thin and undiscriminating in their attempts to chart the various ways social connectedness affects behavior health and outcomes.

There is a growing body of scholarship that emphasizes the historically contingent structure and meaning of networks and isolation,[11] the cultural underpinning of networks,[12] and the potential downsides of being connected.[13] What these accounts recognize, either implicitly or explicitly, is that the net effect of social connectedness is contingent on the structural and cultural contexts that shape other aspects of people's everyday lives. For a senior, seeing family members can provide reassurance or aggravation. Being visited by a friend with a car can provide the chance to get healthy food or go out drinking. Consequently, social connectedness cannot be presumed to mean the same thing for everyone. This chapter explains that understanding why requires a renewed attentiveness to the role of not only structural but cultural contexts. What the data in this chapter shows is that just as cultural motivations and orientations determine what is a desirable, reasonable, or plausible response to a physical problem like developing a cough, shared cultural *understandings* and *norms* about networks set guidelines for how people relate to friends, family members, and acquaintances. Whether reciprocity is earned or general, whether helping is an obligation or an exchange, affect when, how, and to what extent seniors receive help for managing the predicaments of their aging bodies.

Cultural Context and Social Ties

The following comparison of how two groups of seniors responded differently to the same commonplace event illustrates how the meaning of social ties can vary between settings. In each example, seniors had difficulty moving around a public space (the local senior center). All of the people mentioned below spent a large portion of their week at their local centers, in the presence of a regular group of friends and acquaintances. They all had degenerative physical conditions, such as arthritis, which limited their mobility and created problems navigating the physical environment. Everyone used aids such as a cane or walker in order to move about. In the examples below, all four seniors experienced a comparable event caused by their declining mobility. However, the communal responses varied substantially by neighborhood and ethnic group. Two of the seniors were poor African Americans from Rockport; two were middle-class whites from Cedar Hills.[14]

---

[11] See for example Entwisle et al. (2007), Fischer (2011), and Klinenberg (2012). Barbara Entwisle, H. Katherine Faust, Ronal R. Rindfuss, and Toshiko Kaneda. "Networks and Contexts: Variation in the Structure of Social Ties". *American Journal of Sociology.* 112.5(2007): 1495-1533.

[12] See Vaisey and Lizardo (2010) and Berkman (2000). Stephen Vaisey and Omar Lizardo. "Can Cultural Worldviews Influence Network Composition?". *Social Forces.* 88.4(2010): 1595–1618.

[13] See for instance Antonucci et al. (1998) and Rook (1997). Toni C. Antonucci, Hiroko Akiyama, and Jennifer E. Lansford. "Negative Effects of Close Social Relations". *Family Relations.* 47.4(1998): 379-384; Karen Rook. "Positive and Negative Social Exchanges: Weighing Their Effects in Later Life". *Journal of Gerontology: Social Sciences.* 52(1997): S167-S169.

[14]The events below were directly observed during the first phase of this project which involved the observation of individual and group behavior in public settings. They are presented in a way that uses counterfactual logic for comparable events to evaluate the plausibility of a proposition (i.e. the notion that if social connectedness is not contextual, there should be no difference). For more on counterfactual modeling generally see Morgan and Winship (2007). For its application to ethnography as in the case below, see (Smith-Cordery 2012). Stephen L. Morgan and Christopher Winship. *Counterfactuals and Causal Inference: Methods and Principles for Social Research Analytical Methods for Social Research*. New York: Cambridge University Press, 2007; Robert Courtney Smith-Cordery.

I observed the first two events while spending the day with Jewish seniors at a center in Cedar hills:

> *Ruth, an elderly Jewish*[15] *woman entered the room where a group of seniors was at a table discussing a New York Times article. As Ruth struggled through the door with her walker, the discussion stopped, and one of the nearby male seniors got up and held the door open. Another man cleared a spot at the table and a third pulled up a chair. The woman said thank you, and the others smiled and nodded. The discussion resumed. During the lunch which followed in the larger recreation room, there was a similar instance of a senior struggling with mobility. An older man came in the room with a walker. Another man cleared a path for him, and helped him into a chair. The older man said "thank you." The helper smiled and nodded.*

I observed parallel events at the senior center in Rockport:

> *The table was populated by three African American men who were discussing their desire to "get with some ladies." All three had canes. The youngest one, Clinton, who was very overweight and missing teeth, tried to stand up. He grimaced with pain, and fell back in his chair. He did this several more times, rocking his body back and forth before he finally made it to his feet. Nobody at the table commented on the failures. When he finally made it up, Clinton smiled and looked at his neighbors at which point he said "1,2,3, take a licking and keep on ticking. That's how we do it, that's how we've got to do it. Ain't that right Johnny." Johnny, another African American senior at his table smiled and said, "Yes sir." Clinton walked with great difficulty to the bathroom, stumbling along the way with his cane but not falling. After about ten minutes, he returned and sat down again. While he was in the bathroom an elderly African American woman who looked to be in her eighties slowly got out of her chair and began moving towards the lunch table with her walker. As she struggled forward she was having a hard time making headway, and kept bumping into tables and chairs. No one moved the chairs. No one said anything. She grimaced and moved them herself before sitting down at a table with other African American women for lunch.*

Similar events (mobility problems), in the same general setting (a senior center), in the presence of friends and acquaintances, played out differently. The point here is *not* that middle-class Jews will help a foundering senior while poor African Americans will not. In my records, every time a senior experienced a serious fall (i.e. one resulting in an injury requiring medical attention) in the presence of others, someone helped. However, these examples show that "being together" meant something very different for different groups. A typical survey measure of social connectedness would categorize the four seniors in the events above as equally "socially connected"—each saw and talked to friends and family within the span of the last week and attended lunches at the local senior center. What such a measure would miss is that the norms regarding "being together" led to different behaviors.[16]

"Ethnography, Epistemology, and Counterfactual Causality.*" American Journal of Sociology Conference on Causal Thinking and Ethnographic Research*. University of Chicago, 2012.

[15] All of the Jewish individuals observed in this study would generally be considered white, although they often saw themselves as ethnically distinct.

[16] The point is not that connection versus isolation is irrelevant. Voluminous works show that even within a racial group those who are more connected tend to be better off with regards to health on average. As I have shown in past work (e.g. Abramson and Sanchez-Jankowski 2012), even among poor seniors of the same racial group, whether or not one is connected matters for health and health behavior. Still, the effect is not homogenous and ethnography is well suited to showing why. Corey M. Abramson and Martín Sánchez-Jankowski. "Racial Differences in Patterns of

What Being Together Means: Divergent Norms

The examples above highlight two sets of cultural norms regarding how seniors should relate to other people in their networks. Norms operate by setting the parameters for acceptable behaviors by members of a group.[17] They reflect broader *normative schemas,* shared understandings of how the world operates and consequently how people should deal with one another in it. [18] The examples illustrate two very different schemas: *general reciprocity* and *earned reciprocity*. These schemas translate into different norms about when to provide assistance to others in a social network and what that assistance should entail. Different groups shared different schemas. Often, these played out along ethnic lines. General reciprocity was most prevalent among Asian and Jewish seniors . However, it was also seen among tight knit religious communities. Earned reciprocity was most prevalent among non-Jewish whites and African Americans.[19] I now examine these schemas, the norms that follow, and how they produce different forms of social connectedness across communities.

Generalized Reciprocity: "When You Need Something, They Should be There"

The underlying premise of *generalized reciprocity,* seen in the Cedar Hills examples, was clearly stated in an interview with a middle-class Jewish woman. When discussing whether family and friends have a responsibility to seniors she said simply, "Yes." When I asked her what that responsibility was she replied "When you need something, they should be here." Similarly, when discussing the role of family, a Chinese man commented:

> *So I really think family is there for each other, for one another. It's you know, you look after them, they look after you if they need help - take care of them. I need help, come*

Having and Using a Doctor Among the Elderly Poor in The United States". *Research in Social Stratification and Mobility.* 30.2(2012): 203–217.

[17] For a classic statement see Weber (1978) and a useful explication Spencer (1970). Martin E. Spencer."Weber on Legitimate Norms and Authority". *British Journal of Sociology* 21.2(1970): 123-134; Max Weber. *Economy and Society. 2 vols. Vol. I.* Berkeley: University of California Press, 1978.

[18] I define normative schemas as cultural frameworks which "are institutionally reinforced (codified and supported by laws, funding requirements, etc.) and take on normative significance. They prescribe what is seen as the correct course of action for individuals and organizations." Abramson (2009: 86). Although norms and the schemas that underwrite them can be internalized in the classic Parsonian sense, the possibility of sanctions allows them to function without commanding belief (Derne 1994; Swidler 2001). In this way they are different from worldviews. Normative schemas are also different in that they can be more limited in scope. Corey M. Abramson. "Who Are the Clients?: Goal Displacement in an Adult Day Care Center for Elders with Dementia". *International Journal of Aging and Human Development.* 68.1(2009): 65-92; Steve Derné. "Cultural Conceptions of Human Motivation and Their Significance for Culture Theory". *The Sociology of Culture.* Ed. D. Crane. Cambridge: Blackwell, 1994; Ann Swidler. *Talk of Love: How Culture Matters*. London and Chicago: University of Chicago Press, 2001.

[19] It is important to reiterate that this is an observational study that uses interviews to better understand how people make sense of their experiences. Consequently, the claim above about which ethnic groups are more likely to operate under particular norms cannot be interpreted in the same way as in a survey study—e.g. the likelihood of occurring among individuals within a specific population. Rather, the point is that within my data, there was an observed "elective affinity" between demographic characteristics and norms. While ethnography can show how this works in social life, claims about the relative distribution of these norms over the American population cannot be made with this type of data.

help me. Yeah, I mean they don't know what you need. So if I have - if I have something, I probably tell them. I'm sure they will come and help me.

At a class on current events at a Jewish senior center in Cedar Hills, seniors were discussing which charities to donate to in order to respond to the recent Haiti earthquake. Their responses reveal a more general understanding about helping:

One woman noted "It is our responsibility to help because we can help." The facilitator, a middle-aged white man from the local adult school, played devil's advocate and asked if it was America's problem. He asked "What about the UN and the other countries?" The woman replied, "When people are in need like Haiti, in poverty with a disaster, the whole world should help them." The facilitator countered, "What about the poor in other places?" A man said, "We should all help those in need, wherever they are, whatever country they are from." The class nodded in agreement.

What these examples reveal is that in contexts defined by generalized reciprocity, helping others is an acknowledged behavioral norm underwritten by a moral imperative— it is both what people are *expected* to do and what they *should* do. Generalized reciprocity provides default ways of relating to other people in one's network. It is premised on the idea that helping is a general social good and that if people help each other all will benefit. While there can be the possibility of individual gain, people do not help in the expectation of immediate reward.

The extent to which seniors expressed notions of generalized reciprocity in this study had less to do with socio-economic class and more to do with ethnicity, which was a stronger source of identification and group identity for seniors. It was most pronounced among the Asian Americans and Jews in my study. It was also associated with small tight-knit religious communities. [20] While specific helping roles were often mediated by gender (i.e. women should help with the elderly, men should help by bringing in income), the underlying principle that everyone should help was the same. Seniors often implicitly or explicitly connected their understandings of help to group history and filial or communal orientation. A Chinese senior in Elm Flats explained how modern family obligations are linked to cultural adaptations to the historical circumstances of life in China:

You know, the Chinese philosophy is you raise a kid like insurance, you know for old age. Well because in China it's different, there is no social security, you know when you get old, you know your kid don't take care of you, nobody take care of you. So I really think family is there for each other, for one another it's you know, you look after them, they look after you if they need help - take care of them. I need help, come help me.

Similarly, although she does not explicitly relate this to the context of the Philippines, a woman in Baygardens explained that her expectations were transposed from that context:

I was the oldest so I take care of my sisters. Now I live with my daughter; she is unmarried. I have five children, but Pilipino people live with the unmarried daughter. Unless they need you to take care of grandchildren.

With older Jews the role and obligations for helping were typically less starkly defined, but based on the same premise. One senior explained what family members should do for seniors:

[20] This set of norms seemed to be operative among Latinos as well, but given the language barrier that prevented getting substantial access to Spanish speaking areas, I cannot say with certainty.

If I wasn't feeling good they would take me to the doctor. If I wasn't feeling good they would get somebody to clean my house for me. They would go to the market for me. Thank god I don't need anything. So. But that should be their responsibility…[21]

Although the quotes above reveal that there is variation in the extent to which obligations are framed in terms of ethnic history and rigidly defined social roles, in each case the obligation to help was influenced by the understanding of the meaning of family.

Under generalized reciprocity, "strong ties" such as blood relations carry strong expectations— particularly for family members. An African American man from a religious family and close church community in Elm Flats explained:

When you got family they sort of tend to, if they care anything about you, they want to do the best for you that they can, so that means looking after certain things for you, looking at you to see if you are healthy, should you go to the doctor, should you do this or should you do that. On your best interest. So that's what we do. Discuss the bible, and you know, stuff like that.

Under generalized reciprocity, family members are expected to take care of seniors.[22] Although seniors who can drive themselves usually prefer to do so, when they cannot, family members are expected to step in. They frequently drive seniors to doctors' appointments, prepare food for them, and, if necessary, bring the senior into their home to live with them. In some cases, there is a designated individual tasked with carrying for an aging parent (e.g. youngest unmarried daughter), but in most cases the responsibility falls on whoever is geographically closest to the senior.[23] In each case the expectation is that when a senior cannot take care of him- or herself, the family will step in. As a Chinese man from Elm Flats noted, "they will take care of me. [I] don't worry about it, 'cause my kids are good kids, both kids." How families go about this varies. Those with substantial wealth often hire helpers to ease the burden. For instance, one 91-year-old senior from Cedar Hills was provided a helper by her family which allowed her to get around town and feel more independent while creating less work for her children. At lunch at the senior center, she noted "My bones hurt, and my head is fuzzy. I am lucky I have Anna. She is a beautiful woman." Other families, particularly those of Asian heritage, often brought their seniors into the home and then tasked them with caring for grandchildren or great-grandchildren.

Although in principle these close ties supplant the government safety net, and family members become caretakers until death, in practice the obligations were often mediated by socioeconomic issues. Poor and working class families often relied more heavily on state support. In the case of homecare, some families could not afford to have a family member stay home to provide care. In these cases, family members were still seen as responsible for the seniors, but would help secure services to fill in for them—Medicare, transportation, meal services, et cetera. Even many middle-class families could not afford to provide 24/7 care or to hire health aides to take their place. Consequently these families used state resources, but would

[21] Interestingly, this senior was not only close in age to the Pilipino woman, but also was the oldest and was expected to take care of her sisters growing up.

[22] This also raises the question of what constitutes "family". In practice, although typically this involved some sort of blood relation, the relationship worked because the social tie was strong. Therefore, this relationship could exist with "fictive kin" or other non-blood relations. The key distinction is that these people were not just casual friends or neighbors.

[23] This was often a source of major contention among families. Those who cared for the seniors felt that they were fulfilling their obligations at substantial cost, while their siblings were shirking theirs. This sometimes translated into feuds after seniors died or were institutionalized, as the seemingly tight knit families competed over the incapacitated or dead seniors' assets.

handle the logistical arrangements for the seniors. Further, they supplemented the state provided services with their own resources (time, money, and housing).[24]

While some seniors stayed with their families until the end of their lives, many were eventually sent to nursing facilities before death. Often the path was not linear. Seniors would have a health problem, wind up in the hospital, rehab in a nursing facility, then return home, only to repeat the pattern several times. Eventually this pattern would stop when seniors (1) asked to go to an institution on their own, (2) required more care than the household could provide, or (3) died. Those asking to go to institutions had the resources to go to a high-end assisted living facility. More often, the seniors would require more care than the household could provide. The amount of care required increased dramatically as seniors developed moderate to severe dementia or incontinence. These conditions substantially increased the emotional, physical, and logistical toll of care.[25] However, compared to groups operating under the schema of earned reciprocity, family members operating under generalized reciprocity were more likely to regularly visit the seniors in the facility. Some would go weekly or even daily. This was particularly the case with Asian seniors.

Connections to friends, neighbors, and acquaintances were also valuable for seniors in contexts of *generalized reciprocity*. Friends would give one another rides, bring food to the sick, check in on missing members of the senior center, or visit those who had been institutionalized. They neither charged for these services nor expected any sort of direct and immediate reciprocity. As a Chinese senior noted, "The main thing is to be there to lend support." However, the bounds were more limited than with family. It was rare for friends or other members of a senior's network to submit themselves to any sustained financial losses or other extended difficulties that are seen among family members. While help was much more limited, it was still freely given rather than exchanged. The comments of a middle-class Latino man, explaining his relationship with his neighbors are typical: "One of our neighbors got put in the home and that's where she's at right now. We would make it a point to go and help her. We look after each other." They help each other, not because of an expectation of immediate instrumental gain, but because it is "what people do."

Although the level of help varies according to the relationship between people (e.g. friends, family, neighbors), being too focused on personal gain at the expense of others is frowned upon. Fulfilling obligations may provide individual psychological rewards (e.g. feeling good for "doing the right thing"), but it also provides status rewards within the group. Helping others, and having a family that does the same, is often a point of honor or pride. A Pilipino woman in Baygardens explained this to me as she showed me pictures of her family who cared for her and explained that she was "very proud, because they help the community and don't cause trouble." Further, whether someone is liked or whether they have done something good for you in the past is irrelevant—helping is an obligation that group members are simply expected to fulfill. This is seen in another interaction between two Jewish seniors in Cedar Hills. At the communal lunch, Delilah was complaining about "people who sit there and don't talk." Moshe took offense at this and said, in an agitated tone, "You leave them alone. If anybody needs help, I

[24] The financial aspects were often quite complex— as more affluent seniors would have to "spend down" to use certain services like Medicare. A complete discussion of this is outside the scope of this dissertation, the point however, is that the families provided both logistical and instrumental support.

[25] These same criteria were operative in the Adult Day Care study I observed during a previous study (Abramson 2009). These two factors, dementia and incontinence, provided the greatest logistical difficulties and often lead to seniors being removed from the program.

am here. If you fall down on the street, I will be the first one to help you up. Do you need help with anything?" The woman said no, sat quietly for a few moments, then left.

Earned Reciprocity: "What You Give is What You Get"

The guiding principle behind *earned reciprocity* on the other hand, is fair exchange between individuals. Help is like any other transaction between people— people give help with the expectation of a return. The idea is, "If someone helps me, I owe them the same." This schema corresponds to a more limited, individualistic, and contractual set of relationships. As help is an individual exchange, it implies a debt on the part of the person being helped. This is often undesirable as it (1) signals weakness or a loss of independence and (2) creates a debt requiring repayment. An African American woman in Elm Flats described her "disappointing" experience with friends in the context of earned reciprocity:

> *Well, a good friend is a give and take thing. What you give is what you get in friendship. Some people, as the friends get older and things happen in their lives, they just don't give anymore, and they are always afraid that you are going to ask them for something that they can't provide.*[26]

Help is not something that is given to the group with the expectation that everyone helps those in need— it is a direct relationship between individuals. Consequently, even well-intentioned help can result in indebtedness that stresses relationships as the recipient is forced to acknowledge both an undesirable lack of independence and their imposition on others.[27]

As with generalized reciprocity, earned reciprocity was more strongly associated with race and ethnicity than social class. It was particularly noticeable among groups with a strong individualist orientation such as African Americans and whites. These groups were most influenced by notions of independence, individualism, and competence that permeate American society,[28] which made receiving help more of a point of stigma. In situations where there were also communalist undercurrents, such as in close knit church communities, helping was much more prevalent and generalized reciprocity set the bounds for interacting with group members.

Under earned reciprocity, not only were people more reticent about helping, but the nature of obligation to members of a network was more limited. Family members were still often asked to help, but this was premised upon past behaviors— e.g. having been a good parent, brother, or sister. When asked if family had a responsibility to seniors, an African American man noted, "Well, if you are lucky enough to have a family that cares, yes. Many of us don't have the luxury of family that cares about us. Some of them are hit or miss." Others commented that they expected help from their kids, because they raised them and took care of them. One African American woman noted that she would not expect anything if she had been in jail or a drug addict, but since she put clothes on their backs and food on the table, she expected her sons to

---

[26] In this case, the senior was referring to companionship. She noted, "In reality you want the companionship and support more than anything. I don't need the money or anything. It's the love and companionship of a friend that really matters."

[27] James, the African American man in chapter three, made a similar point about how asking for help signals vulnerability when he noted, "This was stated clearly by the African American senior in chapter two who noted "a man has a certain image to project. And that image, it don't include doctors."

[28] See Fischer 2010 and Portacolone 2011. See also Smith (2007) for individualism among African Americans, although her explanation differs in that it emphasizes instrumentality rather than ideology. Sandra Susan Smith. *Lone Pursuit: Distrust and Defensive Individualism Among the Black Poor*. New York: Russell Sage Foundation, 2007.

help. In contrast to the seniors who invoked familial obligations, these seniors were both less certain about their futures and more sensitive to the issue of receiving help. A white senior in Baygardens articulated this ambivalence when she noted:

> *What am I going to do if I get to the point where I can't take care of myself? I have no idea. I have no clue. Is there anybody to take care of me? No. Would I want anybody? No. I don't want to be a burden. No. I don't want that.*

This was not ideal, but neither was it a breach of norms. In general, while relatives still provided social support, they were less likely to drive seniors around, provide substantial material support, or visit the seniors once institutionalized. The level of support provided to a specific senior under earned reciprocity depended less on a generalized obligation of helping family, and more on the contractual understanding that past care creates a debt that can be paid in old age. One of the major consequences was that in the case of serious health problems, seniors could not necessarily rely on extended family care. Consequently the trip from home to hospital to nursing facility was much more linear.

Contractual connectedness affected how people responded to friends, neighbors, and acquaintances, as well. Like those operating under generalized reciprocity, people would still check in on friends and share information. Many noted that they were thankful to see their friends every day or happy to have someone check in on them in person or over the phone— but these people were not obligated to help them in more substantial ways. One white senior noted,

> *It's good to have people to even talk to over the phone, because it's like a, it's like, if someone doesn't hear from you for a while, they call you. If you don't hear from someone for a while, you call them. You have to have a network. Do I have any what I call close friends? No. Not really.*

Among groups where earned reciprocity was the normative schema, seniors still helped each other, but this help looked much more like an economic exchange. For instance, one enterprising senior would drive her friends to Bingo, but would charge them each $5 for the trip. Seniors acknowledged that this was a help and that it was easier than taking the bus, but there was no continued debt because they paid for the service. Likewise, younger seniors often helped friends and neighbors— but received food, alcohol, drugs, or money for doing so. Which resource was provided depended on the socio-economic status of the neighborhood. Seniors in poor areas were more likely to provide marijuana or alcohol for help with a task like shopping, whereas middle class seniors might provide lunch or cash. The principle, however, that a service was offered and the person being helped reciprocated in kind, was the same.

The Ambiguity of Social Ties

In examining the role of these networks, it is essential to reiterate a simple but important fact— in general those seniors who were more connected to friends, family, and neighbors generally had more options for getting around the city, taking care of problems in their homes, and socializing. This was true of seniors across communities and network types. The bigger issue was not whether it was acceptable to charge for a trip to bingo, but whether seniors had an option other than taking the bus. Still, there were times when social ties had much more ambiguous effects. For instance, Jane (discussed in chapter three) often spent her days at bars because, as she put it, all her friends were “alcoholics” and that’s where they would hang out. She wanted more help but did not have the material resources to hire a helper and was hesitant to ask for

things without payment. Often, things around her house remained broken. As I was driving her around the city she commented,[29]

> *I have trouble even getting basic things done. Running errands. The meds make me worry about driving. Even the ones that are not super duper meds, that the doctor said I could drive on, make me nervous. I am so worried about hitting something and can't concentrate. Then I went to the pharmacy, pill hill. People don't help you. I needed to get a non-alcoholic mouthwash. The guy at the store sent me to Isle 17A. I couldn't find it, and he said go back to 17B are you sure you looked? I finally found it, but there were like 50 different mouthwashes, and the print was so small I could not read any of it. Finally another customer helped me. Unfortunately I don't have money to pay someone to help, and my husband, if I move back with him is not healthy either.*

Even though she had friends and a husband, she often felt isolated even near her home.

Jane's marriage and family were further sources of stress. She was in a feud with her brothers over her mother's home. Jane took care of her mother for two years, until her mother's dementia got bad. The mother was then placed in a nursing home. Once her mother was no longer living in the house, her brother decided to sell the home because the property was in his name. Although Jane did not want to move, her brother said she was no longer caring for the mother. This was forcing her to move out. She got a call from her husband, whom she was separated from, saying that he was coming into Baygardens the next week and to prepare. Later that day at the local bar she told me:

> *My first husband died, but we had 16 great years together. He was a professor… I don't like the current one, and we have been living in different cities for 2 years now, but he is a man, he has a pension, and health insurance, so we are going to try to make it work, especially with my brother pressuring me to leave here.*

Her network, including her marriage, provided her access to important resources, but it was also a source of immense stress. Although she enjoyed "hanging out" with her friends, spending time with them encouraged unhealthy behaviors (e.g. excess drinking, eating pub foods) and increased her exposure to risky situations (e.g. driving in cars with people who were drunk or high). So while having a family and friends affected how Jane responded to problems in old age, the mechanisms were more complicated and the effects more ambiguous.[30]

Conclusion: Social Ties as a Fundamental but Contingent Resource

The data above show that social ties can mean different things to different groups of seniors— even if social capital or the extensiveness of networks look identical on popular

[29] She explained as an exchange, although I was driving her, she was helping me with my book.

[30] While it is important to move away from seeing networks as universally "good or bad," it is equally important to avoid doing the same thing with norms. Norms, and the schemas that underlie them, result from complex socio-historical processes that reflect inequalities past and present. The question for social science is not to apply our own moral frameworks to decide which set of norms is "good" or "bad," but to examine how these norms shape the behavior of people and organizations— and to what effect. Whether and how urban ethnographers impose their own moral frameworks on their subjects is a point of assiduous debate— which usually takes place among other urban ethnographers. For example see Wacquant's (2002) criticisms and the responses. Loï¨c Wacquant. "Scrutinizing the Street: Poverty, Morality, and the Pitfalls of Urban Ethnography". *American Journal of Sociology.* 107.6(2002): 1468-1532.

quantitative measures. When, how, and to what extent people seek and provide help is in part structured by cultural norms. These norms reflect shared understandings about the world and how people should relate to one another in it. In other words, while networks form structures of social relations, the effects of those relations are mediated by culture. This explains why the response to the stumbling in the senior centers was different. In the case of the Cedar Hills center, social norms dictated that people should help one another whenever they are able. This was a general extension of a set of understandings that places helping as positive, obligatory, and moral. It was part of a general expectation that people help others, and in turn will be helped when they need it by another member of the group. By helping the stumbling senior, other seniors fulfilled designated social roles associated with these understandings, and did so with little cost to the person being helped. In contrast, in the Rockport center, providing help would have been an acknowledgment of the foundering senior's loss of independence and an imposition on him or her. Helping someone creates a debt that requires repayment.

These responses are not about the morality of helping, but rather the different set of norms and understandings that define what is the "right" way to respond. What is "right" reflects a broader set of normative schemas that determine how people should relate to others in their networks. These schemas, and the norms that are linked to them, reflect and continue to shape group experience. In this case, racial and ethnic group membership is the key factor. The intricacies of how those ties function cannot be understood without examining the cultural underpinnings. While "who you know" matters a great deal, so does the "meaning" of who you know.

Chapter 5
"It's Money": Unequal Contexts and Resources for Aging in the American City

Introduction

Past chapters have shown that seniors from different racial, ethnic, and class backgrounds often deal with the predicaments of growing old in radically different ways— even when those predicaments are similar. Some try to preserve their bodies and sense of independence for as long as possible, others try to have as much fun as they can before they die. Some see their doctors as the ultimate authorities on health; others view them as people just trying to make a dollar. In some networks helping friends and neighbors is a generalized obligation, in others it is a more specific exchange. These aspects of culture reflect past inequalities and determine what seniors see as appropriate in the present. However, seniors face inequality in the present as well. Seniors do not respond to issues, like arthritis, pneumonia, or a fall, in a laboratory where the effect of culture can be seen while "all else is equal." Rather they must confront challenges of aging in the complex and often unequal settings that shape their everyday lives, such as apartment complexes, neighborhood senior centers, and hospitals. Further, seniors face their problems with different levels of material resources like money, health insurance, and property. While past chapters have examined how underlying differences in physical capital, cultural schemas, and networks reflect past inequality and influence behavior, this chapter shows how different *organizational environments* and *material resources* create unequal *contexts*[1] in which seniors age.

We know these contexts reflect spatial inequalities. Sociologists have long shown that where you live matters. The neighborhoods people inhabit affect the resources and opportunities that are available to them throughout their lives.[2] This pattern holds for health as well.[3] Compared to

[1] I use the term "context" to refer to the physical and social environments in which people go about their everyday lives. Sociologically, contexts can be thought of as overlapping mezzo-level social structures, constituted by cultural schemas and resource distributions that operate in a particular historical period (Abramson 2012; Sewell 1992). The sub-categories of context (e.g. structures and schemas) reflect important distinctions between characteristics of these structures, but in reality the distinction is analytical rather than ontological as these contexts are mutual and overlapping. See Corey M. Abramson. "From 'Either-Or' to 'When and How': A Context-Dependent Model of Culture in Action". *Journal for the Theory of Social Behaviour*. 42.2(2012): 155-180; William H. Sewell Jr. "A Theory of Structure: Duality, Agency, and Transformation". *American Journal of Sociology*. 98.1(1992): 1-29.

[2] For example see Jargowsky (1997), Massey and Denton (1993), Massey (2007), and Wilson (1996). P. A. Jargowsky. *Poverty and Place: Ghettos, Barrios, and the American City*. New York: Russell Sage Foundation, 1997; Douglas S. Massey and Nancy A. Denton. *American Apartheid: Segregation and the Making of the Underclass*. Cambridge: Harvard University Press, 1993; Douglas S. Massey. *Categorically Unequal: The American Stratification System*. New York: Russell Sage Foundation, 2007; William Julius Wilson. *When Work Disappears: The World of the New Urban Poor*. New York: Vintage Books, 1996.

[3] For a review see For a review of this literature see Ross and Mirowsky (2008), Smeedley et al. (2002), and Williams and Collins (1995). Catherine E. Ross and John Mirowsky. "Neighborhood Socioeconomic Status and Health: Context or Composition?" *City and Community*. 7(2008): 163-179; David R. Williams and C. Collins. "US Socioeconomic and Racial Differences in Health: Patterns and Explanations". *Annual Review of Sociology*. 21(1995): 349-386; Brian D. Smeedley, Adrienne Y. Stith and Alan R. Nelson. *Unequal Treatment: Confronting*

middle-class neighborhoods, poor areas in the US typically have fewer hospitals and clinics per capita than more affluent neighborhoods and these tend to be of lower overall quality.[4] Research suggests that areas which are poor and racially segregated form "food deserts" where high quality healthy food is more difficult to find and more expensive.[5] The housing environments and physical infrastructure in poor areas are often also more poorly maintained, and residents are disproportionally exposed to toxins and other environmental hazards.[6] Consequently, a person's geographical location can profoundly limit access to key resources for health. Although we know that structural inequality is linked to health outcomes, understandings of how these links operate in the everyday lives of seniors are less developed. This chapter shows which aspects of the contexts for aging are different across the four communities in this study, which are the same, and what this means for how seniors can respond to the predicaments of aging.[7]

Mobility Problems Revisited: Space, Transportation, and Inequality

Space and the physical environment form the backdrop of social life, and can profoundly structure behavior even in modern urban settings. For seniors in this study, the ability to see a doctor, get healthy food, or socialize with friends across town required a way to physically get there. As chapter two demonstrated, navigating the physical environment becomes more difficult as people age. As they age, people often develop problems moving around environments that they could navigate with ease decades earlier. They have less energy available and are at greater risk of falling. As aging progresses, their physical capacities wither and their effective spatial range shrinks. An elderly Chinese man from Elm Flats voiced this common problem in his local senior center:

> *Well you know like before I could walk six block without any problem, now if I can walk a block and a half without getting winded it's a triumph.*

Seniors' remaining physical capacities, the basis of their ability to move through space, reflect inequalities. The poor and socially marginal have more medical problems and shorter lives on average, receive worse care, and confront the physiological problems of being "old" at a younger

---

Racial and Ethnic Disparities in Health Care. Ed. I. o. Medicine. Washington, D.C.: National Academies Press, 2002.

[4] For a review see Kirby and Kaneda (2005). James B. Kirby and Toshiko Kaneda. "Neighborhood Socioeconomic Disadvantage and Access to Health Care". *Journal of Health and Social Behavior*. 46(2005): 5-31.

[5] For a review see Walker, Keane, and Burke (2010). Renee E. Walker, Christopher R. Keane and Jessica G. Burke. "Disparities and Access to Healthy Food in the United States: A Review of Food Deserts Literature". *Health & Place*. 16.5(2010): 876-884.

[6] For a general review of the relationship between the housing environment and health see Shaw (2004). For an example of how environmental hazards can affect everyday life see Auyero and Swistun (2009). Javier Auyero and Debora Alejandra Swistun. *Flammable: Environmental Suffering in an Argentine Shantytown*. New York: Oxford University Press, 2009; Mary Shaw. "Housing and Public Health". *Annual Review of Public Health.* 25.1 (2004): 397-418.

[7] The lack of systematic attention to behavior, lifestyles, and their contextual underpinnings is particularly problematic given the recent spate of studies demonstrating the salience of behavior as a key component in reproducing health disparities. Adler and Newman (2002) offer a useful review of the pathways that link inequality to health disparities, and summarize evidence on the key importance of behavior and lifestyle in this regard. The lack of serious attention to cultural mechanisms is another major issue which I addressed directly in the previous chapter. Nancy E. Adler and Katherine Newman. "Socioeconomic Disparities In Health: Pathways And Policies". *Health Affairs*. 21.2(2002): 60-76.

age.[8] The man above was in his nineties. Seniors living in poverty, like the men from Rockport discussed in the last chapter, often face these issues in their fifties or sixties.[9] While past inequality affects the onset of these mobility problems, present inequality exacerbates them. Ostensibly both middle-class and poor seniors can compensate for their declining physical capacities using other resources to aid mobility. In the case of transportation, they can drive, take busses, reserve taxis, or have friends bring essentials, like groceries or medicine, to their homes. However, middle-class seniors have more resources to offset the problems of physical breakdown. Consequently, while combination of physiological mobility problems and uneven access to usable transportation created major issues for seniors in all four communities, the problems were compounded for seniors who were poor or ill and had fewer options for usable transportation.

It is intuitive but important to note that seniors who could afford cars and still had the physical capacities to drive were better able to get around. The fact that seniors in middle-class and affluent areas were more likely to have cars, and that younger seniors were more likely to be able to drive, is an important point of difference both practically and symbolically. The practical significance in a place like California, where having a car greatly increases your ability to get around the city, cannot be overstated. However, cars also had immense symbolic importance for seniors. Owning a car, and having the mental and physical capacities to pilot it, was a substantial status marker and a signifier of independence. Many seniors noted that one of the hardest things to come to terms with in growing old was acknowledging that they were no longer able to drive safely. Likewise, those who could rely on others in their social networks to drive them places were in a much less precarious position than those relying on other forms of transit. This was partially an economic issue, but also a function of the extent to which people help others in their networks (the topic of chapter four). While access to cars provided an obvious advantage to more affluent seniors, there were also important differences in public transportation options across neighborhoods which profoundly affected the ability of seniors to get around.

It is important to recognize that the bus coverage in these dense urban neighborhoods was much better than what would be found in other parts of the state. Most seniors were within a few blocks of a bus line.[10] Seniors who were relatively healthy and mobile were able to get to key locations around town, which would likely not be the case in less connected rural settings. Still, public transit created substantial barriers, particularly for ill seniors. As anyone who uses public transportation knows, travelling via bus includes walking to bus stops, waiting for the bus, climbing the stairs, riding the bus, often transferring busses, exiting the bus, then walking to the destination. Even with accessibility modifications, this process requires substantially more

[8] The importance of this pathway cannot be overstated. Researchers in the social and biological sciences have shown that the greater physiological stresses they encounter, the toxicity of the environments in which they live, the lack of access to quality care, and their behavioral adaptations to everyday circumstances, lead the bodies of the poor and marginalized to "wear out" and "breakdown" faster. This is discussed in more depth in chapters 1 and 2. For a review see Adler and Newman (2002), Smeedley et al. (2002), and Spalter-Roth et al. (2005). Roberta Spalter-Roth, Terri Ann Lowenthal, and Mercedes Rubio. "Race Ethnicity, and the Health of Americans." *ASA Series on How Race and Ethnicity Matter*. Ed, R. Spalter-Roth, American Sociological Association, 2005.

[9] See Kington and Smith (1997) and Moody-Ayers et al. (2005) for a review of this well documented trend. R. S. Kington, and J. P. Smith. "Socioeconomic Status and Racial and Ethnic Differences in Functional Status Associated with Chronic Diseases". *American Journal of Public Health.* 87.5(1997): 805-810; Sandra Y. Moody-Ayers, Kala M. Mehta, Karla Lindquist, Laura Sands, and Kenneth E. Covinsky. "Black–White Disparities in Functional Decline in Older Persons: The Role of Cognitive Function". *Journal of Gerontology: Medical Sciences* 60.7(2005): 933-939.

[10] I only discuss busses here, as there was no functional train system. Still, the challenges are similar.

physical exertion and time than traveling by car.[11] For many seniors, this was difficult or prohibitive. They simply did not have the stability and stamina required. A white woman in Baygardens explained this to me when she said, "Well I can't stand for a long time, and I need a walker. I'm pretty good while I'm moving, but getting up and down [the bus] can be hard." Consequently, this woman generally avoided traveling by bus and instead used the free shuttle or arranged rides with friends in her building.

Even among those seniors who were physically able to ride busses, many seniors felt that the combination of time, physical activity, and incomplete coverage made using public transportation problematic. An elderly Chinese man from Elm Flats commented:

> *Public transportation is very, very bad. I mean if you are old, you can't drive; it makes it hard to get around. You have to depend on your friend and there's very limited public help that you can get.*

Consequently, being within walking distance of important locations like pharmacies and markets provided a substantial advantage to seniors. One senior reflected on this noting:

> *I happen to live close to a grocery store within walking distance, and you know the pharmacy's right there too now, and the banking is now in the grocery stores too, so things have consolidated, where you don't have to go as far. But for anything else there is not enough public transportation. There are busses, but the way they're run and where you have to get them, it's just not helpful.*

These seniors could take buses if necessary, but often were fortunate in that they were able to get services with less exertion than going to a bus stop by walking. If they needed to go somewhere, they would ask friends or family members for a ride. The bus was there, but it was used as a last resort.

Seniors suffering from more substantial mobility problems often had a hard time transferring buses or even walking to and from a bus stop. For seniors like the Chinese man at the beginning of this section, a few blocks became a prohibitive distance. Some seniors would go so far as to count the number of steps they could make before their legs gave out. Without access to substantial resources (such as a driver or a powered wheelchair), these seniors had a very limited effective range of travel. If they could not get someone to drive them to a doctor's appointment, market, et cetera, they would have to rely on supplemental transportation. Even healthy seniors were concerned with these issues and the implications for their quality of life. One senior from Cedar Hills noted:

> *The main issue with seniors is transportation. They keep cutting back on public transportation; so many seniors with ambulatory issues are just stuck at home. They eat, sleep, watch TV, and take medicine, but can't go anywhere. They become prisoners in their homes.*

This sentiment, which was widely shared, reflects an acknowledgement of (1) the fact that the physical problems of old age create issues for navigating their environment, (2) that public transportation is uncertain and problematic, and (3) when these factors converge, seniors' effective range in the world is limited. This touched on a prevalent fear across groups— losing "independence" or the ability operate in and navigate the world.[12]

---

[11] For a discussion of these, as well as other burdens associated with public transit in California (and how to measure them), see Iseki et al. (2007). Hiroyuki Iseki, et al. *Evaluating Transit Stops and Stations from the Perspective of Transit Users*. Sacramento: California Department of Transportation, 2007.

[12] In sociological terminology, the fear is about lost "capacities for action," losing the resources that allow people to pursue desired ends. Independence is a normative concept, rooted in a particular western ideology, which seniors use

All four neighborhoods had forms of supplemental transportation, which operated with varying levels of coverage and consistency. Cedar Hills, Baygardens, and Elm Flats each had senior transportation programs that were funded by grants that city agencies had won. In addition, seniors in these neighborhoods had access to the county program. In contrast, Rockport residents only had access to the county program. The city programs provided shuttles that stopped at senior centers, major senior housing complexes, grocery stores, pharmacies, hospitals, and doctors' offices. When available, these services were heavily used by seniors in all three neighborhoods. Residents frequently commented that the shuttle or "free bus" made their lives easier and allowed them to get what they needed without asking for help from friends, family, or neighbors.[13] They also added that the sociability provided by interacting with the other seniors and drivers on the bus was desirable. An elderly African American woman from Cedar Hills who used the bus frequently to get around provided a representative view:

> *Cedar Hills is an unusual place because they have a public transportation network for seniors. This year the senior center has taken over that piece, and they can arrange pretty much anything in this area or in [county] for disabled and older seniors to get picked up and take them where they need to go - appointments, errands, whatever they need to do on a basis - can do basis. It happens daily. Our driver who is Danny and the other is Craig; they are very loving and wonderful people. They treat the seniors with love and respect.*

In contrast to Cedar Hills, the services in Baygardens and Elm Flats did not run every day, but still provided an easier alternative to bus travel. An elderly white woman from Baygardens described how she took the shuttle to the doctor:

> *"I took that free shuttle. They pick you up right here [in front of building], and drop you off at [HMO]. They also go to the senior center, [market], and the library. The driver is a real nice young guy, and you know all the people on the shuttle since it is the same each week. It is hard for me to get up and down the steps though. This time the driver helped me, but my legs held up ok [knock on wood motion]." I asked, "Don't they have a ramp for your walker" Senior: "Yes, but I feel bad. They work hard enough already, I don't want to make more work or make everyone wait for me. I have to use my smaller walker which I can carry, which is a pain in the neck, but it doesn't make trouble for anybody."*

During the last year of fieldwork, the Baygardens shuttle was reduced to running one day a week. Seniors complained that this forced them to do all of their errands on one day and that it made visiting the doctor an issue when they could not schedule an appointment to coincide with the bus. The senior above tried to take a bus to the doctor after this change. She ended up waiting for forty-five minutes on the way back which subsequently affected her energy levels, pain, and mood for the rest of the week. The situation in Elm Flats was very similar. There were organized

---

to make sense of this dilemma. For a discussion about how this ties into the deeply rooted normative power of the notion of independence, see Portacolone (2011). For historical perspective on the continuing importance of "competence" and personal efficacy, see Fischer (2010). For a discussion of how capacities for action, cultural and otherwise shape longitudinal strategies of behavior, see Swidler (2001). Claude S Fischer. *Made in America: A Social History of American Culture and Character.* Chicago: The University of Chicago Press, 2010; Ann Swidler. *Talk of Love: How Culture Matters*. London and Chicago: University of Chicago Press, 2001; Elena Portocolone. "The Myth of Independence for Older Americans Living Alone in the Bay Area of San Francisco: A Critical Reflection. *Ageing and Society.* 31(2011): 803-828.

[13] In other words, these shuttles provided both an instrumental benefit for accessing resources, as well as a sense of "independence" that is essential to American identity.

supplemental programs which seniors knew about and used, but they were in the process of being reduced in scope and or cut.

Seniors who lived in Rockport or those off the designated shuttle paths were not as well off. In the absence of developed city programs they had to rely on the larger county program which was notorious for being late or simply not showing up. It also required seniors to file substantial amounts of paperwork, and to book appointments weeks in advance. Further, many adult day service programs, nursing homes, and hospitals, relied on the county transit program to move institutionalized seniors around in order to reduce operating costs— taxing an already overburdened service.[14] Because of the size and dispatch structure of the county program, routes were always different. Consequently, drivers and passengers frequently rotated. Seniors often did not know the other riders or drivers on the shuttles. While the loss of a shuttle community may have affected seniors' subjective wellbeing, the fact that the service often simply did not show up led to missed doctors' appointments and delayed trips to the pharmacy.

In addition to missed appointments, service inconsistencies created a serious drain on the energy levels of ill seniors. For these people, the process of getting ready to leave the house was a major undertaking— something that they would spend the whole week preparing for physically and psychologically. A poor white senior from Elm Flats commented on these issues when I visited him after a trip:

> *"Getting shaved and cleaned and putting on clothes is a major ordeal. Getting transportation is a major ordeal. Seeing the doctor is a major ordeal and it takes my whole day. It is tempting to just not go and keep my schedule free, but that is the coward's way out." He later added, "If I go to the doctor I have to get someone to drive me, or don't know when I'm getting back. Either way it takes all day and it's a major ordeal."*

The senior then explained that the although he had previously scheduled a ride to the doctor weeks in advance with a county program, which he then called to confirm days in advance, the service simply did not show up and he subsequently missed his doctor's appointment. The problems for this senior then snowballed, as missing the doctor's appointment resulted in an unwanted social worker visit.

At best dealing with the vagaries of these transit programs added stress; at worst seniors found themselves stranded or missing appointments. This was not an isolated occurrence. Numerous other seniors said that they had been left places by the county program. One senior from Cedar Hills flippantly commented to a friend at the senior center, "They get you there OK, but then they don't bring you back." The senior went on to say how she was a "guest" on the service with an different friend, and that despite repeated calls and an hour and a half wait, they never picked her up. Although she was mobile enough to take a bus and had money to take a cab, she said that the experience was taxing and that she would not try to use the service again.[15]

---

[14] I discussed some of the issues this can create on the organizational end in my 2009 article on Adult Day Care. Just as individual seniors were often left stranded, the inconsistency of the service created logistical issues for the adult day care center I observed. See, Corey M. Abramson. "Who Are the Clients?: Goal Displacement in an Adult Day Care Center for Elders with Dementia". *International Journal of Aging and Human Development*. 68.1(2009): 65-92.

[15] When I was observing specific seniors, I would often drive them around, so I did not have the opportunity to be there when they were left by the transit agency. However, the fact that seniors are left places and that the transit program is inconsistent is a commonly acknowledged fact, confirmed by myriad seniors and the organizations that deal with them. I have observed this in my past work (e.g. Abramson 2009) and during my time at various senior organizations for this study.

Access to Necessities: Food

Although they faced transportation challenges, the seniors in this study did not live in "food deserts" as conventionally defined. [16] In each of the four areas, including the poor neighborhoods of Elm Flats and Rockport, major supermarket chains were accessible by foot, bus, or shuttle. There were seasonal farmers markets in each of the areas as well, including regular ones across the street from the senior housing complexes in both Baygardens and Rockport. Further, local senior centers in each of these areas offered lunchtime meals for around $2 per day. Many seniors who otherwise had little to do with the senior centers would show up for this lunchtime meal. This was particularly true for men living alone and those in poor areas. While seniors sometimes complained about the taste, these meals provided large portions and basic nutrition. The senior centers also frequently gave away day-old bread from nearby bakeries and other food donations—although the fact that these were "first come first served" gave regulars the first pick. In addition, each of the areas also had food-banks that provided seniors with free food that was collected via donations.

All of the communities were served by county mobile meal service programs, which delivered warm meals to the homes of seniors up to six days per week. These services were particularly important for those who had a hard time leaving the home (physically or psychologically), but many more active seniors received this service as well since it was cheaper and easier than buying food. These meals were typically more than the seniors could eat in one sitting. Seniors would save the extra food for later, share with friends, or offer it as a reward or gift to helpers. Many seniors said that although the taste and variety of these meals was not exceptional, they provided enough nutrition for the day.[17] Seniors who were members of churches were also often given food by congregation members. In a representative example, a senior explained this to me when I was in her apartment in Baygardens:

> *"I used to go to [the food bank], but they just gave me too much food. I am only one person and it was too much to push across back here [it was about a block away]. So I got signed up for [county meal service]. I eat a lot of meat now, much more than I would buy. My girlfriend says they only give you what's healthy, and I eat it all except the salad. It uses that iceberg lettuce, and I don't like it. They cut social security, so I said I won't pay anymore, but they still bring me the food [shrugs]. If it wasn't for the [county meal service], I probably wouldn't be able to get food." She added "the preacher" from her church also brings her food every week.*

After saying this, the senior opened her fridge to show me the leftovers. Further, the food services provided an important source of sociability for seniors in each of the communities. An elderly

[16] This is consistent with an emerging criticism of the food-desert literature that argues that while poor areas do provide access to more unhealthy food, they also provide substantial access to healthy food and access alone cannot explain differences in epidemiological outcomes such as obesity. These studies also raise questions about which metrics are reasonable for measuring food deserts. For a recent example see (Lee 2012). Helen Lee. "The Role of Local Food Availability in Explaining Obesity Risk Among Young School-Aged Children". *Social Science & Medicine*. 74.8(2012): 1193-1203.

[17] As in the senior centers, the meals in general were quite large. They generally consisted of a piece of fruit, some vegetables, starches like rice, and a large serving of meat. The agencies involved would also accommodate seniors' dietary needs. These meals were provided on a sliding scale, so affordability was not a major issue. Further, the ability to socialize with the volunteer driver was a major part of the social life, and a key lifeline, for more isolated seniors.

white woman with substantial mobility problems provided a representative statement when she noted:

> *"I came here 10 years ago. Then I was getting [food service] twice a week. Now I get [food service] six days a week. It really helps because it is hard for me to leave. I spend all my time home alone. It is hard for me to take the bus, and I guess I could take a taxi." I asked her about the free shuttle, she said "yeah I know about that, I guess I could take it."[Although she later told me she never had]*

In general, with the possible exception of some extremely isolated seniors and those with mental illness or other conditions that prevented them from interacting with other people, food insecurity was not a major issue for those seniors over 65 in this study.[18]

Access to Basic Services: Housing, Services Hubs, and Hospitals

Each of the four neighborhoods had a local senior center or several centers. In each community, these centers provided a central hub for services and information for those seniors who attended. Although the centers varied in size and services offered, at minimum each center provided low cost meals, public spaces for socializing, free or low cost recreational activities,[19] and volunteers or employees who helped refer seniors to additional services. Many of the centers also had free health screenings, auxiliary transportation services, and volunteer consultants who could help with taxes or health insurance issues. The centers also held special events for holidays. For the seniors who frequented the centers, many described them as providing a chance to see their friends, socialize, and exchange news. An African American woman from Cedar hills noted, "Coming to a place like this and being with my friends here, that is my life. Because most of my family is gone, they passed away, so this is my family right here at the center." Each of the centers also distributed free booklets such as senior resource guides, which had an extensive list of phone numbers for senior services provided by state and local authorities as well as non-profit groups.[20] While I was flipping through one at a senior center in Rockport, a woman commented "That Guide's a bible. It's free, and it tells you where to get anything you need."

All four neighborhoods were also in close proximity to major health care centers. Both poor and non-poor areas were served by free clinics. Elm Flats and Cedar Hills were close to well-regarded senior health clinics geared towards individuals on Medicare or Medicaid. Further, the senior centers often had health professionals on location who would provide free screening (e.g. blood sugar, blood pressure, podiatry checks, etc.) and referrals. Intermittent senior health fairs offered free medical supplies, such as blood sugar testing strips to those who attended. Additionally, all four neighborhoods were within five miles of a major hospital with an emergency department. Further, each of the four areas had subsidized housing for seniors. Baygardens and Rockport both had large centrally located complexes near stores, senior centers,

---

[18] Further, there were large numbers of overweight seniors in each of these neighborhoods— particularly in the poorer areas. This is not to say that was not the case in other cities. Although Rockport is poor, and Elm Flats was both poor and segregated, these neighborhoods are less physically isolated than what might be found in Detroit or the Southside of Chicago.

[19] Some activities, like Yoga, Bingo or Dance classes typically had fees. Other activities, such as using the tables for mahjong or dominoes, playing pool, talking, or quilting did not require a fee.

[20] In essence, these centers functioned largely as community institutions that distributed information, provided sociability, and status adjudication essential to the social order of the senior community. For parallels in poverty, see Sánchez-Jankowski (2008). Martín Sánchez-Jankowski. *Cracks in the Pavement: Social Change and Resilience in Poor Neighborhoods*. Berkeley: University of California Press, 2008.

and health care. However, while seniors from all four neighborhoods had access to basic resources, the quality and provision of those resources varied greatly.

Unequal Service Provision: The Case of Meal Programs and "Visitors"

Despite the substantial similarities in the presence of these services (which stood in contrast to the uneven transportation), there were noticeable differences in the way services were provided across neighborhoods. The county meal programs provide a key example. Although all four communities had mobile meals programs, associated visiting programs in which volunteers would check in on and socialize with seniors varied greatly.[21] These programs were often administered at the county level, which typically included both poor and non-poor neighborhoods. In these cases, the coverage provided by the auxiliary programs was concentrated in more affluent neighborhoods— where more seniors received more help. The volunteers were typically middle aged or older people from the more affluent neighborhoods who preferred to volunteer near their homes (and to avoid poor areas). In general, even in the counties that included poor neighborhoods, the bulk of volunteers and recipients were from middle-class or affluent neighborhoods. In some cases, the administrators knew very little about poor neighborhoods like Elm Flats or Rockport, even though they were under their jurisdiction. This is seen in my interactions with an administrator who handled volunteers for one of the larger counties. When I tried to volunteer in the city that contained Rockport, the administrator (a middle-aged white woman) shrugged and said:

> *We have a lot from [city]. It is difficult to get volunteers, because it is a bad area. I had one woman who would go to [city], but she didn't want to be in Rockport. I don't know the area, or what that means, but she said it is dangerous with lots of gangs.*

Despite repeated attempts, she was never able to assign me a senior from that neighborhood. Unlike the transportation and food programs, seniors in poorer areas often did not even know these auxiliary social programs existed—perhaps, because in practice they did not.

While more basic services like the meal programs made their way into the poor areas, the same was simply not true of the auxiliary services. This was an issue, as the visitors often functioned as a resource for connecting seniors to services or driving them around so they did not have to take the shuttle or bus. Often, volunteers would develop long-term bonds with seniors and provide much more substantial help. For example, one of the volunteers in Baygardens, a white man in his 60's, described his relationship with a senior at a volunteer meeting in the senior center:

> *I told Eve that we were going down to LA. She has my phone number because she calls me to ask for things, or to talk. I told her not to call when I was in LA unless it was an emergency. She called within a day, and I said Eve is this life or death. She began crying and said yes. It turns out she could not get an appointment for a flu shot. [Shrugs] Of course, I made the appointment and took her when we got back. But I could see it being a problem. I also buy her groceries, and take her to the bank.*

While calling the volunteer on the trip may seem somewhat extreme, it was not atypical. These visitors were key figures in the seniors' lives and often provided instrumental services and social support. This is not to say the poor areas did not have volunteers, but the absence of these programs blocked seniors' access to a useful resource. Further, the number of volunteers,

[21] I volunteered at several of these agencies for a number of years and was able to observe their operations.

particularly in the county run senior programs, was much smaller in the poorer neighborhoods. They did not have the same sort of disposable resources as the visitors in the middle class areas. In the poor areas, volunteers were more likely to be involved with religious or ethnic organizations. Many of these organizations operated as service hubs as well, where more educated members (or ex-members) of the neighborhood would connect individuals and families to medical or social programs. However, most did not provide services specifically for seniors, and the majority of their clientele were non-senior families.[22] Consequently, seniors in more affluent areas had access to a wider variety of auxiliary services that provided transportation, companionship, and advocacy than did their counterparts in poor areas.

Unequal Physical Environments: The Case of Housing

The physical environment also differed noticeably between neighborhoods. The stark contrast was evident at the two state administered senior housing units in Baygardens and Rockport. The Baygardens site had manicured foliage, ponds, well maintained public spaces, wide corridors with handles. From the outside, it would be difficult to tell the difference between the housing complex and nearby condominiums. Maintenance tasks were handled quickly by the resident administrator who also facilitated formal events for holidays and provided informal help for seniors. In contrast, the unit at Rockport consisted of large high-rise apartment style buildings. They were poorly maintained and dirty on the outside. They had narrower halls and unreceptive maintenance. From the outside, the building looked like a classic "housing project." The building administrator was rarely on site. The issue here is not aesthetics. Since most of the seniors in this study had problems with mobility, minor differences in the physical environment could create large problems. Uneven walkways or cracks created issues at both sites. This can be seen in the following example. While I was walking with a woman in Baygardens her walker caught on the pavement. She said "see that? It is worse with the other one [walker]. When I take it on the bus it gets stuck in everything." Later she showed me a spot near the housing complex where she fell. She explained, "I did it wrong and I fell." I asked what happened. She said "People here helped me up. This has been a good year though. I haven't had a fall. [Smiles]" She told me she managed to avoid a trip to the hospital, but had a new [alert system] around her neck in case she fell again.

Whether a sidewalk is cracked or a ramp is in place does not signal the degree of social order in a neighborhood, but it does affect the ability of a mobility-impaired senior to walk down the street without falling. [23] Since a single fall can land a senior in a hospital or nursing facility,

[22] The one notable exception was an informal organization that provided services to Latino seniors in Rockport. This organization was run by a local neighborhood group, and was not directly tied to a church, senior center, or service organization. However, despite repeated attempts I was never able to gain entry into this organization— in part due to the fact that my Spanish is poor, and many of the individuals involved spoke no English.

[23] The broken windows model of social disorganization has never held up to ethnographic scrutiny. From Gans, Suttles, and Whyte, to Duneier, Small, and Sanchez-Jankowski, the otherwise combative field of urban ethnography has continuously shown that poor areas have discernible social orders even if the content of these is different from what is found in more affluent settings. The notion that broken windows, graffiti, and other markers of physical disorder somehow reflect an anomic context characterized by social disorder and a lack of social efficacy is based on faulty assumptions (i.e. the aesthetics of a physical environment are a proxy for the social environment). They are also plagued by measurement problems (e.g. the assumption measures of efficacious organizations focus only on organizations that are effective in non-poor areas) See Duneier (2001) and Sanchez Jankowski (2008). I have argued this is part of a more general analytical error whereby critics make assumptions based on aesthetics and

this was a major issue. Seniors in all areas pointed out the difficulties they encountered with cracked sidewalks or buildings requiring them to use stairs. Those who worked with seniors were generally sensitive to this issue as well, and the profound ramifications of having an environment that was easy to navigate— however senior center administrators have little recourse to ensure that streets get repaved.[24] While seniors in all communities developed strategies for dealing with the environment, such as using a walker in uneven but open environments and using a cane in combination with a wall in narrow environments, the more affluent areas in my study generally had roads and sidewalks that were better maintained.[25] Seniors across communities would point out to me spaces where they had fallen, or where other seniors they knew had fallen, and explained that they would try to avoid those spots. However, since the poorer areas generally had more stairs, fewer ramps, more cracks, and often narrower building interiors, these were harder to avoid. This increased their exposure to spots where they could trip, fall, and injure themselves.[26]

Still, seniors who lived in housing units or apartment complexes with concentrations of other seniors were better off than those who lived alone. These environments often had handles and ramps that made navigation easier and safer. They also provided spaces for sociability with other seniors. Having a common room to talk with friends and share information provided seniors in these locations with an advantage in finding out about and procuring resources (e.g. carpooling or having neighbors pick up free food). Many had systems that made contacting medical providers easier. For instance, a white woman living in the Baygardens housing complex told me how much she liked her home, in part because of sociability, but also in part because of safety. On the car ride back from a trip, Jessica commented that she liked her place because it was nice and inexpensive, and she got to see her friends. She added:

> *"I [also] like how my place now has a string." I asked, "A string?" She replied, "Yeah. One near the bed and one near the bathroom. In case you need to go to the hospital. I*

---

decontextualized meanings, rather than examining what happens on the ground. See Abramson and Modzelewski (2011). Still, social life takes place in physical settings, and the allocation of spatial resources is a key aspect of the contexts of aging. Corey M. Abramson, and Darren Modzelewski. "Caged Morality: Moral Worlds, Subculture, and Stratification among Middle-Class Cage-Fighters". *Qualitative Sociology*. 34.1(March 2011): 143-175; Mitchell Duneier. *Sidewalk*. New York: Farrar, Straus and Giroux, 1999; Herbert J Gans.*Urban Villagers: Group and Class in the Life of Italian-Americans*. New York: The Free Press, 1962; Mario Luis Small. *Villa Victoria: The Transformation of Social Capital in a Boston Barrio*. Chicago: University of Chicago Press, 2004; Gerald D. Suttles. *The Social Order of the Slum: Ethnicity and Territory in the Inner City*. Chicago: University of Chicago Press, 1970; William Foote Whyte. *Street Corner Society: The Social Structure of an Italian Slum*. Chicago: University of Chicago Press, 1993.

[24] The director of Baygardens senior center often noted that this was one of the most pressing issues for seniors, which she was especially sensitive to since her previously healthy uncle (who was in his 70's) had fallen, suffered cognitive damage, and was subsequently placed in a nursing facility.

[25] It would be possible to write an entire paper on the way people adapt to the combination of their environment and physiological problems—but the point here is simply that those living in more affluent areas generally have environments that are easier to navigate.

[26] It is important to note that while inequalities in the physical environment affected both the risk of injury and the opportunity to socialize with other seniors, that rarely provided the sort of dramatic life and death differences found in past research conducted in less temperate regions. Summers in Northern California can be warm, but rarely reach the sort of deadly conditions experienced in Chicago. Winters can be chilly and potentially uncomfortable, but people do not freeze to death as in Michigan. See Klinenberg (2002). While these events are rare, the point is they are possible in less temperate regions. See for example: Candiotti, Susan. "Michigan Senior's Freezing Death Preventable, Relative Says." *CNN.com/US*. 4 Feb, 2009. http://edition.cnn.com/2009/US/01/29/michigan.freezing.death/index.html. Eric Klinenberg. *Heat Wave: A Social Autopsy of Disaster in Chicago*. Chicago: University of Chicago Press, 2002.

had to go once, but it was my fault. I let it get bad with my tricholitis, and boy did my stomach hurt."

The proximity and concentration of other seniors facing similar problems, as well as the comparative ease of checking in on a neighbor who is just down the hall as opposed to across the street, also meant that seniors could check on one another more easily. [27]

Entrepreneurial Funding and Inequality

One of the major reasons for the observed differences in the environment and services between poor and non-poor areas was the entrepreneurial structure of grant funding. Both state and federal programs provide large block and categorical grants that can be used for things like housing development or aging services. City level bureaucrats and private organizations can apply for this money. When they win a multi-year grant, they are compelled to spend the money so as to keep their funding levels up. Cedar Hills and Baygardens had numerous non-profit organizations, large and small, that continually won grants. Many worked with city administrators, although the larger non-profits functioned like corporations, and had employees whose sole job was to write grants. These organizations had people with time and expertise dedicated to winning and spending the money. Further, many had experience with previous grants and a successful track record of spending the money. This provided them with legitimacy that made getting subsequent grants much easier. Consequently, the "equal opportunity" of competition funneled money to programs into the middle-class areas which had established organizations (and individuals) that were adept at navigating this funding structure.[28]

In general, the entrepreneurial system of granting resources funneled limited money to the most affluent areas. While this did not thwart basic access to food, housing, or medical care, it did affect the amount and quality of auxiliary services. Senior housing agencies in the affluent areas had more money and organizations to assist with maintenance and repairs. When austerity measures forced the Rockport senior center to drop classes or increase the price, Baygardens was able to keep their programming constant, while using grant funding to add new computer classes and special events. Seniors in Baygardens and Cedar hills were served by an extensive volunteer network that provided not only sociability, but support with transportation. They did this in the context of neighborhoods that were already easier to navigate, and populated by other seniors who had more social, material, and cultural resources than those in the poor areas.

---

[27] Hochschild (1973) presents similar findings in her ethnography of a senior community— seniors being in the presence of other seniors facilitated sociability and engagement. However, since Hochschild's study lacked a comparative axis, it is unclear whether that finding was the result of the specific community she studied. As I show in the section on norms, while in general proximity to other seniors enhanced sociability, the extent to which people helped one another was not just a function of concentration but cultural understandings of when and how much people should help each other. This feature was especially noticeable in the communal settings of nursing homes where many seniors were often tightly packed together. However, as nursing homes essentially form total institutions for those without substantial networks and resources, the dynamics are much more complex. Arlie Russell Hochschild. *The Unexpected Community.* Englewood Cliffs: Prentice-Hall, 1973.

[28] The more informal organizations found in poor areas, such as local church groups, were not as adept at tapping into these funding sources.

Unequal Material Resources: Money, Insurance, and Assets

Although seniors from across communities generally had basic access to basic public services, the services provided were unequal. Likewise, disparities in material resources gave middle-class seniors more options for dealing with aging and health problems. Just as seniors acknowledged that physical assets like health and mobility were central to their quality of life, seniors in all communities acknowledged that those with money "had it easier" when dealing with old age.[29] One senior phrased this common attitude directly when she noted, "If you have money, you know, you have better benefits. Better food, better transportation and a nicer place. It's money." The seniors were correct in acknowledging the continued importance of material resources: money from jobs or pensions, supplemental health insurance, or wealth in the form of a home, substantially affected how seniors were able to deal with the contingencies of aging.

Having insurance affected where seniors could get care. Although all of the seniors over 65 were eligible for Medicare, many of the middle class seniors held jobs that provided auxiliary insurance coverage into retirement; others could afford supplemental insurance out of pocket. The difference between these seniors and those without supplemental insurance was not so much *whether* they could get health care, but *where*. Those without supplemental insurance could go to free clinics, hospitals, or doctors who accepted Medicare. In contrast, those with supplemental insurance had access to a larger number of providers or HMOs. Although many still complained about wait times, these organizations offer better treatment on average than their more public counterparts.[30] The free clinics and emergency rooms were more crowded and had longer waits. Seniors often had to wait in larger rooms with more sick people, where they were at greater risk of catching airborne illnesses. Because of the increased patient load, doctors and nurses spent less time with seniors. Further, although they were generally more affluent, those with supplemental insurance often paid less out of pocket for a given trip to the doctor. A senior from Elm Flats who worked in a high end manual job during his working years noted, "My insurance covers everything, the best policy my union provided. Even the eye-glass, they take about $500-something a year [without insurance]."

Poor seniors were still able to get seen by doctors, get medication, and receive prescriptions for many basic items necessary for everyday life, like walkers, canes, and protein drinks. The very poor who were documented as such also did not have co-pays because of Medicaid coverage. As one senior noted "I'm not proud to say it, but they look at me and they know I don't have a co-pay. I'm the poorest of the poor." However, their care options were substantially more limited. Poor seniors could only go to doctors who were willing to accept state insurance.[31] Further, even when seniors did not want to visit the doctor, they often had to go regularly in order to maintain access to items more affluent seniors could buy without trouble. Since seniors had a hard time affording these items on their own, they were dependent on prescriptions and

[29] This came up almost without variation in interviews when asked if some seniors had it easier than others, as well as in their comparisons with peers in everyday settings. While almost all seniors noted that those with more money "had it easier," the numbers that said race or gender were factors was much smaller.

[30] The fact that more affluent areas are associated with better care is well documented. For reviews see Smeedley et al. (2002) and Fiscella et al. (2002). Kevin Fiscella, Peter Franks, Mark P. Doescher and Barry G. Saver. "Disparities in Health Care by Race, Ethnicity, and Language Among the Insured- Findings from a National Sample." *Medical Care*. 40.1(2002): 52-59.

[31] Those who were proactive in taking care of health and managing illness (e.g. those adopting a "better safe than sorry" or "fix for fun" strategy), would often go to senior clinics or free clinics. Those who did not often waited until a problem required them to go to the emergency department.

referrals from clinicians and social workers. In effect, this made medical providers gatekeepers for resources—"street level bureaucrats" that had authority over whether seniors could get their Ensure, fix a broken walker, or update their eyeglasses.[32] If they were unhappy with the senior, they could create problems for them ranging from a social worker visit, to a longer wait, to misplaced paper work. For instance, the following observations from a trip to the Elm Flats senior clinic with Dave (a poor white senior), provide a representative example.

Dave came out of the exam room and said that although he got his prescription for the protein shakes, he needed to make an appointment with the hand surgeon, the eye doctor, and his regular follow-up. Dave has a hard time standing up for long times and is anxious in social settings. We went back to the waiting room. Dave was waiting for the long line to die down. Two elderly white men, who seemed to be high on something, were talking loudly about herbs, marijuana, and the government. Dave looked afraid and upset noting, "If everyone can hear you, you are imposing on other people's space. It is too loud. They are on drugs and just come here to socialize." Eventually Dave was called to the window and he staggered over. He had already been standing for several minutes and was breathing hard. One of the loud talkers came over and Dave made a "shoo" motion with his cane. The middle-aged African American woman at the window gave him a disgusted look. She took his paperwork without speaking and disappeared for at least five minutes sitting in front of the computer.

Every person before Dave had been speedily processed. She came back and gave Dave a paper and said there you go. He said, he needed to check the date with me. I said it was fine. Dave, who was visibly shaking and breathing hard now said "I am supposed to have three appointments. That one [shows paper], and the one with the eye doctor. They said the hand surgeon would call." The woman nonchalantly said "I don't know about that." Dave said it is on the chart as he went to pull it out of his bag and she said she would check. She went back to the computer. We waited for 10 minutes. Dave said:

> *There is no reason for this. We had all of our things together. Those other people were here for a social call. The woman over there scheduled an eye appointment for someone else already. This is very stressful and there is absolutely no need for it. I can't stand up anymore. I only have that hour and a half window [of energy] and I used it just getting to the doctor. I did everything right, this is not fair. I am going to sit down.*

Dave went to sit down, and the woman continued at the computer. Other patrons were helped—an old African American man with his son, and another African American man who was alone.

Dave finally came back up. He said to me, if they don't come I am going to knock their mail on the floor and start banging. The woman came by, and Dave said "excuse me." She said "I can't hear you." Dave's conditions prevent him from talking loudly, a fact he is embarrassed about. She came over. He said, breathing heavily "I can't talk loudly. Is there an eye appointment?" The woman said "Oh, I thought you left. She then handed him a piece of paper." She smirked. Dave said he was sorry for knocking over her clipboard. I was there the entire time, but she never said anything. Dave noted this "She knew you were my driver." In the car he reiterated how stressed he was, and that this was unnecessary. He had a harder time than normal getting up the stairs to his apartment and asked me to leave because he needed to "recharge his batteries."

---

[32] For a more in depth discussion of how "street level bureaucrats" engage in gate keeping, see Prottas (1979). Jeffrey Manditch Prottas. *People Processing: The Street-Level Bureaucrat in Public Service Bureaucracies*. Lexington: Lexington Books, 1979.

In addition to issues with stress and gate keeping, providers' assessments could have a profound effect on seniors' lives—often determining whether they were left alone in their homes or whether social services checked in on them regularly. Even those seniors who held a favorable view of doctors (which many poor and minority seniors did not), noted that this was a major source of anxiety. Although visiting the doctor was necessary to get essential items like protein shakes and medicine, the resulting surveillance was both undesirable and potentially risky. One senior from Elm Flats articulated this clearly on our way to see an orthopedist. He said that the appointment would be more "low key" than our visit to the free clinic the previous week. I asked why. He responded:

> *You know they [orthopedists] aren't going to send you to the hospital or the nursing home so there isn't much to worry about. If I had remembered earlier, I probably would have cancelled, but it is better to just go. If you don't go, then you start getting calls and people coming out to spy on you, plus the cancellation fee. To be honest though, I would pay $10 to get out of this [laughs]*.

Although nothing came of the appointment, the senior was concerned that failure to attend would get back to his doctor which could have consequences ranging from paperwork hassles to being placed in a nursing facility.[33]

Relying on clinicians and administrators as gatekeepers often created logistical issues for poor seniors. Overloaded doctors and other medical providers often made mistakes which had ramifications for seniors. They misdiagnosed problems and forgot to file paperwork.[34] Their assessments, erroneous or not, determined the extent to which various state agencies became involved in seniors' lives. As the example with Dave above shows, clerks, aides, and bureaucrats at clinics have substantial power, as well. They can make seniors whom they see as creating problems wait or otherwise punish them. While being forced to wait is an inconvenience for a healthy person in middle-age, for seniors with limited energy waiting an extra half hour is not only anxiety producing but potentially dangerous as having less available energy increases their chances of a fall. Several seniors in this study, mostly from poor areas, discussed how medical errors (e.g. getting the wrong medication) led to them being hospitalized.[35] Even when the errors seem minor or are not intentional, they can affect seniors' quality of life and perceptions of health organizations.

In a free clinic in Elm Flats, I observed the following interactions which show how a seemingly minor problem (i.e. an issue with paperwork) created major issues for a senior.
An old white man walked into the area between the waiting room and the exam rooms in the senior clinic. This is where health aides take vitals and do health screening, and where the nurses' station is located. The man approached the nurses' station. The people behind the station avoided eye contact [this is a frequent behavior in nursing homes and clinics involving seniors]. The man slammed down his cane and said loudly, "I'm not going to take this shit anymore. I've been coming here for years. What the fuck do you people do here?" The whole room looked

---

[33] Poor seniors sometimes talked about the importance of "showing the flag," so as to avoid additional contact outside the clinic or hospital. Middle-class seniors on the other hand, did not talk in these terms presumably because their additional resources provided more autonomy.

[34] It is also likely they can make implicit or explicit assumptions about who is really worth helping that affected the way they provided care. See for instance Bosk (2003) and Timmermans (1999). Charles L. Bosk. *Forgive and Remember: Managing Medical Failure.* Chicago: University of Chicago Press, 2003; Stefan. Timmermans. "When Death Isn't Dead: Implicit Social Rationing during Resuscitative Efforts". *Sociological Inquiry*. 69.1(1999): 51-75.

[35] Negative past experiences with health care were also a major factor that affected senior's orientations towards the body, and issue discussed in chapter two.

over, and an aide said calmly "can I help you?" The man explained that the doctor or someone else had not filed the paper that would allow him to get a new battery for his scooter. He said that the doctor promised it was taken care of but the company said they never received the paperwork. "I've been stuck at home for three weeks… Three weeks because someone didn't fill out the fucking form." The aid said he was using inappropriate language and would have to leave if he did not change his tone. She asked if he had checked in at the front. He lowered his tone and said that this is the second time he had been there without seeing someone, and that he has been without morphine for several weeks. He said he was waiting there for over an hour and was not going to wait any longer. He added another expletive, and the aide said that she would pull his chart, but that if he did not adjust his language he would be asked to leave. The man moved with great difficulty over to a chair. He asked is this one OK. She said yes, and he sat down.

To remedy this problem he could not just lay out money for a new battery, but had to go through the clinic and submit to rules and protocols if he were going to receive the service. While this is true for all seniors, particularly those getting narcotic painkillers, poor seniors depended on prescriptions for food or mobility aids, so the problem was more acute. Consequently, what might have been a minor hassle for someone with more resources (e.g. money to lay out for a battery, a family member to drive to the clinic, a health care center that responded to phone calls, etc.) was a major issue. [36]

While richer seniors had organizations and skills that enabled them to advocate for themselves more effectively, poor seniors also had a distrust of service providers.[37] The case of distrusting doctors was discussed extensively in chapter three, but this phenomenon went further. Seniors in poor areas often saw any agent associated with the government or an affiliated organization as a potential threat to their independence.[38] This view is grounded in a reality. Social workers and others who visit seniors must legally report any sign of abuse or neglect— which includes the nebulously defined self-neglect— to adult protective services or other agencies that can intervene, potentially resulting in a senior being placed in a hospital or nursing home (even if the senior feels this is unnecessary). One senior in Elm Flats articulated this dilemma quite clearly. He was initially introduced to me through a contact at a senior program. After he grew to trust me explained his early hesitance:

> *When Sandra [senior program administrator] wanted to set me up with a visitor I was worried. Everyone, I don't know if this is true for you, is a mandatory reporter. They have to report if you are being abused or if 'you are abusing yourself.' All it takes is one do-gooder misunderstanding something and the social worker is over here, and you lose freedom.*

So while many poor seniors relied on government agents and senior organizations to provide essential access to food, shelter, and medical care, they also acknowledged that there was a

[36] Further, if such an error occurred in a more affluent area, the senior would be dealing with a different set of doctors and administrators (who were likely less overwhelmed) and additional cultural skills for navigating the bureaucracy before it came to that point.

[37] This may very well be related to negative experiences with "state agents" and surveillance over the life course. See for instance Goffman (2009) and Wacquant (2009). Alice Goffman. "On the Run: Wanted Men in a Philadelphia Ghetto". *American Sociological Review*. 74.3(2009): 339-357; Loic Wacquant. *Punishing the Poor: The Neoliberal Government of Social Insecurity*. Durham: Duke University Press Books, 2009.

[38] Many were hesitant around me as well until it became clear that I was a "student" rather than a "spy." For an interesting discussion of how research subjects categorize the researcher, see Venkatesh (2002). Sudhir Venkatesh. "`Doin' the Hustle' Constructing the Ethnographer in the American Ghetto". *Ethnography*. 3.1(2002): 91-1121.

component of surveillance that made them uneasy.[39] However, the picture is complex. While government agents posed a potential threat to their freedom, they also provided access to resources seniors wanted or needed. [40]

Having more disposable income also affected seniors' abilities to access other services related to their health. Seniors with arthritis, fibromyalgia, and other conditions characterized by chronic pain often used massages, herbs, or acupuncture to help them manage pain. Although some HMOs and supplemental insurance plans cover these alternative forms of treatment, most paid out of pocket. Medicare did not provide coverage for these treatments. Consequently, more affluent seniors were both more likely to have these forms of treatment covered, and to have money to pay for them if they were not. At the senior center in Rockport, two seniors were discussing the absence of a woman who used to come regularly. She had issues with pain. One of the seniors noted "Lauretta used to get massages from this girl in [city] while she was going to school for that. It really helped her with her pain. Then the woman graduated, and she wanted too much money so she stopped going." In these cases, a lack of money became a major issue as seniors struggled to afford complementary treatment that improved their quality of life. While poor seniors often engaged in more informal exchanges of services, the lack of money and supplemental insurance limited their options for alternative treatments.[41]

Owning a home, an important form of wealth in America, also provided seniors with substantial advantages. Homes allow wealth to be transmitted between generations and are an important source of prestige and "independence" for many Americans.[42] Although the upkeep of a house can be expensive, seniors who owned their homes outright did not have to pay rent. Owning a home also opens additional avenues for generating cash, such as reverse mortgages or equity lines. Finally, having a home allowed seniors an additional resource to set up informal exchanges. For instance, several seniors "rented" out extra rooms or basements in their houses in exchange for some service— home maintenance, grocery shopping, home care, etcetera. This was part of a vast informal economy among seniors in both poor and non-poor areas. Younger, more mobile seniors in particular often performed services for older seniors in exchange for some nominal fee, lodging, food, alcohol, etcetera. Having a home, spare room, or disposable income provided seniors with greater resources to exchange.

Seniors from more affluent families were sometimes able to hire formal helpers. These helpers were often paid for by insurance, family, or the senior's own funds. Having a helper improved seniors' abilities to accomplish everyday tasks. These paid helpers, typically poor minorities and immigrants, often cooked, cleaned, drove, and provided companionship to seniors. Health aides also helped with tasks like bathing, using the restroom, taking medication,

---

[39] Further, a number of seniors in Elm Flats and Rockport had been incarcerated previously, and even more had some form of previous legal problems. This likely added to their hesitancy. In a sense this supports the literature on surveillance in poverty (e.g. Goffman 2009), or at the very least, that service provisions are seen that way by residents.

[40] This notion of the state as simultaneously generative and constraining fits the Foucaultion model of biopower (e.g. Foucault 1980) better than more Marxist conflict oriented models. However, unlike in the Foucaultian model, not only does subjective experience mater, but it affects strategic and calculated action. Michel Foucault. *The History of Sexuality- Volume 1:An Introduction*. New York: Vintage Books, 1980.

[41] On the other hand, seniors in poor areas often had better access to an illicit drug market which provided access to narcotic pain killers. Many also said that marijuana helped with their pain (whether this is simply a justification is impossible to discern). However, having a market creates additional choices which can be problematic— such as whether to keep ones oxycodone or to sell it someone for $100 a bottle on the street.

[42] See Conley (1999). Dalton Conley. *Being Black Living in the Red: Race, Wealth, and Social Policy in America*. Berkeley and Los Angeles: University of California Press, 1999.

and changing medical equipment. Poor seniors were eligible for free or subsidized homecare services if they could demonstrate need, but to do so they had to navigate bureaucracy, provide documentation, and deal with social worker visits on a regular basis. Consequently, many of those who managed to get this help were people who spent much of their lives in the middle-class but now live on a fixed income and had substantial health problems. For example, an African American woman from Cedar Hills had worked in health care and knew that since she used a wheelchair she was eligible for a helper. The home health worker helped around her home, ran errands, and provided companionship. When talking about where she gets her food the senior noted,

> *There are some local stores like [pharmacy] that I can get in and out of with my chair. Mostly my home worker comes in that is with the state or county, she does my major shopping for me or with me.*

Poor seniors often relied on family or informal networks instead of these aides, as did many non-poor seniors, a topic which I discussed in the chapter on social networks. For those without family in the area, however, access to homecare workers made a substantial difference in their ability to get transportation, clean their homes, and get food they liked. For more affluent seniors with family in the area, it meant that the family could outsource some of the basic tasks to reduce their strain.

Not having money also affected seniors' ability to engage in social activities like trips. This was an issue for seniors who had been middle-class for most of their lives, then found themselves without a substantial income as they got older. This isolated them from friends, and created a subjectively difficult situation as they did not have psychological or practical skills for dealing with material scarcity and its stigma. The connection to health may seem less obvious here. However, both subjective and objective isolation are major issues for seniors that affect both quality of life and outcomes. One middle class senior explained the issue:

> *The money thing is something I think about all the time. I don't go out. I don't, once in a while I'll buy a coffee. I don't go to a bar to have a glass of wine anymore. I can't do it. I can't go out for a lunch or go out for a dinner. It's just not within my budget. So when I said a while back there's loneliness, it makes you, um, I can't travel. So I'm stuck at home.*

A white man who owned a home in an affluent area explained:

> *I got to my golden years without enough gold… I still don't have enough money [laughs]. I'm just living on my social security. A very humble existence compared— I had a really good life. My forty years worth of business, you know, I lived very well. But now I live like a poor person. And I hate it. And I don't see any alternative, unfortunately.*

For the people above, and those in their social network, spending money was a key aspect of sociability and their identity more broadly. Lack of money created both a structural barrier for socializing in the manner in which they were accustomed and also a sense of stigma.[43] In contrast, those who had dealt with poverty tended to have social networks and activities that were not premised upon spending money. Hanging around a pool hall, going to church, or babysitting grand children did not require much disposable income. Getting money was a bonus

[43] This issue was compounded for some groups, e.g. white men, whose identities and networks were closely tied to their occupation. For instance, when asked about friends on man noted "My entire life I've had work friends. So now I have no work, I have no friends. Yeah. Horrible. That's another thing I would tell young people, you know, make some friendships outside of work. Make some real friendships, you know? But I've always just been friends with people at work."

for these seniors, but not having substantial disposable income did not isolate them in the same way. [44]

Conclusion

Explaining the relationship between health and inequality in old age requires addressing four interrelated questions: 1.When do different groups of people face the predicaments of old age (i.e. when do their bodies break down)? 2. How do these predicaments manifest in everyday life? 3. In what sort of contexts do different seniors face them? 4. What resources do they bring to bear in the process? Chapter one addressed the first question in explaining that a major link between inequality and health works out before old age is ever reached— the most disadvantaged simply die before they grow old and those that do survive become "old" at a younger chronological age. Chapter two showed that although the onset of old age varies, the breakdown of the body presents convergent predicaments for seniors across demographic categories. Chapter three and four showed that how people respond to these predicaments is a function of cultural motivations, orientations, and understandings that vary between groups according to their past experiences and responses to inequality. This chapter showed how survivors' options are ultimately still constrained by the unequal contexts and resources that shape their options in the present. If culture shapes action by linking past inequality to people's wants, understandings, and strategies in the present, structure mediates what they get.

This chapter showed that while most seniors had access to basic resources like food, transportation, housing, and medicine, middle-class seniors had access to not only substantially more services but services of a higher quality. The entrepreneurial structure of grant funding compounded this problem by funneling competitive resources to the most affluent areas. Likewise, seniors also approached the problems of old age with vastly unequal individual resources for managing health. Pensions, income, insurance, and wealth in the form of a home provided more affluent seniors with avenues of care that were simply not available to their poorer counterparts. Their substantial resources allowed them to access resources from government institutions, without being totally dependent on them. Poor seniors on the other hand were able to get resources but were reliant on state programs. Consequently social workers, clinicians, and other "street level bureaucrats" maintained substantial control over their lives. At the same time, ongoing funding cuts and other austerity measures threatened to erode funding on

[44] Although I cannot advance this argument in its entirety here, I would hypothesize that the poor were better equipped to deal with the psychological elements of the stigma of growing old. The man above was comparatively healthy. He had a house that was paid for and a car. Yet he only talked about aging in terms of loss. He had a hard time dealing with his diminished status as an "old guy" and people who focused on "the wrinkles." Bracketing questions of irony and fairness (i.e. the connotations of such a role reversal), he was extremely depressed and generally suffering. In contrast, a poor African American senior I visited regularly in a nursing home was always smiling. She was placed in a nursing home following a stroke that left her unable to care for herself, yet she continually emphasized how "blessed" she was to have friends, family, and a roof over her head. She told me that she had bad times before and had been poor for much of her life. She added "we may not have always had a lot of money but love is the most important thing." Although objectively her situation could be seen as more dire— she was better equipped culturally and psychologically and consequently was happier.

a local, state, and federal level and consequently diminish services that poor seniors most depended on.[45]

[45] For a more discussion of this "precariousness" see Portacolone (2011b). Elena Portacolone. *Precariousness Among Older Adults Living Alone in San Francisco: An Ethnography*. Diss. University of California, San Francisco, 2011.

Conclusion

Warped ... gland-dry ...
With spine askew
And body shrunken into half its space ...
Well-used as some cracked paving-stone ...
Bearing on his grimed and pitted front
A stamp ... as of innumerable feet. [1]

Who lives to grow old in America and who dies before having the chance is in part a function of social inequality. From our first breath in the hospital to the day we die, we live in a society characterized by unequal opportunities for maintaining health and taking care of ourselves when ill.[2] These opportunities are not allocated in a random way. Rather, they reflect persistent racial, socio-economic, and gender-based inequalities that are central to social stratification in America. As a consequence, some of the most powerful connections between stratification and health play out before old age is ever reached. Many of the most disadvantaged simply die young. The implication is simple but profound: who shall live and who shall die, the most fundamental and visceral of inequalities, depends in part on social position at birth.

While we know that social inequalities produce unequal health outcomes, we know relatively little about *how* this happens, about how key mechanisms, like differences in resources, culture, and social networks work to produce these outcomes in everyday life. Moreover, inequality affects health differently at different phases of life. Examining inequality in old age provides key insights necessary for understanding the relationship between social stratification and the human body over the life course. Further, this is essential practically as America is aging and the aged are becoming more diverse. The baby boomers are retiring. Young Americans are now likely to spend more time caring for the elderly than their children.[3] These trends show no sign of slowing. They reflect a fundamental demographic shift that has the potential to alter how societies function and reproduce themselves.

---

[1] Lola Ridge. "An Old Workman." *New Republic.* 22.285(1920): 380.

[2] As discussed previously, research in sociology, medicine, and epidemiology has continually shown that that ethnic and racial minorities and those of lower socioeconomic status live shorter lives on average, have access to lower quality health care, receive worse treatment for the same conditions, are exposed to higher levels of psychosocial and physical stresses, receive less preventative care, and are more likely to suffer from a host of medical conditions. For a review see chapter one, as well as Adler and Newman (2002), Smeedley et al. (2002) and Spalter-Roth et al. (2005). Nancy E. Adler and Katherine Newman. "Socioeconomic Disparities In Health: Pathways And Policies". *Health Affairs.* 21.2(2002): 60-76; Brian D. Smedley, Adrienne Y. Stith, and Alan R. Nelson. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care.* Ed. I. o. Medicine. Washington, D.C.: National Academies Press, 2002; Roberta Spalter-Roth, Terri Ann Lowenthal, and Mercedes Rubio. "Race Ethnicity, and the Health of Americans." *ASA Series on How Race and Ethnicity Matter*. Ed. R. Spalter-Roth. American Sociological Association, 2005.

[3] For a discussion of this trend and its cultural implications see Abel and Nelson (1990) and Hochschild (2003). Emily K. Abel and Margaret K. Nelson. *Circles of Care: Work and Identity in Women's Lives.* New York: State University of New York Press, 1990; Arlie Russell Hochschild. *The Commercialization of Intimate Life: Notes from Home and Work.* Berkeley: University of California Press, 2003.

In this dissertation, I presented findings, based on three years of comparative ethnographic research in four urban communities and 60 in-depth interviews, which reveal how seniors from different race, class, and gender groups manage growing old in everyday contexts. In doing so I address a number of empirical questions about the relationship between inequality and health in old age: If the relationship between inequality and health works largely by determining who dies before they reach old age, what happens to those who survive? Does inequality increase or dissipate at the end of the life course? Do the key axes of inequality in America (e.g. race, class, gender) stay the same, or do they shift? What specific role do resource disparities, culture, and social networks play in old age? And perhaps most fundamentally, what does this mean in the everyday lives for the growing numbers of seniors? In this conclusion, I review the answers provided by my data and discuss the larger implications for social scientific understandings of the relationship between inequality and the human body.

Key Findings

Research has often shown that being poor and/or socially marginalized results in a shorter life span and more health problems.[4] Consequently, seniors who are subject to poverty and discrimination over the life course often have to face the problems of being "old" at a younger age. As chapter two demonstrates, although the timing of old age varies, men and women from diverse socio-economic, racial, and ethnic backgrounds ultimately have to deal with the "breaking down" and "wearing out" of the human body. Rich or poor, seniors must confront a new phase of life characterized by decreased energy, pain, declining mobility, cognitive slowing, and sensory changes. They face increased health problems, the deaths of friends and family members, the erosion of prized physiological characteristics like beauty, stamina and wit, and ultimately their own mortality. Despite their past differences, the problems of aging lead seniors from diverse backgrounds to the shared realization that being an "old person" becomes the primary force that shapes their lives. They acknowledge that "old age is a whole other animal altogether," because the biological and social predicaments it creates fundamentally change the way they can act in the world. As they recognized that in old age "the body is precious," seniors emphasized the importance of a fact that is often downplayed in theories of social stratification—the human body forms a most basic resource that enables social action and consequently a fundamental element of social systems. Thus, dealing with the aging body is about coming to terms with the decline, scarcity, and uncertainty of physical resources. This is the shared dilemma that all who grow old face.

As in other contexts defined by scarcity, how people respond to their circumstances depends on cultural motivations, orientations, and tools developed over the life course. These aspects of culture, which reflect past experiences (and past inequalities), determine what is seen as a desirable, reasonable, and plausible response to a predicament. As chapter three shows, people's behaviors reflect different *motivations,* such as protecting the body or trying to enjoy life as much as possible before it breaks. While motivations determine the desired ends (i.e. "what people want"), orientations towards health, illness, and medical institutions affect what people see as a *reasonable* way to pursue these ends. For instance, although seniors may share a primary motivation (for example, some want above all to preserve health as long as possible),

[4] See chapter one for a review, as well as Adler and Newman (2002) Smeedley et al. (2002) and Spalter-Roth et al. (2005).

whether they see the body as a machine requiring maintenance or a natural and self-regulating unit, affects what they do when they are in pain (e.g. getting acupuncture or going to a physician to find the source). Various combinations of motivations and orientations form shared *strategies for aging*. These strategies affect how seniors deal with problems even when they have otherwise similar resources, access, and information. In the end, seniors' strategies for relating to the aging body formed four general patterns: "better safe than sorry," "be healthy, but get help if sick," "fix for fun," and "damn the torpedoes (until you are in the ER)."

Beyond their motivations and their strategies, the relationships seniors have with friends, family, and acquaintances profoundly affect how they respond to growing old. In most settings seniors with robust social networks had access to important resources unavailable to their peers. However, as Chapter Four demonstrates, friends, family members, and acquaintances do not mean the same thing for all seniors. Friends can take seniors to the doctor, or they can encourage them to go to the bar instead. Helping neighbors get to the senior center can be doing "what people should do," or it can be seen as a form of economic exchange that only makes sense if it provides present or future benefit. Helping a senior who trips in the lunchroom can be seen as fulfilling an obligation to a community, or disrespecting the foundering individual by highlighting his or her lost independence. Family can provide care and a place to live, or engage in open conflict over finances. Again, relationships can be approached in the context of general reciprocity or exchange. In other words, the effect of social ties cannot be understood outside of the social contexts and cultural schemas that determine how they function.

Even in old age, America remains unequal. Chapter five shows that the spatial and material inequalities that characterize America still constrain seniors' options. Seniors from all neighborhoods relied extensively on a "safety net" based in both government and volunteer services that can provide basic access to food, housing, and medicine. However, those in more affluent areas had access to more services of a higher quality. Further, individual resources continued to matter a great deal. Middle-class seniors typically owned homes, received pensions, had family members who could hire health aides, or maintained supplemental insurance that gave them choices for dealing with everyday problems. Poor seniors, on the other hand, had little choice but to engage with public services at every turn. Getting the month's protein shakes or replacing a scooter's batteries required interacting with state agencies. In addition to problems of resource quality, this provided social workers, clinicians, and other "street level bureaucrats" with substantial control over the everyday lives of seniors. Poor seniors were often able to meet their everyday needs, but had to do so under a more uncertain context of bureaucracy and surveillance.

Implications: Social Stratification, Bodies, and Culture

This dissertation began with a question: *is inequality exacerbated in old age (cumulative disadvantage) or is it mitigated by factors like state intervention, selective mortality, and converging biology (leveling)*? Understanding the scope and scale of inequality in aging and dying is best answered by demographic and epidemiological methods. However, what these methods do not reveal is *how* inequality affects the everyday lives of the aged. Comparative ethnographic methods show how key mechanisms, like biological degeneration, culture, social

networks and material inequalities, structure the day-to-day behaviors and experiences of old age for different demographic groups.[5]

This study demonstrates that the on-the-ground manifestations of these processes are more complex than the "disadvantage vs. leveling" debate suggests. Further, this dichotomy misses much of how inequality shapes everyday life in old age. My data show that seniors of many sorts do face aspects of what might be called "leveling." Their everyday lives converge in ways that are not true for most younger people. Rich or poor, black or white, male or female, in old age people face a shared set of problems such as mobility issues, cognitive changes, decreasing energy, and the loss of people and of capacities central to their identities. Being "old" becomes a structuring aspect of their experiences. In the process, seniors from different backgrounds come to common understandings about what it means to be old. However, the term "leveling" is problematic. It implies that inequality is supplanted with "old age," when in reality "old age" is itself a *de facto* category of inequality. To be old *is* to be disadvantaged in some ways. While seniors may have acquired wealth and experience over their lives, their most basic resource for acting in the world, the body, is dwindling. Old age is not just about access to entitlements that level inequalities from the past, but being forced to confront the decline of the body and the set of challenges and inequalities this creates in the present.

Growing old is not the same for everybody.[6] Although all those who grow old face convergent problems, the timing of these problems and seniors' responses reflect past and present inequalities. First, when the problems of "old age" set in varies. When people must deal with the decreasing physical function or the potential stigma of being "an old lady," mirrors more familiar race and class inequalities. The bodies of those who are socially marginalized "wear out" and "break down" sooner. The poor and certain racial groups, such as African Americans, generally become biologically old at a younger age. Those who spent their working years performing hard physical labor, inhabiting toxic environments, or dealing with the psychosocial stresses of poverty, often face these problems decades sooner—just as they are more likely to die before ever having the opportunity to face them.[7] Likewise, when the problems of aging do appear as illness or health problems, those with more effective social networks, material wealth, private insurance, and education are better able to secure certain outcomes (e.g. seeing a competent doctor, getting a prescription filled, modifying the home environment, getting healthy food, etc.). In this sense, the model of "cumulative disadvantage" is a better fit than the term "leveling." However, this term is also problematic in that it assumes that the factors that stratify people, and consequently what constitutes "disadvantage," are the same across the life-course.[8] What my data suggest is the need to go back to a grounded empirical

[5] It is also worth reiterating a point made in the introduction: while we know a lot about the macro-demographic processes and their associations, systematic ethnographic work on these topics has been sparse, leaving important gaps in our knowledge of how key mechanisms function at the end of life.

[6] For a review see chapters one and four, Abramson and Sanchez-Jankowski (2012), Adler and Newman (2002), Smeedley et al. (2002), Spalter-Roth et al. (2005). Corey M. Abramson and Martín Sánchez-Jankowski. "Racial Differences in Patterns of Having and Using a Doctor Among the Elderly Poor in The United States." *Research in Social Stratification and Mobility.* 30.2(2012): 203–217.

[7] See Adler and Newman (2002) and Dupre (2007). Matthew E. Dupre." Educational Differences in Age-Related Patterns of Disease: Reconsidering the Cumulative Disadvantage and Age-As-Leveler Hypotheses." *Journal of Health and Social Behavior.* 48(2007): 1-15.

[8] For instance, racial stigma is a disadvantage in seeking employment, but past experiences with stigma can provide psychological resources for coping as seniors adjust to their new status as an "old person." In contrast, white men often have a very hard time making this adjustment. This group also has the highest suicide rate of any race, age, and gender category in the US. See Centers for Disease Control and Prevention. *Suicide Rates Among Persons Ages*

focus on categories and resources that characterize inequality. [9] Which categories matter cannot be determined a priori, but can only be seen in the everyday operations of organizations and behaviors of people in real world contexts.

What we see in examining how people from across the social spectrum respond to old age is that race, class, and gender continue to profoundly shape everyday life in old age. However, the body itself is a fundamental resource and aspect of inequality. It is impossible to explain stratification in old age without acknowledging how the body constitutes an unequal resource for action. It does this both through what it signifies (e.g. race/gender/age) and the capacities for action it provides. In old age, the body changes, and previously abundant resources for action become scarce. Consequently, "being old" constitutes a profoundly powerful biological, social, and experiential category that shapes people's lives. As James, one of the seniors in this study more eloquently put it, "old is a whole different animal altogether."

Although looking at old age highlights limitations to our current understandings of the resources and categories that matter in stratification, it begs another question: *why do people with similar resources respond to growing old in radically different ways?* Why does Jane skip her doctor appointments to listen to jazz with "the lost boys"? Why does Ray go on "garlic fasts" instead of taking western medicine? In health research, the standard answer focuses on the distribution of access to material resources across populations and neighborhoods (e.g. money, insurance, or hospitals) and people's possession of information about the consequences of their actions. Yet Jane is college educated, has good insurance, and has easy access to doctors. She knows that going to the bar instead of chemotherapy is likely going to shorten her life. But she explains she would rather enjoy the time she has left. Likewise, Ray knows that he is "supposed" to go to the doctor to get colonoscopies. He has a pension, a house, a car, and insurance. However, his orientations toward seeing the body as natural and self-regulating, and doctors as people who get a lot of money to treat it otherwise, make the garlic fast seem a much more reasonable way to maintain health. So the larger question becomes, can we explain these outcomes without looking to the meanings, motivations, and strategies that constitute culture? This question is empirical rather than rhetorical, and the answer is no.

Accounts of behavior that discount culture cannot adequately explain the examples above, or the broader patterns of behavior they represent. While having access to money, doctors, and healthy food sets the structural contexts in which seniors manage their aging bodies, these factors alone cannot explain why people in the same neighborhood, with the same basic access to resources, respond to growing old in very different ways. [10] Accounts that rely on variation in material resources or information to explain behavioral differences cannot explain how people behave when those factors are held constant. Further, they miss a key pathway connecting past inequalities and present behaviors— culture embodies the unequal social contexts that shape our lives from birth to death. The shared meanings, motivations, and

---

65 Years and Older, by Race/Ethnicity and Sex, United States, 2005–2009. 2012. Available from http://www.cdc.gov/ViolencePrevention/suicide/statistics/rates05.html.

[9] For a brief overview of stratification in America, and a modern formulation of stratification as the distribution of material resources across categories of people, see Massey (2007). For an overview of trends and changes in the last century, see Fischer and Hout (2006). Claude S. Fischer and Mike Hout. *Century of Difference: How America Changed in the Last One Hundred Years*. New York: Russell Sage, 2006.; Douglas S. Massey. *Categorically Unequal: The American Stratification System*. New York: Russell Sage Foundation, 2007.

[10] I have demonstrated this pattern in past quantitative work on the aged, as well. See Abramson (2010) and Abramson and Sanchez-Jankowski (2012). Corey M. Abramson. "Culture, Health, and Latinos in an Aging America. *Las Voces de CLPR*. Spring(2010).

strategies that form culture, direct action in the present by shaping which behaviors people see as desirable, reasonable, and plausible responses to their present circumstances. Put bluntly, culture matters for stratification over the life course because it profoundly affects how people, and the groups they form, act.

Bibliography

Abel, Emily K. and Margaret K. Nelson. *Circles of Care: Work and Identity in Women's Lives.* New York: State University of New York Press, 1990.

Abramson, Corey M. "Who Are the Clients?: Goal Displacement in an Adult Day Care Center for Elders with Dementia." *International Journal of Aging and Human Development* 68.1 (2009): 65-92.

——. "Culture, Health, and Latinos in an Aging America". *Las Voces de CLPR* Spring (2010).

——. "From "Either-Or" to "When and How": A Context-Dependent Model of Culture in Action." *Journal for the Theory of Social Behaviour* 42 (2012): 155-180.

Abramson, Corey M., and Darren Modzelewski. "Caged Morality: Moral Worlds, Subculture, and Stratification among Middle-Class Cage-Fighters." *Qualitative Sociology* 34.1 (March 2011): 143-175.

Abramson, Corey M. and Martín Sánchez-Jankowski. "Racial Differences in Patterns of Having and Using a Doctor Among the Elderly Poor in The United States." *Research in Social Stratification and Mobility* 30 (2012): 203–217.

Adkins, Daniel E. and Steven Vaisey. "Toward a Unified Stratification Theory: Structure, Genome, and Status Across Human Societies." *Sociological Theory* 2.2 (2010): 99-121.

Adler, Nancy E. and Katherine Newman. "Socioeconomic Disparities in Health: Pathways And Policies." *Health Affairs* 21.2 (2002): 60-76.

Ajzen, Icek. "The Theory of Planned Behavior." *Organizational Behavior and Human Decision Processes* 50 (1991): 179-211.

Anderson, Ronald M. "Revisiting the Behavioral Model and Access to Medical Care: Does it Matter?" *Journal of Health and Social Behavior* 36.1 (1995): 1-10.

Antonucci, Toni C., Hiroko Akiyama, and Jennifer E. Lansford. "Negative Effects of Close Social Relations." *Family Relations* 47.4 (1998): 379-384.

Auyero, Javier and Debora Alejandra Swistun. *Flammable: Environmental Suffering in an Argentine Shantytown*. New York: Oxford University Press, 2009.

Bartley, M. *Health Inequality*. Cambridge: Polity Press, 2004.

Berkman, Lisa F. "The Health Divide." *Contexts* 4 (2004): 38-51.

Berkman, Lisa F., Thomas Glass, Ian Brissette, and Teresa E. Seeman. "From Social Integration to Health: Durkheim in the New Millennium." *Social Science and Medicine* 51 (2000): 843-857.

Bosk, Charles L. *Forgive and Remember: Managing Medical Failure.* Chicago: University of Chicago Press, 2003.

Bourdieu, Pierre. *Distinction: A Social Critique of the Judgment of Taste*. Trans. R. Nice. Cambridge: Harvard University Press, 1984.

——. *In Other Words: Essays Toward a Reflexive Sociology.* Stanford: Stanford University Press, 1990a.

——. *The Logic of Practice.* Stanford: Stanford University Press, 1990b.

Breen, Richard and Jan O. Jonsson. "Inequality of Opportunity in Comparative Perspective: Recent Research on Educational Attainment and Social Mobility." *Annual Review of Sociology* 221 (2005): 223-43.

Bursik, Robert and H.G. Grasmick. *Neighborhoods and Crime: The Dimensions of Effective Community Control.* New York, Toronto: Lexington Books, Maxwell Macmillan Canada, Maxwell Macmillan International, 1993.

Candiotti, Susan. "Michigan Senior's Freezing Death Preventable, Relative Says." *CNN.com/US*. 4 Feb, 2009. http://edition.cnn.com/2009/US/01/29/michigan.freezing.death/index.html.

Centers for Disease Control and Prevention, National Center for Health Statistics. *Deaths and Mortality.* 2011. http://www.cdc.gov/nchs/fastats/deaths.htm.

——. *Suicide Rates Among Persons Ages 65 Years and Older, by Race/Ethnicity and Sex, United States, 2005–2009.* 2012. http://www.cdc.gov/ViolencePrevention/suicide/statistics/rates05.html.

Coleman, James. "Social Capital in the Creation of Human Capital." *American Journal of Sociology Supplement* 94 (1988): S95-S120.

Conley, Dalton. *Being Black Living in the Red: Race, Wealth, and Social Policy in America*. Berkeley and Los Angeles: University of California Press, 1999.

Derné, Steve. "Cultural Conceptions of Human Motivation and Their Significance for Culture Theory." *The Sociology of Culture.* Ed. D. Crane. Cambridge: Blackwell, 1994.

Dohan, Daniel. *The Price of Poverty: Money, Work, and Culture in the Mexican American Barrio.* Berkeley: University of California Press, 2003.

Dohan, Daniel and Martin Sanchez-Jankowski. "Using Computers to Analyze Ethnographic Field Data: Theoretical and Practical Considerations." *Annual Review of Sociology* 24 (1998): 477-98.

Dohan, Daniel, Corey M. Abramson, and Susan Miller. "Beyond Text: Using Arrays of Ethnographic Data to Identify Causes and Construct Narratives." *AJS Causal Thinking and Ethnographic Research.* Ed. Mario Smalls, 2012.

Duneier, Mitchell. *Sidewalk*. New York: Farrar, Straus and Giroux, 1999.

Dupre, Matthew E. "Educational Differences in Age-Related Patterns of Disease: Reconsidering the Cumulative Disadvantage and Age-As-Leveler Hypotheses." *Journal of Health and Social Behavior* 48 (2007): 1-15.

Durkheim, Emile. *The Division of Labor in Society.* 1893. New York: The Free Press, 1984.

——. *The Elementary forms of Religious Life*. New York: The Free Press, 1995.

Eliasoph, Nina and Paul Lichterman. "Culture in Interaction." *The American Journal of Sociology* 108 (2003): 735-794.

Entwisle, Barbara, Katherine Faust, Ronal R. Rindfuss, and Toshiko Kaneda. "Networks and Contexts: Variation in the Structure of Social Ties." *American Journal of Sociology* 112.5 (2007): 1495-1533.

Evans, G.W. and S. Saegert. "Residential Crowding in the Context of Inner City Poverty in Theoretical Perspectives". *Environment-Behavior Research*. Ed. S. Wapner, J. Demick and T. Yamamoto. New York: Kluwer Academic/Plenum, 2000.

Farmer, Paul. *Infections and Inequalities: The Modern Plague*. Berkeley: University of California Press, 1999.

Fiscella, Kevin, Peter Franks, Mark P. Doescher and Barry G. Saver. "Disparities in Health Care by Race, Ethnicity, and Language Among the Insured- Findings from a National Sample." *Medical Care* 40.1 (2002): 52-59.

Fischer, Claude S. "Bowling Alone: What's the Score?" *Social Networks* 27 (2005): 155-67.

——. *Made in America: A Social History of American Culture and Character*. Chicago: The University of Chicago Press, 2010.

——. *Still Connected: Family and Friends in America Since 1970.* New York: Russell Sage Foundation, 2011.

Fischer, Claude S. and Mike Hout. *Century of Difference: How America Changed in the Last One Hundred Years.* New York: Russell Sage, 2006.

Fothergill, A., E. G. M. Maestas, and J. D. Darlington. "Race, Ethnicity and Disasters in the United States: A Review of the Literature." *Disasters* 23 (1999): 156–173.

Foucault, Michel. *Discipline and Punish: The Birth of the Prison*. New York: Random House, 1977.

——. *The History of Sexuality-Volume 1: An Introduction*. New York: Vintage Books, 1980.

Freidenberg, Judith Noemí. *Growing Old in El Barrio.* New York: New York University Press, 2005.

Gans, Herbert J. *Urban Villagers: Group and Class in the Life of Italian-Americans*. New York: The Free Press, 1962.

Geertz, Clifford. 1977. "Religion as a Cultural System." *The Interpretation of Cultures: Selected Essays.* New York: Basic Books, 2000.

Giddens, Anthony. *The Constitution of Society: Outline of the Theory of Structuration*. Berkeley: University of California Press, 1984.

Goffman, Alice. "On the Run: Wanted Men in a Philadelphia Ghetto." *American Sociological Review* 74.3 (2009): 339-357.

Goffman, Erving. *Stigma: Notes on the Management of Spoiled Identity.* Englewood Cliffs: Prentice Hall, 1963.

——. *Frame Analysis: An Essay on the Organization of Experience*. Boston: Northeastern Press, 1986.

Granovetter, Mark. "The Strength of Weak Ties: A Network Theory Revisited." *Sociological Theory* 1 (1983): 201-233.

Hedström, Peter and Richard Swedberg. "Social Mechanisms: an Introductory Essay." *Social Mechanisms: An Analytical Approach to Social Theory*. Ed. Peter Hedstrom and Richard Swedberg. Cambridge: Cambridge University Press, 1998. 25.

Hedström, Peter and Petri Ylikoski. "Causal Mechanisms in the Social Sciences." *Annual Review of Sociology* 36 (2010): 49-67.

Herd, Pamela. "Do Functional Health Inequalities Decrease in Old Age?: Educational Status and Functional Decline Among the 1931-1941 Birth Cohort." *Research on Aging* 28.3 (2006): 375-392.

Holliday, Robin. "Aging is No Longer an Unsolved Problem in Biology." *Annals of the New York Academy of Sciences* 1067.1 (2006): 1-9.

Hochschild, Arlie Russell. *The Unexpected Community.* Englewood Cliffs: Prentice-Hall, 1973.

——.*The Commercialization of Intimate Life: Notes from Home and Work.* Berkeley: University of California Press, 2003.

Hooyman, Nancy R. and H. Asuman Kiyak. *Social Gerontology: A Multidisciplinary Perspective*. 7th ed. Boston: Allyn and Bacon, 2005.

House, James S., Paula M. Lantz and Pamela Herd. "Continuity and Change in the Social Stratification of Aging and Health over the Life Course: Evidence from a Nationally Representative Longitudinal Study from 1986 to 2001/2002 (Americans' Changing Lives Study)." *Journal of Gerontology & Psychological Sciences 60 (2005) Special issue 2: 15-26.*

Howard, George et al. "Race, Socioeconomic Status, and Cause-Specific Mortality." *Annals of Epidemiology* 10.4 (May 2000): 214-223.

Hulka, Barbara and John R. Wheat. "Patterns of Utilization: The Patient Perspective." *Medical Care* 23 (1985): 438-460.

Iseki, Hiroyuki et al. *Evaluating Transit Stops and Stations from the Perspective of Transit Users*. Sacramento: California Department of Transportation, 2007.

Jargowsky, P.A. *Poverty and Place: Ghettos, Barrios, and the American City*. New York: Russell Sage Foundation, 1997.

Kastenbaum, Robert J. *Death, Society, and Human Experience*. Allyn & Bacon, 2008.

Keely, George C. et.al. *Uniform Determination of Death Act*. Ed. N. C. o. Commissioners and U. S. Laws, 1981.

Kim, Jinyoung and Richard Miech. "The Black White Difference in Age Trajectories of Functional Health Over the Life Course." *Social Science and Medicine* 68 (2009):717-725.

Kington, R.S. and J. P. Smith. "Socioeconomic Status and Racial and Ethnic Differences in Functional Status Associated with Chronic Diseases." *American Journal of Public Health* 87.5 (1997): 805-810.

Kirby, James B., and Toshiko Kaneda. "Neighborhood Socioeconomic Disadvantage and Access to Health Care." *Journal of Health and Social Behavior* 46 (2005): 5-31.

Klinenberg, Eric. *Heat Wave: A Social Autopsy of Disaster in Chicago*. Chicago: University of Chicago Press, 2002.

Laitin, David D. *Hegemony and Culture: Politics and Religous Change among the Yoruba*. Chicago and London: University of Chicago Press, 1986.

Lamont, Michele. *The Dignity of Working Men: Morality and the Boundaries of Race, Class, and Immigration*. Cambridge: Harvard University Press, 2000.

Lauderdale, Diane S. "Education and Survival: Birth Cohort, Period, and Age Effects." *Demography* 38.4 (2001): 551-561.

Lareau, Annette. *Unequal Childhoods: Class, Race, and Ramily Life.* Berkeley: University of California Press, 2003.

Lee, Helen. "The Role of Local Food Availability in Explaining Obesity Risk Among Young School-Aged Children." *Social Science & Medicine* 74.8 (2012): 1193-1203.

Lewis, Oscar. *Five Families: Mexican Case Studies in the Culture of Poverty*. New York: Basic Books, 1959.

Li, Shu-Chen. "Connecting the Many Levels and Facets of Cognitive Aging." *Current Directions in Psychological Science* 11.1 (2002): 38-43.

Lin, Nan. *Social Capital: A Theory of Social Structure and Action*. Cambridge: Cambridge University Press, 2001.

Link, Bruce G. and Jo Phelan. "Social Conditions as Fundamental Causes of Disease." *Journal of Health and Social Behavior* 35 (1995): 80-94.

Lynch, Scott M.. "Cohort and Life-Course Patterns in the Relationship Between Education and Health: a Hierarchical Approach." *Demography* 40 (2003): 309-331.

——. "Explaining Life Course and Cohort Variation in the Relationship between Education and Health: The Role of Income." *Journal of Health and Social Behavior* 47 (2006): 324-338.

Massey, Douglas S. *Categorically Unequal: The American Stratification System*. New York: Russell Sage Foundation, 2007.

Massey, Douglas S. and Nancy A. Denton. *American Apartheid: Segregation and the Making of the Underclass*. Cambridge: Harvard University Press, 1993.

Mendes, Wendy Berry. "Weakened Links Between Mind and Body in Older Age: The Case for Maturational Dualism in the Experience of Emotion." *Emotion Review* 2.3 (2010): 240-244.

Mintz, Steven. *Huck's Raft: A History of American Childhood*. Cambridge: Belknap Press of Harvard University Press, 2004.

Moody-Ayers, Sandra Y., Kala M. Mehta, Karla Lindquist, Laura Sands, and Kenneth E. Covinsky. “Black–White Disparities in Functional Decline in Older Persons: The Role of Cognitive Function.” *Journal of Gerontology: Medical Sciences* 60.7 (2005): 933-939.

Morgan, Stephen L. and Christopher Winship. *Counterfactuals and Causal Inference: Methods and Principles for Social Research Analytical Methods for Social Research*. New York: Cambridge University Press, 2007.

Mulkay, Michael and John Ernst. “The Changing Position of Social Death.” *European Journal of Sociology* 32 (1991): 172-196.

Murray, C.J.L. et al. “Eight Americas: Investigating Mortality Disparities across Races, Counties, and Race-Counties in the United States.” PLOS Med 3.9 (2006): 1513-1524

Myerhoff, Barbara. *Number Our Days.* New York: Touchstone, 1980.

Neckerman, Kathryn M, ed. *Social Inequality.* New York: Russell Sage, 2004.

Noar, Seth M. and Rick S. Zimmerman. “Health Behavior Theory and Cumulative Knowledge Regarding Health Behaviors: Are We Moving in the Right Direction?” *Health Education Research* 20.3 (2005): 275-90.

Nusbaum, Neil J. “Aging and Sensory Senescence.” *Southern Medical Journal* 92.3 (1999): 267-276.

Palloni, Alberto and Carolina Milesi. "Economic achievement, inequalities and health disparities: The intervening role of early health status.″ *Research in Social Stratification and Mobility* 24 (2006): 21-40

Pampel, Fred C., Patrick M. Krueger, and Justin T. Denney. "Socioeconomic Disparities in Health Behaviors." *Annual Review of Sociology* 36 (2010): 349–70.

Parsons, Talcott. *The Structure of Social Action*. New York: Free Press, 1937.

——. *The Social System*. New York: Free Press, 1951.

Pescosolido, Bernice A. “Beyond Rational Choice: The Social Dynamics of How People Seek Help.” *The American Journal of Sociology* 97.4 (1992): 1096-1138.

Pescosolido, Bernice A. and Sigrum Olafsdottir. “The Cultural Turn in Sociology: Can it Help Us Resolve and Age-Old Problem in Understanding Decision Making for Health Care?” *Sociological Forum* 25.4 (2010): 655-676.

Phelan, Jo C. and Bruce G. Link. “Controlling Disease and Creating Disparities: A Fundamental Cause Perspective.” *Journal of Gerontology* 60 (2005): S27-S33.

Portacolone, Elena. “The Myth of Independence for Older Americans Living Alone in the Bay Area of San Francisco: A Critical Reflection.” *Ageing and Society* 31 (2011a): 803-828.

——. *Precariousness Among Older Adults Living Alone in San Francisco: An Ethnography*. Diss. University of California, San Francisco, 2011b.

Portes, Alejandro. “Social Capital: Its Origins and Applications in Modern Sociology.” *Annual Review of Sociology* 24 (1998): 1-24.

Prottas, Jeffrey Manditch. *People Processing: The Street-Level Bureaucrat in Public Service Bureaucracies*. Lexington: Lexington Books, 1979.

Putnam, Robert D. *Bowling Alone: The Collapse and Revival of American Community*. New York: Simon & Schuster, 2000.

Rattan, Suresh I R.. “Theories of Biological Aging: Genes, Proteins, and Free Radicals.” *Free Radical Research* 40.12 (2006): 1230-1238.

Reid, Carolina and Elizabeth Laderman. “The Untold Costs of Subprime Lending: Examining the Links Among Higher-Priced Lending, Foreclosures and Race in California.” *Community Development Investment Center Working Paper, Federal Reserve Bank of San Francisco* 09 (2009).

Ridge, Lola. “An Old Workman.” *New Republic* 22.285 (1920): 380.

Roberts, Susan B. and Irwin Rosenberg. 2006. “Nutrition and Aging: Changes in the Regulation of Energy Metabolism with Aging.” *American Physiological Review* 86.2 (2006): 651-667.

Rook, Karen. “Positive and Negative Social Exchanges: Weighing Their Effects in Later Life.” *Journal of Gerontology: Social Sciences* 52 (1997): S167-S169.

Ross, Catherine E. and John Mirowsky. “Neighborhood Disadvantage, Disorder, and Health.” *Journal of Health and Social Behavior* 42 (2001): 258-276.

——. "Neighborhood Socioeconomic Status and Health: Context or Composition?" *City and Community* 7 (2008): 163-179.

Salthouse, Timothy A. “What and When of Cognitive Aging.” *Current Directions in Psychological Science* 13.4 (2004): 140-144.

Sampson, Robert. “Neighborhood-level Context and Health: Lessons from Sociology.” *Neighborhoods and Health*. I. Kawachi and L. F. Berkman. Eds. New York: Oxford University Press, 2000.

Sampson, Robert J., Jeffrey D. Morenoff, and Thomas Gannon-Rowley. "Assessing 'Neighborhood Effects': Social Processes and New Directions in Research." *Annual Review of Sociology* 28 (2002): 443-478.

Sampson, Robert J. and Corina Graif. "Neighborhood Social Capital as Differential Social Organization Resident and Leadership Dimensions." *American Behavioral Scientist* 52.11 (2009): 1579-1605.

Sánchez-Jankowski, Martín. *Cracks in the Pavement: Social Change and Resilience in Poor Neighborhoods* Berkeley: University of California Press, 2008.

Sánchez-Jankowski, Martín and Corey M. Abramson. "Direct Observation and Causal Inference: The Function and Practice of Participant Observation in The Positivist-Behavioral Tradition." *AJS Causal Thinking and Ethnographic Research*. Ed. M. Small. Chicago: American Journal of Sociology, 2012.

Sen, Amartya. *Resources, Values, and Development*. Cambridge: Harvard University Press, 1984.

Sewell Jr., William H. "A Theory of Structure: Duality, Agency, and Transformation." *American Journal of Sociology* 98 (1992): 1-29.

Shaw, Mary. "Housing and Public Health." *Annual Review of Public Health* 25.1 (2004): 397-418.

Shim, Janet K. "Cultural Health Capital: A Theoretical Approach to Understanding Health Care Interactions and the Dynamics of Unequal Treatment." *Journal of Health and Social Behavior* 51.1 (2010): 1-15.

Shrestha, Laura B. *Life Expectancy in the United States*. Ed. Congressional Research Service: Library of Congress, 2006.

Shuey, Kim M. and Andrea E. Willson. "Cumulative Disadvantage and Black-White Disparities in Life-Course Health Trajectories." *Research on Aging* 30.2 (2008): 200-225.

Small, Mario Luis. "Culture, Cohorts, and Social Organization Theory: Understanding Local Participation in a Latino Housing Project." *American Journal of Sociology* 108.1 (2002): 1-54.

——. *Villa Victoria: The Transformation of Social Capital in a Boston Barrio*. Chicago: University of Chicago Press, 2004.

——. *Unanticipated Gains: Origins of Network Inequality in Everyday Life*. New York: Oxford University Press, 2009.

Smedley, Brian D., Adrienne Y. Stith, and Alan R. Nelson, eds. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Ed. I. o. Medicine. Washington, D.C.: National Academies Press, 2002.

Smith, Sandra. *Lone Pursuit: Distrust and Defensive Individualism Among the Black Poor*. New York: Russell Sage Foundation, 2007.

——. "A Test of Sincerity: How Black and Latino Service Workers Make Decisions about Making Referrals." *The Annals of the American Academy of Political and Social Sciences* 629 (2010): 30-52.

Smith-Cordery, Robert. "Ethnography, Epistemology, and Counterfactual Causality*." American Journal of Sociology Conference on Causal Thinking and Ethnographic Research*. University of Chicago, 2012.

Spalter-Roth, Roberta, Terri Ann Lowenthal, and Mercedes Rubio. "Race Ethnicity, and the Health of Americans." *ASA Series on How Race and Ethnicity Matter*. Ed. Roberta Spalter-Roth. American Sociological Association. 2005.

Spencer, Martin E. "Weber on Legitimate Norms and Authority." *British Journal of Sociology* 21.2 (1970): 123-134.

Springer, Kristen W. and Dawne M. Mouzon. "'Macho Men' and Preventative Health Care." *Journal of Health and Social Behavior* 52.2 (2011): 212-227.

Sudnow, David. *Passing On: The Social Organization of Dying*. Englewood Cliffs: Prentice Hall, 1967.

Suttles, Gerald D. *The Social Order of the Slum: Ethnicity and Territory in the Inner City*. Chicago: University of Chicago Press, 1970.

Swidler, Ann. "Culture in Action: Symbols and Strategies." *American Sociological Review* 51 (1986): 273-286.

——. *Talk of Love: How Culture Matters*. London and Chicago: University of Chicago Press, 2001.

Thoits, Peggy A. Mechanisms Linking Social Ties and Support to Physical and Mental Health." *Journal of Health and Social Behavior* 52.2 (2011): 145-161.

Timmermans, Stefan. "Resuscitation Technology in the Emergency Department: Towards a Dignified Death." *Sociology of Health & Illness* 20.2 (1998): 144-167.

——. "When Death Isn't Dead: Implicit Social Rationing during Resuscitative Efforts." *Sociological Inquiry* 69.1 (1999): 51-75.

Turner, Bryan S. 1984. *The Body and Society*. New York: Sage, 1997.

U.S. Administration on Aging. *A Profile of Older Americans*. Washington, D.C, 2009.

Vaisey, Stephen. "Motivation and Justification: Towards a Dual-Process Theory of Culture in Action." *American Journal of Sociology* 114 (2009): 1975-1715.

——. "What People Want: Rethinking Poverty, Culture, and Educational Attainment." *Annals of the American Academy of Political and Social Science* 629 (2010): 75-101.

Vaisey, Stephen and Omar Lizardo. "Can Cultural Worldviews Influence Network Composition?" *Social Forces* 88.4 (2010): 1595–1618.

Valentine, Charles A. *Culture and Poverty: Critique and Counterproposals*. Chicago: University of Chicago Press, 1967.

Wacquant, Loïc. "The Pugilistic Point of View: How Boxers Think and Feel About Their Trade." *Theory and Society* 24.4 (1995a): 489-535.

——. "Pugs at Work: Bodily Capital and Bodily Labour Among Professional Boxers". *Body and Society* 1.1 (1995b): 65-93.

——. "Scrutinizing the Street: Poverty, Morality, and the Pitfalls of Urban Ethnography." *American Journal of Sociology* 107.6 (2002): 1468-1532.

——. *Body & Soul: Notebooks of an Apprentice Boxer*. Oxford and New York: Oxford University Press, 2004.

——. "Habitus as Topic and Tool: Reflections on Becoming a Prizefighter". *Ethnographies Revisited.* Ed. W. Shaffir, A. Puddephatt and S. Kleinknecht. New York: Routledge, 2009a.

——. *Punishing the Poor: The Neoliberal Government of Social Insecurity*. Durham: Duke University Press Books, 2009b.

Walker, Renee E., Christopher R. Keane and Jessica G. Burke. "Disparities and Access to Healthy Food in the United States: A Review of Food Deserts Literature." *Health & Place* 16.5 (2010): 876-884.

Weber, Max. "The Social Psychology of the World Religions." *From Max Weber*. Ed H. H. Gerth and C. W. Mills. New York: Oxford University Press, 1946.

——. *Economy and Society.* Berkeley: University of California Press, 1978.

Whyte, William Foote. *Street Corner Society: The Social Structure of an Italian Slum*. Chicago: University of Chicago Press, 1993.

Williams, David R. and Chiquita Collins, "US Socioeconomic and Racial Differences in Health: Patterns and Explanations." *Annual Review of Sociology* 21 (1995):349-386.

——. "Racial Residential Segregation: a Fundamental Cause of Racial Disparities in Health". *Public Health Report* 116.5 (2001): 404-417.

Williams, David R. "The Health of U.S. Racial and Ethnic Populations." *Journal of Gerontology* 60 (2005): S53-S62.

Wilson, Andrea E. and Kim M. Shuey. "Cumulative Advantage Processes as Mechanisms of Inequality in Life Course Health." *American Journal of Sociology* 112.6 (2007): 1886-1924.

Wilson, William Julius. *When Work Disappears: The World of the New Urban Poor*. New York: Vintage Books, 1996.

Venkatesh, Sudhir. "`Doin' the Hustle' Constructing the Ethnographer in the American Ghetto." *Ethnography* 3.1 (2002): 91-1121.

Appendix 1
Sample Interview Schedule

Most of the questions I will ask you are pretty broad and open ended. There are no right or wrong answers, and everything you say is confidential. I am just really interested in your thoughts. I am going to start with some basic questions:

I. Introductory Info/Rapport

- How old are you?
- Where were you born?
- Where do you live now?
    - *How long have you lived there?*
- When you were middle aged, what did you do for a living?
- Are you retired now?
    - *IF YES: Do you ever still work? What do you do?*
    - *IF NO: What do you do now to pay the bills?*
- *Follow-up: Some seniors look at retirement as a chance to move to a new place, maybe with nice weather or fun things to do; other seniors want to stay around the people they've known for years and in their own neighborhoods. How do you feel about that? Why*? *What have you done? Why?*
- Can you walk me through what a typical day looks like for you?
    - *e.g. What sorts of things do you do from the time you wake up until the time you go to bed?*
    - *Let start in the morning when you wake up.*

II. Transition/Thoughts on Aging

- How would you describe what it is like to grow older to someone who is young?
    - *e.g. What should I expect as I get older?*
- What gets harder as you grow older?
- Is there anything that gets easier?
    - *What is it?*
- Are there things young people do not understand about seniors? What about getting older?

III. Navigating as a Senior

- If you need something from the store, how do you get it?
- If you need medicine for the pharmacy, how do you get it?
- If you need to go to the doctor, how do you get there?
- Are there other ways for a senior like yourself to get around?
- Is it easy for a senior to get where he or she needs to go in your community?
    - Ask about your interviewee specifically
- Is your neighborhood safe?
    - *Why or Why not?*
- Do you like your community?

    - *Why or why not?*
- Do you ever have a hard time paying the bills?
- Do you ever have any other trouble with finances or money?
- Has this ever affected the food you bought?
- Have these ever affected getting medical care?

IV. Social Connectedness

Family

- Are you married?
    - Follow-up - *Were you married previously? How long?*
- How often do you see other members of your family?
    - *What do you do when you see one another?*
        - *kids vs. siblings, etc.*
    - *When was the last time you remember seeing a member of your family?*
    - *What did you do?*
- How often do you talk on the telephone?
    - *What do you talk about?*
- Do members of your family ever help you?
    - *How do they help?*
- Do family members have responsibilities towards seniors?
    - *What are they?*

Friends

- How often do you get together with your friends?
    - *What do you do when you see another?*
    - *When was the last time you remember seeing a friend?*
    - *What did you do?*
    - *How did you meet?*
- Do you have a close group of friends?
    - *How did you meet?*
- How often do you talk to friends on the telephone?
    - *What do you talk about?*
- Do your friends ever help you?
    - *How do they help?*
- Do friends have responsibilities towards seniors?
    - *What are they?*

Neighbors

- Do you see your neighbors often?
    - *What do you do when you see another?*
- Do your neighbors ever help you?
    - *How do they help?*
- Do neighbors have responsibilities towards seniors?
    - *What are they?*

Other

- Do you get help from any senior organizations?
- Do you belong to a religious organization like a church mosque or synagogue? Do they help?
- Is there anybody else that helps you?
    - *What about the government?*
- Does the government have responsibilities towards seniors?
    - *What are they?*
    - *What about society in general?*
- ***Some seniors get a lot of help from their grown children; others feel that they should not bother them. How do you feel about that? Why? What have you done? Why?***
- Do you feel seniors are treated well in your community?
    - *Why or Why not?*
- What about in America overall?
- Are some groups of seniors treated better than others?
    - *Can you give me an example?*
- How should seniors be treated?

V. Health Behaviors 1- Everyday Behaviors

- Can you describe what you eat on a typical day?
    - *Breakfast, lunch, dinner*
- Do you ever drink alcohol?
    - *How often?*
    - *Why?*
- Have you been prescribed medications?
    - *For what?*
    - *How often are you supposed to take them?*
    - *How often do you take them?*
    - *IF DISCREPANCY: why?*
- Do you ever take over-the-counter medications? [medications that don't need a doctor's prescription]
    - *For what?*
    - *How often do you take them?*
- Do you ever take prescription medications that were not prescribed for you?
    - *How often?*
    - *Why?*
- Do you ever use vitamins, supplements, alternative, or herbal medicines?
    - *How often?*
    - *Why?*
- Do you ever take other drugs?
    - *How often?*
    - *Why?*
- Would you say you are physically active?
    - *What do you do?*
- How many hours of sleep do you usually get per night?
- Do you ever have trouble falling or staying asleep?

- *Why?*
- *What do you do?*

V. Health Behaviors 2- Care-Seeking Behaviors

- When you don't feel well what do you do?
- When do you decide it is time to see someone else for a health problem?
  - *Who do you usually see?*
- When was the last time you saw someone for a health problem?
  - *Describe?*
  - *How did you know it was time to go in?*
- Have you ever NOT gone for care and regretted it?
  - *Describe*
- Do you have a usual doctor?
  - *How often do you see them?*
  - *Do you have a good relationship?*
- What do you think about doctors in general?
- Do you see any specialists?
  - *How often do you see them?*
- Do you ever see anybody else for health problems?
  - *e.g. massage, acupuncture, cuaradera, neighbor, nurse*
- Have you ever gone to the emergency room?
  - *When was the last time you went?*
  - *Why?*
  - *Did you end up in the hospital*?
- Have you ever been in the hospital?
  - *Why?*
  - *When was the last time?*
  - *What do you think about hospitals in general?*
- Thinking back, what is the best experience you have ever had with a health care provider (doctor clinic, nurse, herbalist, etc.)?
  - *Describe?*
- Thinking back, what is the worst experience you ever had with a health care provider?
  - *Describe?*

More General Attitudes-[code with normative response index code]

- What is a good reason for a senior to go to the doctor
- What is a bad reason?
- Do you know seniors who go to the doctor too often?
  - *Why do you think they do that?*
- Do you know seniors who do not go often enough?
  - *Why don't they go?*
- Have you ever visited a nursing or rest home?
  - *What do you think of them?*
  - *Have you ever been a patient in one?*
    - *What was that like?*
- Is there an appropriate time for a senior to move to a nursing or rest home?

    - *When/Why?*
- Do you have a general philosophy or way of thinking about how to deal with health and illness?

VI. Health Conditions

- How would you describe your overall health?
- Do you have any specific problems or conditions?
    - *How do these affect your everyday life?*
    - *How do you deal with the conditions?*
- Are you ever in pain?
    - *How often?*
    - *How does the pain affect you?*
- Do you ever have problems getting around?
    - *Why?*
    - *How does this affect you?*
- Do you drive a car?
    - *IF YES: Do you ever worry about driving?*
    - *IF NO: Did you have one before?*
        - *Why did you give it up?*
        - *Do you miss it?*
- Do you have a hard time doing things that were physically easier when you were younger?
    - *What are they?*
- Have you ever fallen?
    - *Describe*
- Are you sad often?
    - *How often?*
    - *Why?*
- Do you worry a lot?
    - *What do you worry about?*

VII. Vignettes about "Responsible" Behaviors

- I'm going to give you some examples of things that sometimes happen to seniors, and ask what you think they should do.
- In the last two weeks a senior you know has been bothered by scaly, itchy skin between their toes. The spots are spreading. What should they do?
- A senior you know fell while trying to step into the bathtub last week and he/she is having a harder time moving around than he/she used to. What should he/she do?
- A senior you know has a lump on *their* back that has been there for a month? What should *they* do?
- There is a senior I know who has breast cancer and is getting chemotherapy. Her doctors told her she should not drink alcohol, but all her friends are heavy drinkers. Even after getting chemo-therapy she would go out to bars with her friends to drink. What do you think of this?

VIII. Closing Demographics

- What was the highest degree in school you received?
- How would you describe your religion, if any?
- How would you describe your race or ethnicity?
- Is English your first language?
    - *If no, what is?*
- Thanks again for a great interview. That was really helpful. Is there anything else you would like to add, or anything you feel you did not get a chance to say?
- Thanks so much. Two last questions: One, would you be willing to have me follow up?
- Two, would you be willing to refer me to other seniors?