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Self, Society, and the "New Gerontology"

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The ''new gerontology,'' built on the concept of successful aging, sets forth the preconditions for and the end product of the process of aging successfully. Focused on health and active participation in life, it vests largely within individuals the power to achieve this normatively desirable state. While acknowledging the contributions of the scientific base for Rowe and Kahn's successful aging model, we emphasize the need for a more careful examination of the model itself. Using critical gerontology as a primary filter, we critique this normative vision by focusing on its unarticulated (and perhaps unexplored) values, assumptions, and consequences. We argue that these unexamined features may further harm older people, particularly older women, the poor, and people of color who are already marginalized. We conclude by suggesting forms of resistance to this univocal standard.

Key Words: Critical gerontology, Successful aging, Feminist philosophy

> The primary task of the critic is to analyze the present and to reveal its fractures and instabilities and the ways in which it at once limits us and points to the transgressions of those limits (Bernstein, 1992, p. 162).

One of gerontology's great strengths has been its multidisciplinary perspective. To date, biology and the social sciences have provided the primary filters through which gerontologists have studied aging and old age. These disciplines have deepened our understanding of the processes of aging, contributed to policy and program development, and influenced new generations of gerontologists. In the past several years, a new paradigm has assumed pride of place. Although linguistically similar to (but quite different in content from) earlier work on successful aging (Baltes & Baltes, 1990), this paradigm, firmly grounded in the 10-year, $10 million MacArthur Foundation Study of Successful Aging (Rowe & Kahn, 1997, 1998), is hailed as the "new gerontology." It is part of a larger movement in gerontology and geriatrics—a vigorous emphasis on the potential for and indeed the likelihood of a healthy and engaged old age. This view seeks to counteract and replace the old "decline and loss" paradigm (Unger & Seeman, 1999) that views aging as a series of individual decrements or losses to which both elders and society needed to adapt or adjust (Phillipson, 1998). In contrast, the new gerontology adopts a prevention model—modify individual behaviors throughout your life and so avoid these decrements and losses.

In addition to publishing in academic journals (Rowe, 1997; Rowe & Kahn, 1997), Rowe and Kahn presented their model and a wealth of evidence-based health promotion and disease and disability prevention advice in the form of a book geared at a lay audience (Rowe & Kahn, 1998). In the years since the publication of *Successful Aging*, this volume has attracted an articulate, popular, and professional following. Greeted as a lodestar for moving the field of aging toward a new understanding of what permits effective functioning in old age (Hendricks, 1998) and drawing on the contributions of many leading scientists in the field of aging, *Successful Aging* is perhaps the single most recognized work in recent gerontology. Intended to

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stimulate this wide recognition, the major public relations effort that followed the book's publication and the resulting media attention have deepened its cultural resonance while also influencing the nation's research agenda on aging.

Time and popularity have not, however, erased our concerns about this paradigm and the associated use of the implicitly normative phrase "successful aging." Its very simplicity and apparent clarity mask vital differences and many critical dimensions of what may be described as a liminal state—"the condition of moving from one state to another" (Heilbrun, 1999, p. 35)—under circumstances marked by change and uncertainty. It is thus timely, we believe, to take another look at the new gerontology. In particular, we want to apply to the successful aging paradigm and its popular manifestations critical and feminist perspectives, whose standpoints can unsettle familiar and conventional ways of thinking by revealing their often-unrecognized underlying values and consequences. To be critical means to engage in "historically and socially situated normative reflection about research methodologies, assumptions and directions" (Holstein, 1998, pp. 2–3). Critical practices reformulate the questions that research asks, insist on broad sources of knowledge generation, and urge asking traditional "subjects" normative questions—what ought to be—as a way of uncovering hidden normative possibilities (Holstein, 1998). As interested in the particular as in the general, in understanding as well as generalizing, a critical approach enlarges our perceptions and so calls attention to what more positivist approaches cannot or do not notice.

After offering some historical context and briefly summarizing Rowe and Kahn's new gerontology and the model of successful aging on which it rests, we highlight key features of critical and feminist thinking. Using these filters, we critique the new gerontology and introduce what we believe to be a needed complexity in thinking about the relationships among individual biography, social and cultural norms, and public policy. Although science seeks parsimony, and individuals or groups seek guidance for aging well and for reducing uncertainty, the normative and the unidimensional qualities of successful aging that seemingly offer these ends are also its greatest limits. As a decontextualized scientific discourse, it unconsciously presumes the neutrality of its privileged standpoint, a presumption that we will challenge. As friendly critics, we engage in this interdisciplinary exploration of the new gerontology and its alternatives in the belief that critical and positivistic discourses, to borrow Lyotard's phrase (1984), are not "incommensurable languages." We believe that these discourses can indeed inform one another. Boundary crossing, getting out of line, and inviting heterodox perspectives into one's horizons of knowledge are risky, inviting, and revealing (Meyers, 1997; Ray, 1999).

Among the exciting changes in the past decade or so is the emergence of a multifaceted literature that does exactly what critique must do. It, for example, clarifies meanings of familiar terms and expressions (e.g., Calasanti, 1996), unsettles that which is taken for granted by exposing how it came to be (e.g., Katz, 1996), and introduces conceptual approaches that move us from studying the "problem of old age" to understanding it as narratively complex and open to restorying (e.g., Kenyon & Randall, 1999; Ray, 1999). Other scholarship reveals how the power of unexamined cultural images subtly invades consciousness even when prejudicial to the person internalizing them. From the "mask of ageing" (Featherstone & Hepworth, 1991) to the cult of activity and "busyness" (Cruikshank, 2003; Katz, 2000), many older people try to become what culture signals as desirable without always recognizing where the pressures originate and even if those efforts are ultimately self-defeating.

Time and space considerations, however, have limited the nature and scope of the critical discourses we can bring to bear in our interrogation of the new gerontology. We mention them briefly. Omitted, except tangentially, from our exploration, for example, are the cogent analyses offered by scholars such as Stephen Katz (1996) and Bryan Greene (1993), whose work reminds us that the discursive practices, which inform gerontology, create ideas about and assume authority over old age. Although appealing to Ruth Ray's (1999) concept of transgressive stories, our analysis does not explicitly include other critical work emerging within narrative gerontology (Kenyon, Clark, & de Vries, 2001; Kenyon, Ruth, & Mader, 1999). With scholars who work in narrative gerontology, we believe that rendering aging visible from the inside necessarily humbles positivistic ideas that we can know the "true story of aging" (Kenyon & Randall, 1999, p. 8). We particularly value the open epistemology upon which narrative gerontology rests; accepting many forms of knowing cannot but challenge a singularly voiced notion labeled "successful aging," especially one in which the many-storied lives of older people are not essential sources of knowledge.

For many years, Jaber Gubrium and James Holstein, both separately and together (e.g., Gubrium & Holstein, 1995, 1998; Holstein & Gubrium, 2000), have enlarged our understanding about identity construction and preservation of agency through narrative and everyday theorizing. Despite postmodern challenges to the unity of the self, individuals can possess agency that allows them to use cultural materials in their own way (Gubrium & Holstein, 1995). "Successful" and "unsuccessful" then become rubrics to interpret, organize, and give meaning to experience. Finally, and while drawing on some feminist scholarship, particularly feminist philosophy, we cannot begin to do justice to the many contributions of diverse streams within feminism that have enriched our understanding of gender

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and aging (Browne, 1997; Calasanti & Slevin, 2001; Dressel, Minkler, & Yen, 1999).

In sum, this article cannot, and is not intended to, offer an exhaustive treatment of the many critiques that can contribute to reexamining the new successful aging paradigm. Rather, its objective is to use selected contributions within the broad field of critical gerontology and feminist philosophy, along with our own observations, to contribute to and further the growing critical dialogue about the new gerontology and its implications.

Successful Aging and the New Gerontology

Ironically, the new gerontology has much in common with the century-old Victorian view of successful aging in which good health signaled a life lived according to the strict dictates of Victorian convention. Albeit without today's scientific foundation and inclined to view "vices," such as vigorous sexual activity, as the cause of an unhealthy old age, it still distinguished between positive and negative experiences of aging rooted in individual action over a lifetime (see Cole, 1992). Even in the 19th century, America scientists "sought a 'normal' old age that contained an unstated ideal of health or maximum functioning—the 'good' old age of Victorian morality" (Cole, 1992).

For many years, the modern gerontological enterprise similarly has sought to understand what can make old age better—healthier, financially more secure, and a period of fulfillment and even growth. In the classic edited work, *Problems of Aging*, published in 1937, Edmund Cowdry invited a stellar group of scientists to bring to the multifaceted problem of aging an "understanding of how things worked" from the perspective of several scientific disciplines (quoted in Achenbaum, 1995, p. 67). In the years since the publication of this first handbook on aging, we have come a long way toward understanding what that early volume called the "problem of senescence." With improved economic conditions, positive changes in physical and often social environments, and improvements in health care and health care access, many more—though certainly not all—older people can have a relatively satisfactory old age. Since the early 1980s, declining poverty and the mitigation of many diseases of old age have facilitated interest in health promotion and wellness and have contributed to richer, more open perceptions about old age (Bernard, 2000; Schmidt, 1994).

The new gerontology is in this tradition. It describes, in detail and with carefully documented scientific support, how individuals can contribute to their continued good health. In this way it provides younger people with an important message about making choices (albeit, as we will discuss, without sufficient attention to the contexts and constraints influencing those choices). Commenting on the impressive scientific grounding of the successful aging model, Scheidt, Humphreys, and Yorgason (1999) noted that "at least a hundred studies have shown the efficacy of modifications to environmental and lifestyle factors for increasing the likelihood that older individuals might achieve success under this triarchic definition. So what's not to like?" (p. 277). We will return to that question after briefly reviewing the premises of successful aging.

Rowe and Kahn (1998) argued that three conditions or characteristics are necessary preconditions for successful aging: (a) the avoidance of disease and disability; (b) the maintenance of high physical and cognitive functional capacity; and (c) "active engagement in life." They further suggested that these three components are hierarchically ordered:

> The absence of disease and disability makes it easier to maintain mental and physical function. And maintenance of mental and physical function in turn enables (but does not guarantee) active engagement with life. It is the *combination* [emphasis in the original] of all three—avoidance of disease and disability, maintenance of cognitive and physical function and sustained engagement with life—that *represents the concept of successful aging most fully* [italics added]. (p. 39)

While Rowe and Kahn have refined their model over the years (1997, 1998; also see Rowe, 1997), reaffirming more strongly, for example, an emphasis on the importance of "active engagement with life," the instrumental or preconditions for successful aging have become transformed, as the aforementioned quote suggests, into the concept itself. In a few short years, this model has become a central theoretical paradigm within the fields of geriatrics and gerontology. Despite its many strengths and contributions, however, the successful aging model and its attendant publicity are problematic. Following a brief review of the critical gerontology framework, we will use these perspectives as lenses through which to more critically examine successful aging and the new gerontology.

A Critical Conceptual Framework

As an amalgam of different approaches to thinking about aging and old age (Cole, Achenbaum, Jakobi, & Kastenbaum, 1993; Katz, 1996; Laws, 1995; Minkler, 1996; Minkler & Estes, 1999; Phillipson, 1998), critical gerontology asks questions such as these: Who benefits and who is harmed by prevailing culturally normative standards? Why does that particular pattern prevail? From its more philosophical stream (Moody, 1988; Manheimer, 2000), it asks: How can we age well? What is a good life? It questions the seemingly unreflexive ways in which gerontological knowledge is created (Katz, 1996) while seeking involved, critical, and overtly political research strategies (Ray, 1999).

Why we age as we do and how we might expe-

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rience a happier, healthier, and satisfying old age will always be questions in search of answers. How these questions are framed, what sources of knowledge are accepted in seeking answers, and what answers are considered satisfactory demarcates critical from positivistic approaches to studying aging and old age. In the tradition of deconstructionism, a critical perspective probes the new gerontology for its contradictions and unstated assumptions that might otherwise go unnoticed.

It locates within nonscientific forms of knowing, such as literature, philosophy, and personal narrative or lived experience, important insights that traditional research methods are likely to miss (see Cole, Kastenbaum, & Ray, 2000; Woodward, 1991, 1999). "How it is for me" opens narrative possibilities that trade the ability to generalize about old age for increased understanding and reduced risk of a false universality.

This critical perspective recognizes that, to understand the problems of old age, we must also understand the effects of gender, class, and race analyses (Calasanti & Slevin, 2001; Cruikshank, 2003) to which earlier work in the political economy of aging called attention (see Cole, 1992; Estes, 1979; Minkler & Estes, 1999; Moody, 1988; Phillipson, 1998; Townsend, 1981; Walker, 1981). In contrast to constructions that singularly or primarily emphasized individual responsibility for health, these alternative formulations insisted that at least equal attention be paid to individual "response-ability," or "the capacity of individuals for building on their strengths and meeting the challenges posed by the environment" (Minkler, 1999, p. 124). Individual response-ability depends heavily on such factors as having an adequate income, access to affordable and nutritional food, a healthy and safe neighborhood in which to live, and affordable, good-quality health care (Minkler, 1999). In this way it calls attention to the lifelong inequalities that might, in Rowe and Kahn's (1998) imagery, play a key role in placing one elderly person on cross-country skis and another in a wheelchair. While the new gerontology acknowledges that we cannot be solely responsible for how we age, it then sets aside the many factors that intimately interact with our individual biographies, the core subject with which it is concerned. In the end, because critical gerontology assumes that it is difficult to imagine "*any* way of life which is both ideal and feasible" (Putnam, 1978, p. 87), it is suspicious of a formula that seems to promise both—and places it largely within individual control.

As a further limitation on individual control, feminist philosopher Diana Meyers (1989) reminds us that choices—including the food we eat and the exercise we do or do not do—rest on the preconditions that make such choices both informed and possible. Making autonomous choices requires a wide range of experiences and knowledge and the ability to put these resources to work. These underlying resources are not equally available. Labeled "autonomy competence," this perspective helps to explain how rampant inequalities, differing life experiences, and the oppressive social and economic situations that give some many more choices than others affect the possibilities for autonomous choice. Philosopher Martha Nussbaum (1999), in discussing the capabilities approach to human development, powerfully argued that societies are morally obligated to move all citizens above a certain basic threshold of capability. Without this foundation present, the ability to age successfully, as defined by Rowe and Kahn, is dependent on chance and social location.

The particular lens of gender also reminds us that our bodies are more than the location of illness and health; they are the interface between public and private worlds of meaning. Our bodies can liberate us as well as circumscribe our actions and elicit judgments that can harm us in that "between and betwixt" (Heilbrun, 1999) condition of old age. Because we are known through our bodies, to affirm that they are "not us," places a barrier between us and the world (Gadow, 1983). We may no longer want to be in the company of others as we expect that our bodies will lead others to judge us. It is now common, for example, to describe an older woman who has wrinkles and some flab as "letting herself go" without taking into account not only gravitational forces but the point of privilege from which we look at that woman. Poverty, widowhood, caregiving, and other life events that primarily affect women all take their toll (Cruikshank, 2003). A gender analysis would thus take issue with blaming language and the meanings embedded within it; it would have us critically examine the new gerontology's tendency to put further demands on older women without taking their biography or context sufficiently into account. Similarly, for men who have held low-wage and often demeaning jobs, the pressures to conform to the bodily images and health standards upheld by the new gerontology are yet another form of oppression unnoticed by the more privileged. Hence, a gender analysis would acknowledge that gender, like race or ethnicity, class, and sexual orientation, is part of broader "interlocking systems of inequality" (Dressel et al., 1999; Stoller & Gibson, 2000). Thus, gender would further be considered in a more inclusive and intersectional framework within which the lived experience of, for example, low-income African American men would be highlighted.

A final perspective achieving growing popularity among critical gerontologists that is promising for our interrogation of concepts such as successful aging, is that of community-based participatory research (CBPR). An orientation to research more than a research method per se, CBPR begins with a topic of importance to a community or group and equitably involves all partners in the research process, including the critical final phase of social action to help bring

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about change (Israel, Schulz, Parker, & Becker, 1998; Minkler & Wallerstein, 2003). Together with related participatory research traditions, this approach "'turns on its head' the more traditional research paradigm in which the outside researcher largely determines the questions asked, the tools employed, the interventions developed, and the kinds of results documented and valued" (Minkler & Wallerstein, 2003, p. 4; also see Gaventa, 1993). Such research also is committed to using study findings to promote social change as an integral part of the research process.

Although CBPR in gerontology is still in its infancy, its potential has been demonstrated both internationally and in the United States (Fadem et al., 2003; Glanz & Neikrug, 1997. Together with feminist analysis and other critical gerontology perspectives, it offers special promise for examining the successful aging paradigm and its meaning for elders and society alike. It affirms that statements of value are too important to be detached from the voices for and about whom they presume to speak.

These perspectives suggest, in contrast to the relatively parsimonious goals of modern science, the likelihood of disharmony, ambiguity, and uncertainty; these features are not seen as paralyzing but as challenges that reflect late life's complexities. And perhaps, above all, such views hold that although well-constructed scientific experiments can provide much needed information about what we must do (if we are able) to have a relatively healthy old age, it cannot tell us what makes that life a good one. Labeling the *pathways* to better health in old age *as* successful aging is too great a leap from a critical perspective.

Applying These Perspectives to the New Gerontology

The Issue of Normativity

Because critical perspectives are concerned about hidden value premises, we turn to the new gerontology's implicit (and thus unacknowledged) normativity. Understood as an objective, scientific discourse, the new gerontology upholds a certain status, defined primarily in terms of health, and labels those who exemplify these standards as aging successfully. This stance affirms normative value commitments, offering ways to think about—and judge—our choices (now and in the past), actions, and their results.

Historians, literary scholars, sociologists, and philosophers, among others (see Cole, 1988; Gubrium & Wallace, 1990; Harper, 1997; Mackenzie, 2000; Meyers, 1994), suggest reasons why cultural norms matter. Cultural images, representations, symbols, and metaphors are important means to withhold or to express social recognition; they offer the cultural imagery from which we construct identities (Mackenzie, 2000). Central to this understanding are notions of the self. Mediating between individuals and their environment, the self is a "biographically anchored and reflexive project," realized in conversations with others and oneself (Dannefer, 2000, p. 272). Norms matter because we are situated selves, embedded in society and culture and resonating with what is valued in the environment. Although resistance is possible, indeed probable, as situated selves, we can rarely ignore cultural norms in the construction of a self. Nor are we able to easily dissent, as individuals, from culture. The theologian Rosemary Reuther observed, "alternate cultures and communities must be built up to support the dissenting consciousness" (quoted in Heilbrun, 1999, from Mairs, 1994). To date, alternative perspectives tend to be ghettoized while the dominant culture accepts as the desired norm the tanned, vigorous couple who are bicycle riding on gently rolling hills and dining in the warm glow of candles.

Even if we put aside the publicity the new gerontology has received, and the strong scientific base of the MacArthur Foundation Study, it is not surprising that the new paradigm has gained popular approbation. Success, a valued attribute in American society, is generally visible and measurable, perhaps countable in dollars, degrees, gold medals, and so on. Evidence of success is commendable, to the individual's credit, and therefore praiseworthy. The new gerontology offers another measurable variable to define success, another source of praiseworthy behavior that has currency in a competitive society.

However, normative terms such as successful aging are not neutral; they are laden with comparative, either-or, hierarchically ordered dimensions. Unfortunately, too many people—most often the already marginalized—come up on the wrong side of the hierarchy and the either–or divide. Its reductionist qualities are revealed by a different sort of comparison: How would it seem to describe a particular kind of childhood or midlife—as such—as successful because the person rarely became ill and participated in many social events? Why then is it is desirable to describe this kind of aging (or more accurately, old age) as successful?

Even if we bracket for a moment our reluctance to apply the term "successful" to aging, the specific norms the new gerontology identifies as measures of success are also problematic. As we discuss in more detail in the paragraphs that follow, if how we live determines how we age, and if how we live is shaped by many factors beyond individual choice, then success is far harder to come by for some than for others.

Hence, because normative concepts are important, dominant cultural images can easily make individual efforts to transform themselves as their lives and bodies change more difficult (Mackenzie, 2000). These concepts tell us what is worthwhile (on different levels of our lives) and give us criteria by which to evaluate our lives. Thus, the power to identify such normative

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concepts is pivotal. For this reason, in particular, the authority to create cultural views and images about aging can only rest in an interactive research process, and in a critical awareness of how context and particularities influence how we grow old and what we value once we get there. Exchanges between older people and academic researchers, for example, are unlikely to accept uncritically that a disease-resistant 80-year-old man playing golf at Augusta or skiing at Aspen is aging more successfully than a woman in a wheelchair who tutors inner city children or writes poetry or feels a passionate energy that she is too fragile to enact (Maxwell, 1968).

Health, as a normative standard, calls for certain virtues—diligence, caution, and perhaps a touch of solipsism. We must be ever wary of how we govern our lives. This view omits the natural lottery imposed by genetics, the general contingencies of human life, and the more specific damages (and often strengths) that marginalization and oppression bequeath to many individuals.

In raising these concerns about normativity, we are not suggesting that Rowe and Kahn intended to launch what can appear to be a coercive standard that affects individuals and groups in different and, in some cases, potentially damaging ways (see the paragraphs that follow). In an interesting irony, had Rowe and Kahn not labeled their landmark work as "successful aging," it may well have remained what it in essence is—a careful, empirically grounded account of how to help individuals stay as healthy as possible for as long as possible. On this foundation, they would be free, within inevitable limits, to construct the kind of life they choose. The use of the term "successful," however, shifts that intention to help people stay as well as possible to something much larger. What was initially affirmed as the preconditions for effective functioning in old age—the *foundation* on which many varieties of life choices may flourish—in an almost imperceptible move became the concept of successful aging. The foundation became the entirety. The concept does not say, These are guidelines to preserve your health and well-being in old age, all things being equal. Although such a statement gives health a high status, it does not equate good health with success. Eating properly, exercising regularly, and not smoking are connected directly to a goal of good health, a goal that, we suspect, most would treasure. However, we suggest throughout this essay, despite its wide appeal, attaining a healthy old age on the individual level should not be universally equated with the attainment of a good or successful old age.

The "Problems" of Feasibility and Disability

Although our discussion raises broad questions about why both the phrase "successful aging," and the model bearing that name are problematic from a normative standpoint, there are other, more specific concerns that challenge its acceptability as an ideal. A major contribution of Rowe and Kahn's paradigm lay in its message that many of the losses associated with "usual aging" are not "normal" aspects of aging at all but are caused primarily by extrinsic factors, such as poor diet and lack of exercise, and therefore are subject to alteration. However, the value of this message from a health promotion perspective is tempered by another, as the authors go on to suggest that "successful aging is dependent upon individual choices and behaviors. *It can be attained through individual choice and effort* [italics added]" (Rowe & Kahn, 1998, p. 37). The single endpoint is effective physical and mental functioning. In Rowe and Kahn's (1998) words: "We were trying to pinpoint the many factors that conspire to put one octogenarian on cross-country skis and another in a wheelchair" (p. xii).

Such a statement is problematic on several counts; key among them is its implication that had the elder who is disabled but tried harder and made different (health-promoting) choices, he or she might also be enjoying a physically vigorous and able-bodied old age. This individualistic analysis doesn't ask if the 80-year-old skier had county club privileges and a winter home in Colorado, or the 80-year-old in the wheelchair had cleaned houses for a living while holding down a second job as a nurses' aide on the graveyard shift in a nursing home. Nor does this analysis inquire about the inner or family life of our 80-year-old in the wheelchair. These contextual features, at a minimum, shape the conditions of possibility for individuals and determine how they choose what to value. If the ideal is not practically feasible for all, or even most, people—even with the best intentions—then it serves to further privilege the already privileged, a danger that a feminist perspective identifies.

The "problem" of disability also looms. Within the successful aging paradigm, and with a few notable exceptions, disability, even visible "oldness," signifies failure or, at best, "usual" aging. "With midlife the universal ideal, older people meet the stringent criteria of successful aging only insofar as they are not 'old.' If the young body is . . . projected into old age as the norm" (Harper, 1997, p. 167), all will ultimately fail. This end is particularly troubling. When norms consider frailty and disability as reflections of failure, they reinforce "cultural fears of bodily suffering (and thus of people who are 'old') and [promote] inadequate policy responses" at the same time that they blame people whose bodies are proverbially "out of control" (Kennedy & Minkler, 1999; Morell, 2003; Wendell, 1996). As was the case with its Victorian era predecessors (Cole, 1988), illness, especially because it prevents "active engagement with life," becomes a transgression of cultural rules (Herskovits & Mitteness, 1994).

This exaggerated emphasis on the degree to which we can control the body contributes to and denies

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older people with functional limitations, most of whom are women, the dignity of their struggle to accept what they cannot change. On a broader level, it contributes as well to the cultural denial of disability, dependency, and ultimately death. That struggle, social ethicist Frida Furman (1997) says, ''is a struggle of the soul to affirm what is yet possible, to let go of what is not'' (p. 102).

Similarly, the ''new ageism'' inadvertently promoted though the skis versus wheelchair analogy simply replaces an earlier generalized dread of aging with a more specific fear of aging with a disability (Cohen, 1988). Frequently internalized by older people themselves, this new variant of ageism ironically can mitigate against the very proactive health promotion and healthy maintenance activities advocated by proponents of successful aging by ''substantially lowering the bar of dreams and expectations for and by elders with disabilities'' (Minkler & Fadem, 2002, p. 231). Looking old and suffering from disabling conditions become personal failures, thereby compounding the ''problem'' of aging and contributing to often self-defeating strategies to preserve ''youthfulness'' and so appear ''not old'' (Calasanti & Slevin, 2001).

Once an individual strategy—staying fit and vigorous—becomes a societal vision, then ''whole social groups and areas of life become marginalized'' (Blaikie, 1999, p. 109). As already noted, such marginalization can elicit damaging and invidious comparisons, particularly if one is disabled, or simply old and ''not well preserved.'' As Blaikie (1999) has argued, the ''constant quest for youth, in stigmatizing [sic] the old and sick, casts off these people as human failures'' (p. 109).

Devaluing of Women's Roles and Acts of Resistance

The cultural scripts that the new gerontology extols particularly affect older women. The greater burden of chronic illness and functional limitations they experience and their far higher poverty rates couple with differential societal norms that continue to assign a higher value to physical appearance and ''youthful physical attractiveness'' among women. However, many women have lived by the norms of their own more intimate society, being responsible for others and attending to the everyday business of life, whether that meant scrubbing floors or caring for a dying parent or a grandchild. These features that mark many a woman's moral life neither gain approbation from the wider society nor give her the leisure to tend to the specifics of health maintenance that contribute to successful aging by the criterion that Rowe and Kahn set forth. Hence, as life course and political economy perspectives remind us, the burden on older women—especially women who live on limited incomes and have experienced exclusions based on color, ethnicity, or class—is often particularly heavy.

The new gerontology can render invisible important adaptive and other actions that allow people to cope with change (see Baltes & Carstensen, 1996). Many people, for example, particularly older women, with their less than perfect bodies and with one or more chronic illnesses, confront cultural narratives of decline on their own terms (Furman, 1997; Gullette, 1997). Rarely noted and seldom valued even if noticed, their acts of resistance—''going gray,'' choosing to live a simpler, less busy life (Katz, 2000), taking the time to give concentrated care to a parent, a spouse, or a grandchild, accepting ''old'' as a way to describe oneself (Calasanti & Slevin, 2001)—are less a bulwark against the loss of self-esteem than they might be if different cultural norms prevailed. Successful aging, for example, only tangentially—through its attention to active engagement with life—attends to aspects of the moral life such as nurturing, caring, friendship, love, and social activism that have been primary in the lives of many women. Such aspects of life that are publicly underestimated and undervalued become vulnerable as sources of self-worth if they lack sustenance and recognition (Flanagan, 1991). Instead of creating conditions that lessen important aspects of women's lives, does society not have a responsibility to ''examine, evaluate, condemn, and change . . . expectations . . . that harm some, and militate against the well-being of all, women?'' (Furman, 1997, p. 95).

Potential Problems for Policy

In the policy arena, the notion that health and well-being in old age are largely in the hands of individuals can do further damage. Ironically, we are successfully old when we conform to society's needs; placing responsibility on the individual mitigates demands on social resources across our lives. Exceptionalism—''I made it, why can't you''—is, in our minds, a failing strategy. It does nothing to eliminate larger patterns of oppression, in which certain individuals and groups lack the advantages privileged groups possess by virtue of their social location (Calasanti, 1996). When the tasks essential to aging successfully are vested in the individual aging person, the young and the middle-aged hear about these splendid people who have aged so well and wonder why all the fuss about old age in America. Policies promoting increased Medicare coverage for home modifications and assistive devices, as well as increased Supplemental Social Security Income payments that would bring elderly and disabled recipients above the poverty line, may well suffer at the hands of a populace and a legislature that has bought the stereotypes of a new breed of successfully aging seniors who no longer need much in the way of government support. Particularly in the current

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political climate of major government cutbacks in the face of economic downturns and military buildups, overly optimistic images of ''successful agers'' may make even more vulnerable the position of many older women for whom more, rather than less, government assistance is vital.

The new gerontology can hinder the development of a thoughtful and morally rich account of dependency and interdependency (see Kittay, 1999, and Robertson, 1999, for two important attempts to do so). The often implicit singling out of disabled elderly persons as unsuccessful agers also allows us to evade the inevitable confrontation with sickness and death. In this way, it may further diminish policy attention to the need for greater engagement with these issues in a rapidly aging society.

Boundary Crossing

A critical perspective does not end with study. It is committed to remedying the underlying conditions that place certain people at the margins. By clarifying the moral and political legitimacy of the changes necessary to remedy these conditions, it contributes to the possibilities for change. From the ''ground'' it would urge radical revisioning of what is important in old age—for individuals, for the relationships in which they are a part, and for the larger social structures. Such activism would challenge the hegemonic voice of the new gerontology, whose narrow focus on what individuals can do for themselves fails to address the broader social context that inevitably influences how older people experience old age.

Ruth Ray (1999) suggested transgressive storytelling that encourages women to move beyond the circumscribed narrative conventions that tell them what their stories ought to be about. Women, through these stories, can redefine problems, elevate new problems, or include previously excluded forms of knowing. Such narratives can give license to heterodox perceptions—the ''aha'' phenomenon of seeing a problem differently—that contribute to redefining familiar situations and hence opening the possibilities for action. Domestic violence, for example, was long ignored in the name of privacy until women (and others) deconstructed the public–private dichotomy and redefined acceptable behaviors between men and women (Rosen, 2000). To recall Rosemary Reuther's words quoted earlier: ''Alternate cultures and communities must be built up to support the dissenting consciousness'' (quoted in Heilbrun, 1999 from Mairs, 1994).

Valuing the processes through which such redefinitions may emerge would require greater attention to qualitative research methods that give voice to older women's views of a good old age, and to the implications of concepts such as successful aging. Such valuing would further support participatory research in which older people themselves determine the issues to be investigated and serve as valued partners throughout the research process—including, importantly, the action phase so often omitted from more traditional research approaches. As Glanz and Neikrug (1997, p. 826), suggested, ''When seniors themselves begin to 'tinker' with social gerontology's theories and ideas as a result of conducting their own research, we may discover that 'the graying of social gerontology' is just what we needed to help find new paradigms for understanding aging in the 21st century.''

Conclusion

Growing old in a society that not only valorizes youth but informs people *whoever they are* that successful aging—defined almost exclusively in terms of health status—''can be attained through individual choice and effort'' (Rowe & Kahn, 1998, p. 37) is potentially damaging personally and politically. Such a perspective tends to trivialize the role of gender, race, socioeconomic status, and genetics in influencing both health and broader life chances both throughout life and in old age. At the same time, and precisely through its failure to take into account the unacknowledged role of broader sociostructural and environmental forces, this viewpoint transforms the particular into the universal and absolves social and political institutions of their responsibilities for the health and well-being of residents. By suggesting that the great majority of those elders in wheelchairs could indeed have been on cross-country skis had they but made the right choices and practiced the right behaviors can burden rather than liberate older people. Hence, we emphasize that concepts such as successful aging are marked by important and unacknowledged class, race, and gender concerns that result in further marginalizing the already marginalized. The perpetuation of privilege is not a desirable end.

However, even setting aside these concerns, the new gerontology offers an impoverished view of what a ''good'' old age can be. As suggested earlier, the MacArthur Foundation Study of Successful Aging led by Rowe and Kahn made a critical contribution in helping to provide a strong empirical base for the utility of a variety of health-promoting practices and behaviors throughout life and in old age. Nevertheless, the equation of good health with successful aging (and by extension, disability and poor health with failure) together with the simplistic popularization of these proscriptive views in the mass and popular culture fail to honor the many ways in which individuals face the physiological, emotional, or contextual changes that accompany aging.

We end with some ideas about how to alter the problematic aspects of the successful aging model's foundational assumptions. Acts of resistance, already touched on, are beginning points. The tyranny of youth-preserving technologies and lifestyles that

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demand more and more time and money hinders a respectful attitude toward old age. How can we respect age if we do everything in our power to deny it? What most assume as a matter of course in youth and middle age—that is, health and activity—cannot be the critical measure of success in old age. At a minimum, it reduces old age to the most basic norms, less than we would accept at other times of our lives. It offers continuity, but old age is also importantly about transformation as we learn to accept what we cannot change, rage when we must, and adopt new ways of life as needed. Writing in her 60s, the late May Sarton (1997), poet, essayist, and novelist, reflecting on the imminence of death, noted that "preparing to die we shed our leaves, without regret, so that the essential person may be alive and well at the end" (p. 230). Biomedicine, as important as it is, does not see the luminous moments that offer promise despite uncertainty and the proximity of death. Its tools cannot diagnose the mischief the very term "successful" can do, particularly in a competitive, youth-driven society.

We might return to the ancient question: What is the good life—for the whole of life—and what does it take to live a good old age? What virtues do we strive for and how do we honor difference? Germain Greer (1999) said it well: "Liberation struggles are not about assimilation but about asserting difference, endowing that difference with dignity and prestige, and insisting on it as a condition of self-definition and self-determination" (p. 3).

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