



Research Article

Perceived Health versus Objectivised Health: Life Turning Points and Advancing Age

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Abstract

This article proposes to examine a paradox which marks the relationship the oldest amongst us have with health, through the results of two surveys carried out in France, one of which is a longitudinal quantitative study (APROVICO) and the other a qualitative one (FIPSIGÂ). Among the 470 people questioned, aged over 60 and living at home in the Occitanie region, a majority qualify their health as “good” or “very good”, at the same time as showing numerous diagnosed health problems. This study is structured around three related parts. After showing the elements of our theoretical framework, and in particular the concept of *déprise*, we will present our main results by examining the meanings that statistically observed health problems have for individuals themselves in order to shed light on the paradox between perceived and objectivised health. In a third step, we will discuss health problems considered as vectors of change over time, as well as the related identity extensions, and discuss the place of death in this continuity made up of ruptures.

Introduction

This article proposes to examine a paradox which marks the relationship the oldest amongst us have with health, through the results of two surveys carried out in France, one of which is a longitudinal quantitative study and the other a qualitative one. Among the 470 people questioned, aged over 60 and living at home in the Occitanie region, a majority qualify their health as “good” (289 participants) or “very good” (89 participants), at the same time as showing numerous diagnosed health problems. The study enables us to put to the test two

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hypotheses linked with turning points in life. While health problems arrive at all stages in life, with time the gradual changes in the field of disease management reflects the shrinking of the subject’s world [1]. Further, this tendency results from the vulnerability caused by the proximity of death, which becomes the principal source of change (H1). Moreover, turning points can occur simultaneously and even converge as vectors of change over time, and these convergences stimulate “extensions of identity” [2] attached to advancing age but not to any specific health test (H2).

This study is structured around three related parts. After showing the elements of our theoretical framework, we will present our main results by examining the meanings that statistically observed health problems have for individuals themselves in order to shed light on the paradox between perceived and objectivised health. In a third step, we will discuss health problems considered as vectors of change over time, as well as the related identity extensions and discuss the place of death in this continuity made up of breakdowns.

Elements of Theoretical Framework

Before exposing our results, it seems essential to explain the sense that the term “turning points” holds for us by examining the place that the theme of health has in the scientific literature relating to life pathways. In addition, we will consider putting into perspective the notion of turning points in relation to health trials via the concept of *déprise* in order to account for identity issues raised by the experience of these turning points and to restore their relational anchoring. In the absence of a consensus on definitions, the literature on life pathways uses the terms “transition”, “event”, “turning point” and “bifurcation” almost interchangeably [3]. For instance, Strauss [4: 95], turning points are “critical incidents that occur in the course of life forcing the person to recognize that they are not the same as before”. As for bifurcation, this refers to unpredictable changes that lead to a drastic, and in principle irreversible, reorientation in life [5,6].

Whatever the semantic considerations decided upon, human experience is rooted in certain discontinuities whose structuring character is reflected in the changes that have taken place in life pathways and identity variations. When transitions are predictable, regulated and initiated by life in society, such as going into retirement, the change they bring about is supposed to be controlled [7-9]. On the other hand, when transitions are substantial, they initiate a reorientation of life pathways, sometimes even a clear break between a “before” and an “after” [10-13]. The result is an empirical typology consisting of the two categories, with health problems in old age placed most often, but not systematically, in the second. In the continuity of this research, this article explores how aging people perceive their health trajectory in terms of continuities or breakdowns, and looks at the extent to which discontinuities reveal identity issues. The paradigm of life pathways provides a relevant analytical framework for understanding the gap between perceived and objective health, and resonates with how the health trajectory carries within it social relationships of class, gender, age and generation. While it is important to consider aging as

a frame of reference, the resources that individuals mobilize to deal with it should also be considered [14]. We affirm that the dynamic of *déprise* makes it possible to render this individual enterprise intelligible. Defined as a “process of reorganization of life” [15] according to the modifications of the body and of relationships that emerge over the years, *déprise* makes it possible to work on the individual experience of aging through a double process, one of “losses” and “gains”. In this sense, the concept invites us to take a different perspective from a functional representation of old age, and indicates that chronological age and loss of capacity are not the indicators of aging most relevant to understanding the plural experience of the process.

Methodology

From a methodological point of view, this article is based on two studies: Analysis of Aging by the Cohort Process (l'Analyse du Processus de Vieillesse par la méthode des *Cohortes APROVICO*)¹ (2014-...), an interdisciplinary and longitudinal survey supported by the Laboratory of Excellence (LABEX) “Structuring Social Worlds” (“Structuration des Mondes Sociaux”, SMS) and the research Fragility, Isolation and Perception of the Sense of Impotence in Old Age (Fragilité, Isolement et Perception du Sentiment d'Inutilité au Grand Âge, FIPSIG), supported by the MUTAC Foundation (2017-2018). The APROVICO questionnaire was proposed in 2014 and includes a random and representative sample of the population of the Occitanie region (N=470). It was stratified by gender and carried out face-to-face, in a procurement mode that follows the conditions of a recorded interview. The questions focus on physical and psychological health, social relationships and participation (with a large section dedicated to social networks), family configurations, activities, material and financial conditions and residential trajectories, as well as opinions and values. The questions were devised to fit the conceptual framework adopted for the project (life pathways and *déprise*), and in accordance with the objective of identifying the various resources available to aging individuals.

As for the FIPSIG research, this follows the same conceptual framework that it discusses in a monograph targeting the same population. Interviews with seniors (N=40) were conducted anonymously, as reported when the two studies were declared to the National Commission on Computing and Liberties (Commission nationale de l'informatique et des libertés, CNIL) and the Commission for the Protection of Persons (Commission de protection des personnes, CPP). The location of the interview was left to the participants' discretion, with the intention of ensuring not only their trust but also optimal conditions for exchanges.

While APROVICO emphasizes the robustness of statistical processing - based on bivariate correlations, multifactorial analyses and linear regressions -, FIPSIGÂ draws its inspiration from grounded theory [16]. The basic orientation of these two studies consists in studying the mechanisms of production of social inequalities in health in context, based on the experience of aging and in relation to the paradigm of life pathways. Taking an inductive approach, respondents and situations were selected according to their ability to foster the emergence of theory and this process was continued during the analysis to the point of data saturation. Informative cases, i. e., minority narratives and observations, were considered in order to take account of the complexity of the phenomena studied.

1. The main points of this survey are available on the following link: <http://sms.univ-tlse2.fr/accueil-sms/le-labex-sms/operations-structurantes/vieillessement/>

Results

Explaining the gap between perceived and objective health

When reading the statistical results, the first thing that comes to attention is the gap between perceived and objectivised health. Two explanatory approaches can be used to account for this observation. The first highlights the mechanisms by which health problems can be banalized. The second reflects a dynamic of positivation despite health problems, re-joining the “open consciousness” of the approach of death described by Strauss [17].

Considering oneself to be in (very) good health

The process of banalization of health problems

Five mechanisms have been identified within this process of trivializing health problems. According to the first, the spouse's health status is perceived as being worse than one's own. Anne-Lise, 91, a mother of two children who has worked as a librarian throughout her professional life, tells us about the difficulties faced by her husband, who suffers from Parkinson's disease and who she cares for on a daily basis. The seriousness of his condition forces her to ignore her own problems related to a breast cancer diagnosis, which she ranks as a lower priority. The second mechanism of banalization is rooted in the chronicity of the disorder and puts the health situation in the category of “old stories”, which are so to speak “done with”. For example, a car accident that happened 20 years ago, from which Marcel, 77 years old, still suffers from after-effects. If the event has disrupted his life, marking a “before” and “after”, he does not blame aging for “the miseries that his knee causes him on a daily basis”. The same goes for Michel who, at the age of 83, tells us about the “crab that is sleeping within him”, that was diagnosed 30 years before. Aging is then put “in the clear”, which gives the individual time to learn how to deal with their illness.

At the opposite end of the spectrum from this mechanism, the third lever for banalization evokes the “fate of aging”. Illness is presented as part of the “game” of growing older. “I have migraines that gnaw at my head, a back that hurts, arthritis in my neck that hurts horribly, a stomach ulcer... But you know what they say: if you wake up after 60 and you have no pain anywhere, it's because you haven't woken up! [Laughs]” (Nadia, 73). But as effective as it may be, the process of minimization is not resistant to neurological diseases, with two key diseases at the top of the podium: Parkinson's and Alzheimer's and their related disorders. Surprisingly, cancer does not fall into this category, despite its seriousness and the potentially lethal nature of its evolution. Pitter, 88, diagnosed with Alzheimer's disease, describes it in these terms: “I hope my body goes before my mind... [...]. Losing your head when you have a functioning body... I think that's probably the worst thing that can happen to you.”

In addition to these mechanisms of banalization, there is one that reflects the effectiveness of the “solution” provided: such as a hearing, eye or dental prosthesis that is eventually forgotten about or, more rarely, a hip or knee prosthesis that allows people to forget the problem. “Oh yes, I have hearing, ocular and dental aids and I also had hip surgery three years ago. It went very well, touch wood [...]. Hearing aids, cataracts and false teeth, everyone has them...” The end of this excerpt from the interview with Evelyne, 75, shows that aside from the effectiveness of the prosthetic device, what is at stake here is also the democratization of its use - a sign par excellence of its

banalization. The final mechanism in this process of banalization of health problems is one that extols the regularity of health monitoring. Here, we are mainly talking about daily medication and annual check-ups, which are sometimes presented as guarantees of control over a problem and sometimes as safety valves. "I am very regular, I do my examinations twice a year and I think I take about 20 meds a day, but what do you want? Once you reach a certain age...", confides Christelle, 68.

A dynamic of positivization despite health problems

The second explanation for the gap observed between perceived and objective health places health within a cluster of multiple affiliations. Here the gap is perceived as the direct consequence of a dynamic of positivization based on a lifestyle considered "satisfactory" and more or less privileged. The proposed analysis then takes account of the difference between "lifestyle", reflected by levels of educational and interpersonal networks, and material living conditions with monthly incomes per household ranging from €2,500-€3,000. Numerous testimonies illustrate the "capacity" of respondents to bounce back by readjusting their activities and renewing their engagement with the world. The notion of *déprise* offers striking illustrations of this logic of anticipation that can be found both in the management of one's health trajectory - particularly around preventive practices - and in the reorganization of one's home. Interestingly, reorganizing where one lives is positively correlated with the number of moves over a lifetime, which suggests a certain increase in expertise in implementing adaptation strategies, thus crystallizing openness to the world. Alongside these markers there is also an "ordered" - but not fixed - lifestyle that embraces the security of routine but has always been able to give way to the extra-ordinary. This logic of adaptability is described in the management of life's turning points, initiated by these health disorders. In line with a "settled" life, we find - not surprisingly - the quality of a couple's life considered as "satisfactory".

Considering oneself in (very) bad health

The study makes it possible to locate the sources and expressions of ill-health that lie beyond or below health problems, taking into account the respondents' social position and the experience of "loss" of a loved one. After a quantified analysis of the profile of respondents who say they are in "very poor" health, the most salient analytical features are shared.

Beyond, or underlying, health problems: the experience of "loss"

Certainly from the age of sixty onwards, health problems become more and more frequent, but during the first decade they remain reversible and benign enough not to be recognised as turning points. Beyond the age of 70, 62% of turning points are related to the experience of the death of a loved one. It is above all the death of spouses that is cited as causing loneliness and "emptiness". But after 70, health (of oneself and others) also causes breakdowns, to the point of being the second source of turning points. Indeed, when it comes to considering the most important biographical organizers of turning points in the eyes of the people concerned, the great majority consist of health issues - alongside families/couples, death, professions, and changes in living spaces.

The average number of turning points revealed increases with the level of education (with the most educated tending to cite more), and

is negatively correlated with perceived health: the more self-reported health is considered "poor", the more the number of turning points decreases. It should be noted that people with low levels of education mention many more deaths and health problems. With regard to gender, although the research was conducted in a country that promotes the professional integration of women and gender equality, men report more work-related turning points and socio-historical events, while women report being more affected by parenting, reproductive health and family life and report more deaths. The deaths of parents are clearly more noticeable by women than by men. The same applies to the departure of spouses for long journeys or separation. In contrast to the first job, which seems to represent a shared marker for both sexes, men report being more impacted by retirement and health risks - which are mentioned much more by men than by women.

The ability to bounce back is undermined here by the ordeal of illness. With lack of preventive logic, it is above all a "reactive" logic that aims to readjust things on a case-by-case basis, according to the displacement of needs, often linked to a worsening of the person's state of health. But this curative logic - essentially male - can only be effective in the face of curable diseases, and is very flawed in the case of the management of the ills that accompany old age.

Between the sources and expressions of poor health

Attempts to identify the sources of poor health reveal three common denominators that mark the daily lives of the respondents who claim to be in "very poor" health. The first highlights - again from a new angle - the impact of neurological disorders on the quality of life of these patients. The result is clear: all respondents who say they are in "very poor" health are concerned by neurological and related pathologies. But the opposite is not observed: not all those concerned by neurological and related pathologies say they are in "very poor" health. In this sense, these pathologies constitute a necessary but not sufficient condition for a pejorative judgment to be made about one's condition.

The second marker that stands out when we examine these health trajectories that follow initial expressions is their grounding in gender. Thus, the overwhelming majority of participants who say they are in "very poor condition" are men, i.e., 7 out of 8 respondents. We then see this combative feminine trait emerge, which does not abandon attitudes that are prospectively optimistic. The male ends up being perceived as a synonym for badness (*mal*), showing the reverse side of a "supposed" advantage in male health. Finally, and this is the third most remarkable point concerning the management of health problems: it all comes down to saying that the more assistance facilities are needed, the less they are used. The name generator which lists the services and supports provided to seniors reports an average of one to five support facilities, a stratified distribution according to the standard of living observed, which suggests health inequalities [18] for the oldest of our fellow citizens: for comparable age and sex, social differences in the use of care are not strictly able to be superimposed on the differences in health conditions - the people most affected by ill health not being the most present during consultations.

However nuanced and relevant it may be, the analysis would be partial if it left out the translation of these shared traits into the daily lives of the seniors considered here. Before presenting the ways in which respondents choose to express their discomfort, it should be noted that these modes of expression are not distributed randomly.

While the culture of the wealthy means they make use of their right to health care, the working class see their access to health services as luck, almost apologizing for having “held out for so long”. First of all, these respondents believe that their health has deteriorated compared to the past and that their health is “worse” compared to other people of their age. These two elements that dictate their relationship to time condition their projection into the future, which appears dark and compromised. Here death is never very far away, and this proximity becomes a source of anxiety, death not being considered as an “escape route”. In addition, and in contrast to other respondents of their generation who say they are in “good” or “very good” health, though possibly “tired”, these participants say they are “ill”. However, if you look closely, it is the limitation of activities that seems to dictate their experience of aging more than the disease. Thus, while hospitalizations, falls and accidents systematically appear in the stories told by these respondents, it is mainly the disabling consequences of their health episodes that are the rule. As a corresponding index, medicine consumption reaches its peak here (up to 30 medicines per day), while pain seems to be part of a bitter everyday life. However, despite the deteriorated state of their health, EHPADs (Etablissements d’hébergement pour personnes âgées dépendantes, medical retirement homes) are not perceived as possible ways out of the crisis.

Discussion

In the scientific literature on *déprise* [19], the work focused on practices of adaptation in response to changes induced by certain life events [20,21] - such as health problems - and the necessary resources that seniors put in place in order to integrate them into their daily lives. The adaptive strategies that operate on various forms of *déprise* are distinctly divided according to multiple socio-cultural backgrounds (gender, generation, level of education, living conditions, etc.), but also relationships with others (family members, professionals, neighbours and friends), showing that the choices of aging people are made within a vast network of interdependencies [22]. The negotiations of aging are therefore carried out in connection with others, and these links allow us to restore the full relational depth of turning points in health, while reminding us that these experiences always imply an external relationship. As Strauss [4: 104-5] notes, “tensions in family and community life are situated exactly at points where the speed of transition is out of the [predictable] alignment”. Let us add that *déprise* is not an irreversible mechanical process and can lead to remarkable developments - including in the face of serious and chronic diseases. During these recoveries, guided by a dynamic of self-determination, seniors show resistance in an effort to preserve their sense of continuity of identity.

This schematic of “visualization” of turning points from the advent of serious and chronic diseases or accidents supports a social reading of the body, leaving the biological reading behind. In addition to death, health issues revisited from intra-family configurations of help involve the role of the caregiver - the child of an elderly parent who is suffering or the partner of a sick person. It should be noted that sometimes the fatal illness of a loved one augurs not only the loss of the other, but also one’s own. Moreover, from the age of 70 onwards, it is not so much the chronic nature as the disabling nature of the disease that is retained by respondents as an event that signals a turning point at the origin of “ultimate *déprise*”, sometimes even of an approaching death.

Whatever the case in old age, turning points are more often marked by losses than by “openings” and give prominence to health issues. If the advent of chronic and disabling illness initiates turning points, these episodes remain marginal around the age of fifty. On the other hand, mourning loved ones is the event most present in the memory of the respondents, projecting them into an awareness of their own finiteness. It should be noted that the regulation of relational life through death is not “natural”. This qualifier refers to biological categories that are not only Western but indeterminate, complex and power-driven [23,24]. To understand the central place of the deaths of relatives in the health turning points reported, it is necessary to consider the role of family institutions, related policies and religions in the development of the filial dynamic, perceived as a founding element of the socio cultural identities of the elderly in question here.

As for the “self”, this relates to changes in identity shaped by previous versions of the self and by moral considerations that prevail in a broader discursive, relational and pragmatic environment, amply configured by health issues. Examined in this way, the identity of aging [23,25] and the individual expectations that go with it are shaped by context. On this point, it should be pointed out that examining the level of education is a good way of assessing the “effectiveness” of a resource, insofar as it can be assumed that its mobilization allows for an inventive anticipation of the future that mitigates and puts into perspective the impact of certain health problems.

With regard to gender disparities, the observations described above confirm Meidani’s [26] thesis on men weakened by disease and the combative trajectories of women. Let us add that health culture is probably all the more gendered when we observe the pre-war generations: the management of health capital and the body being then divided into privileged and female-related subspaces of the intimate, bringing to light a sex-based socialization that unfolds in the private sphere from their earliest age.

Conclusion

This article focuses on the perception of health problems, revisited from the point of view of ageing individuals living at home in France. It shows that the continuity and discontinuities of health trajectories mark life pathways and that, at any age, life is a source of changes. These are mainly attached to health and family, and indicate the structuring place of death in the world of the living. From the age of fifty, death stands out as one of the most important events. In the following decade, it is health issues and their accompanying hazards that gradually impose their influence, while among the seventy-year-olds death and health problems embody the major changes. For 80-year-olds, the geographical proximity of the older person to one of their children or placement in an institution represents a turning point of a spatial nature.

The study confirms our initial hypotheses and shows that over time the gradual concentration of changes in an increasingly small number of areas of life reflects the narrowing of the world highlighted by Schütz and Luckmann [1]. Moreover, this trend results from the vulnerability brought about by the proximity of death, which then becomes the main source of changes and comes as the logical consequence of a body that is gradually becoming exhausted [27,28] under the weight of disease and aging. At the same time, the study shows that turning points can occur simultaneously and even converge as vectors of change over time, and that these convergences drive

“extensions of identity” [2] that focus on the aging process but not on a specific event. Deaths are often at the origin of such extensions.

As turning points in life are constructed from scratch, respondents’ coping strategies reflect the issues of identity continuity. In a world in constant evolution, the management of these biographical breakdowns brings out a reversal of the sense of constancy, thus situating the dual process of banalisation and positivizing health disorders. Turning points can have different meanings depending on the place of the individuals concerned within the changing boundaries of gender and class hierarchies, age and generation. The identities of outdated bodies, weakened by age and disease, are asserted as the dialectic of affiliations unfolds.

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