Anti-Ageing Medicine as Edible Health Insurance: Self-Care and Ageing Well among Older Adults Living in Australia and Japan

Maho Omori
B.A. Hons. Swinburne University of Technology

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Abstract

This study explores the reasons and meanings attached to the use of anti-ageing medicine by older adults living in Australia and Japan. In particular, it seeks to understand how culturally-embedded health beliefs and values, as well as cultural ideologies of old age, influence anti-ageing practices. Existing sociological literature on anti-ageing medicine discusses it predominantly from Foucauldian perspectives, drawing on Foucault’s concepts of governmentality, the technology of the self and biopolitics. However, this study revealed that Australian and Japanese older adults’ self-care repertoires using anti-ageing medicine were formed based on their lived experiences, including their current health conditions, illness history, declining capability to conduct daily activities, observing ageing others, and relationships with others—particularly with their adult children.

As a bilingual researcher, I conducted in-depth, semi-structured, face-to-face interviews in both English and Japanese with 21 Australians and 21 Japanese who take anti-ageing medicine. A cultural similarity was found in that both Australian and Japanese participants considered anti-ageing medicine as edible health insurance — a necessary investment to prolong ‘health expectancy’. It was believed that, as health insurance, this medicine provides them with ontological security for their future lives, expressed as the ability to carry on what they have established throughout their life course and enjoyed as younger adults into the future. In turn, this enabled them to maintain their sense of identity. Cultural differences were evident in two ways with regard to: 1) ways of approaching anti-ageing medicine, and 2) in-depth meanings of the concept of independence, which was, nonetheless, an important contributing factor to ageing well for both Australian and Japanese participants. I argue that it is necessary to give attention to the particular social, cultural, and familial contexts within which older individuals are situated in order to adequately understand how and why older individuals strive for good health using anti-ageing medicine.
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kept me sane throughout this journey. Now I will be able proudly to tell her what I was doing while she was a patient childcare attendee.
Declaration

This thesis contains no material that has been accepted for the award to the candidate of any other degree or diploma. To the best of my knowledge it contains no material previously published or written by another person except where due reference is made in the text of the examinable outcome.

The thesis has been copy-edited and proofread by Dr Jillian Graham (Articulate Writing Solutions), whose services are consistent with those outlined in Section D of the Australian Standards for Editing Practice (ASEP). Dr Graham’s own fields of study encompass Musicology, Social History, Women’s Studies and Psychoanalysis.

Signed    _______________

Date       _______________
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Chapter One
Introduction

This thesis will explore how Australian and Japanese older people’s motivations to conduct self-care practices using anti-ageing medicine are generated by their perceptions of ageing well. Anti-ageing medicine in this study is defined as hormone replacement therapy, Chinese herbal medicine and dietary supplements that are conceivably effective in managing ageing bodies. More specifically, it is claimed that these ‘postpone or relieve the effects of biological ageing’ or even ‘treat or eliminate’ diseases associated with ageing (Vincent, 2006a: 196-7). Particular attention is paid to older adults’ lived experiences, notably culturally-inscribed, lay understandings of health in relation to their health conditions. This study also focuses on the perceived understanding of ageing well among older adults, built through their experiences of observing ageing others, as well as through socially-constructed ideologies and expectations of what older age entails in today’s society. Comparisons will be drawn between Australian and Japanese older adults, with particular reference to cultural similarities and differences in the ways both populations rationalise the use of anti-ageing medicine. Prominent cultural differences are found across Australian and Japanese contexts regarding their approach to anti-ageing practices and definitions of independence in old age. Nevertheless, both Australian and Japanese older adults consider anti-ageing medicine to be edible health insurance—in other words, a necessary investment in their future health, enabling them to maintain a sense of self and continuous engagement in life.

1.1 Impetus of this study

This research in anti-ageing medicine originated from my personal interest in a recent global phenomenon of an ageing population and anticipated social problems associated with this. It is expected that in some countries such as Japan, Italy and Germany, by the year 2025 nearly one-third of the population will be over the age of 60 (World Health Organisation, 2002). It is also predicted that in Australia a quarter of the population will be over age 65 years old by 2060 (Australian Government Productivity Commission, 2013). With the ageing population, governments in many advanced societies are faced with unprecedented issues, for example anticipated increases in medical costs and welfare expenses. Accordingly, ageing policies have been amended in many societies to encourage older individuals to take initiative in their own lives. More
specifically, they are expected to seek active, positive, productive and healthy lifestyles in old age (e.g. World Health Organization, 2002).

Simultaneously, societies have actively sought technological solutions to deal with the ageing population. For example, in my Honours thesis, I argued that the Japanese government has been encouraging automation to compensate for the labour shortage caused by Japan’s rapidly-ageing population. Among various technologies, biomedical technology is the most widely-discussed technological solution across societies to deal with the ageing population (Vincent, 2006b). The idea here is that medical intervention on ageing bodies permits older individuals to be physically active, productive and independent; in other words, it prevents them from becoming a burden on society. The idea that older people are ‘a societal burden’ can be contested for many reasons, however. For example, such understanding is based on economic perspectives and it neglects other aspects of ageing such as their accumulated knowledge, experiences, wisdom and contribution to society they made throughout their life courses. Moreover, nowadays many older individuals are healthy and live independently and therefore, classifying old people as a societal burden is not applicable to many instances.

Nonetheless, there is an increasing attention paid to anti-ageing medicine worldwide. In the context of anti-ageing, biomedical technology, biogerontology in particular, assumes that ageing bodies are treatable with adequate medical intervention. This is based on the following idea:

The disabilities associated with normal ageing are caused by physiological dysfunction which in many cases are ameliorable to medical treatment, such that the human life span can be increased, and the quality of one’s life improved as one grows chronologically older. (American Academy of Anti-Ageing Medicine, 2012)

The American Academy of Anti-Ageing Medicine (A4M), a non-profit organisation established in 1991 in the US, is dedicated to the advancement of technology to detect, prevent and treat age-related diseases by promoting scientific research that develops methods to retard or optimise biological ageing processes. It has more than 2,500 members from 120 countries worldwide, most of whom are physicians, with scientists being the next most prevalent among the membership. As shown in the quote above, the A4M’s belief is that ageing can be medically treated just like other diseases. Here, ageing is medicalised.

Medicalisation is understood as the process whereby non-medical problems or phenomena, which are often considered as social problems, are defined and
treated as medical issues (Conrad, 2007). Given today’s rapidly-ageing population, ageing bodies are largely considered problematic and are often described as time bombs or a societal burden due to anticipated increases in medical costs and welfare expenses (Peterson, 2007). In her work in the 1970s, American sociologist, Carroll Estes argues that in the U.S. society has equated old age with illness, and this influences how society views and deals with the elderly (Estes, 1979). More importantly, the idea that ageing is pathology and can be cured or fixed by medical control has had a significant impact on policy making and federal research funding in biomedicine (Estes, 1979).

The notion of medicalisation of ageing and anti-ageing practices have been gaining in popularity, particularly in the West, where wealthy, older individuals can exercise choice in how they grow older (e.g., Cardona, 2007, Katz and Marshall, 2003). This trend is also seen locally in Australia. On 10 May 2009, Melbourne’s daily newspaper The Age reported the growing popularity of one anti-ageing clinic in Melbourne. The article features a 77-year-old medical doctor who promotes anti-ageing medicine in his clinic. He has been using it himself for the last 15 years to justify his belief that ‘we can battle against biological ageing’ just as suggested by the A4M. He rationalises the use of anti-ageing medicine as follows:

This is the way of the future. You’re going to die eventually, but when you die you still want to have your wits about you; you don’t want to die from Alzheimer’s disease in a nursing home. … About 80 per cent [of my patients] who take it say they feel much better. What I tell them all is I don't really do this to make them feel better. I do this so that when they’re 70, 80 and 90 they don’t end up in a nursing home. They can be independent, live on their own and still have fun (Stark, 2009).

His rationale for his anti-ageing practice is formed around his negative perception of nursing home admission in old age. Not surprisingly, this doctor’s anti-ageing practice to address ‘old age’ has attracted much criticism because his understanding of ageing raised ethical concerns among the public. Nevertheless, we are currently witnessing an increasing popularity in ‘anti-ageing’ practices and products within today’s consumer market. For example, pharmacies and health stores stock a wide array of anti-ageing products ranging from cosmetics to health supplements. Furthermore, particular dietary supplements are produced and sold exclusively for older individuals, on example being Centrum Advance 50+, an ‘age-adjusted multivitamin with a broad spectrum of nutrients that help protect the health of adults 50+’, in particular, heart, brain and eye health (www.centrum.com). The rise in anti-ageing products is indicative of the
perception that old age, like any other disease, can be treated through taking anti-ageing medicine.

The phenomenon of medicalisation of ageing bodies is not restricted to Australia or other Western countries; it can also be observed in non-Western countries like Japan. Another factor that sparked my interest in anti-ageing medicine came from my own personal experience of observing my parents, who have lived in Japan their entire lives. My father has been taking CoenzymeQ10 (CoQ10) in conjunction with vitamin E to improve heart health, and my mother has been taking glucosamine and other supplements to treat osteoarthritis for many years. According to my mother, taking these supplements was not at the suggestion of their doctor but rather her decision, based on the influence of TV programs and commercials explaining the positive effects of these supplements on ageing bodies. She said, ‘I heard taking CoQ10 is beneficial, so let’s try it out’ as if conducting an experiment. As a Japanese person who lived in Japan for 30 years before migrating to Australia almost a decade ago, I have witnessed the growing numbers of various health supplements labelled as ‘anti-ageing’ to facilitate good health in older age in Japan. As evidence of this, whenever I go back to Japan, almost every day I find newspaper ads or inserts about health supplements targeting older people. The words ‘anti-ageing’ are explicitly used in the promotions.

Through my lived experience I have witnessed that Australian and Japanese societies have placed different expectations towards old age, which are derived from culturally practiced ideologies—individualism and collectivism respectively. It is expected that such ideologies will have significant, albeit distinct, impact on decision-making of using anti-ageing medicine among older individuals living in Australia and Japan. This comparative study will shed light on how culturally embedded understandings of ageing and ageing bodies lead to different rationale for using anti-ageing medicine among older Australians and Japanese.

1.2 Anti-ageing medicine for prolonging health expectancy

Active promotion of anti-ageing medicine by A4M and growing interest in anti-ageing medicine among the public as consumers may reflect the fact that considerable numbers of elderly people worldwide live with age-associated chronic health conditions such as hypertension (Wagner et al., 2001). For example, in the US 88 per cent of people over 65 years old have one or more chronic conditions (Wolff et al., 2002). In addition to the high prevalence of chronic ill health conditions among older adults, the incidence of so-called age-
related diseases increases rapidly with ageing (Meydani, 2001). These are
extensively discussed not only in scientific medical journals but also in other
sources including government policies, health information websites and health
magazines. Age-related diseases include cancer, cardiovascular disease, cataracts,
diabetes, dementia, osteoporosis, osteoarthritis and neurodegeneration (for
example Alzheimer’s disease) (Clark, 2008).

Because of this, there is increasing scientific and clinical interest in research,
especially medical research that explores the association between nutrition and
ageing, and particularly age-related diseases. For example, the academic journals
Nutrition and Aging and The Journal of Nutrition Health Aging publish studies
that investigate the effects of diets and dietary components on ageing or age-
related diseases. It is reported that one of the factors that lead to morbidity and
poor mobility in older age is malnutrition (Miquel, 2001). Therefore adequate
nutritional supplementation could contribute to the prevention of certain age-
associated diseases. For example, Miquel (2001) suggests that the intake of
dietary antioxidants can potentially reduce the risks of degenerative disease such
as cardiovascular disease and immune dysfunctions. Salerno-Kennedy and
Cashman (2006) indicate that dietary lipids, antioxidants and certain vitamin B
supplements could be beneficial in preventing dementia and Alzheimer’s disease.

Although such scientific research findings are not conclusive, it can be speculated
that various dietary supplements could potentially be used in treating age-related
ill-health conditions, or to prevent age-associated illness. As referred to above, my
mother suffers from knee pain, which she believes is caused by her age.
Accordingly, she keeps searching for effective supplements that could ease the
pain. This indicates that there are opportunities for older people to seek out
supplements in order to improve their health conditions. In other words, anti-
ageing medicine could have the potential to prolong ‘health expectancy’, which
means maximising optimum health by reducing risk factors that possibly cause
morbidity or disability prior to death (Kendig, 2004).

1.3 Existing social research into anti-ageing medicine and its limitations

Anti-ageing medicine as a focus of research interest is a relatively new
phenomenon, having emerged in biogerontology in the 1990s (Mykytyn, 2010).
Given that anti-ageing medicine has only recently attracted the attention of social
scientists, social research in this area is limited in scope. Most research focuses on
certain types of anti-ageing medicine such as Viagra, cosmetic surgery and
hormone replacement therapy, which elucidate gender issues such as masculinity
and femininity (e.g. Brooks, 2008, Katz and Marshall, 2003, Lock, 1993, Potts et al., 2003). There is limited empirical research that exclusively focuses on anti-ageing medicine as defined in this study. Yet existing studies offer rich insights into how anti-ageing medicine is conceptualised within the social sciences. Sociologists view anti-ageing medicine in a critical light, with discussions revolving primarily around the associated ethical concerns (Dumas and Turner, 2007, Lafontaine, 2009, Peterson and Seear, 2009). The medicalisation of ageing upon which the use of anti-ageing supplements rests is contested as biological reductionism because it ignores the social aspects of ageing (Vincent, 2006b, Vincent, 2008).

Much existing empirical research adopts a critical view towards anti-ageing medicine. In particular, it adopts Foucault’s ideas of governmentality, technology of the self, and biopolitics (Cardona, 2007, 2008). Such discussions also point to consumerism, with its emphasis on the virtues of youthfulness (Katz and Marshall, 2003). Based on these theoretical frameworks, the discussion revolves around how society has created a discourse of ‘new old age’: that is, older people are responsible for making choices to be healthy, active, youthful, independent and autonomous in old age (Katz and Marshall, 2003). In essence, older people are seen as vulnerable to pressures in today’s society that require them to conform to the socially-constructed idealisation of old age (Cardona, 2007).

A US empirical study that investigates the use of anti-ageing medicine, and in particular various hormone replacement therapies, has a different prospect. Watts-Roy (2009: 439) argues that the use of anti-ageing medicine among participants is ‘a powerful criticism of the traditional biomedical encounter’. More specifically, their decision to move towards anti-ageing medicine use is derived from the participants’ lived experiences that biomedicine or medical doctors had not satisfactorily treated their ill health in the past. Anti-ageing medicine is chosen as an alternative, preferable option to Western medicine to deal with their health conditions.

Watts-Roy’s (2009) finding coincides with Dill et al. (1995) and Turner’s (2004) suggestion that one’s health practice is to a large extent formed based on everyday experiences. Following this idea, the reasons why older people use anti-ageing medicine might be multifaceted. For example, they might choose certain types of anti-ageing medicine based on their health conditions. With their experiences of getting older, they might anticipate a decline in health in the future, and this becomes the impetus to use anti-ageing medicine. Moreover, it might be used as a preventive health practice for age-related diseases based on their experiences of observing ageing others who had suffered from any of these diseases.
1.4 Situating this study

Taking into account the discussions derived from Foucauldian analyses of the use of anti-ageing medicine and the suggestion by Turner and Dill et al. that health practices are shaped based on one’s lived experiences, this study aims to understand how older individuals’ self-care practices of using anti-ageing medicine are influenced by their lived experiences. Specifically, this thesis sets out to explore the motives and beliefs attached to the use of anti-ageing medicine in relation to the perceptions of ageing well among older individuals living in Australia and Japan. It endeavours to illuminate the impact of culture in guiding decision-making regarding its use by comparing and contrasting two cultural contexts. In this exploration, three questions are asked:

1. How do Australian and Japanese older adults define and perceive their self-care practices using anti-ageing medicine?

2. How do culturally-shaped health beliefs and health practices influence Australian and Japanese adults’ use of anti-ageing medicine?

3. How do Australian and Japanese older adults conceptualise their use of anti-ageing medicine in relation to their perceptions of ageing well?

To answer these questions, a qualitative research method has been employed in this study. This method allows the researcher an in-depth exploration of people’s life experiences that ‘give greater substance and depth to the problem the researcher wishes to study’ (Denzin, 2002: 350). In 2010 I conducted in-depth interviews with 21 older Australian adults living in Melbourne, Australia and 21 Japanese older adults living in Osaka, Japan. These interviewees were selected based on their health practices: that is, they were taking some kind of hormone replacement therapy and dietary supplements for anti-ageing purposes. Anti-ageing purposes are defined as those aiming to ‘postpone or relieve the effects of biological ageing’ and at ‘treating or eliminating the diseases’ associated with old age (Vincent, 2006a: 196-7).

There is no single theory or conceptual framework that satisfactorily explains the reasons why participants use anti-ageing medicine. This thesis combines a few distinct approaches that examine self-care in different social contexts to suggest that the reasons underpinning the use of anti-ageing medicine embody one’s lived experiences. Firstly, the conceptualisation of the self in the context of chronic illness management offers the useful insight that identity is closely connected to one’s bodily experiences. In other words, a sense of self can be easily violated by illness experienced by the body because it interrupts one’s articulated life trajectory or biography (Corbin and Strauss, 1991). This notion can be extended
to ageing bodies that are vulnerable to functional declines as a natural process of ageing. Shilling (2008) argues that ageing bodies potentially make it difficult to carry out habits or routine activities, which can lead to an identity crisis. Moreover, Gilleard and Higgs (2013) suggest that older individuals strive for an ideal ageing identity through various forms of bodywork, which they call ‘embodied practice’. In essence, maintenance of the body enables older individuals to achieve culturally-embedded ideals of who they are and what they want to become in old age. Drawing upon these ideas, this thesis suggests that older individuals use anti-ageing medicine as a part of self-care practices in order to achieve a sense of who they are: that is, maintaining coherence in life and a sense of self.

1.5 Thesis structure

The thesis explores in-depth meanings and beliefs relating to anti-ageing practices followed by Australian and Japanese older individuals. The thesis structure is presented below.

Chapter Two establishes the theoretical framework of this study. It begins with defining what self-care is. The discussion then turns to the ways in which self-care has been conceptualised in sociological literature focusing on two different frameworks: Foucauldian and embodiment. While Foucauldian approaches have had a significant influence on the existing sociological literature on anti-ageing medicine, they do have limitations. The embodiment approaches are drawn from multi-disciplinary fields within the social sciences, and offer the alternative explanation that anti-ageing medicine is used to maintain harmonious relationships between ageing bodies and the self.

Chapter three examines how different socio-cultural contexts define ageing and ageing well in socio-cultural contexts, focusing on Australia and Japan. I begin by reviewing how culturally-embedded familial beliefs and values and the government’s ageing policies have formed specific living conditions for old people in Australia and Japan. Then I move on to discuss how Australian and Japanese older adults have experienced getting older in such specific circumstances. Given that different societies have different expectations of old age, this chapter further explores how people within particular cultures understand the concept of ageing well.

The methodological aspects of this study are outlined in Chapter Four. I begin by situating myself as a bilingual researcher. Advantages and limitations are
outlined, and finally, details of the sampling method, recruitment and approach used for the data analysis are provided.

Chapters Five, Six and Seven present the findings of this study. Chapter Five explores the ways in which Australian and Japanese older adults define and conceptualise anti-ageing practices in relation to their experiences of ageing bodies. It also explores the perceived importance of such practices. This chapter presents the novel argument that anti-ageing medicine provides older individuals with a sense of security both physically and psychologically.

Chapter Six examines how Australian and Japanese older individuals approach anti-ageing medicine and integrate it in their self-care practices. The discussion revolves around culturally-embedded health beliefs and practices. In particular, the roles of Western medicine and medical doctors in the process of decision-making regarding the use of anti-ageing medicine in two cultural settings are compared and contrasted. This chapter highlights that although both Australian and Japanese older adults strive for good health using anti-ageing medicine, the pathways to their anti-ageing practices are culturally-guided.

In Chapter Seven I examine how anti-ageing practices are conceptualised in relation to participants’ perceptions of ageing well. I begin by defining what constitutes ageing well and its hierarchical components. Then the meanings of the constituting factors in relation to the use of anti-ageing medicine are unpacked in depth. While many similarities are found, there are substantial cultural differences in the meanings of independence in old age. This reflects the different historical paths Australian and Japanese societies have taken to create their political ideologies regarding what old people should be.

Chapter Eight draws together the key themes and arguments of the study. The use of anti-ageing medicine reflects one’s life trajectory, including one’s own experiences of age-related bodily change, change in social status, observations of ageing others, histories of illness and relationships with their adult children. I argue that it is important to pay attention to ‘the phenomenological subjectivity of the lived body in the life world’ in order to understand older adults’ self-care practices using anti-ageing medicine (Turner, 2004: 170).
Chapter Two
The Self and Self-Care in Older age

The overarching theme of this thesis is self-care in later life. As people get older, their bodily functions deteriorate and they are more likely to face age-related illness and disease than younger people. Ill health in older age may negatively affect older individuals' everyday lives, causing interruptions in their continuous engagement in everyday activities. It is reported that negative changes in life-style due to ill health often disrupt one’s coherent biography, which can lead to identity crises (Shilling, 2008). Scholars argue that individuals practise self-care in order to avoid disruptions to their lives (e.g. Bury, 1982). In other words, individuals strive to maintain good health in older age in order to feel a sense of coherence in their lives. This may be one of the reasons why older individuals list good health as one of the most important aspects in their perceptions of successful ageing (Bowling et al., 2003).

This chapter begins with a review of how self-care is conceptualised in the social sciences, highlighting the different foci of biomedical and holistic models. This is followed by a discussion of the two dominant sociological frameworks of self-care. I first look at Foucauldian approaches to the body and medicine in relation to self-care, and demonstrate how the self is formed within this paradigm. The embodiment approach to self-care will then be examined. This review will demonstrate that although the Foucauldian understanding of self-care is predominantly applied to the existing discourse around anti-ageing medicine in social science, people’s embodied experiences as represented in the embodiment approach should not be overlooked in understanding why and how they develop self-care repertoires in relation to their desire to maintain coherent selves. The material in this chapter is drawn from a variety of disciplines within the social sciences, including the sociology of health and illness (or medical sociology), public health, the sociology of the body and medical anthropology.
2.1 The definition of self-care used in this study

Self-care is broadly defined as health activities undertaken by individuals for the purposes of ‘promoting their own health, preventing their own disease, limiting their own illness, and restoring their own health. … The generic attributes of self-care are nonprofessional, nonbureaucratic, nonindustrial’, although medical professionals play a role as informers of technical knowledge (Levin and Idler, 1983: 181). Departing from this fundamental point, many definitions of self-care have been developed by scholars in the social sciences. For example, some research emphasises individuals’ decision-making processes, particularly focusing on reactions towards symptoms and illness for treatment choices (e.g. Haug et al., 1991). Other research from a poststructuralist perspective focuses on individuals’ motivations to participate in self-care practices in relation to the concept of self-control and social processes of normalisation or problematisation (e.g. Thompson and Hirschman, 1995). Further research explores how self-care practices are developed and managed by individuals through the journey of their lived experiences (Dill et al, 1995). The definitions of self-care across these studies are inconsistent because they are dependent on the context or purpose of the research (Dill et al., 1995).

In understandings of self-care framed around the biomedical model, the main focus is the management of ill health, which is ‘composed of immediate responses towards symptom experiences’ (Dill et al. 1995: 12). In this model, health is measured in biological terms as the absence of disease. This is derived from the Cartesian philosophy that mind and body function independently and disease is a mere manifestation of malfunctions in the body’s biological mechanisms, which can be repaired or fixed by medicine (Bowling 1997). Self-care in this paradigm is based on the premise that illness and disease can occur in any situation, and therefore one has to engage in preventive actions. This notion has been overtly prevalent in medicine, especially among health professionals and in public health policies. For example, active promotion of lifestyle changes such as ‘healthy eating’ or ‘quit smoking’ stimulates the idea that individuals are responsible for their own health. The biomedical model has been critically scrutinised by scholars
in social science because it tends to neglect social and psychological factors (Gastaldo, 1997, Lupton, 1995, Peterson and Lupton, 1996).

In fact, social scientists point out the limitations of self-care framed within the biomedical model. For example, Dill and her colleagues (1995) argue that it lacks the notion of embodiment. More specifically, the biomedical model of self-care emphasises body and mind dualism, focusing on bodily representations of health. This perspective does not consider a holistic self: that is, a self consisting of body and mind—a whole self that becomes ‘active agent, reactive object, and reflexive subject’ (Dill et al., 1995:13). The holistic model argues that ‘human existence is simultaneously biological, psychological and social’ (Hughes, 2000: 16). The body in this perspective is no longer seen as a machine; rather it is seen as an active and expressive means through which the progress of the self can be achieved (Frank, 1991). This holistic approach suggests that self-care practices reflect all dimensions of human life.

Following these holistic notions of self-care, other scholars have extended the definition, focusing not only on the prevention of disease but integrating it with other psychosocial and cultural aspects of life. For example, the World Health Organisation (WHO) defines self-care as:

The activities individuals, families and communities undertake with the intention of enhancing health, preventing diseases, limiting illness, and restoring health. These activities are derived from knowledge and skills from the pool of both professional and lay experience. They are undertaken by lay people on their own behalf, either separately or in participative collaboration with professionals (WHO 1983 cited in Ziguras, 2003).

This quote emphasises the importance not only of individuals preventing their own disease as emphasised in the biomedical model, but also of enhancing health through the integration of social activities, individual experiences and
professional help. The emphasis on ‘lay experience’ may be key since there is a ‘significant variability in responses by different people to similar symptoms’, which ‘emerge from personal experience, cultural definitions, and the social interactions that develop around illness’ (Stroller, 1998: 24). Individuals’ experiences of being ill (or even observing someone being ill) and cultural habits to deal with certain symptoms are all important aspects that help to construct self-care practices.

Following this framework, Dill et al. (1995) investigate self-care strategies among older people and argue that self-care is not merely responding to physical symptoms. Rather, it ‘involves the attempt to re-establish a sense of wholeness, to regain the ability not to attend to inconsistency, present or potential in one’s life (p.35). Wholeness in this sense means ‘bringing mind/body to durable balance’ (Strauss, 1987: 203). Dill et al. continue on to say that:

… self-care transcends the acknowledgement of discomfort and subsequent treatment of symptoms; it also involves the interpretation of present and past illness experiences. … Looking at how individuals interpret and respond to conditions affecting their health requires an understanding of their social and economic circumstances, personal biographies, health beliefs and self-concept (1995: 9).

Dill et al. propose that self-care as practised by individuals is more complex than the biomedical model suggests. It involves an active, conscious, reflective self located within a social and cultural context in order to maintain one’s wholeness as a person. This is supported by Leventhal et al.’s (1998) statement that maintaining functionality in everyday live is needed in order to sustain consistent life, which is an important part of preserving a sense of self. This is one of the most important aspects of self-care strategies.
This study adopts the definition of self-care suggested by Dill et al. (1995) with a particular focus on cultural influences that shape one’s health beliefs and behaviour. Culture is powerful here because it guides people to certain beliefs, values and actions in all aspects of life. Helman (1990: 22) elaborates:

To some extent, culture can be seen as an inherited ‘lens’, through which individuals perceive and understand the world that they inhabit, and learn how to live within it. Growing up within any society is a form of enculturation, whereby the individual slowly acquires the cultural ‘lens’ of that society.

According to Helman, individuals acculturate to the culture in which they live, and in this process they develop and acquire understandings of particular customs and practices. This notion is highly relevant to people’s understandings of health and illness. Kleinman (1978) discusses the importance of understanding relationships between culture and people’s perceptions of health/illness and care-related activities in finding adequate explanations for health behaviour:

The health care systems articulate illness as a cultural idiom, linking beliefs about disease causation, the experience of symptoms, specific patterns of illness behaviour, decisions concerning treatment alternatives, actual therapeutic practices, and evaluations of therapeutic outcomes. Thus, it establishes systematic relationships between components (Kleinman 1978: 87).

Kleinman refers to health/illness beliefs and behaviours, and care-related activities as health care systems, arguing that they should be understood in relation to cultural systems. Existing research clearly supports this notion. For example, Becker and colleagues (2004) report that self-care practices among African Americans are strongly tied to cultural themes including spirituality, familial support and traditional medicine. In Japan, self-care has traditionally been conducted by corrective diets; in other words, people self-medicate through
particular food intake (Ohnuki-Tierney, 1984). These examples demonstrate strong cultural influences on people’s health practices. It can be argued that self-care embodies culturally-formed health beliefs and actions which individuals develop through everyday life situations.

2.2 Two distinct frameworks of self-care

As discussed above, there are different dimensions to definitions of self-care. More specifically, these hinge on how the body is seen and analysed. Turner (2006) elaborates two distinct ways of analysing the body and self, which bear a strong relation to the understanding of self-care. He continues:

There is either the cultural analysis of the body as a system of meaning that has a definite structure existing separately from the consciousness and intentions of individuals, or there is the phenomenological study of embodiment that attempts to understand human practices or the performativity of the body (Turner, 2006: 223).

Turner isolates two analytical schemes to examine the body: the body as structured by social order on the one hand and the body as embodied on the other. I suggest that the first part of Turner’s quote can be extended into Foucault’s understanding of the body as regulated by governmental interventional control. Foucault’s idea of governmentality and technology of the self has particular relevance. This analysis provides an understanding of outside influences such as political strategies that regulate and control bodies through a medical regimen (Williams and Bendelow, 1998). It maps the body’s possibilities and limitations based on its biological mechanisms and provides the normative framework within which bodies can understand themselves (Williams and Bendelow, 1998). What is normal or abnormal is assessed based on a biomedical evaluation. Under this paradigm individuals are motivated to care for their own bodies in order to
conform to a socially-created standard. In other words, health behaviour is addressed structurally.

In contrast, Turner suggests in the second half of the quote that the active, conscious self is embedded in bodily performances. This implies Dill et al.’s (1995) sense of an ‘holistic self’ that influences individuals’ self-care strategies. Here, the body is seen as conscious subject: that means ‘the active body as an expressive basis of meaning and ideas’ (Williams and Bendelow, 1998: 52). Merleau-Ponty (1962: 206) continues:

We are in the world through our body, and ... we perceive that world within our body ... by thus remarking contact with the body and with the world, we ... also ... rediscover oneself, since perceiving as we do with our body, the body is a natural self, and as it were, the subject of perception (cited in Williams & Bendelow 1998: 52).

This suggests that we exist through the interaction between body and mind. It is mind and body that feel and experience external environments in order to create wholeness within the self. Consciousness and external factors are integrated together through the body. Self-care can thus be explained as a reflection of embodied experiences.

Figure 1 summarises two distinct ways of looking at the body and self that lead to different understandings of self-care.
In the following sections, I examine these two frameworks in depth to highlight their differences, especially with regard to the ways in which they construct the self in the context of self-care. Through these comparisons, I argue that although the Foucauldian framework is useful in grasping how societal forces influence individuals’ health behaviour, we should not overlook embodiment approaches in understanding the participants’ autonomous decision-making in looking after their health through self-care practices using anti-ageing medicine.

2.3 The Foucauldian analysis of self-care

Foucault’s explanation of the self and body in relation to medicine is one of the most influential analyses adopted in the sociology of health and illness and medical sociology (Lupton, 1997b). Existing sociological literature on anti-ageing medicine predominantly discusses its use through the lens of Foucault’s understanding of medicine and power. Sociologists frequently point out that anti-ageing medicine medicalises ageing processes, including bodily dysfunctions and emotional changes associated with older age. These processes are seen as pathology and treatable by medical intervention (Katz and Marshall, 2003, Cardona, 2007, Cardona, 2008, Cardona, 2009, Conrad, 2007, Peterson and Seear,
2009, Fishman et al., 2010). Scholars in this paradigm argue that older bodies are seen as undesirable and in need of medical control. For example, a decline in male erectile function associated with old age is now treated as a problem, and Viagra and other remedies are used to improve it (Katz & Marshall 2003). Moreover, menopause, once seen as caused by the natural decline in hormonal levels in older age, is now treated by hormone replacement therapy (Lock, 1993).

2.3.1 Governmentality: power, discourse and the autonomous self

In this approach, anti-ageing medicine has created a new discourse and sense of normalisation about “what an ideal self should be in older age”, propelled by societal emphasis on the importance of youthfulness and encouraging older people to participate actively in anti-ageing practices in order to be considered normal (Cardona 2007). Here, conformity to socially-oriented normalisation is vital. In this context a new type of discipline of self-care, which ‘produces new identities and behaviour’ among older people, is constructed (Cardona 2007). Lafontaine (2009) suggests that anti-ageing medicine, which makes it possible to re-engineer the body, is ‘the most accomplished manifestation of biopolitics’ (p.54). In other words, older individuals are responsible for examining their ageing bodies to maintain and improve bodily functions through the use of anti-ageing medicine. This, argues Lafontaine, is the ultimate type of risk management.

In these analyses of anti-ageing medicine and discourse, the Foucauldian understanding of medicine is social control, which is regarded as productive power. Foucault emphasises power as ‘the positive and productive rather than the repressive nature of power’, which produces disciplinary power (Lupton 1997b: 98):

What makes power hold good, what makes it accepted, is simply the fact that it doesn’t only weigh on us as a force that says no, but that it traverses and produces things, it induces pleasure, (it) forms
knowledge, (and it) produces discourse. It needs to be considered as a productive network, which runs through the whole social body, much more than as a negative instance whose function is repression (Foucault, 1991a: 61).

Foucault distinguishes disciplinary power from repressive power, which is imposed on individuals. The former works within individuals and induces the sense of an active and autonomous self, which leads to certain behaviours. Foucault refers to the body constructed through disciplinary power as the ‘social body’.

A fundamental element of disciplinary power, which produces an autonomous self, is in Foucault’s term ‘governmentality’. Foucault refers to governmentality as ‘the art of government (governing)’: that is, regulatory principles of social structure through rational decision-making (Schirato et al., 2012). Foucault (1991b) defines government here as an abstract term rather than limiting it to state politics alone as ‘a right manner of disposing things so as to lead not to the form of the common good … but to an end which is ‘convenient’ for each of the things that are to be governed’ (p.95). Governmentality is deliberately accommodated by society in order to accomplish its set goal. Disciplinary power produces norms (normalisation), which are rationally calculated for a government’s convenient end (Foucault, 1991b), and individuals submit themselves to accept the normative values because they do not want to become delinquents (Schirato et al., 2012). In this sense, the government apparatus induces a tendency in individuals to participate actively in disciplinary practices in order to meet societal norms.

This notion conceptualises self-care behaviour in older age according to the discourse of anti-ageing. That is, bodily deterioration associated with ageing can be medically controlled and it becomes individuals’ responsible choice to regulate (control) their ageing bodies through self-care practices (Katz & Marshall 2003). Older adults feel responsible for the maintenance of youthful bodies that are fit, productive and even attractive, which they believe will lead them to ideal ageing.
Using anti-ageing medicine in this context is seen as a necessary choice (Cardona 2007) because in the discourse of anti-ageing, allowing bodily deterioration is regarded as irresponsible.

2.3.2 The self within governmentality: Technology of the self

The central idea of Foucault’s governmentality is that discipline not only imposes authoritative control upon individuals, but also encourages them to participate in spontaneous corrective actions because they do not want to be regarded as delinquent (Schirato et al., 2012). In other words, governmentality is a productive force. Foucault (1991a) uses the term ‘docile body’ to explain that individuals submit themselves to discipline to gain a sense of mastery over their bodies. This in turn enables them to feel that they are social actors within societies. Individuals are not seen as oppressed or repressed, but rather, active. Foucault believes that the process of disciplinary apparatuses facilitates the creation of a ‘subject’s relation to the self’ (Schirato et al., 2012: 139), in other words, subjectivity. Foucault goes on to argue:

No individual should be understood to be inherently or intrinsically him or herself. We become subjects as a result of the various networks of relationships and discourses in which we grow up and live. … subjects become individuals precisely because of power. Power, manifested particularly through discourse of truth and knowledge, makes us what we are (cited in Schirato et al., 2012:139-140).

For Foucault, subjectivity and power cannot be separated, because they make individuals aware of what they ought to do and be. Power is eventually internalised within the self. The autonomous self created through disciplinary power empowers individuals to regulate themselves. Individuals gain certain corrective techniques in the process of knowing themselves in comparison with
social norms in order to seek conformity. Technologies of the self, according to Foucault,

permit individuals to effect by their own means or with the help of others a certain number of operations on their own bodies and souls, thoughts, conduct, and the way of being, so as to transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection, or immortality (Foucault, 1988: 18).

From this perspective, individuals are expected to make the right choice in order to become a ‘normal, healthy, attractive and desirable subject’ (Schirato et al., 2012:169). Institutions such as communities, families, schools and workplaces all play a role in monitoring individuals’ behaviour to ensure that they are in accordance with societal standards (Schirato et al., 2012). For example, local communities provide education to older people about lifestyle changes such as incorporating exercise and healthy eating into their daily lives. Medical clinics set up annual medical check-ups for older people as a way to detect the early onset of disease or to provide advice about preventative actions. Such professional (medical) interventions act as a social gaze on the lives of older individuals, whereby they are expected to strive for healthy, independent living in older age. Under the guidance of various authority figures, individuals become autonomous in the sense that they actively engage in a practice that will produce ‘successfully ageing’ selves.

In Foucault’s view, the self and subjectivity are formed within discursive regimes that involve various institutions and multiple authorities which serve to create cultural discourse and normalisation within a specific time and space (Schirato et al., 2012). Under such circumstances, individuals spontaneously participate in corrective activities for their own good.
2.3.3 Biopolitics: risk management as civic duty

The discussion on anti-ageing medicine presented earlier has explicitly addressed the idea of biopolitics, which is, according to Foucault, governmentality over the life of the population itself. Foucault (1991a: 262-263) explains that biopolitics operates as ‘supervision through entire series of interventions’ over people’s ‘biological processes: propagation, births and mortality, the levels of health, life expectancy and longevity … operated in the sphere of economic processes’. With the paradigm of anti-ageing medicine where ageing bodies are seen as out of normal health states (or even undesirable) and are in need of medical control, the government actively creates political strategies to control the health of older populations. Government policies such as ‘healthy ageing’ and ‘active ageing’ create normalisation and idealisation of health in older age and play a role in educating older individuals to practise self-care according to government definitions. There is rational calculation behind such strategies: that is, to avoid increasing demand for welfare and medical expenses for the rapidly-growing older population. Foucault (1991b) calls this ‘economic government’.

Following Foucault’s death, the concept of biopolitics has been in a constant process of redevelopment. Many scholars, notably Nikolas Rose, have redefined biopolitics in order to accommodate today’s societal climates. Rose (2001) argues that corporeality has become the central focus of our selfhood, more so in contemporary societies than in any other period. Like Foucault, the key dimensions associated with the current conceptualisation of biopolitics are biomedicine and authoritative control. However, contemporary scholars of biopolitics have further extended Foucault’s original analysis by including the notion of risk management.

With the rapid advances in biomedical technology, Rose and others are particularly interested in understanding how molecular genetics have changed the ways in which individual bodies are managed (Novas and Rose, 2000, Rabinow and Rose, 2006, Rose, 2001, Rose, 2007a, Rose, 2007b). Rose (2001:1) argues that today’s biopolitics are understood as ‘risk politics’. More specifically,
molecular genetics has given way to a new process of managing risk at the molecular level through the detection of biological abnormality or deficiency. According to Rose (2001: 16):

Life now appears to be open to shaping and reshaping at the molecular level: by precisely calculated interventions that prevent something happening, alter the way something happens, make something new happen in the cellular processes themselves.

Genetic screening tests can detect an individual’s susceptibility to certain illnesses and disease in the future, and provide appropriate intervention that aims to prevent them from happening. Individuals who are at risk of certain genetically-inherited disease are now seen as having ‘genetic responsibility’ and are thus required to ‘seek advice on how to conduct their lives appropriately’ (Novas and Rose, 2000:503).

The practice of risk management at the molecular level is applicable to older people, given that ageing cells are more susceptible to illness and disease than young cells. Most obviously, there is an increasing chance of age-related illnesses and diseases such as arthritis, osteoporosis, cataracts, dementia and cancer. Older people are expected to examine their ageing bodies and engage in certain practices of risk management to prevent the onset of age-related illness and disease. A good example is the use of anti-ageing medicine and supplements by older people. Rose (2007a:134) describes such individuals who proactively engage in health behaviour to reduce risks as active ‘biological citizens’. The process of biopolitics therefore serves to ‘control and manage our vital processes of the body and mind’ and of life itself (Rose, 2007a: 8).

To briefly summarise the argument so far, the self in self-care within a Foucauldian framework is underpinned by notions of ‘conformity to normalisation’, ‘responsibility’ and ‘risk management’. Societies dictate that individuals, as a part of their civic duties, need to be responsible for their actions.
In effect, it is the active, autonomous, responsible self who is considered a good citizen.

2.4 Limitations of the Foucauldian analysis: Alternative view of self-care

Foucault’s idea of normalization is useful in understanding how medical interventions standardize human experience, but a phenomenology of the body provides a basis for a better appreciation of the actual experiences and subjectivity of embodiment. (Turner, 2004:172)

The Foucauldian notion of governmentality and biopolitics, including its recent reconceptualisation, provide great insights into how broader social forces, including disciplinary power, may influence self-care behaviour in older age. However, as the above quote suggests, it has limitations in terms of explaining individuals’ self-care behaviour at the micro level. For example, it does not adequately explain how it is closely related to their everyday lives (Turner, 2004, Lupton, 1995, Lupton, 1997b). Within a Foucauldian framework, the use of anti-ageing medicine is narrowly viewed through the lens of self-responsibility whereby it is assumed that an individual’s self-care behaviour is largely shaped by their desire to be a ‘good citizen’ who performs his or her civic duty to be healthy. However, such a narrow view fails to take into account other motivations for engagement in self-care practices. For example, some older people take supplements such as glucosamine to prevent arthritis because they wish to continue playing sports that they have enjoyed their entire lives. Some older people may take Coenzyme Q10 (CoQ10) for heart health, as a result of the unpleasant experience of watching a parent suffer following a heart attack.

In his own critique, Turner (2004) argues that the Foucauldian approach does not take into consideration individuals’ lived experiences, particularly in terms of the factors or circumstances that lead them to engage in self-care practices. According to Turner, the social construction of the self and body as viewed from a Foucauldian perspective fails to explore embodiment. Rather, Turner (2004)
distinguishes embodiment as ‘the phenomenological subjectivity of the lived body in the life world’ from governmentality as ‘the production of the body as an object of professional knowledge and practice’ (p.170). Within the Foucauldian paradigm, agency is guided to a large extent by the power of authorities. However, Turner believes that agency is constructed through environments (such as cultures) within which individuals are located, and experiences they have had. For example, Foucault’s view cannot take into consideration the fact that an individual’s health status is largely influenced by socio-economic status (Williamson and Carr, 2009). Moreover, there are substantial cultural differences in individuals’ health management. For example, in the US, older women are encouraged by medical doctors to undergo hormone replacement therapy to overcome discomfort caused by menopause, whereas women in Japan are encouraged to accept it as a natural phenomenon caused by older age and to cope with it well in their everyday lives (Lock, 1993). These examples show that habits, cultures and other environmental factors surrounding individuals influence how they perceive and manage their own health. This is a striking difference from the Foucauldian analysis of the responsible self in self-care behaviour, constructed through conformity to societal norms.

Turner (2004) argues that lay understandings, beliefs and assumptions of health and illness are largely derived from everyday experiences of being sick, having had certain diseases or having observed others who are sick. These are mediated through social environments. Experiences of discomfort or even social exclusion caused by illness and disease ‘open up opportunities for self-reflection’ (Turner, 2004: 183), which may influence how individuals view and manage their health. Here, the body has become ‘an experiencing agent’ (Csordas, 1994:3). It is important to consider these notions when examining individuals’ self-care behaviour. Lupton (1997b) encourages the empirical investigation of subjectivity in health practices in relation to embodied experiences. More specifically, it is necessary to expand the scope of investigation to understand how an individual’s agency is formed and practised through everyday experiences. In the following
section, I discuss the relationship between the self and self-care through the lens of the embodiment approach.

2.5 Self-Care as embodied practices in the maintenance of biographical coherence

The existing literature on self-care as it relates to individuals’ embodied or lived experiences is mostly limited to the investigation of chronic health conditions. To date, there is very little research that draws on the perspectives of healthy individuals. That said, studies exploring the self and self-identity in the context of chronic illness experiences, particularly the work of Corbin and Strauss (1991), have strong implications for the analyses of self-care behaviour among healthy older adults. More specifically, it provides ample scope for understanding the connections between the body and a sense of self.

Older individuals may develop repertoires to take care of their own health in order to maintain a coherent sense of self through past, present and anticipated future experiences. This position is heavily influenced by the works of Shilling (2008), Giddens (1991) and Gilleard and Higgs (2013). The common thread running through each of these authors’ work is the notion of embodiment (or embodied self-identities). Giddens (1991), for example, argues that individuals actively participate in ‘building/rebuilding a coherent and rewarding sense of identity’ through understanding and integrating internal and external environments (p.75). From this perspective, self-care provides a means of enabling older individuals to seek, obtain or even maintain socially and culturally-formed ageing self-identities (Gilleard & Higgs 2013).

In the following section, I first examine how the self is conceptualised in the existing literature in the context of chronic illness management. This notion is elaborated into the understanding between the self and ageing body according to Shilling’s discussion. I also discuss how self-care in such circumstances may be considered by older individuals. Finally, I draw on the work of Giddens and
Gilleard and Higgs in an endeavour to build the framework of self-care as embodied practices that help older individuals (re)construct self-identity in later life.

### 2.5.1 The self in chronic illness management

There has been significant research on the embodied self within the context of chronic illness management. Such research is particularly concerned with how the self is negatively influenced by bodily experiences of illness and how it is reconstructed within such environments (e.g. Bury, 1982, Charmaz, 1983). Corbin (2003:258) argues that the experience of chronic illness threatens a body/mind connection and has a negative impact on the self ‘because of the self, which is affected by what happens to body’. For example, Williams and Bendelow (1998:160) argue that ‘pain tears apart a harmonious relationship between the body and mind’. Similarly, Asbring (2001) argues that violation of embodiment often results in a loss of identity because the body can no longer perform in a way that the mind would like. In this context, coherence in the self and in life more generally is threatened. Therefore the restoration of a harmonious relationship between body and mind is crucial to regaining a sense of coherence in the self (Williams, 1984).

Corbin and Strauss (1991) analyse the self in chronic illness management using the trajectory framework. Using the concept of biography, this framework explains how identity crises occur in the course of one’s experiences of illness. It suggests that ‘illness disrupts people’s ‘biographical body conception’ constituted by ‘a sense of biographical time, bodily coherence and functionally-coherent and morally-valid identities’ (Shilling, 2008:114). According to Corbin and Strauss (1991), to varying degrees, chronic illness or disability undermines all these aspects of one’s biography. Firstly, biographical time, which ‘includes experiences derived over a lifetime of living and all the associated memories and emotions that one carries within the self’ (Corbin, 2003:259) is interrupted.
through illness. Secondly, bodily coherence can no longer be sustained because of limitations on body movement caused by ill health. Shilling (2008) explains:

Chronic illness and disability can make people feel that they are inhabiting ‘broken’ bodies, or even that they have become ‘imprisoned’ within a physical shell that has failed them, no longer allowing them to make desired contacts with their environment. (p. 115)

People with chronic illness may experience limitations in what they can do, which may in turn violate a sense of bodily coherence. Finally, there is no doubt that these disruptions in biographical time and bodily coherence negatively influence self-identity. Shilling (2008:115) argues that ‘the effects of disrupted biographical body conception can manifest themselves in full-scale crises of selfhood’. It means that continuity of the self might be disrupted. Often, sufferers of ill-health can no longer conduct themselves as they did previously, and coherence in their lives may be interrupted or even halted. This may cast a question on their own identities and possibly cause a feeling of loss of self (Corbin and Strauss, 1991).

Other scholars have developed similar conceptual frameworks of the self in relation to chronic illness experiences. This is evident in Bury’s (1982) study of ‘biographical disruption’, Charmaz’s (1983) analysis of ‘loss of self’ and Williams’ (1984) work on ‘narrative reconstruction’. Underpinning each of these studies is the argument that experiences of chronic illness cause disruption to daily life, which in turn disrupts one’s sense of self (Bury, 1982). Furthermore, an individual’s social status may be changed due to ill health, which may negatively affect their social identity. For example, the shift from being employed to unemployed as a result of ill health may have serious implications on one’s self-identity.

While sufferers of chronic illness often experience violation of their identities, it is through the process of restoration or adjustment that they are able to regain a
sense of self (Williams, 1984). In response to biographical disruption, individuals are required to rethink their own biography and renegotiate their past self-identities. However, the disruption does not always have negative consequences. Many sufferers of chronic illness try to make sense of what has happened to them and rewrite (or readjust) their life narratives accordingly. They engage in recreating ‘a sense of coherence’ in their biographies in order to reset their lives in a positive direction (Lawton, 2003:26-27). Williams (1984) explains this using the concept of ‘narrative reconstruction’, which he defines as ‘an attempt to reconstitute and repair ruptures between body, self, and world by linking-up and interpreting different aspects of biography in order to realign present and past and self with society’. Rebuilding embodiment is critical to the process of narrative reconstruction. In response to the new situation, individuals make active, conscious efforts to regain coherence in their senses of self and in their lives generally. Thus new biographies are created.

Thus far, I have used chronic illness management as an example to explain a relationship between the self and body, and how individuals with chronic conditions readjust their lives in order to sustain coherence in life and self. The sufferers of chronic illness are located in the specific circumstances derived from their illness experiences and are required to rewrite narratives in a way that the self and body are in tune. The crucial aspect of chronic illness management is to understand bodily capacities and incapacities, and integrate them into life stories in a positive manner. The body in this context is portrayed as an expressive, communicative agent, which helps recreate ‘a world of which it is a part’ (Frank, 1991:80). The following section explores how this notion can apply to ageing, particularly ageing bodies that are not affected by extremely debilitating chronic illness.

2.5.2 Ageing bodies as a cause of crisis

It is evident that the self is closely tied to internal bodily experiences, which are represented as chronic illness (although such experiences are not limited to
chronic illnesses). The reason why the self is strongly emphasised in the studies of chronic illness management is that maintenance of self-concept: that is, the organisation of the self, is crucial in terms of carrying out everyday lives (Charmaz, 1983). This insight sheds much-needed light on how the self is (re)constructed within an ageing body. Shilling (2008) observes that in the ageing body there is great potential for imbalance between the self and body, which in turn, causes identity crisis:

Crisis occurs when there develops a significant mismatch or conflict between the social and physical surroundings in which individuals live and their biological needs and bodily potentiality. … In terms of changes occasioned by the internal environment, aging can throw our actions out of equilibrium with our bodily needs. A health regime may no longer prevent ill-health, a diet may become ineffective, and new body frailties and disabilities may restrict stamina, movement and the capacity to act in routinized ways. (Shilling, 2008: 16)

As the body experiences internal changes, actions that were once familiar habits may no longer be carried out in a similar manner. This is problematic because the self and habit: that is, ‘habitual ways of being in the world’ (Shilling, 2008: 17), are closely interconnected. Merleau-Ponty (2002) suggests that habits are the ultimate form of embodiment because they are cultivated by one’s interactions between internal and external environments through the body. Therefore, interference in one’s habits can potentially break a harmonious relationship between mind and body (Shilling, 2008). In other words, it violates the embodied self.

It is undeniable that ageing bodies often require changes in habitual actions or activities. For example, older people may need to give up day-to-day activities such as driving due to deterioration in eyesight or cognitive functions. In other instances, they may need to alter diet due to a decline in organ function.
Participation in favourite sports may no longer be possible because of arthritis, which is a common age-related health condition. Furthermore, they might not be able to produce the same outcome in various activities as they had done before. For example, they might not be able to complete household chores as quickly, or some chores such as mowing the grass may be difficult. Older individuals may negatively perceive their capacity to conduct daily activities previously embedded in daily life. Such negative views or restrictions on habitual activities ‘challenge an individual’s identity by destroying their confidence in their bodies and their world’ (Shilling, 2008: 17). As a result, continuity in one’s life may be disrupted or even halted.

In these circumstances, self-care can be considered as those practices that help older individuals store the physical capacities that allow them to have continuous engagement in habitual actions or activities. Initiating such practices involves ‘adventure, experiment and intelligent engagement with, and evaluation of, the circumstances in which individuals find themselves’ (Shilling, 2008: 21). In particular, it requires ‘creativity’ in Shilling’s notion. He elaborates: ‘Creativity is associated with actions that alter certain aspects of oneself and/or one’s surroundings in order to repair or enhance one’s embodied capacities for action’ (p.19). This involves reflexivity: ‘practical reflection’ and anticipation that consists of memory and foresight, and intelligent deliberation with one’s surroundings (Shilling, 2008: 19). Applying this perspective to self-care for ageing bodies, older individuals are required to evaluate their bodies that no longer function in the same manner as when they were younger, and take action to sustain the youthful bodily functions that are capable enough to carry out habits. Using anti-ageing medicine can thus be considered as a creative action.

Self-care for ageing bodies has particular importance, because it helps older individuals to (re)adjust their internal and external environments. This enables them to achieve consistency in life, and thus the maintenance of a sense of self (Shilling, 2008). In other words, whether or not older individuals can sustain self-identity in old age is contingent on their physical capability. The body here has
become a vehicle that directly interacts with thinking, feeling and action (Corbin, 2003). As already noted, self-care refers to a health practice that ‘involves the attempt to re-establish a sense of wholeness, to regain the ability not to attend to inconsistency, present or potential, in one’s life’ (Dill et al., 1995:35). Self-care among older adults can be understood as an attempt to maintain a harmonious relationship between the self and body, which in turn leads to continuity in life.

2.5.3 Self-care for ageing bodies and construction of self-identity in later life

As noted above, self-care enables older individuals to create a sense of wholeness in their lives. Shilling particularly emphasises the importance of one’s embodied experiences derived from everyday life situations in relation to the maintenance of self-identity in old age. By contrast, Gilleard and Higgs (2013) examine embodiment in relation to ‘the particular cultural history of a society and its institutions, and its customary way of narrating and practicing embodiment’. In particular, they elaborate upon the idea of constructing ageing identities as a consumerist practice that enables older individuals to seek the ideal self in old age. Consumer culture has been discussed as providing ‘a world of new opportunities for self-improvement, fulfilment and expanded possibilities as more and more activities are mediated through images of the good life’ (Featherstone and Hepworth, 2005: 358). It has further pushed the image of youth as equivalent to being healthy and fit with its strong emphasis on bodily maintenance and self-representation (Featherstone, 1991). In this context, a loss of control over bodily functions in older age, for example, or a decline in mental and physical capacities, are expressed as bodily betrayal (Featherstone and Hepworth, 1991). Self-care in consumer culture is regarded as a necessary practice that permits older individuals to maintain both the body and the self in ways they desire.

Gilleard and Higgs (2013: 31) focus on the collective consciousness of the ‘baby boomer’ generation in respect to reforming self-identity in old age, and how consumerism has made the body in later life ‘a site for embodiment from which
new ageing lifestyles can be fashioned’. Self-care in this context is driven by consumer culture that has created a new ageing lifestyle emphasising the virtue of maintaining youthfulness, which means that chronological ageing has become less acceptable. Subsequently, older individuals are encouraged to engage continuously in cultivating the self through body management, aiming to age differently from the previous generation (Gilleard and Higgs, 2013). Here, the self embodies the ideology of consumer culture and ‘circumscribes our choices and creates our possibilities’ (Leonard, 1994:47).

This notion is particularly important in the second modernity where individuals continuously search for a self-identity that can be rewritten through embodied experiences. Giddens (1991) calls this identity (re)formation a reflexive project in which ‘we are, not what we are, but what we make of ourselves’ (p.75). The identity (re)formation occurs within a trajectory of one’s life from the past to the anticipated future (Giddens, 1991). The critical component here is that the body plays an active role in perceiving and integrating external and internal environments. It means the body is ‘an embodied platform for what is possible’ (Gilleard and Higgs, 2013:17). Older individuals reflexively search for what they want to become and identity reformation is possible through active engagement with their bodies.

Gilleard and Higgs (2013) express a particular interest in the ways in which older individuals engage in various practices on ageing bodies—otherwise known as ‘body work’—as a means of constructing later-life identities. The practices range from fashions, cosmetics and exercise to cosmetic surgery, which Gilleard and Higgs (2013) refer to as ‘aspirational medicine’. Here, the body is specifically seen as ‘a continuing source of desire’ (Gilleard and Higgs, 2013: 20). It is through these self-care practices that older adults strive to obtain the socially, culturally-oriented desirable self. Gilleard and Higgs (2013) call such practices ‘embodied practices’, and suggest that they are generation specific.
The experiences of those cohorts who were born in the 1940s, of contacts and engagement with bodies both different and similar to their own, of personal discovery and do-it-yourself lifestyles, of enhanced self-care and reflexive self-regard, served to create the conditions under which the chronological habitus of age could be challenged. Mixed with the old fears about old age were new hopes for ageing differently, for not having to become old on other people’s terms (p.29).

Gilleard and Higgs observe that ‘baby boomers’—individuals who were born between the years 1946 and 1964—have a particular interest in engaging in body work in order to age differently from the previous generation. Higgs and Jones (2009) point out that this generation of baby boomers was influenced by the new social recognition of older age, notably the third-age ideology that encourages them to reject the idea of ‘old’ or ‘aged’. Here, the traditional view that ageing is essentially a decline in physical and mental forms is rejected. Instead, individualisation is emphasised in terms of understanding ageing and the choice to treat the body in order to create new possibilities. Older individuals’ desire to age differently from previous generations is indicative of the current consumer culture whereby individuals are always striving for a better lifestyle (Gilleard and Higgs, 2013). Self-care as embodied practice helps them ‘orientate the body towards distinct social, cultural personal identities and their associated lifestyles’ (Gilleard and Higgs, 2013: 159).

The question arises as to what ageing differently from previous generations or a better lifestyle mean in the context of consumer culture. It is useful to consider the idea of an ‘arc of acquiescence’ proposed by Higgs and Jones (2009) as a metaphoric understanding of the trajectory of ageing. The arc of acquiescence refers to ‘a gradual withdrawal from successful body maintenance and the greater acceptance of bodily limit’ (Higgs and Jones, 2009:86). Higgs and Jones (2009:86) argue that in the second modernity, the curvature of this arc has been stretched out among the elderly, particularly among those who have established
‘social, cultural and economic capital to support continued engagement with the individualised demands of a somatic society’. Somatic is defined as ‘of the body’, as distinct from the mind. In a somatic society where ‘the body becomes the site of political debate and social anxiety’ (Turner, 1992:13), the maintenance of healthy bodies has become a primary focus for individuals. Those who have access to resources that can extend the ‘arc of acquiescence’, such as good diet, gym and medical technology, are able to continue enjoying their lifestyles. In other words, they are able to prolong continuity in life. This is a particular feature of consumerism in which individuals can consume services, products or technology, which facilitates what they hope to be (Featherstone and Hepworth, 1989). The extension of the ‘arc of acquiescence’ allows older individuals to delay the onset of physical decline associated with ageing. This allows them not only to have continuity in life—that is, carrying out what they have done before—but also to sustain the youthful self that represents ‘choice, autonomy, self-expression and pleasure’ (Gilleard & Higgs, 2013: 160).

A key component in Gilleard and Higgs’ (2013) argument is that the desired self in older age can be constructed through understanding bodily changes associated with ageing, and then readjusting or modifying them in order to maintain a personally-set standard. This practice is influenced by the idea of new old age—that is, not becoming old—facilitated by the consumerist ideal of youthfulness. Body management through self-care, considered a reflexive project in Giddens’ (1991) sense, allows older individuals to exercise the choice to pursue desirable lifestyles in older age within certain circumstances. This in turn leads to desired later life self-identities.

In summary, there is commonality in the discussions between the self in the contexts of chronic illness management and in the works of Shilling and Gilleard and Higgs, although each has a different focus. In these contexts, the self is mediated through the body in the matrix of societal and cultural relations in the specific time and space in which the body is located. Older individuals are required to comprehend what has happened or what is happening to their bodies,
and to try to negotiate these happenings with their identities in order to maintain coherence in their biographies. In this approach, self-care practices facilitate a harmonious relationship between the ageing body and the self, which is fundamental to identity formation. Such practices are addressed in a specific way ‘on the basis of the projections, expectations, and memories derived from a multiplicity but ultimately limited repertoire of available social, public and cultural narratives’ (Somers, 1994: 614). However, it is clear that self-care leads to a sense of wholeness among older individuals.

2.6 Conclusion

This chapter has contributed to an understanding of what self-care means in older age through two different sociological analyses of self-care: the Foucauldian and embodiment approaches. These differences reflect Turner’s (2006) two analyses of the body: the body as structured by external force and the body as phenomenologically embodied. In the Foucauldian analysis of self-care practices, disciplinary power (social order) works on the body. In other words, societal values decide the body’s possibilities and limitations, particularly through medical regimes. The self is constructed through the active participation in corrective practices that produce a social body. In this process, the active, autonomous, prudent and responsible self emerges around the notion of risk management.

By contrast, in the embodiment analysis, the body has become an active agent that perceives the outside world and communicates within the self to create new possibilities. In other words, the body acts as an instrumental and expressive agent that communicates ‘within the self and between the self and environment’ (Freund, 1990:456). Here the self is mediated through bodily experiences of internal and external worlds. The idea of self-care as an embodied practice suggests a close relationship between the self and self-care behaviour. Here, self-care is considered as a practice that facilitates (re)construction of a later-life self-identity. Older individuals are reflexive and creative actors who take initiatives to carry on their own lives in ways that maintain biographical coherence. To do so,
they develop their own self-care strategies through the narratives derived from their past and present experiences, and anticipation of the future.

In Chapter Three I examine how people’s experiences of ageing are influenced by cultural beliefs and values as well as societal conditions, including governmental policies focusing on Australian and Japanese contexts. I also explore what is meant by ‘ageing well’ and how older adults in different cultural settings perceive this.
Chapter Three
Ageing and ageing well in socio-cultural context

If old people show the same desires, the same feelings and the same requirements as the young, the world looks upon them with disgust: in them love and jealousy seem revolting or absurd, sexuality repulsive and violence ludicrous. They are required to be a standing example of all the virtues. Above all they are called upon to display serenity: the world asserts they possess it, and this assertion allows the world to ignore their unhappiness (de Beauvoir, 1970:10).

French feminist and philosopher Simone de Beauvoir begins her book, *Old Age*, by describing how older age is typically viewed in a negative light. De Beauvoir (1970) argues that society has created a certain image of older people, that of ‘serenity’. If they deviate from this image, they are looked upon with ‘disgust’. By constructing stereotypical perceptions of older age, society attempts to ignore the reality of what older people are really like, including their needs and desires. De Beauvoir (1970: 17) argues that older people are seen as a nuisance if they exert any signs of a strong self-identity because they are in the process of ‘irreversible, unfavourable change: a decline’. De Beauvoir’s (1970) analysis of old age has great relevance to the sociology of ageing, particularly in the West. A number of social theories view old people in a negative light, assuming that they are structurally forced to be dependent on society due to their declining capacity in productivity (Townsend, 1981). Although some social theories now view old age in more a positive light, as discussed in Chapter Two, negative images of old people are still prevalent in many present-day Western societies. There is persistent ageism, which refers to a discourse that devalues and discriminates against the elderly, not only at institutional levels, but in people’s perceptions (e.g. Cuddy et al., 2005).
However, it is important to note that such a negative, disrespectful image of older age is rather ethnocentric and not applicable to many non-Western cultures. For example, in many Asian nations where intergenerational dependency within the family is traditionally practised, the authority of elderly people within the household is preserved and their experiences and wisdom are respected (Streib, 1987). Accordingly, perceptions of elderly people and their lived experiences are different from those seen in many Western societies.

The purpose of this chapter is to compare and contrast how societies create a particular way of life for elderly people based on culturally-constructed values. Particular attention is paid to Australian and Japanese contexts. Furthermore, the chapter explores how cultures and various societal conditions influence the meanings of quality of life in old age perceived by older individuals living in different cultures, including Australia and Japan.

3.1 Culture, social policies and ageing


The above quote invites reflection on what growing older is. The answer may vary depending on what individuals focus on, where and which culture they live in and moreover, in which time they live. For example, for some people it might be retiring from work. For some, it might be having grandchildren, and having wrinkles or grey hair might be a sign of ageing for others. These different understandings of old age are constructed through individuals’ lived experiences (e.g. Fox, 2005, Vincent, 1995, Wray, 2003).

Vincent (1995) explains ageing as individuals’ experiences of ‘collective, social process’ in one’s life course. According to Vincent (1995:9), ‘(L)ife courses are sociological phenomena because experience through life is socially structured’.
To explain the social construction of the life course more specifically, he continues:

“(L)ife courses” happen to people in historical time and in particular places, so they reflect the fact that “life cycles” change over time and place. “Life courses” vary not only between different social groups, for example across genders, but significantly they also vary historically. … The “life course” is the individual experience of the collective social process of ageing. Life courses are social because they have general and observable patterns, which are a part of the structure of society. Life courses can be seen to be structured by norms and values, for example those associated with the life cycle, but they are also given characteristic forms by historical patterns of social change. (Vincent, 1995:9)

Within this life course perspective, when considering individuals’ experiences (or perceptions) of growing older, we cannot neglect the life courses followed since they were born.

It is necessary to comprehend societies and cultures to understand the meaning of older age, because these provide guidance for individuals throughout the life course (Vincent 1995). In other words, one’s experience of ageing is culturally specific. This is supported by some empirical studies, which take a phenomenological approach to examining cultural differences in experiences and meanings of ageing among older people (e.g., Fox, 2005, Vincent, 1995, Wray, 2003). Fox (2005) explores how Australian and Thai elderly people aspire to ideal ways of ageing. The Australian elderly believe in the importance of independence (including physical, financial and emotional independence) in older age, which is strongly emphasised in, and encouraged by, Australian culture. In contrast, elderly Thai people show a positive understanding and acceptance of physical and financial dependence on their children. This is due to the social norm in Thailand based on Buddhist culture, which strongly emphasises the importance of mutual
care within a family and respect towards the elderly. Fox (2005) found that those differences in cultural (societal) practices have an enormous influence on older people’s experiences of ageing in both Australia and Thailand. He concluded that ‘culture must be taken seriously in exploring the experience of growing older, and that cultural factors underpin many of the other social relations of care’ (Fox, 2005:494).

Drawing on Fox’s suggestion of cultural specificity, in the following sections I examine beliefs in and expectations towards old age at both societal and individual levels in the Australian context in comparison with the Japanese context. Specifically, they endeavour to highlight the influences of political strategies that have produced certain values regarding getting older, and lead older adults to conduct themselves in a specific manner.

3.2 Getting old in Australia: Ageing policies

Australians are living longer and healthier lives than in years past, and are more active in their older years. Over the next 40 years, Australia will need to embrace the potential of this talented older population group, particularly by valuing their increased and ongoing engagement in the workplace and community. (Commonwealth of Australia, 2015: 96)

The excerpt presented above is from the recent 2015 Intergenerational Report Australia in 2055, which was released by the Australian government on the 5th of March 2015. This report provides projections for Australia’s future economic growth and prosperity over the next 40 years, with particular emphasis on the nation’s ageing population and its associated implications. Specifically, the report raises serious economic concerns about increasing public spending for older people under circumstances of significant decline in labour force participation and productivity among this population. Accordingly, as the above quote clearly illustrates, the government encourages older adults to be positive contributors to
Australian society through their continuous workforce participation. For example, Treasurer Joe Hockey, in support of the report, emphasises that ‘(T)he grey army is going to deliver prosperity in Australia's future and we need older Australians, we want older Australians, if they choose to do so, to remain in the work force and to come back into the work force’ (Kenny and Massola, 2015).

While the Australian government regards older Australians’ workforce participation as of utmost importance for the future of Australia, it is clear from the report that retired Australians are viewed as an economic burden. The report reveals plans to reduce expenditure for old-age pension and aged care in the future. This indicates that older adults are expected to live independently and self-sufficiently as long as possible without depending on government support. This strategy is underpinned by the widespread ideology of neoliberalism, which values ‘increased participation and productivity, and enhanced independence and autonomy’ (Kendig, 2004: S9).

In an exploration of what is expected in the process of ageing in the Australian context, it is crucial to examine ageing policies promoted by the Australian government, since they have played a central role in forming collective understandings of how to get old. In essence, the policies are developed based on the principles of the Ottawa Charter (World Health Organization, 1986) and the Jakarta Declaration (World Health Organization, 1997) (Asquith, 2009). Another policy framework proposed by the World Health Organization (WHO) (2002:2): *Active Ageing*, has a profound impact in informing ‘discussion and the formulation of action plans that promote healthy and active ageing’. Active ageing is defined as ‘the process of optimizing opportunities for health, participation and security in order to enhance quality of life as people age’ (World Health Organization, 2002:12). Here there are three pillars constituting active ageing: participation, health and security. Specifically, health enables older individuals to manage their own lives and allows them to continue participating in social, economic, cultural and spiritual activities. Moreover, social, financial and
physical security provides older individuals with a sense of protection when they are no longer able to support themselves (World Health Organization, 2002).

This is ‘a rights-based approach by recognising the rights of older people for opportunity and treatment in all aspects of life’ (Hussain et al., 2005:35). Underpinning this policy is the importance of maintaining autonomy and independence. The WHO (2002) suggests that quality of life in older age can be achieved by maintaining these aspects through individuals’ choice in conjunction with family support, community help and adequate medical support. The goal of this policy is to spread the recognition that ‘healthy older persons remain a resource to their family, communities and economies’ (World Health Organization 2002:3). This policy assumes that older individuals are active contributors to societies as long as they are healthy and can look after themselves.

With reference to the WHO’s policy frameworks, in Australia the government has established the National Strategy for an Aging Australia in which various concerns regarding old age are discussed, including ‘the retirement income system; a changing workforce; attitudes, and lifestyle through community support; healthy aging; and world class care’ (Kendig, 2004: S10). Moreover, the government has published various educational booklets for older people such as Choose Health: Be Active, Better Health and Active Ageing for all Australians to promote positive ageing. The term ‘positive ageing’ can be interpreted as successful ageing, productive ageing and healthy ageing. The purpose of these booklets is to educate older people to make the right choices in order to maintain independence for as long as possible. Older individuals are expected to make the right choices that enable them to continue healthy, active and independent life in old age. To assist them to achieve this, there are various recommendations suggested in these booklets, including nutritional advice, an adequate, regular exercise strategy and information about access to various community supports including medical help for preventive health.
Plath (2008) argues that the word ‘independence’ is a central feature in Australian ageing policies, and therefore is widely used with a number of different meanings depending on the policy contexts. It includes living at home (not living in a institution such as a nursing home), quality of life and well-being, making a valued and active contribution to society, accessing various services provided by communities, functional capacity and financial independence (not relying on the pension) (Plath, 2008). What is prominent in the promotion of independence in old age is its individualised approach. In other words, Australian older people are encouraged to maintain independence through responsible behaviours (Asquith, 2009, Plath, 2009).

3.2.1 Neoliberal ideal of independence in old age

Such active promotion of independence through self-responsibility in old age originates from Australian society’s historically strong focus on individualism (Rowland, 1991). This has certainly influenced older people’s lives. Rowland (1991: 195) observes:

In Western societies, modernisation has brought greater emphasis on individualism and personal autonomy, and less on collective goals and the role of the family as a source of financial security and instrumental support in old age.

Rowland considers in particular Australian characteristics, and suggests that modernisation has changed expectations of how older people should be in society. Australian ageing policies have shifted in a way that encourages older people to live in their homes and maintain their autonomy for as long as possible through self-management (Rowland, 1991, Plath, 2002, Plath, 2008).

With the ascendancy of neoliberalism in Australian in the 1980s, this individualistic notion of independence in old age is further encouraged. A central feature of the neoliberal idea of citizenship is that individuals must be ‘liberated
from ‘big government’ and state interference’ (Powell, 2005:64). This notion has certainly affected welfare policy for the elderly in such a way that all citizens are responsible for their own welfare (Western et al., 2007). Those who can look after themselves are called active citizens (Powell, 2005). This idealisation is applicable to older people. The main purpose of neoliberal ageing policies is to encourage older people to strive for self-funded (retirement) so as not to become a ‘burden’ on society. Aligned with this, the Australian government has tightened eligibility requirements for the age pension, which has shifted the notion of the age pension as ‘a social right to, increasingly, a selective provision based on economic need’ (Borowski and Olsberg 2007:195). The age pension is means-tested. In turn, Australia has spent less per capita on older people than other OECD nations (Harvey and Yoshino, 2006). This tendency will be further strengthened by the recently announced proposal in the Intergenerational Report that the government will reduce expenditure for the age pension in the future (Commonwealth of Australia, 2015).

The emphasis on cost reduction for the elderly has expanded into care provision (Harvey and Yoshino, 2006, Commonwealth of Australia, 2015). One example is the Commonwealth Home and Community Care (HACC) program, which provides services that help older people stay independent at home and be more independent in the community. The services range from nursing care to domestic assistance (e.g., help with cleaning or shopping), personal care (e.g., bathing), home maintenance, centre-based day care and respite service. People aged 65 years and over are eligible to receive those services (Australian Government, Department of Social Services, 2015). Howe (2001) points out that the HACC program highlights the current emphasis on cost reduction. Specifically, there has been a remarkable decrease in the outlay on nursing care services since the late 1980s, and an increase in that for community care/support services. Howe (2001:102) sees this trend as ‘moving the balance of care towards lower cost services and maintaining the broad base of the service pyramid as a means of containing the high-cost services’. It means that there is a pyramid shape to care divisions with the top division of high-cost nursing care having relatively few
recipients. Recipients who receive care support from the government and from their family members are in the middle, and large numbers of independent elderly who do not require immediate support are at the bottom (Harvey and Yoshino, 2006).

This shift from institutional care to community care also promotes familial care. However, families influenced by individualism tend to provide less instrumental help than in collective cultures, and instead make use of welfare services (Powell, 2005). Despite the government’s expectation of a shift in care provisions, research in the 1980s reports that elderly Australians strongly believe in self-reliance and independence and are reluctant to be dependent on others, including their children (Kendig and Rowland, 1983). It is also reported that although they are willing to receive support from family members when necessary, it is more likely to be limited to emotional support—‘intimacy at a distance’—rather than physical and instrumental support (Kendig and Rowland, 1983:645). This trend has been extended into present-day Australian society as Dempsey and Lindsay (2014: 234) explain Australian adults’ attitudes to family involvement and support as ‘intimacy without dependence.’ It is clear that the individualistic notion of independence—that is, self-management in all aspects of one’s life—is prevalent among Australian elderly people.

3.2.2 Critiques of neoliberal ageing policies

The Australian government’s active promotion of positive ageing has been criticised as ‘the responsibilization agendas of contemporary, neoliberal governmentality’ (Asquith, 2009: 256). Current policies have been formed through political economic perspectives, which see population ageing as a problem that will place an economic burden on public health and welfare systems (Aberdeen and Bye, 2011). In order to avoid financial crises potentially caused by growing numbers of old people in the future, the government places ‘new expectations of responsibility on older people’ (Aberdeen and Bye, 2011: 10). This means that they should be self-sufficient and able to meet their own needs.
Despite the fact that the health promotion policies proposed by the WHO in the Ottawa Charter (1986) and the Jakarta Declaration (1997) emphasise the importance of building infrastructure at both individual and community levels, the critique of Australian ageing policies argues that in essence, the government provides little practical support for the elderly (Asquith, 2009).

Australian ageing policies presuppose homogeneous patterns in old people’s lives. In other words, they do not consider diversity in older individuals’ lived experiences, largely shaped by various social conditions such as social class, gender, marital status and ethnicity. For example, Aberdeen and Bye (2011:15) suggest that ‘social class is the most significant factor in determining possibilities for older people, as the potential for individual opportunity does not exist separately from social opportunities’. Without considering diverse experiences among the elderly and social conditions that determine possibilities in old age, policies can be coercive and also restrictive (Aberdeen and Bye, 2011). In fact, Bye’s (2007) qualitative research presented in Aberdeen and Bye (2011) reveals the critical and cynical views among older Australians towards government policies. For example, one of the participants explicitly states that the government’s strong emphasis on good health in old age is aimed at keeping older people away from the health system. Other participants questioned the government’s active promotion of productive ageing that encourages workforce participation among older individuals. They believe that they have contributed enough in their working lives, and should now be able to engage in activities other than work. Another participant, Jane, believes that she is unfairly treated by the Australian government welfare agency. She is continuously urged to work in her older age. It is not taken into account that she has experienced enormous difficulties in her life due to emotional distress, physical constraints and health problems caused by death of her husband.

Despite the Australian government’s effort to actively promote the idea of positive ageing, it seems clear that there are conflicting understandings of ageing or old age between government bodies and the public. In the following section, I
examine how older Australian individuals understand and experience the process of ageing in a social climate where independence and autonomy are strongly emphasised.

3.2.3 What do Australian elderly people expect in old age?

Irrespective of the critiques of Australian ageing policies as ‘hyper-individualism’, (Asquith, 2009) and the negative reactions towards them among some Australian elderly people found in Bye’s (2007) research (cited in Aberdeen and Bye, 2011), it is evident from the literature that the discourse on the importance of maintaining independence in old age has widely prevailed among Australian elderly people (e.g. Fox, 2005, Kendig and Rowland, 1983, Kendig et al., 1999, Quine and Morrell, 2007). A typical example is to be found in the negative perceptions towards nursing homes among Australians. Nursing home admission is thought to mean an ultimate loss of independence for elderly Australians: it means that they can no longer stay at home and take care of themselves, which is the most important aspect of independence (Cheek et al., 2006, Quine and Morrell, 2007).

The prevalence of this discourse is also seen in the statistics showing the living arrangements of older Australians. The Australian Bureau of Statistics (ABS) (1999) reports that over 80 per cent lived independently (either with their partners or on their own) in 1999. A similar trend was found in 2003 by Qu and Weston (2003) and in 2011 by the ABS (2012). This proportion is significantly higher than in Japan, where almost 46 per cent of older people lived with their adult children in 2004, and the proportion of intergenerational co-habitation tends to increase as they get older or frailer (Someya and Wells 2007).

In independent living circumstances, Qu and Weston (2003) report that elderly Australians benefit from social engagement as much as younger cohorts. Many of them enjoy participating in social activities such as playing sports, hobby activities and volunteering, as well as visiting friends, neighbours and their own families (e.g. Baum et al., 2000, Heuser, 2005). Communities provide
environments that encourage elderly Australians to enjoy social activities. For example, there are more than 200 University of the Third Age (U3A) groups in Australia. These provide older adults with a wide range of educational courses such as languages, literature, history, music, photography, and sports such as Tai Chi, Yoga and line dancing, to name a few. Some U3A groups have attracted more than 1,000 members (Swindell et al., 2009). With respect to participation in volunteering activities, the estimated economic contribution of elderly Australians is $2 billion a year (National Senior Australia Productive Ageing Centre, 2009). This shows that they are productive and can make positive contributions to Australian society.

Maintenance of physical and mental capacity seems to be particularly important in making social connections with others. It is often reported that engagement in social interactions is beneficial for the health and well-being of older adults (e.g. Findlay, 2003). It not only reduces loneliness, but produces social support that increases the morale of older people (Gray, 2008). This is particularly evident in Heuser’s (2005) ethnographic study of older women’s participation in lawn bowls. They (re)discovered a sense of purpose and commitment by getting involved in this sport. Importantly, by sharing interests (playing lawn bowls), they managed to build friendships, through which they display ‘genuine concern for one another’ (Hueser, 2005:57). In this sense, ‘bowls became the vehicle through which this particular group of women built community’ (Hueser, 2003:45). Community-based social support in older age may be particularly important in Australia where intergenerational interdependence is not a social norm. It can be argued that by participating in activities outside their homes, older Australians intentionally connect themselves to society. In other words, they actively create social connections outside the house in order to build mutual social support networks.

In summary, it is clear from the literature that Australian society has set up an environment in which older individuals are expected to strive for independence in old age. Government strategies have been successful in creating a discourse
around how to age successfully, and it has become well embedded in the lives of elderly Australians. In the following sections, I examine how Japanese people experience getting older.

### 3.3 Getting old in Japan: from filial piety to modernisation

Historically, Japan has been a gerontocracy-type society in which there has been a link between status and age: the older the better. This type of society values experiences, and therefore older people are respected and cherished. With the rapid advancement of industrialisation as well as fast economic growth after the war, Japanese people underwent a big transition in lifestyle, and the gerontocracy-type society crumbled (Someya and Wells, 2008). That said, the idea of respect for the elderly was culturally embedded, and extended into familial practices of elderly care seen in the ideology of filial piety. Importantly, this had an enormous impact on policy-making regarding the elderly in Japanese society.

Filial piety originated from Confucian philosophy, which teaches the virtue of respect for elderly people. In family practice, this means that the elderly are supported by the younger generations (Ikels, 2004). More specifically, Hashimoto (2004: 182) explains:

> Filial piety defines a hierarchical relationship between generations, particularly that of the parents and child. In this ordered space, filial piety prescribes the ideology of devotion by the grateful child to the parents, and also places debt and obligation at the heart of the discourse on parent-child relationships.

In essence, in cultures adopting the idea of filial piety, intergenerational dependency is a social norm (Fox, 2005), particularly the familial practice whereby children look after their parents in gratitude for the nurturing they received in childhood. Physical and financial dependence by ageing parents on their adult children is considered a virtue. Ikels (2004) suggests that Asian
countries have developed familial practices based on filial piety that reflect their own histories, economics, population change and people’s living circumstances. Within the philosophy of filial piety, Japan purposefully encouraged a specific living arrangement for the elderly: that is, ‘the patri-lineal, parti-local stem family’ (Koyano, 1996). This living arrangement was upheld by law, and had a significant influence on the historical treatment of older people in Japan.

### 3.3.1 Traditional ie system in Japan

In Japan the dependence by the elderly on their adult children was traditionally a societal regulation. Filial piety and co-residency between parents and adult children were seen as normal (e.g., Koyano, 1996, Yamato, 2006). This particular condition was created (or even forced) by civil law in 1898, called the ie system, which literally means ‘household system’. Briefly, under the ie system (also called ‘ie ideology’), ‘a retired household head and his wife, or his widow, lived with the successor’s nuclear family and was given every kind of support by the successor, his wife and children’ (Koyano, 1996:52). The successor here is usually the eldest son. In exchange for providing support to the elderly, the successor inherited all assets. This system was legal and practised until the end of the Second World War (Yamato, 2006). The ie system emphasised the importance and moral value of filial obligation and older people’s dependency on their children (Yamato, 2006). Under this system, it was normal for older people to be dependent on their children, both physically and financially.

After the Second World War, the ie system was officially renounced and completely removed from civic law (Koyano, 1996, Yamato, 2006). The dramatic economic growth in post-war Japan created wealth among the citizens, and also a new form of family structure, the nuclear family. In turn, people’s attitudes towards the ie system changed dramatically (Koyano, 1996). Nation-wide opinion polls showed that in 1953, 73 per cent of people showed positive attitudes towards the practice of ie ideology, decreasing to 51 per cent in 1963, 36 per cent in 1973 and 27 per cent in 1983. Similarly, older people’s desire for dependence on their
children changed (Koyano, 1996). This implies that independence became more important to older people in this period. This is supported by the decline in co-residency rates during that time. Although over 90 per cent of older people lived with their children in the 1940s and 1950s, the proportion decreased to 79.6 per cent in 1970, 69.8 per cent in 1980, 60.6 per cent in 1990 and 49.5 per cent in 2000 (Yamato, 2006).

Notwithstanding this decrease, the proportion of co-residency for two generations is still much higher than in the West, and tends to increase when older parents move into very old age or get more frail (Koyano, 1996; Someya and Wells, 2008). For example, the proportion of intergenerational co-residency among older people aged between 65 and 69 was 49.5 per cent and increased to 72.9 per cent among those who were aged 80 years and older in 1992 (Kono 2000). Kono (2000) explained this phenomenon by the fact that welfare policies were formed (and reformed) in a way that families were still regarded as the main source of care giving. It is also speculated that older people in these circumstances still had some expectations towards their adult children in terms of physical support, and that adult children still retained a sense of obligation to look after their older parents.

### 3.3.2 Long-term care insurance system

In anticipation of a rapidly-growing ageing population that would progressively increase the dependency ratio and welfare expenses, a new welfare scheme for older adults, called the long-term care insurance system (LTIS) was brought into practice in Japan in 2000. Briefly, the LTIS is a mandatory contribution for Japanese citizens aged over 40, which means that they are obligated to pay a contribution (ranging from 3,000 yen to 5,000 yen depending on locality) every month. Then, the LTIS provides various services in the public and private sectors, including residential and community care services, home nursing, day care, respite care, home repairs and rental for nursing appliances. People over the age of 65 can then request assistance from this fund (Someya & Wells, 2008, Izuhara,
2010). Under the LTIS, caring responsibilities are shared by a variety of providers (Izuahara, 2010). Older people who receive care through this scheme are recipients of assistance enabled by this citizens’ tax, rather than being dependants on welfare. This system has reduced the stigmatisation of dependence on public support, which was traditionally regarded as shameful or undesirable (Yamato, 2006, Izuahara, 2010). The LTIS has changed the public discourse of elderly care from filial obligation to a modernised system of professionalised, institutionalised care (Jenike, 2003).

This shift in discourse, together with the actual practice of the LTIS, has promoted attitudinal changes with regard to culturally-embedded family-driven care provision. Not only older people, but also middle- or older aged care-givers—mostly women—have alternative choices to familial care (Jenike, 2003). Jenike’s (2003) qualitative study highlights these changes. It explores the attitudes of daughters-in-law who lived with their older parents’-in-law with severe age-related disabilities, for whom they used to provide complete care, and focuses on their decision-making regarding the utilisation of public services to care for their parents-in-law. Here, the parents-in-law were eligible to be financially supported by the LTIS. The study found that with the use of public services and professional help, these women felt liberated from the heavy burden associated with the total care they were previously obliged to provide. They shared the belief that they were the last generation willing to take on the burden of care-giving, and had no expectation to be fully cared for by their own children—particularly their daughters-in-law—when they eventually need assistance with living (Jenike, 2003). This is because they have discovered that the workload of prolonged long-term care for the frail elderly is too heavy and sometimes practically impossible, and that it causes physical and emotional strain. Moreover, their experiences as care-givers instilled a desire in them to live independently in older age rather than being dependent on their own children, though some had never considered what it might mean to be living alone in older age (Jenike, 2003). The attitudinal change derived from their lived experiences was prominent in this study and the availability of the LTIS certainly played a role in facilitating it.
3.3.3 Where to from here?

Following Jenike’s (2003) study, it can be speculated that more and more older Japanese people hope to obtain a sense of independence in older age. In fact, Matsubayashi et al. (2006) found that 87 per cent of elderly Japanese people participating in their research rated the question of ‘being able to take care of myself until close to the time of my death’ as an important element in successful ageing. The words, ‘close to the time of my death’ imply that they are unwilling to be dependent or to become a burden on their children. This differs from the finding in the 1993 survey that nearly all older Japanese older participants expected informal support from families if care was needed in the future (Kendig et al., 1999). Although these two studies have different foci, they are helpful in grasping the changes in how older people perceive the later stage of life. With the breakdown in filial obligations, in conjunction with the LTIS, older Japanese adults may be given a new opportunity to seek autonomous selves that allows them to choose their ideal life style.

Nowadays, elderly Japanese people are enjoying more choice in how to lead their lives; they are less constrained by traditional ways of life than previous generations. Ueno (2009) argues that the later stage of life should be treated as an opportunity to reorganise identity. Importantly, she suggests that the social identity of the elderly needs to transform from negative to positive. Historically, Japanese society did not allow older people to reorganise their identities in a positive manner. Ueno (2009:220) suggests that industrial modern Japan purposefully created an image of older people as ‘sweet old persons’, removing their dignity and responsibility. This means that older people are free from any responsibility, and enjoy the same high level of freedom experienced by infants (Ueno, 2009).
However, with the new social movement encouraged by the LTIS, as well as accumulated wealth among many older people through home ownership\(^1\) and superannuation, they are able to regain power and to reconstruct their autonomy. This implies that Japanese older people have become more active and responsible rather than the manifesting the passive and powerless position previously commonly acknowledged in Japanese culture. It is important to acknowledge, however, that this notion might only be applicable to those who enjoy good health and a comfortable financial situation. It is reported that Japanese older individuals who are socioeconomically disadvantaged tend to have ill health conditions (Fukuda et al., 2005) that may make it difficult for them to seek active, autonomous lifestyles in old age.

The Japanese government now encourages a positive image of old age. It proposes that in order for older people to achieve successful ageing, it is necessary to create ‘old people friendly living circumstances’ by reforming work environments and welfare (including easy access to community services for care), and by creating friendly community environments to which older people can make valued contributions (Cabinet Office, Government of Japan, 2009). Instead of encouraging older individuals to be active and healthy, leading to a sense of independence as shown in Australian policies on ageing, the Japanese government’s emphasis is more on reforming the social factors surrounding older people in order for them to achieve successful ageing. As an example, in 2001 a not-for-profit organisation, the Japan Old Person’s Co-operative Union (日本高齢者生活協同組合連合会), was established at a community level in order to build an environment where older individuals could seek quality of life. This organisation provides a variety of services ranging from emotional and physical support, home-visit-care, meal delivery, organising voluntary work for healthy retired people, and the provision of cultural activities aimed at enhancing morale. Moreover, it provides care training for those who want to become qualified carers (for more information: Japan Old Person’s Co-operative Union:日本高齢者生活

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\(^1\) Eighty-four per cent of Japanese people aged 65 or over owned their homes in 2003 (Someya and Wells, 2008)
Following societal promotion of successful ageing, recent ageing research in Japanese contexts shows positive aspects of ageing among elderly Japanese people. Takahashi et al. (2011) found that ‘ordinary’ older Japanese people actively seek new hobbies, learn new things, develop their skills and expand social capital through participating in group activities (in Takahashi et al.’s research, the photograph club), and this enhances quality of life in older age. As a consequence of community participation, levels of life satisfaction increased (Takahashi et al., 2011). Now increasing numbers of local communities like U3A in Australia provide various social activity classes ranging from sports such as tennis, dance and softball to calligraphy, choral-singing and floral arrangement (Doba and Hinohara, 2011). At a community level, Japanese society has started setting up social environments where older people can strive for an active ageing identity.

In summary, with the current social climate of a rapidly-ageing population, both Australian and Japanese governments have created social environments where older individuals are encouraged to actively seek positive experiences of ageing. More specifically, governments promote positive or successful ageing whereby older people can enjoy an enhanced quality of life that incorporates personal autonomy and self-fulfilment. Prominent cultural differences are evident in Australian and Japanese processes of transforming perceptions of old age from negative to positive. In Australia, modernisation has brought individualism and personal autonomy (Rowland, 1991), and this notion has been a focal point in Australian ageing policies. Accordingly, older Australians are constantly encouraged to search for independence through self-responsibility. By contrast, elderly Japanese people have traditionally experienced a social norm whereby dependence in old people on their adult children was legitimised by law through the ie system. After the demolition of the ie system, together with various social and policy changes, including the ageing population and the newly-established
LTIS, Japanese older individuals are in transition in terms of their understanding of old age. They are moving from passivity, powerlessness and dependence to a position of independence that corresponds more closely with the Australian experience.

3.4 Perceptions of ageing well

It is clear that different cultures place different expectations on ageing individuals. Accordingly, older individuals experience ageing differently. Thus there are varied perceptions across cultures as to what ageing well is (e.g., Molzahn et al., 2011). Throughout this thesis I use interchangeably the expressions ‘ageing well’, ‘successful ageing’ and ‘quality of life in old age’. In order to understand these expressions, in this section I examine how these concepts have been defined and studied. The subsequent section investigates how culture impacts older adults’ perceptions of ageing well. This will be achieved through an exploration of studies of cross-cultural comparisons of successful ageing and quality of life in old age.

Rowe and Kahn (1997) define successful ageing in a broad sense as a mix of three components: absence (or low probability) of disease/functional disability, high physical and cognitive functions and active engagement with life. Researchers investigating successful ageing tend to use this definition as a point of departure in identifying predictors of successful ageing (Tan et al., 2010). However, there is no consensus about what constitutes successful ageing or quality of life in old age. Research foci are different, and research tends to concentrate on one dimension only. For example, a biomedical approach, which is often adopted in medical fields, focuses on good health, or an absence of (chronic) disease. By contrast, a psychosocial approach emphasises life satisfaction and psychological growth, including a positive outlook, self-efficacy, a sense of autonomy and independence, and adaptability. However, concentration on one dimension does not adequately explain how older people understand and experience successful ageing (Tan et al., 2010). Some researchers have found that many older
individuals consider themselves to be ageing well, even though they have health problems or functional limitations (e.g., Borglin et al., 2005, Bowling and Dieppe, 2005, Reichstadt, et al. 2010). Accordingly, it is suggested that a broader context be examined in order to develop a definition of successful ageing (Bowling, 2007, Reichstadt et al. 2010).

Bowling (2007) argues for a more multidimensional approach to defining successful ageing. In particular, it is important to incorporate older people’s views, because perceptions of quality of life are largely dependent on individuals’ life experiences (Borglin et al., 2005, Bowling, 2007, Bowling, et al., 2003, Farquhar, 1995). Reflecting the fact that people have different life experiences, Bowling (2007) found that lay people understand the concept of successful ageing in various ways. They include physical health and functioning, mental and cognitive health, psychological well-being and a sense of happiness, social relationships, productivity, activities, personal growth, self-acceptance, coping, financial security, spirituality, sense of purpose and accomplishment. This finding indicates that lay views of successful ageing are influenced by personal attributes and individual living conditions and circumstances such as age (for example, the old or the oldest old), gender, socioeconomic status, marital status, ethnicity, health conditions, family traditions and inherited cultural values.

Most empirical research that explores successful ageing and quality of life in old age has been conducted quantitatively in order to determine clusters of factors that constitute these concepts as listed above. Qualitative research conducted by Borglin et al. (2005), Bergland and Narum (2007) and Reichstadth et al. (2010) provides valuable insights into how the various factors are experienced and narrated by older people. Although participants in these three studies have distinct features in terms of age, gender and cultural settings in which they reside², there

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² Borglin et al. (2005) targeted old men and women (80 years and over) in Sweden who have maintained physical functionality, so they are able to live independently in their homes. Bergland and Narum (2007) focused on old women (age 75-93 years) living in various circumstances in Norway. Reichstadth et al. (2010) interviewed community-dwelling men and women over 60 in San Diego, CA.
are commonalities in the ways they contextualise their perceptions of ageing well. There are two concurrent themes across these studies. First, the participants believed that ageing well means preservation of continuity and coherence in both self and life. In order to achieve this, they understood the necessity for self-acceptance and for making adjustments. More specifically, they accepted the fact that old age requires some life style change due to functional decline. Therefore, they need to cope with change, adjusting their life styles to fit their new situation or environment (Bergland and Narum, 2007). Here, the words ‘change’ or ‘difficulty’ have various meanings depending on the participants. For example, some experience difficulty because of the death of significant others, which has a big impact on their lives. For others, it means limitations in their daily activities due to ill health. Nevertheless, this notion coincides with continuity theory as originally suggested by Atchley (1972) (cited in Bowling, 2007). This theory suggests that ‘people who age successfully are those who carry forward their values, lifestyles and relationships from middle to later life’ through ‘adjustment and adaptation’ to challenges caused by ageing in various situations and activities (Bowling, 2007:267). Doing so can help older adults to construct their ‘continuum of selfhood’, in other words, ‘sameness within change’ (Bergland and Narum, 2007:49).

The second theme is continuous engagement in life. This is believed to contribute to personal growth, personal enjoyment and fulfilment, and the improvement of others’ well-being, all of which enhance one’s self-esteem (Reichstadt et al., 2010). Through social interactions, older adults can gain a sense of connectedness that leads to psychological security. Moreover, by remaining independent and autonomous, referred to by Bergland and Narum as ‘empowerment’ (2007), they can maintain initiative in controlling their lives. This is believed to provide a sense of purpose, and eventually make their lives meaningful (Bergland and Narum, 2007, Borglin et al., 2005).

According to older adults’ perceptions of ageing well based on their lived experiences, these qualitative studies reveal that the factors that constitute
successful ageing are not experienced independently. Rather, they interweave with each other and have particular meanings for older individuals. Moreover, they perceive and understand what is meant by ageing well by creating their own life stories reflecting past, present and future selves. It is clear that lay perceptions of successful ageing are uniquely tailored through older people’s lived experience within their specific living conditions and circumstances.

3.4.1 Cross-cultural comparisons on quality of life in old age

It is argued that definitions of successful ageing or quality of life in old age are extracted from Western literature, and therefore they tend to reflect Western values. Therefore the applicability of definitions in a non-Western cultural context needs to be examined (Tan et al., 2010). Investigations of these concepts across diverse cultures are still works in progress (Molzahn et al., 2011). Through an examination of the limited empirical research that exists, it is clear that an understanding of culture and societal conditions is crucial to grasping what successful ageing means to older adults in a socio-cultural context. For example, Harris and Long (1999) found that White-American men and Japanese men who care for their ageing parents hold different views towards successful ageing. For the former it means maintaining maximum levels of independence in old age, while the latter show levels of acceptance of dependence on others in old age. This suggests that for Japanese people, independence might not be as important for ageing well as it is for their American counterparts. The differences are based on traditionally-embedded family practices in the U.S. and Japan (Harris and Long, 1999). Similarly, Ikels et al. (1992) found that Americans have an individualist understanding of successful ageing that encompasses self-motivation and self-sufficiency, whereas elderly people living in Hong Kong believe it is formed around intergenerational living and familial support.

Molzahn et al.’s (2006) cross-cultural comparisons of perceived quality of life in old age across 22 countries reveal substantial differences as well as similarities between those living in developing and developed societies. On the one hand, the
importance of health and physical and mental functionality that enable them to conduct daily activities are universally emphasised across the nations. On the other hand, some policy-related aspects, such as being able to receive adequate social care and securing financial resources, are more important to those living in developing nations than for their counterparts in developed countries. Presumably, this reflects the insufficient (or even scarce) provision of welfare by governments in developing countries.

Phelan et al. (2004) and Tan et al.’s (2010) studies that compare and contrast meanings of successful ageing between White- and Japanese-Americans, and Anglo- and Chinese-Australians respectively, highlights the fact that lay perceptions of ageing well are fluid rather than fixed. They depend on time, place and cultural context. Both studies found that Japanese-Americans and Chinese-Australians show certain levels of acculturation to their adopted countries: the U.S. for the former and Australia for the latter. Specifically, the new cultural values adopted, which are distinct from the ones inherited from their original cultures, are manifested in their understandings of successful ageing. For example, there was no prominent difference in how White- and Japanese Americans value ageing well. The Japanese-Americans emphasised the importance of individualist values such as independence, autonomy and self-sufficiency as much as did White-Americans (Phelan et al., 2004). Moreover, Tan et al. (2010) found that Chinese-Australians believe that financial security, which means not being financially dependent on others including their children, is of the utmost importance in successful ageing. This finding is strikingly different from the traditional Chinese practice of children being financially responsible for their ageing parents (Tan et al., 2010). These examples reveal that the ways older individuals hope to age vary depending on where, when and in what circumstances they are situated.

### 3.4.2 Ageing well in Australia and Japan

To date, there is little research that exclusively compares and contrasts older Australian and Japanese adults’ understandings of successful ageing. However,
drawing upon existing literature and empirical evidence, it is possible to make a reasonable assumption. As discussed earlier in this chapter, Australian and Japanese societies are moving closer together in terms of encouragement to construct positive ageing identities. This might be indicative of a perceptual change in what it means to age well, particularly for the Japanese. Some research already shows a shift in attitude by Japanese people from positive to negative regarding traditionally-practised familial care for the elderly (Koyano, 1996). Accordingly, levels of awareness of the importance of maintaining independence in old age have increased (Matsubayashi et al., 2006). This finding differs from that of Harris and Long (1999) discussed earlier, which suggested that Japanese people generally accept the notion of dependence on others in old age.

Useful survey data is to be found in Molzahn et al.’s (2011) cross-cultural comparisons of perceived quality of life in old age across 22 nations, including Australia and Japan. The data revealed that older Australian and Japanese people have similar views on what they consider to be important contributing factors to ageing well. Apart from health-related aspects, the three highest-rating factors out of 33 possibilities were maintaining autonomy, ability to conduct activities of daily living and mobility. Although significant similarities were noted, this quantitative data does not allow further, in-depth investigation of how these factors are grounded in Australian and Japanese people’s beliefs and values, and experienced by these two cohorts in their everyday lives. This qualitative study will add to the knowledge of the ways in which older Australian and Japanese individuals experience successful ageing in relation to their own life histories and family relationships, as well as culturally-inherited beliefs and values about old age.

### 3.5 Conclusion

This chapter has explored two distinct but interrelated features: 1) how cultures and political ideologies influence processes of ageing in Australia and Japan, and 2) what is meant by ageing well and how culturally-inherited values and societal
conditions influence this. This discussion sheds light on how motivations and experiences of ‘anti-ageing’ activities manifest in different cultural settings.

In both societies, current ageing policies have been formed in a way that encourages older individuals to be active, autonomous, independent citizens. Considerable emphasis is placed on independence in the Australian context, which originates from individualist ways of living brought about by modernisation. In contrast, from a history of intergenerational dependency, the Japanese government has attempted to set up an old-people-friendly environment that enables them to be active and autonomous. An example is the LTIS established in 2000, which opened up more options for the provision of care to the elderly, encouraging them to take the initiative in making choices about their care. This has encouraged Japanese people to be more autonomous in older age.

It is suggested that perceived quality of life in old age is largely influenced by lived experiences. In other words, it is dependent on context. Reflecting the fact that people have different life trajectories, the existing quantitative research has identified a variety of contributing factors in lay individuals’ perceptions of ageing well. In addition, existing qualitative research reveals that these clusters of factors are integrated into two overarching themes: 1) preservation of continuity in the self and life, and 2) continuous engagement in life (Bergland and Narum, 2007, Borglin et al., 2005, Reichstadth et al., 2010). Although older adults face different living conditions and circumstances, successful ageing is thought to be the ability to ‘carry forward their values, lifestyles and relationships from middle to later life’ (Bowling, 2007:267), which in turn, help them to maintain a sense of who they are.

The definitions of ageing well outlined above are arguably ethnocentric and may not be applicable to non-Western nations (Tan et al., 2010). Taking this into account, some research has found substantial differences in meanings of successful ageing across cultures. They largely reflect socially-constructed ideologies of old age, and moreover, societal conditions. Reflecting the fact that
Australian and Japanese societies share similar values in terms of what they expect for older people, empirical research data reveals prominent similarities between the two cohorts’ beliefs about what constitutes ageing well: autonomy, maintaining functionality for daily living and mobility. However, due to the limited information gleaned from the quantitative data, the ways in which these two cohorts’ perceptions of ageing well are grounded in their ageing processes, and practised in everyday living, are unknown. This study will take a qualitative approach to investigating this aspect.

In the next chapter, I discuss the methodological approaches adopted in this study. As a bilingual researcher, I also examine methodological issues associated with collecting and analysing data in two different cultures.
Chapter Four
Methodology: doing cross-cultural research

A person with a sociological imagination thinks critically, historically and biographically. … Such a researcher is led to seek out subjects who have experienced the types of experiences the researcher seeks to understand. The subject in the interpretive study elaborates and further defines the problem that organizes the research. Life experiences give greater substance and depth to the problem the researcher wishes to study. ... It is contained within the self-stories and personal experience stories of the subject (Denzin, 2002:350).

This study applies an interpretive approach to explore older individuals’ self-care practices through the use of anti-ageing medicine and supplements in Australia and Japan. As the above quote suggests, an interpretive study helps researchers understand and explore lived experiences in some depth by examining life stories critically, historically and biographically (Denzin 2002). This approach lends an insightful analytical technique to this study. Self-care practices cannot be studied without taking into account participants’ lived experiences (Dill et al., 1995). Moreover, an interpretive approach enabled an in-depth investigation of people’s lives in different cultural contexts through the close examination of cultural beliefs and values. In order to reveal cultural similarities and differences in the Australian and Japanese contexts—the main feature of this study—comparative research perspectives were adopted.

This chapter discusses the research methods utilised in this study and reviews the advantages and limitations of the qualitative methodological approach. I begin by locating myself as a bilingual researcher in this cross-cultural study, and in particular the ways it affected data collection and analyses. I continue on to discuss the practical methods of sampling, recruitment, conducting interviews and data analyses adopted in this study.
4.1 Cross-Cultural Research

Cross-cultural studies often involve studying cultures and languages unfamiliar to researchers. This potentially places extra demands on researchers in achieving sound research outcomes. Denzin (2002) describes a crucial principle in the conduct of interpretive qualitative research, which is of great relevance to cross-cultural comparisons:

Interpretive research centers the hermeneutic circle by placing the researcher and the subject in the center of the research process. ... The subject who tells a self-story or personal experience story is, of course, at the center of the life that is told about. The researcher who reads and interprets a self-story is at the center of his or her interpretation of that story. Two interpretive structures thus interact. The two circles overlap to the degree that the researcher is able to live his/her way into the subject’s personal experience stories and self-stories. (Denzin, 2002: 354)

This quote shows that qualitative research with an interpretive orientation requires researchers to be able to interpret participants’ perspectives in an appropriate manner to understand what is happening. Researchers’ own stories will also affect their interpretations. In order to adequately interpret data, it is necessary to acquire a sound understanding of the culture or cultural practices that influence participants’ beliefs, values and thoughts. In cross-cultural research, the possibility that researchers are not familiar with cultures other than their own must be borne in mind. In addition, language is key to cultural understanding because stories are told and narratives are created in a particular language.

In conducting qualitative cross-cultural research, some researchers are concerned about linguistic issues: that is, where the researcher and participants do not share the same language (e.g., Williamson et al., 2011). Shklarov (2007) and Kokanovic et al. (2009) discuss the risks of applying a concept defined in the West to another culture without considering its appropriateness, as this potentially affects research
outcomes. For example, according to Kokanovic et al. (2009), the meanings of depression vary depending on whether a society is traditional or advanced. It is necessary to adjust accordingly to carry out cross-cultural research properly. In other words, it is necessary to consider the “insider’s” interpretation of customs or beliefs’ with regard to concepts within particular cultural settings (Neuman, 2006: 449). These notions are relevant to this study, which compared and contrasted self-care practices through the use of anti-ageing medicine among Australian and Japanese participants. Not only did the participants speak different languages—English or Japanese—but the findings revealed that the values and beliefs sustaining self-care practices reflect cultural practices, and varied across these two cultures.

4.1.1 The author as a researcher and language translator

As a bilingual researcher who speaks both English and Japanese, and who has lived in both in Australia and Japan, I was at an advantage in conducting this cross-cultural research. More specifically, with my knowledge of both cultures and my bilingual skills, I was able to take on the double role of someone who is ‘simultaneously acting as a researcher and a language translator’ (Shklarov, 2007: 530). Briefly, I was born in Japan and spent approximately 30 years of my life there (including tertiary education and seven years in the workforce) before I migrated to Australia. Therefore, I am familiar with Japanese traditional customs, values and beliefs. Moreover, through my experiences studying sociology in Australia, I am sensitive to recent cultural (or attitudinal) changes in Japan brought about by Western influences. After migration, a decade spent living in Melbourne with my Australian partner, together with my years of study experience in sociology at Swinburne University (undergraduate and honours degrees, and Doctor of Philosophy) have greatly helped me to understand Australian culture from the perspectives of both academia and everyday life.

My personal lived experiences have helped me to understand both Australian and Japanese participants’ self-stories in an appropriate manner. This is particularly
important because according to Shklarov (2007: 536-7), interpretations of data involve ‘a complex social and cognitive process that can influence the ethical standing and general outcomes of the research’. Therefore, having an adequate understanding of the cultures researched, including beliefs and values associated with particular practices—in this case health practices—is necessary. However, in playing this double role, it is also important for the researcher to keep his/her knowledge of the culture researched up to date. This is shown in an example provided by Kokanovic et al. (2009:711). If hired translators are long-term immigrants and educated in a host country, their understanding of the language, culture and values of their home countries can be ‘frozen in time’, and this might result in misinterpretation of data. I was particularly careful to avoid misinterpretation caused by my understanding and knowledge of Japanese culture, which may potentially have been ‘frozen in time’ since I left Japan. I believed that reading Japanese newspaper on a daily basis and keeping up with changes in societal trends in Japan positively contributed to my knowledge update.

4.1.2 Doing bilingual research

The first task was to prepare interview schedules in both English and Japanese. Both schedules followed exactly the same structure. The original interview schedule was created in English. Then, I translated it into Japanese taking care not to change the meaning. When translating an interview schedule from one language to another, attention needs to be paid as to the way it is done. Neuman (2006) suggests that direct translation can sometimes distort (or change) meanings of words if a researcher (or translator) is not aware of the characteristics and specificity of a particular language, or of the connotations and cultural meanings of particular words. Keeping this notion in mind, I was careful about ‘adequacy and accuracy’ in contextual cross-cultural interpretations (Shklarov, 2007:529).

To enhance the credibility of my translation, the back translation technique—in which ‘a phrase or question is translated from one language to another and then, back again’—was employed. This technique facilitates the achievement of
‘lexicon equivalence’ between two statements written in different languages (Newman, 2006:445). In other words, through the technique of back translation, the two interview schedules written in English and Japanese acquired the same contents. I asked a fellow Japanese PhD student at Swinburne University to complete the back translation of my interview transcript to make sure that these two interview schedules were equivalent in content. I gave her the Japanese version of the interview transcript, and asked her to translate it into English. I then compared her English translation with my original English transcript to see if there were any obvious differences.

My bilingual skills brought some advantages to data collection and data analyses. Specifically, these skills were beneficial both in terms of maximising levels of exploration during the interviews and ‘ethical soundness and knowledge outcomes’ in the data analyses (Shklarov 2007:531). In conducting interviews as a bilingual researcher, I did not have to worry that an interpreter potentially mediates interview contents. This concern was based on the discussion around ethical considerations in using interpreters when conducting interviews in cross-cultural settings: for example, the objectivity and neutrality of interpreters during an interview (Shklarov, 2007, Williamson et al., 2011). Williamson et al. (2011) argue that interpreters can become mediators who could potentially positively or negatively influence interview content.

A second advantage was noted during the interviews. The semi-structured, open-ended interviews adopted in this study allowed the possibility of asking additional questions to enable further elaboration of participants’ comments. In this process, the ability to make good decisions on the spot about what I wanted to follow up was an important element. My bilingual skills made it possible to do so during the interviews with both Australian and Japanese participants.

The benefits of the double role were also apparent in data analysis. As discussed earlier, cross-cultural researchers have to consider “‘insider’s” or “native’s” interpretation of customs or beliefs’ in particular concepts within specific cultural
settings (Neuman, 2006:449). This notion was particularly apparent in interpreting the Japanese data. For example, the Japanese participants frequently used colloquial expressions during the interviews. Without fluency in the Japanese language, subtle nuances in meaning might have been missed. As another example, many Japanese participants made a link between diet and intake of particular supplements that they believed to have anti-ageing effects. More specifically, they mentioned that they eat ‘good food’ but that dietary supplements are also needed as a source of extra nutrition in their old age. Here I interpreted the meaning of ‘good food’ in a culturally-specific way, as food or eating habits represent particular cultural practices (Lupton, 1996). For example, a famous Japanese folk belief, ‘Ishoku Dougen (医食同源)’ shows that medicine and daily diet are of equal importance for the maintenance of a healthy body. Accordingly, many Japanese people believe that particular foods can help prevent disease. This is represented by a popular phrase, ‘with umebosi (a pickled Japanese plum), we don’t need a doctor’, for example. To understand what Japanese participants meant by ‘good food’ in relation to self-care practices, a cultural understanding of food (or eating habits) was necessary for the conduct of in-depth analyses. Many Australian participants also emphasised that they eat good food. However, the meanings of good food did not include the same cultural connotations as they did for Japanese participants. They often referred to vegetables, fruit and fish as opposed to buttery, oily and sugary food such as fast food, chocolate and cakes, which are often considered by Australian participants to be bad food. The Australians often talked about food as if there were an hierarchical order from good to bad, rather than a healthy diet being culturally embedded.

Thus far, I have examined the advantages of my position as a bilingual researcher in conducting this cross-cultural research, particularly in terms of data collection and analyses. I did not experience particular disadvantages in these processes. The following sections describe in detail the methodological approaches, including sampling strategies, recruitment, interviews and data analyses. Reflection on the influence of cultural differences on these methods is included.
4.2 Sampling

Neuman (2006) argues that qualitative researchers are concerned with finding cases that will enhance the knowledge gained about the process of social life in a specific context. In particular, qualitative research permits researchers to interpret and better understand the complex reality of a given situation. It is especially effective in obtaining culturally-specific information about the values, opinions, behaviours, and social contexts of particular populations (Mack et al., 2005). Qualitative research methods allowed this study to follow its research interest of the exploration of how older people were motivated to use anti-ageing medicine and supplements in order to maintain good health in older age. This study highlighted how different cultures (Australia and Japan) influenced individuals’ decision-making in the use of anti-ageing medicine and supplements. These ‘how’ questions made it possible for the ‘emergence of “what is going on”’ in a specific social setting (Glaser, 1998:41). Accordingly, a combination of the purposive and snowball sampling methods was adopted. Purposive sampling refers to approaching a specific population meeting participation criteria for ‘identifying particular types of cases for in-depth investigation’ (Neuman, 2006:222). Snowball sampling allowed the acquisition of more participants through word-of-mouth via people who had already taken part in this study.

There were two main criteria participants had to meet in order to take part. They had to be older adults who were taking some kind of anti-ageing medicine or supplements. Regarding the latter criterion, anti-ageing medicine or supplements were defined in this study as nutraceutical and pharmaceutical products that ‘postpone or relieve the effects of biological ageing’ (Vincent, 2006a:196). Specifically, anti-ageing medicine and supplements decrease the risk of illness and conditions associated with ageing such as coronary heart disease, arthritis, osteoporosis, dementia and cataract among others. They also function to alleviate symptoms caused by age-related illness and disease. In the body of this thesis, frequently-used terminologies regarding ‘anti-ageing medicine’ and ‘anti-ageing supplements’ refer to any form of HRT and nutraceutical dietary supplements with anti-ageing effects. I was careful to ensure that all participants were aware
that the supplements they were taking had some kind of ‘anti-ageing effects’ as described above. This meant that they acknowledged they needed those supplements, which are specifically manufactured and targeted to older individuals.

In the research advertisement designed for this study, I asked for people taking ‘some forms of anti-ageing medicines or supplements’, and provided some examples such as Omega3, CoQ10 and anti-oxidants. The purpose of this open inquiry was twofold. First, I sought a variety in the types of anti-ageing medicine participants were using. Second, I wanted to facilitate participants’ awareness that the hormone treatments, dietary supplements and herbal medicine they were taking may have anti-ageing effects. Their beliefs and thoughts about the anti-ageing effects of supplements were carefully assessed during initial exchanges regarding their suitability for participation in the research. As a consequence of this, I had to exclude three people. For example, one of them told me that she has been taking vitamin C to prevent her from catching a cold or the flu, but did she not describe this as an anti-ageing practice.

The other sampling criterion was that all participants be older adults. The way of defining ‘older age’ raised some questions, because there is no universally-consistent definition across societies. Vincent (2003) argues that old age is a social construction. It means that our perceptions of young and old age categories are constructed by societal regulations. Vincent (2003) explains that our chronological age is especially important in the West due to the fact that

(S)ociety regulates public life according to chronological age…. The conventional definition of chronological old age as starting at 60 or 65 stems from standardisation and bureaucratisation of the life course around the administration of retirement pensions (p.8-9).
This shows that categorisation of old age is important in terms of implementing a government policy or scheme, in this case, the retirement pension. However, societal regulations vary and are often subject to change depending on the social climate. For example, at present Japan and Australia have adopted similar age criteria for eligibility for the aged pension (provided by governments): 65 years old for both men and women in Japan; 64.5 years old for women and 65 for men in Australia (Cabinet Office, Government of Japan, 2007, Australian Government, Department of Human Services, 2013). However, in Australia it will increase to 65.5 for both men and women in 2017, and subsequently it will increase by six months every two years (Australian Government, Department of Human Services, 2013).

In keeping with the above policy contexts, this study adopted age criteria based on the ways Australian and Japanese societies specify the age categories of senior citizens. For example, in Australia, individuals who are 60 and over are eligible to apply for a Seniors Card, although the eligible age for the retirement pension is 65 and over. In Japan, the retirement age at the time of these interviews was 60 years old (it was amended to 63 in 2013). Taking these factors into account, I set the participants’ age criteria for this study as 60 years and above.

Previous sociological research into the use of anti-ageing medicine among older individuals has focused on those who visited anti-ageing experts and were then introduced to some kind of anti-ageing medicine to combat health issues associated with ageing (e.g., Cardona 2007, Cardona, 2009, Watts-Roy 2009). Moreover, the participants, especially in Cardona’s study (2007 and 2009), predominantly fell into the upper-middle and upper class categories, and had professional occupations such as lawyers and doctors. This study investigated the underlying motivations for the use of anti-ageing medicine. The aim was to obtain more diversity in a sample than that contained in studies such as Cardona’s (2007, 2009), because the use of anti-ageing medicine, particularly supplement treatments, can be initiated by lay individuals’ own decisions independent of consultations with anti-ageing specialists. This assumption is made based on the
fact that there are plenty of anti-ageing products sold in pharmacies, health stores and even at supermarkets. Hormone replacement therapy (HRT), which used to be available only through consultation with medical doctors, can now be purchased online in a supplement form (not all types of HRT, however) (see, Life Extension, 2015). This implies that HRT can now be more easily accessed by older individuals who cannot visit their doctors due to circumstances such as geographical distance, or who are reluctant to consult with them regarding anti-ageing treatments.

Within the sample, the current study aimed to achieve diversity in age, gender, educational status, occupational status, marital status and types of anti-ageing medicine and supplements consumed. Miles and Huberman (1994) suggest that obtaining diversity in samples allow researchers to draw more solid findings. This strategy is particularly beneficial for qualitative research, which investigates novel situations through an inductive and theory-building approach (Miles and Huberman, 1994). It was expected that the increased diversity in the sample population enhances the credibility of research outcomes.

4.3 Finding and interviewing participants in Australia and Japan

Recruitment and interviews took place after approval to conduct the fieldwork of this study was granted by the Swinburne University Human Research Ethics Committee. In Australia, data collection was conducted between February 2010 and July 2010. In Japan, it was carried out from August 2010 to mid November 2010. Finding participants in both Australia and Japan was not easy. The same recruitment strategies were adopted in Australia and Japan. However, because of cultural differences, in the end it was necessary to adopt different processes in each country.
4.3.1 Recruitment in Australia

In Australia, participants were sought and found exclusively in Melbourne. It was clear which recruitment methods were successful or unsuccessful. A large number of participants were recruited from one community-learning centre for senior citizens: University of the Third Age, and through an institution that conducts research on ageing: The National Seniors Productive Ageing Centre. The rest were recruited through word-of-mouth.

There were clear reasons why recruitment through these two sources resulted in success. Firstly, the leading members of the community-learning centre for seniors showed an interest in this study and invited me to their monthly meeting of members. Briefly, this learning centre provides a variety of classes for its retiree members. In general, these members are keen on learning new things in older age. I was given an opportunity to present my research, and some members showed their willingness to participate in this study there and then. The opportunity to present my research and communicate my enthusiasm for the study directly to potential candidates was helpful. There was also the opportunity for me to spend time talking to the candidates after the presentation, which enabled me not only to provide more details, but also to build a rapport with them.

The second successful recruitment strategy involved assistance provided by National Senior Australia Research, the research arm of the National Senior Australia, which is a membership-based community organisation that provides economic and social benefits to people 50 years and over. The research officer of this institution willingly consented to post my advertisement in member newsletters. Several participants were identified through this process. It was anticipated that the members of National Senior Australia might be familiar with ageing research to some extent, given that National Senior Australian Research distributes research reports to them (also available on the website). This encourages members to participate in ageing research.
Several Australian participants regarded this research as particularly important in terms of future orientation toward health policies for older Australians. Therefore they were keen to have their voices heard. They raised their concern that healthy older adults are, in general, neglected in the process of policy making, and that current ageing policies or health policies rarely reflect what older people really need and want. They saw this research as providing them with an opportunity to have their say.

4.3.2 Recruitment in Japan

To find participants in Japan, I targeted Osaka city. This meant I could stay with my parents while conducting my fieldwork. As in Melbourne, some recruitment methods were more successful than others. Recruitment through community groups for seniors proved to be the most fruitful. By contrast, recruitment through a local newspaper and member-based online communities targeting senior citizens was less successful.

As mentioned above, a large number of Japanese participants were identified through community groups ranging from community learning centres to volunteer groups. I was able to access these communities through acquaintances of mine, including family connections. The research advertisement and plain language statement were mailed out to the leaders of each group, and the members were then notified. Some potential candidates contacted me directly and others did so via the leaders. Following their interviews, a few participants cooperated in sourcing additional participants through word-of-mouth. More than half the Japanese participants were recruited from these groups.

Participants were also sought from a health centre and from customers of a clothing shop; this was another successful recruitment strategy. The owners of these places were acquaintances of mine, and cooperated with me in informing their clients about this research by distributing the research advertisement. The owners provided me with the contact details of potential candidates who had
agreed to participate in this study. I then contacted them to ensure they met the criteria for participation.

Reflecting on the recruitment process in Japan, I was surprised how willing Japanese participants were to take part in this study. I had assumed that qualitative research involving face-to-face interviews would not be a research technique with which Japanese people were familiar. My own investigations had made it clear that most social research by research institutions or government bodies in Japan is conducted using the random sample technique for their surveys. I was concerned that this might discourage people from participating in this study. However, this proved to be ill-founded. It is possible the participants’ willingness was due to the fact that I knew the community leaders and the owners of the shop and health centre. This may have promoted a sense of cooperation among Japanese participants. This could also explain the lack of success in recruiting from newspaper and online communities with which I did not have a personal connection.

Overall, there were clear differences in the recruitment process between Australia and Japan. A wider range of strategies was employed to find Australian participants. This might be related to levels of cultural familiarity with participation in (qualitative) research. In Australia, qualitative research that involves interviews is a common research method. It is likely that many lay individuals are familiar with it to some extent. In fact, some Australian participants told me that they had previously participated in research that required them to express their opinions. Such experiences may well have been a positive push factor. In contrast, Japanese people would be less likely to have had such experiences, which might explain why I had more difficulty in recruiting participants with whom I had no personal connection. The degree of familiarity with research itself could potentially positively or negatively influence lay individuals’ decisions regarding participation. This should be taken into account for recruitment methods in different cultures.
4.3.3 Participant characteristics

When finding participants in Australia and Japan, it is important to consider the fact that there are prominent differences in the ethnic diversity of the population between these two countries. This could affect not only sampling, but also research outcomes. Australia is multicultural, while Japan is well-known for its relative cultural homogeneity. The 2011 census reports that approximately one-quarter of Australia’s total population is overseas born (Australian Bureau of Statistics, 2012). In contrast, the proportion of foreigners residing in Japan in 2010 was only 1.67% of the total population (Ministry of Justice Japan, 2012). While there was little chance of having ethnic diversity among Japanese participants, this was less possible for the Australian sample. The range of ethnicities among the Australian sample could mean that their perceptions of ageing well, especially in relation to their family practices and relations, would vary. This assumption is based on existing research showing that migrants and Anglo-Australians have different values and beliefs in life. For example, while Anglo-Australians emphasise individualistic values in their life styles, Greek and Italian migrants often adhere to traditional, collective values that emphasise the importance of family and community bonds (Rosenthal et al., 1989, Smolicz et al., 2001). As discussed in Chapter Three, this cultural diversity has the potential to affect perceptions of ageing well.

However, most Australian participants were Anglo-Australians and born in Australia. Three participants were migrants who moved to Australia nearly 25 years ago. Of these, two of them were a married couple who emigrated from Poland, and the other was a Sri Lankan woman who had been married to an Anglo-Australian man for over 20 years.

This study sought to obtain an equal (or similar) number of women and men in both Australia and Japan. However, the final sample consisted of more women than men in both counties. Overall, this study obtained 13 female and eight male participants in Australia and 16 female and five male participants in Japan. The higher numbers of women participants may be due to my personal attributes: that
is, I was a woman in my mid-30s when the data was collected. For example, older males could be more reluctant to talk to me about their personal health issues than older females. Alternatively, females could be more interested in participating in social research than males. In fact, some Australian male participants were encouraged by their wives to participate in my research.

With regard to the age of participants, diversity was found among both Australian and Japanese participants. The age range was between 58 and 84 in Australia, and 58 and 79 in Japan. The majority of participants were in their 60s and 70s. Although the research advertisement specified a target age group of 60 years and over, two participants (one Australian and one Japanese), both aged 58, contacted me to express an interest in taking part. Based on their subjective understanding that they are no longer young, I decided to include them. They acknowledged that they are moving into older age, and their beliefs and values underpinned their use of anti-ageing medicine. Thus they met my criteria.

In terms of participants’ socio-economic status, most of them were from a middle-class background. Some Japanese participants were from the upper-middle class. Considering the fact that anti-ageing medicine can be costly, requiring considerable out-of-pocket consumer expenses, participants’ socio-economic status may affect the types of anti-ageing medicine they consume. People from lower socio-economic classes might not be able to conduct the same health practices using anti-ageing medicine as the participants of this study were able to do. This may place limitations on this study.

With regard to the types of anti-ageing medicine and supplements taken by the participants, the existing literature led me to believe that they would be using a wide range of anti-ageing medicine and supplements. These range from nutraceutical dietary supplements such as CoQ10, alpha lipid acid, magnesium, Omega 3, anti-oxidant, glucosamine and fish oil, among many others, to pharmaceutical products; hormone replacement therapy (HRT), including Human Growth Hormone (HGH), the steroid hormone called dehydroepiandrosterone
(DHEA), testosterone and estrogen. Also included are traditional herbal medicines such as ginseng and ginkgo biloba (Cardona 2008). In this study, the majority of participants were taking a combination of nutraceutical anti-ageing supplements. Four female Australians were taking a combination of some form of HRT and some nutraceuticals, while no male participants were taking HRT. No-one was taking HGH. Participants were taking a greater variety of nutraceutical supplements than was noted in the literature, and actively sought suitable supplements to meet what they believed their bodies’ needs to be.

Whether or not to include the participants who were taking HRT in this study required consideration. HRT is different from anti-ageing supplements in that it requires a physician’s prescription. I decided to include them for a number of reasons. Firstly, these participants shared the same beliefs and values towards their health practices using anti-ageing medicine with other participants who did not take HRT but other forms of anti-ageing medicine. Secondly, they were also taking supplementary forms of anti-ageing medicine along with HRT. Moreover, they emphasised the importance of taking bio-identical HRT in order to avoid possible side effects, which is often discussed as the downside of taking conventional HRT in the research field of medical science. They mentioned that bio-identical HRT is an alternative option to conventional medical practices. More specifically, they talked about it as if it were a complementary and alternative medicine (CAM) rather than a medical practice.

Last of all, it is important to note that all participants considered themselves to be healthy and were conducting daily activities without difficulty, although many of them were experiencing chronic health conditions associated with ageing such as knee and back pain. This issue may lead to possible limitation of this study. For example, if the participants in this study had included less well individuals as well as healthier ones, the collected data might have been different particularly in respect of what ageing well means for the former and the latter.
A list of Australian and Japanese participants is presented in Appendix 1 of this thesis. It includes gender, age, occupational status, marital status and the types of anti-ageing medicine taken.

4.3.4 Interviewing participants

The interviews were conducted in places where participants felt comfortable, mostly in their homes, although other venues were used in some cases, including work studios, a café, a community centre and a communal room at Swinburne University’s library. These venues did not seem to inhibit the development of a good rapport, or to affect the nature of participants’ responses. Most interviews lasted for over an hour, with the shortest lasting 50 minutes and the longest nearly three hours. All interviewees signed a consent form and were provided with the plain language statement presenting a brief description of the study. Confidentiality was assured, with pseudonyms used to enhance this outcome. All interviews were audio-recorded and later transcribed by me for data analysis.

The interview questions were semi-structured and open-ended. This provided participants with the opportunity to explore and freely generate their thoughts in relation to the topic. A more in-depth exploration was facilitated through asking additional questions to encourage participants to elaborate on their statements. The interview schedule consisted of three main themes. (1) the use of anti-ageing medicine and supplements, (2) perceptions of ageing well and (3) ideal relationships with significant others, particularly family members, in the process of ageing. The second and third themes related to the use of anti-ageing medicine and supplements. In addition to these pre-generated themes, the flexibility of the interview schedule enabled modifications to be made as new themes emerged from the interviews. This means that this study was not constrained by pre-determined conceptual frameworks, but rather it was ‘as free and open as possible to discovery and to emergence of concepts, problems and interpretations from the data’ (Glaser, 1998:67). With this openness, a new theme emerged in relation to a
role of medical doctors and medical practices, and their influence on the use of anti-ageing medicine and supplements.

Most interviews were conducted one on one, although three married couples from Australia and one from Japan were interviewed as couples due to time constraints or personal requests. The participants in these three interviews did not appear to be inhibited in their responses by the presence of their spouses. However, in one interview the wife dominated, with the husband mostly listening and nodding. I did not assume that he was agreeing with all his wife’s comments and opinions. Rather I guided him towards expressing his own view and thoughts. Hertz (1995) argues that more valuable insights can be derived through interviewing couples separately, because their values, knowledge and understanding towards a particular topic are not necessarily the same. This led me to organise individual interviews for the two remaining couples in the study.

There were few differences in the quality of interviews between Australian and Japanese participants. Moreover, gender did not seem to affect the progress of interviews. Based on my observations, neither Australian nor Japanese participants treated me as an outsider. My personal attributes, including gender, age and ethnicity, seemed to have minimal influence on the willingness of participants to express their thoughts and opinions. It was anticipated that Japanese participants would regard me as an insider due to my ethnic background. Although I was considerably younger than them, which could have caused them to view me as an outsider, (Merriam et al., 2001), this was not the case. The Australian participants treated me in a similar manner. I did not feel that I missed any important information during the interviews because I am not Australian. Merriam et al. (2001) argue that in cross-cultural research, some researcher attributes such as gender, race and educational status, can sometimes outweigh the cultural identities that determine researchers’ positions as an insider or outsider. I believe that the research I had done prior to conducting these interviews about the complex relationships between Australian culture, ageing policies and
expectations towards old age greatly facilitated the development of fruitful conversations with Australian participants.

4.4 Data analysis: making sense of cross-cultural data

Data analysis in qualitative research requires uncovering the meanings of data, which are not naturally ‘embedded in (your) field notes or in interview transcripts or documents’ (Esterberg, 2002:152). In other words, it involves seeking meanings and themes in the data, conceptualising phenomena and then organising them into categories (Neuman, 2006). In this study, some themes were predetermined when the interview schedule was created, and additional themes were sought in the process of data analysis. To define concepts and themes and further elaborate them, I initially carried out both open and axial coding. Cross-cultural comparisons were then made between the concepts derived from the Australian and Japanese data.

4.4.1 Coding

All interviews were transcribed using Microsoft Word and de-identified. The transcripts were then printed out and I read them through carefully and repeatedly. This practice enabled me to familiarise myself with the data, and more importantly to highlight comments and emerging themes. Open coding was applied in this case. According to Neuman (2006:461), ‘open coding brings themes to the surface from deep inside the data’. In other words, concepts and themes are identified using this method. The highlighted comments were then set out in a table based on the shared meanings that formed coding schemes. As coding proceeded, the coding schemes were cumulatively built up. Then, they were named to represent the phenomena.

In investigating practical reasons for the use of anti-ageing medicine and supplements, the coding generated many concepts, for example, ‘to revitalise body cells’, ‘to maintain a good feeling’, ‘to strengthen bone density’, ‘not to get
pain’, ‘to reduce pain’, ‘to reduce levels of high blood pressure/cholesterol’, ‘not to get age-related illness/disease’, ‘to avoid medical intervention’, ‘to maximise good health’, ‘to maintain energy level’, ‘to function as normal’, ‘to maximise fitness’ and ‘to slow down deterioration’. These various expressions were then consolidated into three conceptual categories: (1) maintenance of current good health, (2) prevention of future occurrence of age-related illness/disease and (3) treatment for existing age-related health issues. This is shown in Figures 2, 3 and 4.

**Figure 2 Maintenance of current good health**

![Diagram showing maintenance of current good health](image)

**Figure 3 Prevention of future occurrence of age-related illness/disease**

![Diagram showing prevention of future occurrence of age-related illness/disease](image)

**Figure 4 Treating existing age-related health issues**

![Diagram showing treating existing age-related health issues](image)

After this, axial coding was carried out for further elaboration of the analyses. In doing axial coding, researchers focus on an initial conceptualisation beyond the data by ‘ask(ing) about causes and consequences, conditions and interactions,
strategies and processes, and look for categories or concept that cluster together’ (Neuman, 2006:463). Using the concepts listed above, I explored any connections between the aspects of improvement, prevention and treatment. I re-read the interview transcripts and asked questions such as ‘why do participants use the anti-ageing medicine and supplements for these purposes?’, ‘why are these practices important for them?’ or ‘how are these practices embedded in their life?’

4.4.2 Cross-cultural comparison

The main feature of this study was cross-cultural comparisons in the use of anti-ageing medicine and supplements among Australian and Japanese older adults. To make these comparisons, cross-case analyses were conducted, with a combination of variable-oriented and case-oriented strategies. Miles and Hubermas (1994) argue that using these combined strategies enables preservation of the complexity of contexts and narrative sequence. The variable-oriented strategies involve ‘look(ing) for themes that cut across cases (Miles and Hubermas, 1994:175). In this process, prominent commonalities and differences were sought across the two sets of data. When searching different features across the data, attention was paid to ‘locat(ing) cases that are similar in many respects but differ in a few crucial ways’ (Neuman, 2006:473). The approach of seeking differences was particularly useful in developing the discussion on cultural differences, and also in analysing causal features associated with the differences. For example, different meanings associated with a sense of independence among the Australian and Japanese participants were derived from this method (discussed in-depth in Chapter Seven). With case-oriented strategies, a theoretical (or conceptual) framework is used for an in-depth investigation on one case and applicability of the framework is examined in the other case (Miles and Hubermas, 1994:174-175). This method was useful in elucidating a striking difference in one theme across Australian and Japanese data (discussed in Chapter Six).
4.5 Conclusion

This chapter has described the methodology adopted in this study, with its specific focus on cultural comparison. Qualitative research was applicable, with its potential for exploration of the circumstances that encouraged the participants to use anti-ageing medicine and supplements in the Australian and Japanese contexts. Semi-structured, open-ended interviews and participants’ willingness to disclose their personal stories enabled in-depth exploration. In order to interpret the data accurately and in a culturally-appropriate way, systematic coding and cross-cultural comparisons with variable-oriented strategies and case-oriented strategies were carried out. These procedures elicited cultural similarities and differences in the reasons underlying the use of anti-ageing medicine and supplements among the Australian and Japanese participants. Without a doubt, my position as a bilingual researcher who has lived in both countries brought some advantages. Specifically, my bilingual skills enabled me to conduct the interviews and data analyses as researcher, translator and interpreter simultaneously.

The following three chapters present the findings and related discussions. In Chapter Five, I explore the practical reasons why Australian and Japanese participants use anti-ageing medicine in relation to their health conditions, and why they believe it is important to include it in their self-care practices. Chapter Six compares and contrasts how Australian and Japanese participants come to use anti-ageing medicine. Culturally-embedded health beliefs and practices are the key. Chapter Seven investigates what ageing well means for Australian and Japanese adults—the motivating force underpinning the use of anti-ageing medicine.
Chapter Five
Anti-ageing medicine as edible health insurance

This chapter explores how and why Australian and Japanese participants use anti-ageing medicine. In particular, it examines the ways participants understand the use of particular supplements and hormone treatments in relation to their own health conditions. One of the research questions introduced in Chapter One is explored: How do Australian and Japanese older adults define and perceive their self-care practices using anti-ageing medicine?

Australian and Japanese participants’ health practices using anti-ageing medicine reflected a health trend seen among many older individuals worldwide. Recent research shows that although older people are healthier and live longer than previous generations, significant numbers of them live with age-related chronic health conditions such as hypertension (Lucke and Hall, 2005, Wagner et al., 2001). Moreover, the incidence of age-related diseases increases rapidly with age (Meydani, 2001). Capturing this, scientific and clinical research has reported that adequate nutritional supplementation could possibly prevent certain age-related diseases. To attain good health in old age, managing chronic conditions or preventing age-related diseases is a focal point, which was clearly seen in the self-care practised by all participants.

The findings outlined in this chapter show substantial similarities in the ways Australian and Japanese participants conduct their self-care practices using anti-ageing medicine. A cultural similarity was also seen in the beliefs attached to these practices. Two participants, a married couple, commented that anti-ageing medicine served as edible health insurance, and almost all participants relied on it, not only for their physical requirements, but also for psychological security. To demonstrate these notions, I first define what anti-ageing practices mean for the participants. I continue by discussing specific uses of anti-ageing medicine, and illustrate various health concerns associated with ageing. Finally, I develop the
argument that anti-ageing medicine is considered as a necessary investment for the future health of participants.

5.1 The definition of anti-ageing practices

The definition of anti-ageing practices varies depending on the context in which they are conducted. In medical science, the discussion is mostly developed within a framework of life extension: in other words, prolonging life expectancy (e.g. de Grey 2007). Accordingly, scientific research has been conducted to develop medical interventions that could possibly halt or slow ageing processes (Lucke and Hall, 2005). In social science the previous literature on anti-ageing practices focuses on ageism and consumerism, and maintains that they facilitate the achievement of qualities of agelessness such as youthful appearance, maintenance of sexual functionality or the higher energy levels normally associated with young people (e.g. Katz and Marshall 2003, Brooks 2008, Cardona, 2008). Anti-ageing in this context means that it provides older individuals with the opportunity to seek an ideal self in older age.

In this study, both Australian and Japanese participants talked about their anti-ageing practices exclusively in relation to prolonging good health conditions, which I term ‘health expectancy’ (rather than life expectancy), into old age. It was clear in the interviews that many participants shared the same meanings of anti-ageing. An Australian participant, Rowena (67) expressed her understanding of what anti-ageing practices means:

It’s impossible to stop ageing because we are going to age. Each year we get another birthday candle. I would like to think that this is just age accumulation. We are still going to age. However, the body deterioration, which is normally associated with ageing, is slowed down hugely by taking these supplements.
Rowena believed that by taking particular supplements she can slow down bodily deterioration associated with ageing. In other words, she can control biological ageing or the ageing body with supplements, although she admits that chronological age (getting older year after year) is not controllable.

It is important to note here that although previous literature on anti-ageing practices usually discusses achieving agelessness or life extension in the ways discussed above, none of the participants demonstrated the desire to halt ageing, remain young or live forever. Some even had a negative attitude towards the idea of obtaining a youthful appearance in older age. An Australian participant, Angela (64) observed:

The strong emphasis on physical [appearance] has been placed as in ‘looking in the mirror’ types of ageing. So you look at your face [in the mirror] and see your eyes are drooping and your breasts are hanging, you know. And the instinct is ‘oh, let’s go to a cosmetic surgeon and get fixed up from the outside’. I found that it’s really, really sad.

Angela was pessimistic about societal emphasis on the importance of youthful appearance in old age. Instead of fixing ageing from the outside, she places the importance on inner physical health.

As with Angela, a main focus of all participants in self-care practices using anti-ageing medicine and supplements was the maintenance of a healthy body (or bodily functions) rather than a youthful appearance. They believed that by taking anti-ageing medicine and supplements in conjunction with adequate exercise and a healthy diet, they would retain good health in the future. In other words, they attempt to prolong ‘health expectancy’ with the help of anti-ageing products. Anti-ageing medicine and supplements provide the participants with the hope and possibility of managing their own health in order to achieve ideal health.
conditions in their twilight years. Health among these participants was treated as a capital investment in the future (Williamson and Carr, 2009).

5.2 Practices using anti-ageing medicine

Both Australian and Japanese participants used some kind of anti-ageing medicine to seek ideal health status: in other words prolonging health expectancy in older age. They were also aware that they are becoming more vulnerable to certain diseases and have a higher chance of suffering from chronic health conditions than when they were younger. Many of them had minor health issues associated with older age. Commonly these are hypertension, higher levels of cholesterol, and knee pain. Moreover, some have experienced a decline in their health including reduced levels of fitness, lowered levels of bone density and hearing loss. Anticipation of future occurrences of various age-related diseases motivated many to initiate preventive actions. Their use of anti-ageing medicine was largely derived from their own experiences of deterioration in health and anticipation of future occurrences of ill health.

The interviews revealed three varieties of anti-ageing practices:

1. Prevention: reducing the likelihood of illness and disease in the future
2. Maintenance: maintaining current good health or normal bodily functions
3. Improvement: alleviating existing symptoms

These categories were relevant to both Australian and Japanese participants. However, these are not mutually exclusive and depending on interpretation, some data overlaps these three categories. That said, the categories were useful in grasping different health concerns in the process of ageing and helped to illuminate the various reasons why participants used particular anti-ageing medicines.
5.2.1 Prevention

One of the purposes of self-care practices through the use of anti-ageing medicine and supplements was prevention of future occurrences of illness and disease associated with older age. Some health conditions were considered preventable, and this idea was prevalent among both Australian and Japanese participants. The most commonly-mentioned physical dysfunction, which many participants sought to prevent, was osteoporosis. Moreover, certain diseases and illnesses that are expected to increase with age such as stroke, heart disease and prostate problems, were also believed to be preventable. Some Japanese participants were also concerned about a decline in eye function or eye disease such as cataracts. Prevention practices with particular anti-ageing medicine and supplements involved reflexive decision-making by the participants, including anticipating their future health, reflecting on past experiences of being ill and observation of ageing others, including their friends, neighbours and families.

5.2.1.1 Osteoporosis

One of the preventable physical deteriorations discussed by almost one-third of the participants, both Australian and Japanese, was osteoporosis. They had strong beliefs that anti-ageing medicine would prevent osteoporosis. Such beliefs are strongly supported by well-established clinical research that shows the benefits of vitamin D and calcium supplements for osteoporosis prevention (e.g. Tang et al., 2007). For example, Catherine (76) said: ‘I take calcium and that keeps my bones strong. So I don’t get osteoporosis’. Ferren (74) mentioned: ‘I’m taking calcium, the supplement called Osteo-plus, and I need to stick to it. I also take Protos, which is a mineral, it’s on prescription, for my bones’. An Australian man, Bill (74) also noted, ‘you have to keep calcium up with the supplement if you want to avoid osteoporosis’. Such statements were also expressed by some Japanese participants. For example, Fumiko (76) and Miyuki (67) take calcium to strengthen their bones and prevent osteoporosis. By strengthening bones or
increasing bone density with calcium and mineral supplements, they hope to prevent osteoporosis. Medical evidence supports this preventive strategy.

The pharmaceutical anti-ageing medicine, hormone replacement therapy (HRT), was also perceived to have positive effects in preventing osteoporosis. Barbara (77) and Angela (64) believed that HRT has improved their bone strength. Initiation of HRT for both of them was not for the purpose of preventing osteoporosis. Barbara’s doctor prescribed an estrogen patch to treat her depressive mood. Later, she found that it is also beneficial for osteoporosis. She said:

I was quite depressed some years back. It was almost 10 years ago. And I said it to my doctor who was a Chinese doctor and he did acupuncture or other stuff as well, which I tried but I didn’t believe, so it didn’t work. So, he said that this estrogen patch would help me to ease depression. And I discovered that it was also supposed to help against osteoporosis. So I keep going on that [the HRT] with the excuse. I haven’t got osteoporosis but I’ve got osteopenia, which is pre-osteoporosis, but mine is not quite bad. And it [estrogen patch] prevents it from getting any worse because I’m pretty strong for my age.

In the same vein, Angela initially took HRT to enhance sexual function when menopause hit her. Later on she found that testosterone is beneficial for bone health. Angela continued:

I’m on hormone, particularly testosterone is really good for bones and consequently, I think, it helps absorbing more calcium and vitamin B. … Well, I was concerned about osteoporosis. I know the biggest killer in ageing is broken hips. It seems such a preventable thing.
Both Barbara and Angela were taking HRT to treat other health issues such as depression or sexual dysfunctions, and in the process of these treatments, discovered the benefits of HRT in preventing osteoporosis. Angela talked about it in this way: ‘in the process of maximising my sex life, I was doing service on my body’. Although Barbara and Angela’s sources of information regarding HRT’s ability to strengthen bone conditions were different (Barbara learned about it from a TV program and Angela heard it from her doctor who is an anti-ageing expert), both of them have taken advantage of additional benefits from HRT and keep taking it even after achieving the original purpose.

Many Australian and Japanese participants were afraid of breaking bones in old age. Kyla (71) showed great concern about this: ‘I don’t want to break my bones, it will make me crazy! I don’t want restriction in my life.’ They all had a clear vision that with broken bones, their lives would be restricted. In other words, it would negatively affect quality of life. Barbara (77) was living proof of this. Her story about the experience of having a broken hand showed how much it negatively affected her everyday life both physically and psychologically.

Barbara: Once, even when I broke my hand, I couldn’t play golf and it was very debilitating and I just had miserable 6 weeks until I could use it again.
Maho: So the broken bones made you miserable.
Barbara: Oh, yes.
Maho: Why was that?
Barbara: I couldn’t do housework, I couldn’t eat properly, sort of I was eating with one of the little fork things, which I’m not good at using. And I was not able to play sport. I could walk, so I walked an awful lot. But I couldn’t do what I wanted to do like getting out once a week at least for golf.

The broken bone made it difficult for Barbara to conduct normal daily activities and to do what she liked to do. Although Barbara’s broken hand allowed her to
keep some mobility, she was frustrated with the restriction to her lifestyle. Disruption to Barbara’s everyday life—in other words, her usual active lifestyle—made her feel ‘miserable’. This echoes Shilling’s view that illness can possibly lead to crises of selfhood because the self is closely connected to what the body can do (Shilling, 2008).

This notion is supported by Miyuki (67), a Japanese participant, whose strong sense of the necessity to prevent osteoporosis derived from her experience of seeing the plight of a neighbour who broke her leg. Miyuki said there was a clear transition in the neighbour’s life after the incident: ‘She (the neighbour) can’t move without a wheelchair and her husband does household chores. This makes me really think that I don’t want to have broken bones. That’s why I’m taking calcium’. This neighbour is now dependent on her husband to carry out daily activities. Miyuki considers the neighbour’s dependence on her husband unfavourably, and she wants to avoid this situation. Miyuki has another elderly neighbour who is nearly 80 years old and still lives independently, including looking after herself, minding her grandchildren and growing her own vegetables in her backyard. Miyuki considers this latter neighbour’s lifestyle to be ideal, and showed compassion for the former because of her loss of independence. Carrying out normal daily activities including house chores without relying on others certainly provided Miyuki with a sense of self. To avoid being dependent on others because of broken bones, the prevention of osteoporosis is important to many participants. This preventive practice is derived from reflection on their own past experiences, observations of ageing others and injuries among friends, neighbours and other family members.

5.2.1.2 Cardiovascular disease, cancer and dementia

Some Australian and Japanese participants believed that certain life-threatening degenerative diseases such as cardiovascular disease, cancer and dementia are preventable with intake of particular supplements. This is supported by the evidence of medical research. Research on nutrition and ageing shows an inverse
relation between particular nutrition and the occurrence of these diseases. For example, intake of dietary anti-oxidants potentially reduces the chance of cardiovascular disease (Miquel, 2001). Similarly, several studies show that regular consumption of fish (or dietary lipids) could minimise the chance of developing any forms of dementia (Salerno-Kennedy and Cashman, 2006). Some participants had obtained information that maintained that particular nutrients work positively to prevent certain diseases.

Ryan (67) said that his doctor had suggested that taking vitamin E could reduce the chance of cancer:

At the health check-up the doctor suggested to me because of my age that there have been some research results that are favourable, particularly anti-oxidants with a lot of focus on cancer. So, you need something defined as free-radical. That’s why they suggested to me taking vitamin E, which is anti-oxidants.

Ryan understood the increasing risks for age-related disease as he gets older, and followed the doctor’s suggestion. He actively engages in practices that he thinks could prevent cancer.

Other participants believed that taking supplements assists with the maintenance of good blood circulation, which facilitates heart health. This may result in reducing the chance of cardiovascular diseases, including heart attack and stroke. For example, Newton (84) told me that ‘I take vitamin E mostly every 2nd morning, one capsule. That’s for the heart, blood stream and heart’. Similarly, Peter (80+) takes vitamin E in combination with anti-oxidant tablets for heart health. Based on their own research, both men believed that these supplements help maintain blood circulation, thus preventing cardiovascular problems associated with older age. Takeshi (63) added:
When I was watching the NHK\(^3\) TV program a professor at Kyoto University mentioned that an extract of an umeboshi [a Japanese pickled plum] helps to soothe the bloodstreams. He showed the experiment that demonstrated its effectiveness. He said, good health is constituted by a good bloodstream. That’s why I drink the umeboshi extract every day.

Takeshi told me that he thought the information given on the TV program would be reliable because the medical expert explained the effects of umeboshi in the show. In Japan, the importance of ‘ketsueki sara sara’ (literally in English, smooth blood streams) has been widely promoted by health organisations including the Ministry of Health, Labor and Welfare. More specifically, stagnate conditions can trigger blood coagulation, which might result in cardiovascular failure such as arteriosclerosis or stroke (Kaibara et al., 2004). Therefore, maintenance of ‘ketsueki sara sara’ is important in preventing these conditions. Takeshi’s comment reflects this. His practice was also influenced by the experiences of six of his close friends who had had operations for heart conditions and cancer in the same year this interview was conducted. Through expert knowledge and his own observation of ageing others, he has rationalised the importance of maintaining good blood flow.

### 5.2.1.3 Cataracts

Several Japanese participants spoke of an eagerness to avoid cataracts. It was surprising that Australian participants did not show concerns about cataracts, despite the fact that this is one of the most common age-related diseases worldwide, and their prevention with particular nutrients has been widely researched (Meydani 2001). For example, Rhone and Basu (2008) have found the positive effects on eye health of water-soluble flavonoid pigments, called

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\(^3\) NHK refers to Nippon Hoso Kyokai or Japan Broadcasting Corporation in English.
anthocyanins, contained in blackcurrants and blueberries. Various Japanese health websites as well as pharmaceutical and nutraceutical companies promote certain nutrients such as beta-carotene, anthocyanins and DHA for eye health (e.g. http://www.wakasa.jp/blueberryeye/). The Japanese participants who engaged in cataract prevention were taking supplements that contain blueberry extract or a compound supplement called ‘eye-care’ to prevent or delay the occurrence of cataract or glaucoma. Setsuko (70) said:

There are many people who develop cataract. In fact, one-third of my friends have had surgery for them. I don’t want to have cataract because one of my favorite hobbies is watching plays. It would be difficult to watch if I have eye problems and I don’t want that. I heard blueberry is good for the eyes or a supplement with DHA [dehydroascorbic acid] is good, so I’ve been taking the supplement for almost 10 years.

Setsuko acknowledged that cataracts are a common disease among older people, and she hoped to prevent them. She said that she has not developed any signs of cataracts while she has been taking the supplements.

Some participants had experienced the negative impact of cataracts on daily life, and seek to prevent their recurrence. Fumiko (76) who had once developed cataracts and had surgery, told me that the cataracts had made it difficult to conduct daily activities: ‘(B)efore the operation, it was like I was in a thick fog. I couldn’t see far away and traffic lights. So I was scared of walking in the street. I also had to be careful not to trip over, so I was always looking down on the street’. Like Setsuko, she now takes blueberry supplements for her eye health to prevent its recurrence.

There are no known reasons why cataracts should disproportionately affect Japanese as opposed to Australian people. This might reflect the ways certain age-related health conditions are discussed in society. For example, the Victorian
Government’s health website, Better Health Channel, which provides health and medical information, reports that cataracts are a normal process of ageing and prevention strategies are still unknown except that sun protection and non-smoking may help. Livingstone and his colleagues (1998) argue that a lack of adequate knowledge about age-related eye diseases among the public in Australia may have stopped people at great risk from engaging in adequate preventive practices. This indicates there might be a link between health promotion programs that disseminated advice and the kinds of issues that concerned participants in different countries.

As shown in the stories above, by taking various types of supplements, the participants believed they were engaging in the prevention of age-related health issues. Many participants obtained knowledge of nutrition and age-related diseases for their preventive practices. This information has become readily available to the public through the Internet, pharmacies and health shops. Moreover, participants’ own experiences of being ill in the past, or observation of ageing others, were of particular influence in their decision to commit themselves to preventive actions. It seemed that health promotion regarding certain age-related conditions is not uniform in different countries, and this affected participants’ engagement in preventive actions. This is shown in the discussion about cataracts.

5.2.2 Maintenance

You have losses all the way through your life and they become greater in ageing. I mean your own physical loss. Your eyesight deteriorates, your hearing deteriorates, your mobility deteriorates. I had a bone scan after 5 months I started taking Proto (prescribed mineral) and I had a huge improvement, 8% in sacrum. I mean, that is unprecedented in my age. You don’t normally put bone back. The best you can usually look for is ‘don’t lose more’ (Farren, 74).
The maintenance of ageing bodies was a preoccupation in the interviews. Farren talked about her understanding of her ageing body and how she could manage it. As shown in the quote above, the common perception of the association between health and ageing among the participants was losing ‘normal’ physical functions as they get older. Farren believed that individuals can endeavour to maintain their current health conditions. The participants believed that taking particular supplements helps them maintain good physical functions: ‘normal’ bodily functions, including bodily mobility, cognitive function, and organ function. They used a wide range of supplements ranging from vitamins, minerals, fish oil, enzyme, CoQ10, a Japanese plum extract to gingko (Chinese herb) depending on their health maintenance schemes.

5.2.2.1 Maintenance of good organ functions: slowing down the degeneration of body cells

It is reported that nutrition is important in sustaining organ health, for example, anti-oxidants for heart health (e.g. Meydani, 2001). Several participants were taking vitamins and minerals that they understood would help to maintain good organ functions. They acquired the knowledge from various sources. For example, Rowena (67) and Anthony (75), a married couple, regularly attend information seminars regarding supplements manufactured by a particular nutraceutical company. Olivia (60), Peter (80+) and some others are interested in reading various publications regarding nutrition and ageing. Olivia said:

To me all the minerals and vitamins are just keeping organs that age at the maximum functioning ability. Obviously as you age things change and things wear out. But why not keep them fit and well so that they can be 90 or 100 years of age. To me it’s completely a part of supplying every part of working physiological body with the all nutrients needed to function superbly rather than 50% or 60%. I want them to be functioning 100%, as much as they
can in my old age. When I’m 90, if I can get to be 90, my body would be pretty healthy because of that.

Olivia believed that by maintaining optimal bodily functions through the adequate intake of supplements, her body (including organs functions) can function at maximum capacity in her older age. In other words, they will not lose any functional abilities due to ageing. This idea was shared by a Japanese participant, Akira (68): ‘As you get older various organ functions deteriorate, so it’s important to improve them. It is a clue to being healthy in old age’. For Olivia and Akira, without adequate supplement intake, they believe that their organs would degenerate, resulting in a decline in those functions.

Other participants spoke about how degenerating body cells cause bodily malfunctions. In order to maintain ‘normal functions’, it is necessary to rejuvenate them in older bodies. Glenda (66) talked about knowledge obtained from a book that explains CoQ10:

My understanding is that the book called ‘the little book on CoenzymeQ10’ says, it [CoQ10] is like a spark of life, the one that stimulates the growth of protein in your body. This is my understanding. As you are ageing, it says your cells start to degenerate, so you supplement them with something and we keep them more robust and more useful.

Rowena’s (67) comment further expands on the point made by Glenda: ‘(T)hese supplements don’t heal, they don’t eliminate any disease, they just help the body do what body is meant to do from the cellular level’. Glenda and Rowena understood that the supplements work directly on cells that are about to degenerate due to older age, encouraging them to work properly. With the use of supplements, they believed that their bodily functions would work at similar levels to those of their younger selves.
5.2.2.2 Maintenance of fitness

It was a common perception among participants from both countries that as you get older, your fitness levels decrease. Several participants had experienced such a decline or anticipate it in the future. However, some believed (or experienced) that adequate supplement intake allows them to maintain high levels of energy. In other words, they can be as fit as when they were younger, or as their younger cohorts. Jackie (74) and Rowena (67) talked about their experiences:

I feel so fit and have so much more energy than my girlfriend. I can do more stuff than she does. … She is sort of dragging, you know. I don’t know she takes anything [any supplements]. Anyways, I feel really good. (Jackie)

My energy level, you know, what I am able to do physically stands out a lot compared to my friends because I know none of my friends are able to work as long, as hard as I am. None of them. I had a cardiovascular test done and my cardiovascular system was about 32-year-old, you know. My heart was 32 year old. I [my age] was more than double at that stage. So, it’s showing, you know. It’s definitely, definitely showing that the supplements are working. (Rowena)

Jackie’s and Rowena’s subjective observations that they are fitter and have more energy to work harder and longer than their friends led them to believe that the supplements contributed positively to the maintenance of their high energy levels. For Rowena, this was supported by the results of a medical check-up that showed her heart age. Ryan’s (67) observation was that the supplements were enabling him to keep up with his much younger son:

You would really need these sorts of supplements to keep you fit on top of a healthy diet and regular work out. I’m talking about ‘pretty fit’. … I normally play tennis within the over 50’s
competition and I can compete well against the guys nearly 50s. Now our son is 38, he is very fit, he doesn’t play tennis a lot but he can play. And we’ll hit and once again, I have no problem hitting with him.

Ryan believed that in order to maintain the level of fitness that allows him to compete against younger men in tennis, the assistance of supplements is necessary.

A Japanese participant, Kazue (76) told me that due to having used particular supplements for many years, she rarely gets tired. Although she admitted that her muscle strength has weakened to the extent that she now has difficulty in carrying heavy items, she can still teach yoga every day, something she has been doing for the last 35 years. She said; ‘the supplements made a huge difference in terms of my levels of tiredness. I hardly ever get ‘very’ tired because I am on them’. While practising yoga is likely to be a contributory factor to her good health, Kazue believed that the supplements have made it possible for her to teach yoga everyday in her late 70s, and she has no intention of retiring. Moreover, she can enjoy her life, indulging in activities such as going shopping and going out with her yoga friends, all of whom are younger than her. Maintaining physical fitness does not require her to compromise her lifestyle in the process of getting older.

The stories of Rowena, Ryan and Kazue, who considered themselves healthier than ageing others, were shared by other participants in both countries. It seemed important for them to compare themselves with ageing others or younger cohorts to justify their use of supplements. In other words, social interactions with others appeared to fuel their confidence in the effectiveness of the supplements they were taking.

The above stories revealed that the participants actively engage in health maintenance through taking a wide range of anti-ageing medicine and supplements. They firmly believed that these provide adequate nutrition to make
ageing bodies keep working. Moreover, they believed that through this practice, they can extend their ‘health expectancy’, in other words, the capacity of their bodies to work with maximum capacity without degenerating. They often justified their anti-ageing practices by comparing themselves with ageing others who are not as healthy or mobile as themselves, or even with younger cohorts, in order to show their high levels of bodily performance.

5.2.3 Treatment: Improving health conditions

The third reason for taking anti-ageing medicine and supplements is to treat existing symptoms. This is different from the former two practices—prevention and maintenance—as motivations for taking supplements. In this scenario, certain physical dysfunctions associated with ageing such as (osteo)arthritis or hypertension had already developed, and the participants started taking particular anti-ageing medicine and supplements to reduce symptoms (such as pain). Participants utilised common strategies in order to select adequate supplements: self-diagnosis—active examination of their own health problems, self-research—conducting personal research to find a particular supplement that suits their health problems, and self-experiment—experimenting with the effectiveness of particular supplements using their own bodies. In this sense, the participants have become lay practitioners and developed their own understandings of the relationships between their health issues and the supplements. Many of the participants who engaged in this practice told me of the positive outcomes of supplement intake. For example, the levels of pain caused by osteoarthritis had reduced or disappeared. Some were confident in their anti-ageing practices because the results of medical check-ups showed improvements. With such positive experiences, they obtained a strong belief in the positive effects of anti-ageing medicine and supplements to improve health problems associated with older age. There were two main driving forces that led the participants to use them: to improve existing health conditions and to avoid acute medical intervention such as surgery. In this section I examine the former in detail and
leave the latter for the following chapter because it is highly relevant to the discussions in Chapter Six.

5.2.3.1 Improving existing conditions: osteoarthritis as an example

The most common existing health issue talked about by some Australian and many Japanese participants was knee pain, which was, the participants assumed, most likely to be caused by osteoarthritis. They were taking supplements such as fish oil, glucosamine, chondroitin and some compounded supplements for osteoarthritis produced by nutraceutical and pharmaceutical companies. Many of the Japanese participants who were taking supplements for osteoarthritis had not consulted with doctors about their knee problems. Rather, they assumed that knee pain was caused by old age. Encouraged by the promotions of glucosamine or chondroitin for knee problems seen in TV commercials or in advertisements by pharmaceutical and nutraceutical companies, they chose particular supplements to manage this. Chizuko (66) talked about her experience:

One day I felt acute pain on my knee. With the peculiar pain I knew that the joint cartilage was wearing away. I had never experienced such pain when I was young. It was different from muscle pain or anything else. I don't know how to explain it. At the time, I came across this supplement. My son laughed at me and said that it wouldn’t help. He said, ‘if it heals pain, the doctor would already be using it’. But I feel it’s working [reducing the pain], so I’d better to continue rather than doing nothing and having more pain. I’ve been taking it for 6 or 7 years.

Chizuko knew that she had osteoarthritis because she had never experienced knee pain like this in her younger age. She realised that ‘the peculiar pain’ must be caused by degenerating knee joint cartilage. This was the usual way that participants (Japanese participants, in particular) self-diagnosed their knee pain as osteoarthritis. While her son was sceptical about the health benefits of the
supplement, she did not dismiss its effectiveness because she had experienced lower levels of pain since taking it. Despite the fact that medical research on the effect of glucosamine on osteoarthritis is not conclusive, actually showing conflicting results (Reginster et al., 2001), many of the participants told me of their positive experiences of feeling less pain since they started taking particular supplements.

Some participants showed different understandings of the way supplements work for osteoarthritis, in that they understood it could possibly slow down future deterioration. Miyuki (67) explained it in this way:

I don't think glucosamine completely eases knee pain but rather, it may slow the progress of getting worse. I understand that the supplement works in this way. With the supplement, the speed of going downhill might be reduced, for example, it normally goes at 30kms per hour but with the supplement the speed might be slowed down by half. I want to slow down the speed at which my knee problem gets worse as much as possible.

During the conversation Miyuki reported reduced pain in her knees since she started taking the supplement. However, she was not totally convinced that it can improve her knee problem. This is because ‘a supplement is not a [pharmaceutical] medicine’. In her understanding, medicine has an immediate effect, but supplements do not provide an immediate, complete fix and therefore it is necessary for her to continue taking the supplement for a long time before any effect can be noted. She hoped that in the long term, the supplement will slow down the deterioration of knee cartilage.

This idea was shared by another Japanese participant, Yoshio (76). He stated, ‘I’ve been taking the supplement for more than 10 years but when asked if it’s working or not, I am not sure how to answer to it. But I shouldn't stop taking it’. This shows that although he is not sure about the effectiveness of the supplement,
he still hopes that in a long term it is working to improve the knee condition. Kazuki (67) explained this situation with a Japanese proverb ‘oborerumonoha warawomo tsukamu’, which translates into English as: ‘a drowning man will clutch at a straw’. This means that when you are desperate you will look for anything that might help you, even if it cannot help you very much. For Kazuki, glucosamine and chondroitin supplements are rescue remedies, which could possibly save him from the knee problem. He said, ‘I want to prolong the life expectancy of my knees as long as possible’. Prolonging the life expectancy of knees may be crucial to maintaining quality of life in older age, because it directly affects mobility. This was apparent for Kazuki and Yoshiho. Their engagements were derived from their enthusiasm to play golf, which is their favourite activity.

In the above stories, I used osteoporosis as an example to explain how some participants engaged in anti-ageing practices that attempted to improve existing age-related health conditions. In a similar manner, some other participants used supplements to help rectify lowered levels of bone density or to reduce high levels of blood pressure and cholesterol. The common belief underpinning these self-treatments is that with the intake of particular supplements, participants can regain good physical functions or at least stop the symptoms getting worse. This can be explained by the discussion of self-care for chronic illness presented in Chapter Two. People with chronic illness often experience limitations in their bodily movement, which violate ‘biographical body conception’ (Shilling, 2008: 114). Ultimately, this leads to an identity crisis. In chronic illness management self-care is considered important to regaining coherent bodily movement, enabling individuals to experience bodily coherence. Consequently, it also helps to prevent crises of selfhood (Shilling, 2008). As shown in Kazuki’s story, self-treatment using the supplements for his knee problem is necessary because of his belief that it will enable him to continue playing golf, which is clearly an important part of his life. Similarly, the other participants can maintain their engagement in everyday activities by treating their health problems using particular supplements.
5.2.4 Summary

It was clear that self-care practices using anti-ageing medicine are uniquely tailored based on participants’ lived experiences, including their own health conditions, past experiences of difficulty in daily life due to illness or injury, and observations of ageing others. They self-examine their health in anticipation of its future condition, and choose adequate supplements accordingly. Many of them acquire knowledge of a relationship between nutrition and health through self-study such as reading health magazines and books, watching health-related TV programs and even researching medical journals. Joyce and Loe (2010) coined the term ‘technogenarians’ to describe older individuals who creatively use technological artifacts to meet their health needs for quality of life. Here, anti-ageing medicines can be considered to be technological artifacts. This notion fits with the self-care practices conducted by the participants. Their active negotiation in selecting particular supplements revealed that they are active consumers who consciously seek nutraceutical and pharmaceutical assistance to maximise their health status. Many participants talked about the use of anti-ageing medicine as an important investment in their future health. In fact, many participants said that it is like health insurance. This issue is developed in the following section.

5.3 Anti-ageing medicine as ‘edible health insurance’: investment for future health

In the previous sections, I explored practical reasons why participants engage in anti-ageing practices. Many are proactively seeking good health for the future. Importantly, the participants have great faith in the use of these products. In other words, they strongly believed that their use of anti-ageing medicine is the right way to slow the ageing process. This perception is based on their subjective experiences of being on anti-ageing medicine that had resulted in improvements in health. Not all participants were confident of the exact levels of effectiveness of anti-ageing medicine, however. For example, Bill’s (74) explained: ‘We [my wife and I] can’t tell if it [taking the supplements] is efficient or not. But because we
feel well, we think it’s ok and we keep doing. We believe they are helping us stay healthy’. The sense of ‘feeling well’ was commonly used to justify their supplement intake if they had not felt obvious effects. It was clear that taking anti-ageing medicine allows the participants to imagine good health in the future.

Many participants believed that managing health for the future using anti-ageing medicine is a necessary investment in spite of the relative expense. For example, Reiko (62) spends more than 20,000 yen (approximately $200AUD) on a variety of supplements each month. She stated: ‘although it costs a fortune, it [taking supplement] is investment in my future health. Having good health is the most important capital’. Similarly, Rowena (69) and her husband Anthony (75) referred to necessary supplements as ‘edible health insurance’, which relates to ‘health insurance’, which helps maintain good health from the inside of the body, as opposed, ironically, to social health insurance, which only supports individuals who are actually ill. Anthony and Rowena provided the following explanation:

Anthony: I suggest to say, Rowena created the word [edible health insurance] because health insurance is sickness insurance. It means when you are sick, you get the insurance.
Rowena: Yes, you only claim [for a benefit] from the health insurance like Medibank [private health insurance] or Medicare when you are sick. We need health care, not sickness management. So, we can be proactive, not reactive. That’s what the present medicine is about: it’s reactive. Absolutely. We are so reactive to everything. Something happens, we throw something to band-aid rather than trying to prevent it from happening, you know. We have to do something proactive. The only way you can help your health is being careful of what goes in there [inside body]. Oh well, there are a lot of other things, too, of course.

Anthony and Rowena understood that the social health insurance system is for sickness management. However, they believed that what they need for health
management is ‘health insurance’ that enables them to proactively maintain their
good health conditions. With this in mind, they referred to anti-ageing medicine
as ‘edible health insurance’ that directly assists them in managing their own
health.

In investing in their future health, some participants felt that they needed decide
on their priorities because of the costs involved in anti-ageing practices. This was
often described as ‘choice’. Catherine (76) and Angela (64) represented this
notion well:

If I didn’t take them [the supplements], I definitely wouldn’t live as
long or healthy. I clearly know the health benefits. If I didn’t have
them, I wouldn’t be able to get about and move like I do, do all I do
now, move my arms or walk. A lot of people can’t walk and they
don’t take anything. And I think ‘just try those ones, try them’. But,
of course, a lot of people can’t keep it up because of the cost
involved. I would go without a new dress or a pair of shoes. I
would choose vitamins before that. Then I know I can feel good
and healthy, happier myself. But a new pair of shoes doesn’t make
me happy or healthy. (Catherine)

You have to make a choice. You need to be obviously able to
afford [to have the HRT]. A lot of people can’t. I rather spend
money on that [the HRT] than on a holiday or, you know, 150
dollars for a seat at a theatre. 150 dollars can keep me on hormone
for a couple of months. (Angela)

Catherine’s and Angela’s comments highlighted the prioritisation of good health
in old age. They emphasised keeping good health as the most important aspect in
their lives, and considered investment in their health as a necessity at their age.
They certainly believed that the vitamins (among other supplements) and
hormone treatment enable them to be more vital and active in their lives than
people who do not take any. They emphasised the importance of choosing a right thing in their life and the cost to them was regarded as a necessary expense.

Like Catherine and Angela, some participants were clearly aware that they have made the right choice because they feel the health benefits of anti-ageing medicine. For example, Chizuko (66) and Priya (66) felt that their knee pain disappeared after they started taking glucosamine. Keiko’s (58) cataract condition got better after she started taking the blueberry extract supplement. Moreover, when Catherine stopped taking all supplements for a period of two weeks before and a month after she had an operation on her hand to remove a tendon, she clearly felt the difference in her health condition. She recalled: ‘I could tell the difference. I got tired because I lacked vitamin Bs, and my joint ached. I can tell the difference. You know it when you go off them’. Similarly, a few other participants told me that they had experienced adverse reactions when they stopped taking supplements. They firmly believed that their current good health was derived from their use of anti-ageing medicine.

Many participants clearly stated that if they were to cease taking supplements, this would have a negative impact on their health. When I asked them to imagine what their health would be like without the supplements, their responses were similar.

That [ageing without the supplements] is gonna be awful, would be dreadful. I wouldn't even want to try it. My body would deteriorate. I mean that’s how I feel. (Newton, 84)

[Without the supplements] I don’t think I would be as healthy. I wouldn’t feel well, I don’t think I’d be eating as well. Now I eat well, I sleep well and I think those wouldn't be possible if I wasn’t doing this. (Peter, 80+)

Newton and Peter envisaged negative outcomes if they stopped taking supplements. This shows a strong faith in the effectiveness of the supplements for
their ageing bodies. Their perception of using them was beyond the idea of being the ‘right choice’. For them, the practice was understood to be a necessity in keeping their bodies functioning well.

It was clear that many participants believed anti-ageing medicine is an important investment for current and future health. The idea of ‘edible health insurance’ was applicable to all of them. This clearly supports Williamson and Carr’s (2009) notion that practising preventive health is analogous to a capital investment for the future.

5.4 **Anti-ageing medicine provides psychological security**

While the participants were clearly reliant on anti-ageing medicine for their positive physical health outcomes, many participants were also dependent on it psychologically. For example, for those, like Bill, who were unsure about the exact effects of anti-ageing medicine, they still considered that to cease taking it would involve some risk. They often made statements like ‘I can’t imagine what I feel like if I stop doing this. Maybe I’ll feel fine but I guess, I’m not gonna risk it’ (Jackie, 74). George (65) elaborated:

> If I feel ok, I continue to take it [the supplement]. I don’t want to experience something like I stop taking it and then something happens. And then I will think, ‘did it happen because I stopped taking this or did it happen because of other reasons?’ I don’t want to think about that.

Jackie and George chose to continue taking anti-ageing medicine because they do not want to feel worried or anxious about their health. It seems that anti-ageing practices play a role in reducing unnecessary worry, anxiety or stress over anticipated health issues in older age.
A few participants had developed an emotional attachment to anti-ageing medicine. Sanae (62) talked about the ways in which the supplements work for her both physically and psychologically:

They [the supplements] are for me like a talisman. I’ve been taking them for the last 7, 8 years, so I’ll feel insecure to stop if I stop taking it. Maybe, this is not a physical but a psychological thing. I’ll feel psychologically insecure [if I stop].

Sanae’s comment clearly demonstrates that to a certain extent she relies psychologically on supplement intake for her self-care. Her experience of having good health for the last seven or eight years, while she has been taking certain supplements, may have created an emotional connection to them. In fact, the word she used, ‘talisman’, symbolises this attachment. It is as if their presence in her life provides good luck or protection. This notion is similar to the meaning of ‘insurance’, which is, according to Oxford Dictionaries (2015), ‘(A) thing providing protection against a possible eventuality’. Clearly, a talisman for Sanae is insurance that provides a sense of protecting her future health, which deteriorates as a natural process of ageing. Similar to Sanae, Taeko (64) and Kazuki (67) also used the word ‘talisman’ to explain their psychological reliance on the supplements they take. The continuous use of anti-ageing medicine has become insurance that provides them with a feeling of security.

It was clear that the acquisition of psychological security is as important as good physical health in self-care practices using anti-ageing medicine. Many of the participants experienced psychological benefits through taking anti-ageing medicine because they feel it contributes to physical wellness and brings a sense of security. This was well articulated by Peter (80+): ‘If I believe they [the supplements] are doing good, they must be positively working on my body. Mind will affect health conditions as you’ve heard about that placebo works marvellously. Even they are placebo, I’m happy’. Peter, who often reads medical research articles out of interest, used the word ‘placebo’ to emphasise the
importance of the positive influence of his supplement intake on his mind, which will, in turn, positively affect physical wellness. This shows that self-care practices with anti-ageing medicine continued because of a subjective sense of self-satisfaction. As Barry (2006) states in the literature on complementary and alternative medicine (CAM), patients’ belief systems and emotions are powerful healing instruments, and indeed the participants’ beliefs in the anti-ageing medicine seemed the most important aspect in their practices. Anti-ageing medicine as ‘edible health insurance’ have created this belief system and provided the participants with a sense of physical and psychological security.

This phenomenon is explained by Giddens’ (1991) notion of ontological security, which comprises a feeling of biographical continuity, enduring conception of one’s aliveness and a stable sense of self-identity. To retain ontological security involves active engagement in life. Giddens (1991:40) elaborates as follows:

> The sustaining of life, in a bodily sense as well as in the sense of psychological health, is inherently subject to risk. The fact that the behavior of human beings is so strongly influenced by mediated experiences, together with the calculative capacities which human agents possess, mean that every human individual could (in principle) be overwhelmed by anxieties about risks which are implied by the very business of living.

The quote shows that our physical and psychological health is constantly exposed to risks that may result in undermining our sense of security. This notion has great applicability to ageing processes. As noted in Jackie’s and George’s stories, anti-ageing medicine plays a role in reducing the levels of anxiety derived from the decline in health associated with ageing, or from concerns about future health conditions. The concept of anti-ageing medicine as health insurance further supports this claim. The participants believed that active engagement in the anti-ageing practices would reduce the risks of negative physical and psychological health.
5.5 Conclusion

This chapter has described how participants actively used anti-ageing medicine in their self-care practices. There were substantial similarities among Australian and Japanese participants. Specifically, they shared the meaning of anti-ageing practices: that is, preventing age-related illness and disease, maintaining current good health conditions and treating existing health problems caused by older age. They chose particular anti-ageing medicine according to their health requirements. This involved (1) self-study to learn the effectiveness of supplements, (2) self-examination of their bodies and (3) self-experiments to perceive any positive effects of the supplements on their bodies. All participants engaged in their anti-ageing practices in a similar manner and had strong faith that ‘anti-ageing medicine must be doing good on our bodies’. They had become ‘technogenarians’ who creatively use technological artifacts, including anti-ageing medicine, to meet their health needs and quality of life (Joyce and Loe, 2010).

Both Australian and Japanese participants considered anti-ageing practices as a necessary investment in their future health. Rowena (67) and her husband Anthony (75) coined the expression ‘edible health insurance’ to describe the supplements they take. This means that they work directly on the insides of their bodies to slow down bodily deterioration caused by ageing. They saw their self-care as proactive action in managing and prolonging good health. This idea was shared by most of the participants. This was clearly demonstrated by the belief of many that if they were to stop taking anti-ageing medicine, it would have negative consequences on their bodies. It was clear that the participants treated their health as a capital investment in the future—in this case their future good health (Williamson and Carr, 2009).

Some Australian and Japanese participants believed that anti-ageing medicine had positive effects both physically and psychologically. Words such as ‘talisman’ and ‘placebo’ were used to explain the positive effects on their mind-sets. In other words, it works as psychological security that reduces levels of worry or anxiety about future health deterioration. In this sense, it provides the participants with
ontological security that enables them to forecast good health outcomes that will result in their continuous sense of aliveness and stability in their self-identity (Giddens, 1991). The idea of anti-ageing medicine as health insurance further supports this.

Overall, considerable similarities between Australian and Japanese participants were found. However, Australians and Japanese are guided to their anti-ageing practices in culturally specific ways, and this will be discussed in-depth in the next chapter. In Chapter Six, I explore how Australian and Japanese participants come to use anti-ageing medicine in their self-care practices. The discussion revolves around culturally-embedded health beliefs and practices in Australia and Japan. More specifically, the role of Western medicine and medical doctors in decision-making regarding initiating the use of anti-ageing medicine in Australian and Japanese contexts are compared and contrasted.
Chapter Six
Western medicine in anti-ageing medicine use among Australian and Japanese participants

Chapter Five revealed that Australian and Japanese participants had a shared understanding of anti-ageing practices and values associated with them. The aim in this chapter is to illuminate how they perceived the roles of medical doctors and Western medicine in the process of developing self-care practices using anti-ageing medicine. Watts-Roy’s (2009) empirical study investigating the reasons why people use anti-ageing medicine in the U.S. context reveals that the practices of medical doctors and anti-ageing specialists have a significant influence on the decision to use anti-ageing medicine. This finding is apparent in this study, but only in the Australian context. Throughout this chapter I endeavour to compare and contrast the influence of their relative cultures on Australian and Japanese participants’ perceptions about the importance of medical doctors (or Western medicine) in anti-ageing medicine use.

It is important to note here that one’s health/illness beliefs and behaviour and care-related activities are to a large extent guided by culturally-embedded health practices. Kleinman (1978: 87) argues that culture establishes systematic relationships between ‘beliefs about disease causation, the experiences of symptoms, specific patterns of illness behaviour, decisions concerning treatment alternatives, actual therapeutic practices, and evaluation of therapeutic outcomes’. Accordingly, previous studies have reported variations in health beliefs such as different ways of perceiving one’s health condition and medical practices, including preferable treatment options for ill health across cultures (e.g. Lock, 1993, Becker et al. 2004). This notion was also apparent in this study in terms of how Australian and Japanese participants understand their health and care-related activities.
This chapter consists of three parts. In the first section, I present one cultural similarity, that some Australian and Japanese participants were motivated to use anti-ageing medicine in order to avoid surgery. The following two sections demonstrate cultural differences in the ways Australian and Japanese participants understood the roles of doctors and medical practices in relation to their self-care. First, I discuss how the Australian cohorts develop self-care repertoires in a culture where Western medicine has been dominant in regulating people’s health. An examination follows of the ways in which Japanese culture shapes Japanese participants’ understanding of health management, and this is extended to the use of anti-ageing medicine.

6.1 A cultural similarity: reluctance to have surgery

One aspect shared by several Australian and Japanese participants was their reluctance to have surgery for age-related health problems such as osteoarthritis and cataracts. Instead, they chose particular anti-ageing medicines rather than surgery as a preferred option for dealing with their health problems. Australian participant, Priya (66) told me that after her doctor diagnosed that her knee pain was caused by a torn cartilage, she tentatively started taking fish oil and glucosamine regularly to see whether or not it helped. She initiated this practice while her doctor was organising surgery. She explained:

He explained to me what was involved [in the surgery]. Anyway, I came back and thought, ‘do I have to have this arthroscopy done?’ In the mean time, I had been taking fish oil but not regularly, haphazardly. It was like one day I might take one, every other day I just take one. After the diagnosis I increased my intake of fish oil to 3 capsules a day and I started taking glucosamine. Three weeks later I went to have my annual medical check-up and all of that was done and the result was there. And I had no pain at all in my knee. So, after the consultation I said to my doctor, ‘look, for some reason I don’t have any pain in my knee, should I go ahead with the
surgery?’ and he said ‘of course, not. You can cancel the surgery and see how you go’. I have no doubt that because I increased my intake of fish oil supplements and I also started taking glucosamine, I could avoid having the surgery. Surely something is working in there. I firmly believe that they have helped. I will continue because I don’t want to have surgery.

In the process of diagnosis and setting up treatment for the torn cartilage, arthroscopy was the only option provided by her doctor. Her reluctance to have surgery motivated her to try the alternative treatment of using fish oil and glucosamine and her symptoms (pain) disappeared. While she believed that this was due to the benefits of these supplements, it might also imply that her knee condition was not serious enough to require this surgical procedure.

Similarly, Bill (74) showed his determination to avoid surgery. He had once had surgery for a torn cartilage and his doctor suggested that he would need it again in the near future. Bill explained his experience:

The doctor said, ‘you will be alright for a little while but in 5 years time, you will need a new replacement in there’. So, I said to myself, ‘no I won’t’. I went to the gym, started exercising all muscles around the knee and taking glucosamine because it’s supposed to encourage cartilage growth or regrowth of cartilage. So I took glucosamine, you know. And 12 years gone, my knee is still alright.

Bill believed he has been successfully maintaining his knee health by taking glucosamine along with regular exercise. This self-maintenance overturned the doctor’s prediction that Bill may need further surgery on his knee in five years time. Bill dismissed his doctor’s diagnosis, as he was confident that he could maintain his knee condition himself without surgical intervention. Bill not only
showed enormous pride in his practices, but also a resistance to being a passive recipient of his doctor’s advice.

6.1.1 The experiences of Japanese participants: Wakae and Setsuko

Like Priya and Bill, several Japanese participants followed a similar path because they did not want surgery, although most of them had not been advised to have surgery by their doctors. They felt negative towards surgery, and some were even fearful at the thought of it. Moreover, they envisaged that there were risks involved in surgery. This was based on their experiences of having seen others who had undergone surgery. Wakae (79) and Setsuko’s (70) stories highlighted this:

I have heard stories that my friends and other people who had surgery to treat arthritis or broken hip. I understand that there’s nothing much else we can do to treat it [other than having surgery] because of our age. But I feel a bit scared of surgery because I know some people who had surgery can’t walk and go out by themselves anymore. (Wakae)

My friend told me about her knee surgery. She said the pain disappeared but she can’t bend her knee anymore. It would be inconvenient if I couldn’t bend my knees, so I decided not to have knee surgery. Surgery for back problems is the same. I heard that it doesn't heal completely—like it just temporarily reduced the pain or something. Based on my observation, 60 to 70 per cent of people who had surgery think they shouldn’t have had it. (Setsuko)

In anticipating her future based on seeing the others’ experiences, Wakae felt that there was a risk that surgery might cause a loss of mobility. Moreover, Setsuko understood that surgery might not be the best option for knee and back problems because it did not seem to provide a complete solution based on her observations.
For them, observing their friends’ and acquaintances’ experiences was important because it helped them make decisions regarding the best outcomes for their health issues. The potential adverse effects of surgery may certainly undermine an ideal lifestyle. For Wakae, the loss of mobility she had seen in her friends signalled the potential for her own loss of independent living. Setsuko was concerned that she would not be able to sing nagauta music (Japanese traditional epic song), which is one of her hobbies, if she could not bend her knees, because this activity involves kneeling and sitting on one’s heels.

It may be important to consider the risks involved in surgery in older age due to the lowered capacity for intensive physical rehabilitation after the surgery. This is supported by previous research that investigated functional recovery after surgery for hip fracture among old people. It is reported that of those people over 65 who underwent surgery, the physical capacities that allow the conduct of normal daily activities (including, walking outside the house, going shopping and looking after self) decreased to large extent (van Balen et al., 2001, Lin and Chang, 2004). More specifically, van Balen et al. (2001) reported that only a very small minority (17%) of the participants recovered the same level of daily activity that they had enjoyed prior to surgery for hip fracture. Surgery in old age has the potential to bring negative consequences, which undermine quality of life. This may explain older people’s tendency to have a negative perception of surgery. This was the case for several Australian and Japanese participants.

While reluctance to have surgery was a shared theme in the Australian and Japanese contexts, a difference was found in the factors that influenced their decision to avoid surgery. Wakae and Setsuko drew on the experiences of ageing others to assess the efficacy of surgery. By contrast the Australian participants did not reference others’ experiences of having undergone surgery. Rather, they used supplements of their own volition based on their past experiences or self-study. These differences might be explained by different cultural emphases in Japan and Australia—the former on collectivism and the latter individualism. In Japan, one’s behaviour is often influenced by the thoughts, feelings and actions of others,
whereas people in Western cultures view themselves as independent, with their selves determined by internal thoughts, feelings and actions (Aronson et al., 2006). This notion was also reflected in both Australian and Japanese participants’ choice of supplements. The Japanese often said, ‘my friends recommended me to use this’ (Setsuko, 70) or ‘my mother has been using this’ (Seiko, 61). On the other hand, many of Australian participants stressed, ‘we are all different, so we need to find suitable supplements for each of us’ (Alan, 63) or ‘I read a lot of books about supplements and chose the ones I need based on the problems on my body’ (Glenda, 66).

6.2 Cultural differences: Western medicine and self-care practices among Australian and Japanese participants

There were prominent cultural differences in the ways Australian and Japanese participants conceptualised the roles of medical doctors and medical practices in their self-care practices using anti-ageing medicine. For most Australian participants their experiences of interactions with medical doctors and medical practices created significant push factors that led them to initiate anti-ageing medicine use. In contrast, medical doctors and their practices had minimal influence on Japanese participants’ decision-making to use anti-ageing medicine. Such differences originated from culturally-shaped health practices and health beliefs. In the following sections, I explore the details by presenting Australian and Japanese data separately.

6.3 Developing self-care repertoires with anti-ageing medicine in Australian context

In Australia as a Western nation, health has been predominantly regulated through the lens of Western medicine. Here, medical doctors take an authoritative role in managing health using specific medical knowledge (Foucault, 1991a). Accordingly, doctors take a central role in providing information for various
health promotions that aim to change a wide range of individuals’ health
behaviours. For example, *The National Strategy for an Ageing Australia* (2001)
has made general practitioners (GPs) primarily responsible for providing older
adults with useful health information in order to promote healthy ageing (Sims et
al., 2000). The National Strategy emphasises the importance of maximising good
health behaviour among older adults, which is, it believes, derived from having
adequate knowledge about specific health issues, particularly about the prevention
and control of chronic diseases. In fact, some medical researchers suggest that
GPs are important agents of behavioural change due to their influence at a
population level (Livingston et al., 1998). Here, the idea is that providing
adequate knowledge about age-related illnesses and diseases can foster preventive
health behaviour among older adults.

Following the above notion, the majority of Australian participants established
their self-care practices using anti-ageing medicine based on their experiences of
interacting with their doctors or other health practitioners. Over one-third of the
Australian participants mentioned that their doctors positively contribute to their
supplement use. In contrast with this, nearly half of them chose anti-ageing
medicine as an alternative choice to manage their age-associated health problems
instead of receiving medical interventions, including allopathic medication. This
is because many of them questioned the efficacy of conventional medical
practices for age-related health problems.

### 6.3.1 Positive roles of medical professionals in self-care practices

Over one-third of Australian participants appeared to react positively to their
medical doctors when they provided useful advice and encouragement on their
self-care practices using anti-ageing medicine or supplements. The positive roles
of medical doctors were described based on two themes: (1) providing useful
information and (2) encouragement regarding self-care practices. According to
these participants, the doctors in these contexts fulfilled their important roles of
promoting good health behaviour. The ways the participants evaluated their
doctors—whether or not they are useful for their self-care practices—were related to the doctors’ openness (or acceptance) towards practices other than Western medicine such as complementary alternative medicine (CAM) (for example, supplement treatment or Chinese herbal medicine) or integrative medicine (combination of CAM with Western medicine). The consistent attitudes of these participants were that they are willing to listen to suggestions from their doctors regarding how they can successfully manage their health in less medically-interventionist ways. This is well illustrated in Bill’s (74) comment: ‘We [I and my wife] ask our medico, our general practitioner, if we are doing the right thing. And we tell him that we are here to ask for any suggestion to help us’. It was clear that Australian participants had certain expectations towards medical doctors to help their health management strategies, which included health advice and support on supplement use.

6.3.1.1 Doctors provide useful information

Some Australian participants had found that their doctors provided useful advice on supplement intake in dealing with age-related health problems. Some doctors recommended it to treat existing health problems and others suggested its positive effects in preventing certain diseases. Angela (64) talked about her doctor’s influence on her supplement selection. Her doctor, who is a GP and also a specialist in ageing, suggested that she take good-quality fish oil to reduce her higher levels of blood pressure. Angela explained:

My doctor started giving people different types of supplements and sees which supplement improves their blood. Fish oil is the one thing that made a significant difference. She’s absolutely convinced about it.

Angela was impressed by her doctor’s endeavour to treat people’s health issues using dietary supplements. As advised by her doctor, Angela changed the type of fish oil to a ‘good-quality’ one and increased her intake of it.
It was particularly important for Angela that her doctor endorsed an alternative, natural option to improve her blood rather than relying on medication for high blood pressure. When she talked about the prevention of osteoporosis she clearly showed an unwillingness to use pharmaceutical medication (which she called ‘aggressive pharmaceutical medication’) because she believes it will cause significant side effects. Thus her doctor’s advice on supplements and her preferred approach worked together to improve her health issue. She talked about her high level of satisfaction with the medical consultation with her doctor: ‘I like the fact that I see her every six months. She checks upon me. I get a little tick, you know, ‘yes, this is ok, this is ok’. That reinforces me, I know obviously, subjectively’. For Angela, the role of her doctor in managing her health was significant. Moreover, good results at her regular check-ups further motivated her to continue taking the supplement.

Bill (74) and Ryan (67) also talked about how their doctors suggested taking supplements to prevent age-related health problems. Bill’s doctor found low levels of vitamin D in his blood and suggested that he take a supplement, because according to his doctor, a lack of vitamin D leads to a greater risk of osteoporosis. Ryan’s doctor recommended that he take certain supplements based on his age in order to prevent future occurrences of age-related disease. In particular, his doctor explained to him the positive research results regarding the efficacy of vitamin E in preventing cancer. Both Bill and Ryan followed their doctors’ advice and have been taking those recommended supplements ever since. Their doctors actively integrated preventive health approaches in their medical practices by suggesting that Bill and Ryan take certain supplements.

It can be argued that Angela, Bill and Ryan’s doctors’ behaviour is consistent with an approach that Broom and Woodward (1996) call constructive medicalisation. This is distinguished from medical dominance. They suggest that constructive medicalisation involves not only finding the cause of disease to enable its cure—the main focus of Western medicine—but also humanistic approaches: building reciprocal interactions—that is, doctors share medical
knowledge with their patients in order to develop adequate treatments. This approach emphasises the importance of doctors’ support of individuals’ efforts to conduct self-care practices and encourages their involvement in decision-making regarding treatment choices. It seeks an ideal treatment in a collaborative way between doctors and patients. This in turn helps enhance patients’ overall wellbeing (Broom and Woodward, 1996). Angela, Bill and Ryan’s doctors constructively medicalise ageing bodies and seek an alternative way to treat their bodies to prevent future occurrences of age-related disease and illness. In so doing, they integrate a degree of knowledge outside Western medicine. This openness may have made Angela, Bill and Ryan willing to collaborate with their doctors to receive ideal treatment. Within this context, there is a reciprocal relationship built between them and their doctors.

6.3.1.2 Doctors’ encouragement, support and praise for self-care practices

Other Australian participants put their trust in their doctors when they provided continuous encouragement or positive appraisal for their self-care practices. Barbara’s (77) doctor shows his understanding of the importance of optimal health and encourages her to strive for overall wellbeing. She clearly shows her trust in and appreciation of her doctor because he continuously encourages her to maintain her current standard of health to maintain quality of life. This involves providing not only medical advice, but also advice on activities such as weight control and regular exercise. Barbara continued:

I have an interview every year with my doctor. He said I must be very careful with my cholesterol because if I had stroke I would have no quality of life. So, I must do everything I can prevent stroke, which is what affected my mother. She had stroke when she was much younger than I am now. And she spent 8 years driving everybody quite crazy in the nursing home. You know, it would be very bad. The doctor says I gotta keep this current standard as long
as I can, which is what I’m trying to do. I do my best and do as my
doctor says.

For Barbara, keeping her current standard of health is crucial to preventing a
stroke, which she is fearful of having, because she knows the consequences of it
from seeing the experience of her own mother. This convinced Barbara of the
relevance of her doctor’s emphasis on the importance of maintaining her current
standard of health through her own efforts. Taking her doctor’s advice seriously,
she lost 23 kilograms in the past few years and walks four kilometres every day.
She mentioned that her doctor’s encouragement has an enormous influence on
maintaining her current good health through regular exercise. Moreover, she
commented that the oestrogen treatment for osteoporosis prevention contributes to
her ability to exercise daily.

In addition to the verbal encouragement Barbara received, it seemed important for
some Australian participants to have doctors who do not dismiss lay attitudes and
understandings of health, including self-acquired knowledge about the benefits of
supplement intake. Catherine (76) told me that her doctor respects her preference
to manage her health naturally, avoiding pharmaceutical medications unless it is
absolutely necessary. According to her, ‘once you start using them, they destroy
other parts of body’. The idea of ‘managing health naturally’ is now observed
elsewhere in Australia because of the increase in consumer demand for natural
medicine products due to dissatisfaction and frustration with biomedical
treatments (Baer, 2008). Catherine mentioned that her doctor is cooperative in that
he appreciates her opinions and tries to incorporate them in his health advice. For
example, he suggested treatment with supplements instead of pharmaceutical
medication, even though the former is often regarded as unorthodox because of
the lack of conclusive research outcomes in evidence-based Western medicine
(Baer, 2008). She has developed trust in her doctor, and his supportive attitudes
have motivated her to continue self-care practices. Here, a reciprocal relationship
of mutual trust is the key, and also one of the important aspects in the constructive
medicalisation approach (Broom and Woodward, 1996).
To give another example, some participants took pride in their doctors’ positive comments derived from the results of a medical check-up as a powerful incentive for their self-care practices. Rowena (67) talked about an occasion when her doctor saw her excellent blood test result. He clearly expressed his surprise and praised her efforts. She continued:

When he saw my HDL [High-Density Lipoprotein, in other words, good cholesterol] range, compared to the average in early old age, he said, ‘I’ve never seen the HDL level as high as yours’. His words were, ‘I didn’t even think it was clinically possible to have such a high HDL’.

Rowena’s doctor was amazed at her good cholesterol level. She told me, ‘I believe that taking specific supplements has been a significant factor in attaining the excellent blood test readings, although this is impossible to prove’. She was proud of her health management with supplements, and believed it had contributed to own good health as demonstrated in the blood test result. She took her doctor’s words, ‘I didn’t think it was clinically possible…’ as praise for her efforts in managing her health. It was clear that her confidence in her self-care practices was further strengthened by her doctor’s positive attitudes towards it.

It can be argued that Barbara, Catherine and Rowena’s doctors take a holistic, empowering approach: that is, they encourage individuals to actively engage in preventive health activities, which are often used in CAM (Barrett et al., 2003). The doctors’ verbal encouragement, respect and praise for their health behaviour empowered these women and enhanced their confidence in their abilities to manage their own health. Although their self-care practices are ‘belief-centered and value-laden’, unlike evidence-based medical practices (Barrett et al., 2003:943), it seemed that the doctors understood the importance of their subjective beliefs about the supplements’ efficacy in strengthening positive health behaviour.
As these examples show, some Australian participants appreciated their doctors’ advice, support and encouragement in keeping their current levels of health or improving their health status. From the interviews, it was clear that doctors like Angela, Ryan and Bill’s, who provided supplement advice, are in a minority. Moreover, only a few Australian participants talked about their experiences of having attentive support from their doctors, and this situation further encouraged them to continue self-care practices using anti-ageing medicine. Yet these participants believed that their decision to conduct self-care using anti-ageing medicine was respected by their doctors and they were satisfied with their relationships with them. In this context the doctors play an important role in promoting good health in older age.

6.3.2 Dissatisfaction and frustration with medical practices

Nearly half the Australian participants mentioned that their decision to choose an alternative way of managing their own health with anti-ageing medicine was largely influenced by their past negative encounters with Western medicine. There were two distinct experiences cited. The first is that they had experienced (or witnessed) that Western medicine did not provide satisfactory solutions to their (or significant others’) health issues. The second is that medication used in Western medicine had side effects considered harmful to their health. These findings partly reflected those of Watts-Roy’s (2009: 439) empirical study, which found that the decision to use anti-ageing medicine was a ‘powerful criticism of the traditional biomedical encounter’. Specifically, these participants have experienced (or observed) limitations in what conventional Western medicine has to offer.

6.3.2.1 Negative encounters with medical practices in the past

For several Australian participants their past experiences of negative encounters with Western medicine—medical practices went wrong or did not provide any
positive solution for their health issues they suffered—had a strong influence on their perceptions of the roles of Western medicine in relation to their age-related health problems. Natalie (64) gave an example:

Maybe three, four years ago, I became very sick. I didn’t know what was wrong and it just got worse and worse. The doctor did all possible tests but could not find anything wrong physically in all the regular tests that Western medicine is practicing, like blood test or urine test or whatever. I was advised to go and seek an alternative. And I did. I was really ill, like physically very unwell. I couldn’t walk. I could hardly move and bend. I was shutting down. I was recommended to see the particular doctor who was Chinese and I went to see him. And the upshot was that it was depression that caused physical damage. I never thought that depression can make you physically ill. I thought depression is mental. Well I was surprised. Anyway, he treated me with acupuncture and herbal medicine and I got better.

In this context, Western medicine failed to manage the unknown illness because it could not find its cause and a solution. Natalie was advised to seek alternatives by her doctor, which solved her problem. Following her recovery from ill health caused by depression, Natalie continues taking Chinese herbs to maintain good health and general well-being. She believes it is greatly contributing to her anti-ageing practices because it provides both mental and physical health, which allows her to maintain her quality of life.

For other participants, encountering the limitations of Western medicine raised awareness that they do not necessarily need to rely solely on it, and that there are other options available to manage their health, especially age-related health issues. This does not mean that they completely dismiss Western medicine. Rather, the experience of its limitations made them aware of an ‘alternative choice’ in their self-care strategies. Through their lived experience of illness, they gained health
knowledge, which empowered them to exercise choice. This is well illustrated by Joanna’s (58) story. Joanna suffered from long-term ill health following her hysterectomy. She talked about her experience of what she went through while she was very ill:

I spent thousands of dollars to find out why I was so unwell and lacked energy dreadfully. And the doctor couldn’t help me at all. So, I got myself onto the road of alternative therapy and I tried many. All helped a little, but nothing really fixed me.

After the long journey of seeking all possible treatments, including Chinese herbal medicine and acupuncture for her ill health, Joanna was referred by a naturopath to see an ageing specialist, who suggested she take natural hormone replacement therapy (HRT). Briefly, natural HRT uses a bio-identical hormone, which is derived from a plant and modified to be structurally identical to endogenous human hormones, and has little or no adverse effects (Chervenak, 2009). Natural HRT with a combination of a variety of supplements including vitamins, CoQ10 and Gingko suggested by the naturopath greatly improved her health. Now, Joanna’s focus is on maintaining her good condition with these supplements into her old age. She told me where she stands now:

I find where I am now in my life, alternative medicines work for me. I am not saying that I dismiss what you call, Western medicine because I think it’s wonderful and those doctors and surgeons achieve miracles every day, saving life. They are amazing people. But what seems [to] work for me is going down on a natural road, and if something happens to me, if I need a specialist like doctors and surgeons, I would go, but I’ve always survived in the best way I can.

Joanna certainly shows respect for conventional Western medicine, which she acknowledged as achieving miracles by saving people’s lives through surgery or
other medical practices. However, she believed that alternative medicine is the thing that supports her self-care practice. Her experiences of having undergone various treatments led her to understand, even subjectively, that Western medicine and CAM can be used for different purposes.

6.3.2.2 Unwillingness to accept the side effects of medication

Unlike Natalie and Joanna’s perceptions that Western medicine did not achieve satisfying outcomes, some participants were frustrated with its practices because they experienced unexpected adverse side effects. What frustrated them more was that these effects were not adequately explained to them, and that their experience of them was not taken seriously by their doctors. Such events made these participants reconsider the necessity of following Western medical practices, and caused them to experiment with alternatives. For Farren (74), a side effect of prescribed medication was a big concern, because the cholesterol medication she was taking, Lipitor, caused incredible pain. This possibility had not been explained to her by her doctor. In her case, health professionals of CAM helped her gain knowledge about the side effects associated with the medication and suggested she take CoQ10. Her medical doctor had not advised her to take this. Farren told of her experience:

I was fortunate that I found a doctor who practices chelation [a treatment to remove metals from the body] and said to me ‘throw the drug in the rubbish, it is digesting your muscle’. It is actually more complex than that. It destroys the CoQ10, which is essential for the cell metabolism. When my husband was put on this a year ago, he had cramps and I said ‘magnesium would probably help you’. I take magnesium when I have cramps. So he was in the health food shop to buy it and the young woman who is a naturopath asked what kind of medications he is on and said, ‘oh he’s on Lipitor, he definitely needs CoQ10’. Now this knowledge
is known at our local pharmacy but the doctor never says the word about it.

Farren was informed by the CAM doctor and the naturopath about the side effects of Lipitor, but her medical doctor had not explained this to her. She took their advice and stopped taking Lipitor. She wondered why her medical doctor had not told her of its potential side effects. This experience undermined Farren’s trust in her medical doctor and his medical practices in managing her health issue.

Like Farren, some other participants shared the idea that experiencing side effects of medication along with the treatment of existing age-related health problems is not ideal. Moreover, doctors’ indifferent attitudes towards these side effects led them to doubt the role of medical doctors in managing health. Newton (84) strongly asserted: ‘(T)hey know nothing about, very little, very little about health. They are trained in sickness’. This comment was made based on his experiences of consulting his doctor regarding his blood pressure issues. He continued:

I went to the medical check-up with a doctor and he said, ‘oh, your blood pressure is up. You better to take these tablets’. I took them and I developed bad dry cough. It was the tablet, I knew that. So, I stopped taking them and threw them in the rubbish bin. I went back to the doctor a few years later and he said ‘your blood pressure is up a bit, do you still take those tablets?’ and I said, ‘no, they gave me cough’. ‘Try these’, so he gave me different one. But I bought a blood pressure machine at the chemist and I check my blood pressure every day, couple of times a day. It is up and down and up and down, all over the place. So I go to the doctor once a year or something and he puts me on medication, you know, that’s rubbish. I monitor it and I stopped taking any medication. I don’t take any medication now at all. But I monitor my blood pressure, I’m not foolish, I’m conscious. If it did go up and stay up that can be dangerous, sure. In the case, you gotta have an artificial thing to
counteract it. But walking helps, I know after I come back from walk and golf, and check it, it’s down. I told him that ‘look I monitor it, I’m conscious, I’m not being careless about it’ and in the end he said ‘alright’. Then, he said, ‘I can’t help you’. Well, He didn’t say that but that’s what he looked like.

Newton believed that closely monitoring and understanding his blood pressure patterns, adequate exercise and supplements all help obtain better overall health than prescribed medication that causes a bad dry cough. He makes a conscious effort to closely monitor his health using a blood pressure machine, even though his doctor did not support this practice. Self-awareness of the state of his health through daily examinations certainly empowered Newton to challenge his doctor’s advice and made him confident in his own self-care practices.

Turner (2004) suggests that individuals form their own understandings, beliefs and assumptions of health and illness experientially. Specifically, experiences of discomfort or social exclusion caused by illness and disease ‘open up opportunity for self-reflection’ (Turner, 2004:183). This notion was apparent in the above stories, where personal experiences of encountering the limitations of Western medicine and its harmful side effects were strong motivating factors in leading participants to use anti-ageing medicine to deal with their health issues. Through their lived experiences, the participants have come up with their own ways of managing their health. Such actions were often creative and experimental, which fits well with Shilling’s (2008:19) concept of creativity. According to Shilling (2008:19), ‘Creativity is associated with actions that alter certain aspects of oneself and/or one’s surroundings in order to repair or enhance one’s embodied capacities for action’. Joanna’s example shows that she reflexively created the best health practice through undertaking various treatments that include both Western medicine and CAM. In a similar manner, nearly half the Australian participants experientially developed their beliefs and values about their health, and these are reflected in their anti-ageing practices.
6.3.3 Summary

The findings from the Australian data reveal that there were different views towards the roles of medical doctors and medical practices in relation to their self-care. Specifically, Western medicine and medical doctors had significant impacts, positive and negative, on decisions to use anti-ageing medicine. Some showed appreciation of their doctors for their collaborative approach to managing their health. Moreover, the doctors’ understanding of what needs to be taken into account in self-care in older age greatly encouraged them to conduct self-care practices using particular anti-ageing medicine and supplements. This included the doctors’ knowledge of the necessity for nutritional supplements for ageing bodies for disease prevention, and attentive support for their health beliefs. By contrast, other participants’ experiences of ineffective medical practice and harmful side effects from medications made them question the efficacy of these practices in managing their health issues in older age. Such experiences were a powerful motivating factor in leading them to choose supplements as an alternative option.

Australian health promotion, such as a healthy ageing policy, indicates that older adults are passive recipients of health information. It advises them to ask their GPs and other health professionals such as dieticians for useful health information and advice. Older adults are considered to be good listeners and follow professionals’ advice. Older individuals were once seen to be more likely to comply with doctors’ advice without questioning their practices than younger cohorts, but consumerism has gradually reduced the power relation between doctors and patients (Lupton 1997a). It means that lay people are gaining awareness about alternative treatment options, and thus do not have to accept their doctors’ suggestions unconditionally. The findings of this study showed that Australian participants were not passive recipients of medical information. They autonomously examined their doctors’ advice to decide whether or not it was suitable for their health management. Medical doctors are no longer regarded as taking an authoritative role in this context. The increasing popularity of CAM in Australia and better accessibility to plentiful health information from various
sources, including the Internet, may have changed the dynamics of doctor-patient relationships. As the concept of constructive medicalisation suggests, doctor and patients relationships have become more mutual, more specifically, they share ‘mutuality of participatory power’ (Goodyear-Smith and Buetow, 2001: 451-452). In the following sections, I explore Japanese beliefs and values regarding health, and how these pertain to self-care using anti-ageing medicine among Japanese participants.

6.4 Japanese culture and self-care: traditional health beliefs and practices

While many Australians in this study associated their use of anti-ageing medicine with their doctors and medical practices, Japanese participants tended not to make the same connections. One aspect they did share with the Australians was an unwillingness to have surgery, along with fearful feelings towards it. Otherwise, there were prominent differences in the ways the Japanese participants made the decision to use anti-ageing medicine. Haug et al. (1991) report substantial differences in self-care behaviour between American and Japanese elderly. They found that the Japanese showed a lower desire for their doctors to provide them with health information and less preference for care by physicians than American cohorts. This notion is relevant to this study. The experiences of Japanese participants in initiating their anti-ageing practices are investigated through two themes: cultural practices of self-care and the lack of significance attributed to Western medicine and doctors in managing ageing bodies.

6.4.1 Using anti-ageing medicine as a part of a corrective diet

For many Japanese participants, eating a variety of good foods is as important as (or more important than) taking anti-ageing supplements to maintain good health in older age. Accordingly, a statement shared by many of the Japanese participants was that they take particular supplements because they think the nutrients contained in them are hard to get from their diet. For example, Chizuko
(66) takes glucosamine for her knee problem: ‘Glucosamine is hard to take from food. It is contained in crab or something, but I don’t or can’t eat crab that much’. Moreover, Tokiko (69) takes a supplement made from black vinegar believing that it is good for general health and moreover, good for her hypertension. She mentioned: ‘I know vinegar is good for health but I don’t generally like vinegar much. But this supplement makes it easy to take’. When Japanese participants talked about the intake of supplements, there was often an association between the supplements and food.

Such sentiments are deeply rooted in the Japanese folk practice of health management through diet. In Japanese culture, foods have traditionally been emphasised as particularly important in treating or preventing illness and disease. This is called ‘shokuji-ryohou:食事療法’ (corrective diet), and refers to managing one’s health through diet, including treating illness and disease and preventative health (Ohnuki-Tierney, 1984). This idea is also shown in a Japanese idiom, ‘ishoku dougen:食食同源’ (the idea of preventing or healing disease by eating a balanced diet in everyday life). In this paradigm foods are regarded as natural medicine (Yoshikawa, 1999). Ohnuki-Tierney (1984:83) notes that ‘(F)or almost all major illness, there are several kinds of books telling how to treat the illness through diet’. Moreover, some specific foods have been officially recognised and labelled by the Japanese Ministry of Health, Labour and Welfare as functional foods which are medically and dietetically proven to be effective in reducing the risk of developing particular illnesses or diseases, or to improve one’s health (Enomoto, 2002). A good example is an umeboshi (Japanese plum, which is pickled, sour and rich in citric acid). There is a saying in Japan that ‘with an umeboshi we do not need a doctor’. It is thought to have multiple effects including anti-bacterial properties, enhancing organ functions (especially the stomach or liver), helping bodily recovery from fatigue, lowering cholesterol and so on. Currently some medical doctors in Japan are paying attention to the effects of umeboshi for preventing serious disease, such as cancer, stroke and diabetes (Kishu Ume Kounou Kenkyukai 紀州梅効能研究会, 2010). Such recognition of umeboshi is beyond the common understanding of the popular proverb in the
West, ‘An apple a day keeps the doctor away’. Umeboshi has culturally-established recognition as a functional food, is integrated into Japanese diet for its health properties and had been historically used as a medicine in Japan long ago. Although some aspects of corrective diet have attracted medical doctors’ interest in further research in Japan, lay individuals use it without medical doctors’ help. This is regarded as folk medicine and is embedded in their everyday life. Therefore dietary advice from medical doctors is not needed in Japan. In fact, most Japanese participants told me that they are confident about their eating habits. To maintain their current good health, they have a balanced diet containing a variety of foods such as seaweed, tofu, natto (fermented soybeans), miso, umeboshi, sesame, fish, vegetables and so on. According to their beliefs, particular supplements bring some nutritional value that is hard to get from foods. Often, the participants got this information from a variety of sources including newspaper articles, (health) magazines, TV commercials and via word-of-mouth from friends. When I was staying in Japan for three months to conduct interviews, almost every day I saw advertisements for a variety of anti-ageing supplements in the newspapers and on TV. With this information, they chose particular anti-ageing medicines relevant to their health conditions or anticipated future deterioration in health. However, no-one said that their doctors were the source of this information or expected doctors to be forthcoming with this kind of information.

6.4.2 The use of Kampo and alternative medicine in self-care practices in Japan

In addition to corrective diets, it is also common for Japanese people to make use of Kampo and CAM for managing their health (Ohnuki-Tierney, 1984, Suzuki, 2004). Briefly, Kampo is a Japanese traditional medicine that includes plants and animal medicine derived from Chinese medicine. It was introduced to Japan in the sixth century, and since then it has ‘undergone extensive transformation within the Japanese sociocultural milieu’ (Ohnuki-Tierney, 1984:91). Kampo has been integrated into the Japanese medical system, and medical doctors understand its
effectiveness for some health conditions such as chronic illness (Watanabe et al., 2001). Aside from the medical uses of Kampo, it is also integrated into lay people’s daily health practices. For example, ‘Yomeishu’ (養命酒) is a popular liquid product made from 14 natural herbs (the origin of which goes back more than four centuries), and is used for good health and longevity in Japan. I can recall that my grandmother drank it every day to maintain her good health.

Such health practices are relevant not only to older individuals but also to younger adults. This is clearly supported by a survey conducted in 2001. It reports that the use of CAM, including dietary supplements, Kampo, massage and acupuncture, among others, outnumbered the use of Western medicine in the last 12 months (76% and 65.5% respectively) among Japanese people (Yamashita et al., 2002). The two main reasons for CAM use were that ‘their health conditions were not serious enough to consult medical doctors’ and for ‘preventive health’ (Yamashita et al., 2002). It is also reported that a high percentage (78.9%) of Japanese people who use CAM, including dietary supplements, did not disclose this to their medical doctors (Suzuki, 2004). These findings indicate that Japanese people clearly distinguish the roles of CAM and Western medicine in their health practices. To them, managing health, including the maintenance of the current standard of health, improving one’s health and disease prevention do not require consultation with medical doctors. This means that in Japan, self-care practices have been formed outside the domain of Western medicine. Thus it is argued that using anti-ageing medicine to manage their own health among Japanese participants may be derived from culturally-oriented health practices. In the following section, I explore how Japanese culture has shaped Japanese participants’ understanding of the roles of medical doctors and medical practices in their self-care.

6.4.3 Roles of doctors in health management in Japan

Many of the Japanese participants, unlike the Australians, did not really expect their doctors to provide them with meaningful advice on ways to keep their
current levels of good health. For example, while some were advised by their doctors about the necessity of weight loss or reducing the amount of alcohol intake, none of them mentioned that such advice was helpful. Moreover, they never talked about their experiences of negative encounters with Western medicine, or of having side effects from medications, which were the big push factors for many Australian participants to develop their own self-care practices. There was a general lack of concern for intervention by doctors in their self-care practices among Japanese participants. This is well demonstrated in the responses of Yoko (65) and Sanae (62) when I asked whether or not Western medicine or doctors played any role in maintaining their good health. Both answered: ‘I don’t think any’. Many other Japanese participants held similar views. Moreover, several Japanese participants believed that the results of medical check-ups are not very reliable, and that awareness of their own health is more important for taking care of themselves. Seiko (58) gave her view on this:

I think, it [the result of a medical check-up] gives you warning, warning about what I have to be careful of. But in the end, it [health management] is all up to myself, up to my conduct. The result is just data shown in numbers and it doesn’t tell much. It can sometimes be not accurate. One day, I had a medical examination and it was suggested that I have another examination because the result wasn’t good. Then I had another medical examination and the result was very different from the first one. I thought ‘why? It wasn't long ago that I had the first one’. I know the result varies depending on what I ate the night before. So, I thought I don’t need to worry about it much. I know my health better than the doctor and my health management is more appropriate than what that result tells me. The doctor wouldn’t be happy to hear that though.

Seiko understood that a medical check-up is important to the extent that it suggests areas in which she might need to be careful. Yet she has also learnt that the results of medical check-ups are not always reliable. She is confident in her
knowledge of her own body, and this means that she does not fully rely on external sources of health advice. With similar understandings, several other Japanese participants also developed their own repertoires of health management without relying much on their medical doctors.

Further, Sanae’s (62) story highlights the specific roles of doctors and medical practices in her health beliefs and how such values are formed. She had an operation for gastric cancer several years ago and trusted her doctor and the treatment provided by him when she went through surgery and recovery. Her words show that she relied on Western medicine to fight against gastric cancer. However, she has less faith in its role in maintaining her good health following her recovery. She does not even think that having regular check-ups contribute to keeping her healthy, despite the fact that she had once had cancer. Sanae continued:

I had monthly check-ups for five consecutive years after I had surgery. I haven't had any medical check-ups after that, so for the last two and half years. I hadn’t had any even before the cancer was found, either. I went to see the specialist when I had stomach pain. I thought something was seriously wrong and I knew I was ill. … After I experienced the gastric cancer, I knew for certain that it was caused by my unhealthy state of mind. Looking back on the time when I had cancer, I realised my mind was exhausted. I was busy, enormously stressed and pressured from running my restaurant by myself. Now my mind is positive, my mind is filled with satisfaction in running the business together with my family, although I’m very busy every day. I have this strange faith that if my mind is happy I won’t get sick.

There are two cultural beliefs about self-care embedded in Sanae’s quote. The first is the role of doctors and medical practices. It is clear that for Sanae, medical check-ups were for the purposes of examining any recurrence of cancer, and she
stopped having them when no recurrence was found. Her attitude towards Western medicine seems to be that its primary focus is to provide a cure when she feels something is wrong with her body. This is consistent with Long (1984) observation that Japanese patients do not expect a doctor to give them advice regarding daily activities such as regular exercise and diet based on the results of medical check-ups. Rather, a doctor’s role is to cure disease and illness.

Secondly, Sanae’s association between a positive mind-set and good health reflects the often-quoted Japanese proverb, ‘yamai ha ki kara’, which means in English, the mind rules the body. The notion that disease and illness are caused by a negative state of mind is a holistic approach towards health. She believes that medical check-ups are not necessary because she has a positive attitude to life, which helps prevent ill health, although she also admitted that this perception is a little optimistic. Nevertheless, several other Japanese participants believed that the maintenance of a positive mindset is important in preventing illness and disease. For example, Taeko (64), who regularly has a breast cancer screening test, stated, ‘if I am happy, this will keep cancer away’. This implies that she certainly relies on Western medicine to detect breast cancer, but more importantly, she believes that whether or not she gets a disease such as cancer depends on her attitude towards life. As Sanae and Takeko’s stories indicate, the prevalence of Japanese folk beliefs regarding self-care may have some influence on the way Japanese people limit medical practices (including doctors) to a certain role: detecting and curing disease.

6.4.4 Bodily deteriorations in older age as a part of natural ageing

There is another reason that may explain why doctors are not as involved in self-care among Japanese older people. Many Japanese participants perceived their age-related health issues such as knee pain, loss of energy and deterioration of organ functions as natural, and therefore they had not sought medical help, particularly if these ailments were not life threatening. This view is even
encouraged by some medical doctors in Japan. Miyuki’s (67) comment highlights this point:

Miyuki: I have a lot of health issues, which have the word ‘senile’ on their titles, such as senile cataract, senile hearing loss, etc. My doctor told me that these are the same as my hair turning grey. So, I can't do much about these issues. I can’t reverse these conditions. The doctor told me that so far I don’t need surgery or special treatment for these.
Maho: So, your doctor told you that these conditions are simply caused by your age?
Miyuki: Yes, yes. These are due to my old age. It's good because it makes me realise that I’m old.

Miyuki told me that these health issues were discovered during a medical check-up, and her doctor explicitly told her that they were caused by old age, and did not require any treatment. In this case, to some extent her doctor naturalised the deterioration in health associated with old age. Indeed, his comment on her health issues was not particularly constructive for Miyuki in terms of how she could manage the discomfort or inconvenience associated with these problems. This might be because her age-related health issues are so far not serious enough to require medical treatment. Miyuki’s experience is consistent with my own experience of observing my mother, who is 69 years old. Her doctor told her that her thyroid symptoms, such as sudden cough, a choking sensation and discomfort in her throat, were due to her old age, and that no treatment was necessary. By contrast, in the case of an Australian participant, Angela (64), her doctors explained that her thyroid problems were potentially fatal, and they were treated with hormone therapy. The doctors’ respective ways of explaining Miyuki’s and my mother’s failing bodily functions certainly influences the way they comprehend and manage their losing functions.
Many Japanese participants had not consulted their doctors regarding their age-related health issues, particularly osteoarthritis. This could be explained by the fact that many of these issues are seen as natural ageing processes. This suggests that the medicalisation of ill health conditions caused by older age is not a universal phenomenon. There are cultural differences in how people perceive health and illness, and these extend to medical doctors’ ways of perceiving health deterioration caused by ageing. Lock (1993) elucidates this with the case of menopause and its treatment in the U.S. and Japan. HRT was intensively used in the American context. By contrast, it was perceived by Japanese doctors as unnecessary, because menopause is considered a natural process of ageing. This reasoning coincides with Miyuki’s doctor’s statement that her loss of functions is due to her old age.

Yoshio’s (76) story further highlights the above notion. As a medical doctor still practising, he told me that he has been managing knee pain caused by osteoarthritis with glucosamine and chondroitin supplements for the last 10 years. However, when he had acute pain in his knee that meant he was unable to walk for a few days, he did not seek medical treatment. I asked the reason and he answered: ‘I don’t need to show this to a specialist. I don’t need any special treatment for this. I have pain sometimes, but it has been integrated in my everyday life’. He understands the knee pain as a part of his ageing identity. His knee condition varies every day, and he adjusts his activities accordingly. Even though he is a medical doctor, he does not believe in the necessity for medical treatment. The reasons for medical doctors not being involved in Japanese participants’ self-care practices may be related to their perceptions that some age-related health issues are natural processes of ageing and do not require medical advice. This could explain the fact that some Australian participants have already had surgery for osteoarthritis and arthritis, or their doctors have encouraged them to have it. In contrast, most Japanese participants hardly ever consult with the doctors for these problems.
6.4.5 Summary

For many Japanese participants their decision-making regarding the use of anti-ageing medicine was largely influenced by the culturally-embedded health practice of corrective diet. This involves the technique of self-medication through particular nutrients deemed necessary for specific health conditions. They applied this to supplement selection for their ageing bodies or failing functions. With the firmly-established practice of self-care, along with the popularity of Kampo and CAM, they understood the role of medical doctors as limited to the detection and cure of disease. Therefore little involvement by medical doctors in self-care practices was found among Japanese participants. Another explanation for this might lie in the fact that there was an understanding shared by some of their medical doctors that some deterioration in health associated with ageing was a natural part of getting old. This view influenced some Japanese participants’ ways of comprehending and managing the discomfort caused by ageing bodies.

6.5 Conclusion

The findings outlined in this chapter have revealed the different circumstances leading Australian and Japanese participants to use anti-ageing medicine. Kleinman’s (1978) suggestion that health activities should be understood in relation to cultural systems rings true for the participants in this study, who were largely influenced by culturally-established health practices. Almost all Australian participants explained their use of anti-ageing medicine in the context of interactions with their doctors or medical practices. This suggests that health is largely regulated by Western medicine in Australia. By contrast, no Japanese participants related their anti-ageing practices to medical contexts, apart from one instance that was also shared by a few Australian participants: the reluctance to have surgery. Negative perceptions of surgery in older age were a universal phenomenon in Japanese and Australian contexts. These were often derived from the participants’ anticipations that having surgery in older age could have detrimental effects. In particular, quality of life might be impaired due to the
difficulty to achieve full functional recovery after surgery in older age, and this is supported by medical research (e.g., van Balen et al., 2001). With this in mind, they chose to take anti-ageing medicine instead.

Apart from the similarity, there were striking differences in the way in which Australian and Japanese participants perceived the roles of medical doctors and medical practices in the process of developing their self-care repertoires. For the Australians, their influence was enormous in various ways. A minority of Australian participants worked out their self-care using anti-ageing medicine in cooperation with their medical doctors. In contrast to Foucault’s (1991a) suggestion that medical doctors take an authoritative role to managing health, particularly in the West, these participants’ doctors took a constructive approach by developing reciprocal interactions with them. This meant that the participants were given the opportunity to develop suitable treatments with their doctors, and the doctors were supportive of their decisions (Broom and Woodward, 1996). In this context, they developed trust in their doctors and this encouraged them to continue self-care using anti-ageing medicine.

Many Australian participants showed serious concerns regarding the limitations of Western medicine, although they were not specifically asked to consider them in relation to their self-care practices during the interviews. They took their past experiences of negative encounters with medical practices as a departure point to search for alternative health practices. Specifically, their feelings of dissatisfaction and frustration with medical practices motivated them to use anti-ageing medicine. This coincides with Watts-Roy’s (2009: 439) empirical research, which found that turning towards anti-ageing medicine was a ‘powerful criticism of the traditional biomedical encounter’. These Australians developed their own health practices through reference to their embodied experiences.

In contrast with Australian cohorts, Japanese participants showed that they made no association between the use of anti-ageing medicine and their interactions with medical doctors or medical practices. Rather, their self-care was uniquely tailored
by the culturally-embedded health practice of corrective diet. Moreover, with the high popularity of CAM and integration of Kampo use into daily life for health management in Japan, Japanese participants showed their understanding that self-care can be conducted outside the domain of Western medicine. Accordingly, they shared an understanding of the narrowly-defined role of medical doctors: to detect and cure diseases.

Australian and Japanese participants reached their anti-ageing practices through different, culturally-guided journeys. However, it was apparent that both of them shared the same aspiration: that is, striving for good health. In the next chapter I explore in-depth the impact of good health in old age. In particular, the chapter compares and contrasts how the Australians and Japanese contextualise the use of anti-ageing medicine in relation to their culturally-addressed perceptions of ageing well.
Chapter Seven
Anti-ageing medicine will lead us to age well: Meanings of ageing well in Australia and Japan

We [my husband and I] believe it [taking supplements] helps us stay healthy and age successfully. Keeping health is the top of the list of important things. Very much. If you don’t have good health, you are not going to age well, are you? (Dina, age 72).

This chapter examines how participants’ perceptions of ageing well underpin their use of anti-ageing medicine, and the cultural values attached to them. It will illuminate cultural similarities and differences in how Australian and Japanese participants think about their ideal ways of getting older. As demonstrated in the previous chapters, all the participants were very conscious about the maintenance of their good health in old age. An inquiry into the concept of ageing well will unpack the reasons for its importance. Moreover, the cultural comparisons will highlight how individuals’ understandings of getting older reflect the societal expectations, political ideologies and traditional/cultural values on older age.

As exemplified in the above quote from Dina, all participants agreed with the idea that good health is the most important component in the process of ageing. Specifically, they believed that good health allows them to obtain ideal lifestyles without any hindrances. The question then arises as to what ideal lifestyles in old age mean. As pointed out in Chapter Three, scholars argue that people’s perceptions of quality of life in old age are multifaceted, and are largely dependent on individuals’ life experiences (e.g. Borglin et al., 2005, Bowling, 2007, Bowling et al., 2003, Farquhar, 1995). This suggests that they reflect people’s biographies and various social factors surrounding them, including class, gender, marital status, cultural beliefs in old age and family traditions (Browne et al. 1994). This notion is clearly shown in this study.
In Chapter Three, I discussed the quantitative data obtained in Molzahn et al.’s (2011) cross-cultural comparisons of perceived quality of life in old age across 22 nations. This study revealed that Australian and Japanese older adults understand in a similar manner what it means to age well. This study supports this notion, but simultaneously found notable cultural differences between Australian and Japanese counterparts in in-depth meanings of one concept: ‘independence in old age’. To demonstrate this, I begin by describing what ageing well constitutes for Australian and Japanese participants. Each contributory component of ageing well is then discussed in detail in the following sections. The findings highlight prominent cultural similarities in Australian and Japanese participants’ understandings of the concept of continuity in life. Cultural differences in these cohorts’ understandings of what is meant by independence in old age reflect culturally (socially)-constructed ideologies of what old people should be.

7.1 Hierarchical components of ageing well

Both Australian and Japanese participants placed significant importance on obtaining good health when they talked about their insights into the concept of ageing well. In other words, they emphasised that good health was a precondition in seeking their ideal lifestyle in older age. It was clear that participants had consciously (or unconsciously) placed the facets of ageing well in a hierarchical order. These are presented in Figure 5.
The hierarchical components of ageing well presented here highlight Ball’s (2002) suggestion of what people seek in older age. It consists of active lifestyles involving family/friends, community participation/voluntary work, (self) employment, learning/personal development, travel/leisure and home/garden activities. As shown in Figure 5, good health was considered to be at the top of the hierarchy. Below this, many participants hoped to continue active engagement in life. This was thought to mean the ability to maintain current lifestyles, including continuous commitment to house duties, paid and unpaid work and hobby activities. This theme was understood in a similar manner by both Australian and Japanese participants. Active engagement in life also meant that the participants could be independent (look after themselves without anyone’s help) and take initiative in life (autonomy). Both Australian and Japanese participants talked about these aspects side by side, therefore I placed them under the theme of independence. Below this, there were several contributing factors thought to help the participants to be independent in older age. In this case, there were substantial cultural differences between Australian and Japanese participants, particularly in their perceptions of the meaning of independence.
The following sections are set out according to these themes, highlighting cultural comparisons. First, I demonstrate cultural similarities based on two themes: (1) health as a fundamental requirement of ageing well and (2) active engagement in life. Then I move to the theme of independence in older age, which elucidated significant cultural differences between Australian and Japanese participants.

7.2 Cultural similarity I: Health as a fundamental requirement for ageing well

When I asked questions regarding their perceptions of ageing well, almost all Australian and Japanese participants mentioned that the maintenance of good health is crucial in older age. Japanese participant Tatsuya (60) explained that good health would add value to his life:

An ideal way of ageing is keeping good health in older age. If you are not healthy, you can’t travel, you can’t enjoy eating beautiful meals. Even if you have money, if you are not healthy, you can’t use it. So, health is the best thing to have when you get older.

Tatsuya’s comment, ‘traveling’ and ‘enjoying eating beautiful meals’, connotes positive, active and enjoyable lifestyles. As he cited pleasurable activities in explaining what makes his life meaningful, many others formed an association between a meaningful life and a positive self, such as playing lawn balls and line dancing, teaching yoga and ballet, flying helicopters, taking photos, running a family business and pursuing professional careers, all of which require good health. A positive self may bring a sense of contentment to their lives. In fact, previous research shows that both Japanese and Australian elderly people think it is one of the most important contributing factors to ageing well (Molzahn et al., 2011).

When our conversations turned to what constitutes health, many Australian and Japanese participants spoke about both physical and mental health, and were
greatly concerned about dementia. The participants considered physical health to be important, because it allows them to continue normal daily physical activities such as cooking, shopping, household chores, work and hobby activities. Regarding mental health, many of them believed that dementia would take away their sense of self, and therefore they hoped to avoid getting dementia. Moreover, they were aware of the importance of having a good balance between physical, emotional and mental health because these are interrelated. Maintaining overall good health has become imperative in order to achieve a sense of ageing well.

Some Australian and Japanese participants believed emotional health—that is, a feeling of happiness or contentment—to be as important as physical health in ageing well. Peter’s (80+) comment highlighted this:

Ageing well means that you can do all those things necessary to keep yourself going and happy. If you are depressed or something like that, that’s not what I call successful ageing. Just being alive is not good enough. It’s not good to say that ‘I’m 100 [years old]’ if you are not happy.

Peter observed that longevity without emotional happiness—in his words, ‘just being alive’—is not considered to be ageing well, even though it is possible to live longer with good physical health. For Peter, ageing well can be achieved when both physical and emotional health are present. This leads to a worthwhile later life. Similarly, Japanese participant Taeko (64) emphasised that in order to age well, it is important to have a mind-set that is open to feelings of pleasure in everyday life. She believes in a common saying: ‘the mind rules the body’. This matches the previous finding that satisfaction in both body and mind is the key to quality of life in older age (Borglin et al., 2005).

Capturing this, the ways in which emotional health is negatively affected by ill health was highlighted by Yoko’s (65) experience of observing her mother-in-law.
While she was mentally alert, she was bedridden due to her leg problems and was looked after by Yoko and her husband at home. Yoko commented:

> I need to be healthy in both mind and body. Because if you get sick, it affects your mind state, like you become jealous [of others] or depressed. Even if you don’t develop depression, you may definitely feel down. Observing my mother, I can tell she has been very depressed, often saying ‘why me?’

Yoko’s observation of her mother-in-law showed the connection between bad physical health and a depressed mental state. Because of her ill-functioning legs, which made her dependent on others, Yoko’s mother-in-law certainly developed self-pity. Yoko’s mother-in-law’s feeling of self-pity may have been caused by her frustration at not being able to control her own body and thus her own life. Yoko wanted to avoid this situation happening to her in the future because she had witnessed her mother-in-law’s lack of enjoyment in life.

In order to maintain overall good health, many Australian participants told me that they try to use their brains as much as possible by reading books and newspapers, and by doing crossword and Sudoku puzzles to maintain their mental state. Moreover, some of them were taking a particular supplement to keep the brains active. Many of them used the words ‘mental health’ when they were thinking about mental frailty associated with older age, especially in relation to dementia. Some of them were particularly afraid of losing their sanity. This may be because, as discussed in previous literature on the topic, dementia is the most feared condition among older individuals because it is perceived to be ‘signifying the ultimate loss of control, identity, and dignity’ (Corner and Bond, 2004:153), which may directly influence one’s quality of life. Negative emotional responses to dementia were seen among most of the Australian participants and it was sometimes generated through their own experience of seeing others with dementia. For example, Catherine (76) talked about her negative feelings towards dementia based on her experiences:
Mental health is more important for me than physical health because my mother had dementia and I wouldn’t like to be that. You never know anybody, you don’t know your family. It’s awful. ... When I went to see her at [nursing] home, people were just sitting there, you know, no quality of life or whatsoever. I don’t want to be like that.

For Catherine, being exposed to a mother with dementia who spent the rest of her life in a nursing home without recognising her family evoked a strongly negative feeling towards dementia. She believed that dementia completely destroys quality of life. In this sense, dementia and ageing well cannot coexist. Her experience of seeing her mother and other older individuals with dementia at the nursing home has become a strong motivation for Catherine to train her brain in order to prevent it.

Although Japanese participants were not particularly concerned with getting dementia, or did not show negative perceptions towards it, they agreed with the idea that dementia leads to a loss of the self. Many of them told me that if they did develop dementia, that would be the time to move into a nursing home. A common statement shared by some Japanese participants was, ‘if I become mentally senile, my children can throw me in a nursing home’ (Akira, 68). This comment shows that dementia is symbolised as taking away one’s control in life. In this context, a sense of self is absent. Borglin et al. (2005:213) cited Lawton’s (1983) argument that self is a vital aspect of quality of life, stating that the ‘most meaningful aspect of the good life is stored in the self’. This is apparent in discussions of the self in chronic illness management. In particular, violation of the self, which is often caused by ill health, undermines one’s biography (e.g., Corbin and Strauss, 1991). Following these statements, the self and one’s life and biography are closely connected, and therefore a loss of self may be considered almost equivalent to a loss of life.
As discussed above, many Australian and Japanese participants regarded good physical, emotional and mental health as the basis for a good life in older age. Self-care using anti-ageing medicine as edible health insurance helps them obtain physical health and this, in turn, positively works on both emotional and mental health. As shown in Dina’s (72) comment at the beginning of this chapter, health was considered as ‘a top of the important things’. Good health allowed participants to seek what they want to do, which they believe, will lead to ideal ways of getting older. In the following sections, I explore what brings quality of life in older age.

7.3 Cultural similarity II: Active engagement in life – continuity in life

Another theme that constitutes ageing well shared by both Australian and Japanese participants is ‘active, continuous engagement in life’. In particular, all participants believed that life continuity—that is, carrying out what they are engaging in currently for as long as possible—leads to quality of life in older age. This is consistent with the discussion in existing research that ‘people who age successfully are those who carry forward their values, lifestyle and relationships from middle to later life’ (Bowling, 2007: 267). Australian participants Anthony (75) and Angela (64) showed this:

I don’t believe my life would be that much different in five or ten years time. It might slow down a little bit. Because in 10 years, I’ll be 85, so I would expect that. But I’ll be disappointed if I’m not almost exactly as I am now. (Anthony)

I think, to cut off, say I’m 60 years old and somehow everything changes, is silly. … In ten years, if health permits, I should be probably doing what I’m already doing now. (Angela)

Anthony and Angela thought of their future as one in which they could continue their current lifestyles. Ageing was not stopping them from continuing to do in the
future what they are doing now. For Anthony, this included volunteering at the local church, playing golf and investing in stocks. For Angela, it meant teaching yoga at her own studio. When I asked a question about what the participants hoped to be doing in the near future, almost all participants (both Australian and Japanese) pictured themselves doing the ‘same things’ they are doing now. They shared the idea of continuity in life meaning that they could carry out daily domestic activities such as eating, cooking, going shopping and gardening, and they expanded these to include social engagements, working, hobby and volunteering activities. As shown in Angela’s comment ‘if health permits’, having good health is the key to continuity in life. The participants believed that taking anti-ageing medicine helps them to achieve this.

Managing these activities on one’s own was believed to be highly important to maintaining those values in life that lead to the participants’ senses of self in older age. Some participants were critical about societal stereotypical understandings of what older people should do. Peter (80+) observed:

There is no thought in my mind that at any age you should say, ‘oh, I’m retired and not going to do this and that’. No! I do everything I can physically do. … In 10 years time I would be doing what I am doing now. Perhaps, a little slower but I have no intention on stopping anything that I’m currently doing except if it becomes physically impossible. No longer you can physically do that, that’s the only way that would stop me doing it. Otherwise, I continue doing what I’m doing now, climbing up the roof and getting leaves out the gutter. I would continue to do that.

Peter has certainly noted societal expectations on what older people are expected to do, which may not be ‘climbing up the roof and getting leaves out the gutter’ in his 80s. However, Peter strongly resists the socially-constructed division of activities between age groups and insists that he is going to do what he has been doing his entire life. For Peter, maintaining activities such as gutter-cleaning
might help preserve his value in life and also his identity. Catherine (76) supports Peter’s idea, saying, ‘I sometimes think, ‘oh, I get old’ because I’m 76 but next time I feel not old. I still can do all things I did when I was 50’. For Catherine, having the capacity to do things she has been doing since she was younger evokes a feeling that life has not changed, even though she is now 76 years old. Continuity of life may make older people forget about their chronological age and still feel they can manage their lives without hindrances. The ability for active engagement in daily activities may be important for older individuals’ confidence that they are managing their lives well.

7.3.1 Active engagement in work and community participation

Some Australian and Japanese participants laid great emphasis on their work in helping them maintain continuity in life. For instance, Angela (64) runs a private yoga school and teaches yoga there. Angela said, ‘I have no intention to retire’. This shows her strong will to work in older age. Australian participants Joanna (58), Rowena (67), Olivia (60) and Alan (63), and Japanese participants Yoshio (76), Kazue (76) and Reiko (62) shared a desire similar to Angela’s about their future life in relation to their work. Because these participants run their own businesses, it is not necessary to stop working once they hit retirement age. In this sense, their lives in older age may be more similar to their younger lives through their active engagement in work, compared to those who worked in companies where a retirement age is imposed on employees. Yoshio and Kazue, whose age is far above the current retirement age in Australia and Japan, still hoped to continue working for as long as possible. They believed they can do so as long as they are healthy. Work for these participants occupies a vital part of their lives because it brings not only financial security but more importantly, joy and satisfaction. Moreover, aspects of their work, such as interactions with others (for instance, students for Angela, Kazue and Reiko and patients for Yoshio), were considered

Joanna (age 58) and Rowena (age 67) are therapists working at their own clinic. Olivia (age 60) and Alan (age 63) are artists. Yoshio (age 76) runs a private hospital and works as a medical doctor. Kazue (age 76) and Reiko (age 62) teach yoga and ballet respectively.
necessary for them to age well. Kazue (76) said: ‘I get energy from my students who are much younger than me’. Yoshio commented: ‘my old patients and I encourage each other, saying ‘we’ll do our best’.

Those participants who had already retired also hoped to continue social engagement, though in different ways to those whose participation in work provided continuity in life. The lifestyles of retirees are no longer institutionalised, with what they do in their new lives after retirement depending on their own choices. Many who are no longer in paid work (including some Japanese participants who had been housewives for most of their lives) had found something new to do in their everyday lives, such as participating in community activities and seeking hobbies. These activities have brought a sense of purpose and joy to their lives. In other words, they had found a new position for themselves within society outside work settings. In a study of quality of life among older people conducted by Bowling et al. (2003), the importance of social roles and activities is rated high in achieving quality of life. In this study, it was clear that involvement in these activities brings various benefits that may lead to quality of life in their older age.

George (65), head of a community organisation for senior citizens, described how older individuals of pre-retirement age should prepare for their retirement:

When you know that you are going to retire or even before, you start making plans about what you are going to do in retirement. This is the one very important thing that we tell friends of ours who are not yet retired. We tell them that without them, it will be like, on Monday morning you get out of the bed and put your feet into slippers and you think, ‘right, why am I getting up today?’

(George, 65)

According to George, finding new things to do seemed to help avoid a feeling of loss or a sense of discontinuity after retirement. Moreover, it helps older
individuals preserve a sense of self—a *raison d’être*. George showed that life continues even after you stop working. Due to an increase in longevity in both Australia and Japan, it is obvious that people spend longer in retirement than in the past. Therefore George believed in the importance of looking for alternatives to work so as not to lose a sense of continuity in life. This contributes to the ability to sustain a sense of self and achievement. As does George, many retired participants actively engage in a wide variety of activities, and are preoccupied with their hobbies and community roles. Maintaining a social position and participating in social activities are the key aspects of ageing well (Borglin et al., 2005).

Like George, many other participants, including Kyla (71), Catherine (76), Barbara (77), Ryan (67), Natalie (62), Priya (66), Tokiko (69), Setsuko (70), Miyuki (67) and Fumiko (76), maintained that the acquisition of a social position or purpose in life provided by communities is vital in keeping them young. This notion was particularly apparent when Catherine and Barbara compared themselves with ageing others who ‘don’t do anything’:

Some people who are 60 are older than people who are 90, mentally and physically because I believe, they don’t do anything in their life. (Catherine)

Like my brother-in-law, he doesn’t do anything. He just sits in front of TV, rubbing his hands all day. He’s overly overweight and he can’t move much. He has no purpose in life whatsoever. (Barbara)

Catherine believed that having no purpose in life makes people grow older faster. Moreover, Barbara did not want to be like her brother-in-law because she believed that his life has no value. Old age here was not only chronological age but rather was perceived as physical inability or loss of the ambition to seek purpose in life. To avoid this happening, they actively join in various activities. Barbara gets
involved in the management of a senior learning centre. She also teaches some classes there. Catherine participates in various classes at the community centre and wants to teach crochet. They believed that these engagements provide value and purpose in life. Catherine talked about the benefits provided by the community group she belongs to: ‘a wonderful thing at the community, a place like that, is [that] people are meeting people that keep you young’. Here, ‘keeping you young’ means that being with people at the community centre where many of them are younger than her gives her confidence to think that in her late 70s, she can still do what other people do. Litwin (2001) notes that social networks through locally-integrated communities with diverse members increase older people’s morale. Catherine and Barbara have certainly taken advantage of these benefits.

Social connections with others in community settings have brought different meanings and values to others, particularly those who do not have their family around them. For example, Tokiko (69), a widow with no children, emphasised the importance of community activities in connecting herself to people. Without these networks, she would have no-one around her except for her own siblings who are much older than she is. She has received both physical and psychological support from her community friends. She commented:

I want to take good care of my friends. And also, I have been taken good care of by those people. I have a lot of help from them. When my husband passed away, it was exactly 10 years ago, my friends from the community supported me psychologically. Also when I moved to the current house, they provided me with physical help. So, I have had a great help from them mentally and physically.

Tokiko’s comment shows how important it is for her to maintain good relationships with her friends in order to receive support. Moreover, when I asked what connections with her friends brought to her life apart from getting help, Tokiko answered, ‘it may be a sense of security’. Some other Australian and
Japanese participants, particularly those who do not have partners (even though they have children and grandchildren), told me a similar story. It was clear from their commentaries that social activities act as a bridge to connect them with others outside their homes. They also provide a sense of connectedness with others, joy and a sense of security.

7.3.2 Accepting and adjusting: not giving up but slowing down

Based on the above discussion it is clear that both Australian and Japanese participants hoped to continue active engagement in domestic life, work and social activities because they believe this contributes to ageing well. However, they are also aware of the fact that due to their age, the capacity to conduct these activities is declining or will decline. As noted in Chapter Three, Bowling (2007: 267) suggests that in order to achieve continuity in life in older age it is important to consider ‘adjustment and adaptation to challenges of aging by the substitution and redistribution of activities’. Borglin et al. (2005:209) further explain older people’s understandings of the bodily changes caused by ageing and the impact of this on everyday lives. They use the words, ‘accepting and adjusting’, which meant helping to handle everyday life differently. This means that older individuals can modify and adjust activity levels according to their changing capacities. As discussed earlier, the participants rejected the idea of giving up certain activities because of their age. Instead, they have learned to accept a decline in bodily functions and adjust their actions accordingly in order to avoid frustration, disappointment and dissatisfaction. This is represented in Peter’s (80+) comment quoted earlier that he hopes to be doing the same things in 10 years, but a little slower. The participants often used words such as ‘slower’, ‘smaller scale’ and ‘downsize’ when speaking about adjusting their lifestyle in anticipation of a future decline in their physical capacity. For instance, Ryan (67), who lives on a one-acre property with his wife, commented:

We’d like to continue to live our current lifestyle as long as we can but we might downsize [it] eventually because we’ve got a pool, a
tennis court and three sheep in the back. Maintaining an acre [of property] to a high standard requires a reasonable amount of work, which I fairly enjoy doing now. As we get older, we accept slowing down. We are going to slow down regardless how we feel, how good we think we are. We know we are not going to be able to generate the same output.

Ryan clearly anticipates that it is impossible to sustain the same pace when he gets older, and used property maintenance as an example. But he did not sound pessimistic about it. Rather, he believes that slowing down or even downsizing their house is a way he and his wife can comfortably continue an ideal way of life.

Some participants have already adjusted their ways of handling activities in which they engage. Miyuki (67) told me about how she performs household tasks now compared with a few years ago.

Before, I could get domestic chores done in an hour without a break. But now, I want to take a rest every 30 minutes because I get tired. So, I have tea after 30 minutes of work and read a page or two pages of book and then, restart doing some work again. I don’t have to push myself hard. I don’t have to get it perfectly done, either.

Miyuki acknowledged that she is slower at doing household chores, and not as productive as she was a few years ago. But she compromises in her expectations of the results. Miyuki considered this to be a normal phenomenon of ageing and adjusted the ways she performs tasks accordingly. The idea of ‘accepting and adjusting’ was seen in many of the statements participants made regarding the performance of tasks. Some related it to their hobby activities such as playing golf and learning languages. Others still in paid employment showed willingness to reduce their workloads if necessary. The participants have a philosophy of continuous engagement in activities: slowing down is fine but stopping is neither
ideal nor acceptable. The important thing for them is to keep doing and enjoying, rather than giving up because of their decline in capacity due to ageing.

7.3.3 Summary

It was clear that all Australian and Japanese participants hoped to maintain their current lifestyles, actively engaging in domestic chores, as well as work and community activities, for as long as possible. They outlined various rationales underlying their belief in the importance of social participation. These reflected their identities such as occupational status (retired or not retired) and marital status (married or widowed). Yet they all shared the idea that the maintenance of continuity in life is an ideal way of getting older. To achieve this, they accepted (or would accept) a decline in bodily functions and adjusted (or would adjust) their ways of handling tasks with the philosophy that ‘slowing down is ok but stopping is not ideal’. In addition, the participants believed that self-care using anti-ageing medicine helped enable continuity in life. Specifically, as health insurance, this was believed to help them prolong health expectancy, which would, in turn, help them extend the ‘arc of acquiescence’ defined as accepting ‘the decline associated with a gradual withdrawal from successful body maintenance and the greater acceptance of bodily limit’ (Higgs and Jones, 2009: 86). With this approach, both Australian and Japanese participants believed they would be able to continue various activities they had enjoyed as younger adults throughout their life.

All participants sought coherence in their biographies by protecting what they had established through their life courses. This could be particularly important for them in terms of maintaining a coherent sense of self. Shilling (2008) argues that habitual activities can be terminated by changing bodily needs, which are particularly apparent in ageing bodies. Subsequently, change disrupts one’s biography and potentially results in an identity crisis. This notion was supported by many participants who compared themselves with ageing others who have lost the physical ability for a continuous engagement in life, and indicated that ‘that’s
not me’. This helped them preserve a sense of self in older age. Self-care became a health practice that ‘involves the attempt to re-establish a sense of wholeness, to regain the ability not to attend to inconsistency, present or potential, in one’s life’ (Dill et al., 1995: 35).

Overall, substantial cultural similarities were noted between Australian and Japanese participants in the concept of continuity in life, and the desire for it was similar to the desire for independence. However, meanings of independence and reasons why independent living was considered to be important in ageing well were perceived differently by Australian and Japanese cohorts. Cultural differences in the concept of independence in older age are discussed in the following sections.

7.4 Cultural differences: A sense of independence in older age

Concepts of continuity in life—maintaining current lifestyles as long as possible—and independence seemed closely linked. However, from my analyses of the interviews, the participants clearly separated these concepts. When I asked them a question about what they would be doing in five and 10 years, their first answer was continuity of lifestyle, as discussed above. As the conversations went on, many raised their concerns about and desire for independence: that is, looking after self and doing what they want to do without anyone’s help in older age. The reasons for the importance of independence varied depending on individuals’ current living situations, marital status and past experiences of observing ageing others such as their parents and siblings. Importantly, there were cultural influences in the desire for independence between Australian and Japanese participants. Interestingly, Japanese men (only five participants) made no comments related to the concept of independence. In comparison, their Australian counterparts showed much concern about independent living. These differences may be derived from the cultural practice of care in Japan, which is traditionally regarded as the responsibility of women. For example, Yoshio (76) clearly stated: ‘I have already told my daughter to look after me if I get frail, saying ‘I’m
counting on you”. He showed his acceptance of becoming dependent on his daughter when he can no longer maintain independence.

The concept of independence is frequently cited in the literature on quality of life in older people and successful ageing. It is often regarded as being able to do things for oneself and not being a burden or a nuisance (e.g., Bowling et al., 2003, Borglin et al., 2005). It is also argued that the concept of independence is closely related to the concept of autonomy, although Haak and his colleagues (2007) argue that these concepts should be considered separately because of the complexity of constructing a concept of independence. Nonetheless, the participants talked about these concepts side by side. Many of them defined the concept of independence as ‘doing everything necessary for myself without borrowing anyone’s hand, like going shopping, cooking for myself, doing the laundry and so on’ (Kazue, 76). Moreover, they added comments such as ‘I want to go wherever I want to go at my own will. I don’t want to be asking someone to take me there. I want to go whenever and wherever I want to go’ (Fumiko, 76). This implies a sense of autonomy. However, there were prominent cultural differences seen in the in-depth meanings of independence between the Australian and Japanese participants, especially with regard to intergenerational relationships.

7.4.1 Strong desire for independence from their children among Australian participants

Previous Australian studies show aspects associated with a sense of independence as significant attributes of successful ageing, followed by maintaining good health (Kendig et al., 1999, Tan et al., 2010). This notion is highly relevant to this study. Most Australian participants talked about their desire to be independent in relation to their adult children. As reported previously by Kendig et al. (1999), they believed independent living, which is synonymous with ‘not becoming a burden’ on their children, is crucial to the maintenance of harmonious relationships with their adult children. This is because good relationships with children are believed
to lead to quality of life in older age.

Catherine’s (76) central idea of ageing well was associated with her strong motivation to maintain her own independence. This idea was clearly linked to her reasons for using anti-ageing medicine. When I asked her what she hoped to be doing in five or 10 years, she immediately answered:

I’ve thought about it very seriously because I don’t want my children to look after me. They’ve got jobs and children to bring up and things to do. … In 10 years time, I hope to still be able to stay in my home, stay with my husband, two of us together, look after one another, hope to say. So I take every caution, I take every calcium and vitamin E and all different things to keep me healthy as long as possible. And I eat very well and exercise. I reckon, I’ll last for another 10 years. … Even I lost my husband, I would still want to be able to cook my own food, buy my own food. I wouldn’t like to have to ask people to do for me.

When Catherine considered her future following my question, she instantly connected it to the idea of being cared for by her children. Clearly, she is fearful of causing her children trouble in the future. In her mind, looking after herself and doing normal daily activities such as cooking and shopping without asking people for help—the central idea of independence—is the most important aspect of ageing well. Catherine insisted that the only person in her family whom she can rely on is her husband, because they share a life together. As previous research shows, spouses are of primary importance for support in older age (Kendig et al., 1999), and many Australian participants shared this view.

Catherine’s aspiration towards independence was so strong that she made the comment: ‘if I couldn’t be independent, I wouldn’t want to live. I wouldn’t want to be in the world’. This mindset was derived from her experience of having looked after her mother for 10 years after she developed dementia. She still
remembers the enormous difficulties she experienced when she was caring for her mother, as well as doing paid work and domestic chores at the same time. She continued:

I felt guilty the whole time because I couldn’t do enough for her, because I was working, I was doing everything. And I started resenting my mum. And I felt guilty by resenting my mum. How awful. I don’t want that to happen to my family. I don’t want them to resent me. I want them to come and love me. Come on my birthday, hug me and take me out for a drive, do all loving things.

Catherine clearly struggled to juggle her filial responsibility to look after her mother with the reality that she did not have enough time for it, juggling this with other duties. Caring for her own mother caused negative emotions in Catherine’s mind, including a feeling of guilt for not having supported her mother well enough (even though she wanted to do more) and regret about resenting her mother. These mixed feelings undermined the relationship between them. She was quite afraid of this situation happening if she became dependent on her children. She believes that independence allows her to maintain a harmonious relationship with her children, which will lead to a happy life. This was Catherine’s motivation to seek anti-ageing medicine. Other Australian participants like Dina (72), Bill (74) and Peter (80+), who also experienced caring for their parents or partners, shared Catherine’s view.

The aspiration to maintain good relationships with their adult children was clearly the main contributing factor to the desire for independent living among the Australian participants, despite the fact that many of them had not experienced caring for ageing parents. Some strong opinions were expressed on this topic. For example, Barbara (77) said, ‘I hope I have stroke or heart attack and die easily because I don’t want to be a burden on my children or anyone’. George (65) and Natalie (62), a married couple, said, ‘We’d rather jump off from the bridge if we
had to be cared for by my children. We don’t expect it from them at all’. Rowena (67) also showed strong emotion, even using the word ‘fear’:

My worst fear is that I’m burden to our children. I will fiercely guard my independence. We are making move to make it easier for our children. So, they will not have a responsibility, thinking ‘what I can do with my mum and dad’. That would be just awful. I think to hold that over children’s head and say ‘you are going to have to look after me’ is just horrendous. We have a wonderful relationship with our children. My children, particularly my daughter, is my best friend.

Barbara, George, Natalie and Rowena’s statements show a strong resistance to becoming a burden on their children. Rowena even believes that it is not desirable for her children to contemplate what they could do for their parents. Her understanding of ‘a wonderful relationship’ is that she is not a worry to her children. Accordingly, she and her husband take anti-ageing medicine to manage their health and also renovated their house to accommodate a wheel chair. They removed steps, relocated cupboards and attached handrails in the shower.

As shown in Rowena’s statement, ‘my daughter is my best friend’, good friendships with their adult children were emphasised by many Australian participants when they talked about their understanding of independence and intergenerational relationships. Bowling (1994) suggests that friendship is a voluntary relationship based on expressive and emotional domains like companionship, but not a resource for physical and instrumental support. This means that these Australians do not expect physical and instrumental help from their children, but they would like emotional support. Kyla’s (71) comment highlighted this. She emphasised, ‘I can’t imagine my life without my family’ and this statement was based on the idea of companionship. Kyla continued:
If I am not feeling well, it’s nice to have someone to talk to, or go to stay with my daughter or get other daughter to come to stay with me. Just for emotional support. … Independence is necessary. It’s nice to have a company but it’s also nice to be able to make decision just for you. You need distance. You can’t be in their pocket.

Kyla expressed her desire to have her daughters beside her for emotional support when she feels unwell. Simultaneously, her comment, ‘you can’t be in their pocket’ captures a sense of autonomy: self-direction and decision-making, and the freedom to determine one’s own actions and behaviours (Haak et al., 2007). It may be important for Kyla to limit the role of family to emotional support in order to maintain a sense dignity within her family. This is supported by Pyke’s (1999) argument that in individualist cultures, older individuals maintain power within their families by receiving limited support from their children. Kyla may have understood that by protecting their own independence and autonomy, she could maintain a well-balanced relationship with her children.

As seen in the stories above with Australian older adults, a strong resistance to becoming a burden on their children reflects the current societal expectation placed on older individuals in Australia. Policies such as successful ageing and active ageing promote ‘hyper-individualism’ shown as independence in later life through individuals’ responsibilities for their own life choices (Asquith, 2009: 260). Under such circumstances, support from family can possibly conflict with individuals’ belief in self-reliance and independence (Kendig and Rowland, 1983). Moreover, it is believed that instrumental dependency on children negatively impacts harmonious relationships between older parents and adult children (Kendig et al., 1999). In other words, if older parents become frail or suffer from physical disabilities that affect their capacity for independent living, the pattern of child-parent interactions will be altered (Mancini and Blieszner, 1989). Correspondingly, one of the biggest fears of Australian elderly people is the loss of independence (Quine and Morrell, 2007). Australian participants’
desire to be independent can be taken as a feature of individualism in intergenerational relationships.

7.4.2 Independence within the influence of filial piety in Japan

Like the Australians, Japanese participants also believed in the importance of maintaining independence to ageing well. In particular, they hoped to take care of themselves without causing any trouble to others for as long as possible. This resonates with the findings based on quantitative data from Molzahn et al.’s (2011) study. These show that apart from health-related aspects, Japanese older adults emphasise the importance of ‘maintaining autonomy’ and ‘ability to conduct activities of daily living’ as the most important in ageing well. However, this quantitative data did not allow me to investigate in-depth how these factors are grounded in Australian and Japanese people’s beliefs and values and experienced in the everyday lives of these two cohorts. This study found that Australian and Japanese participants had different understandings of what is meant by independence in old age. While many Australians had individualistic ideas of independence, the Japanese participants often considered it in relation to the traditional practice of care for the elderly by their adult children, namely filial piety. By way of a reminder, ‘filial piety’ originates from Confucian philosophy, which teaches the virtue of respect for older people. In familial practice, it refers to intergenerational physical and financial dependency by the old on the young (Ikels, 2004).

For instance, Japanese participant Wakae’s (79) desire for independence was sustained by the Japanese traditional view of family care. Her desire not to become a burden on her daughter was a push factor for Wakae to maintain her independent living. Wakae currently lives in a retirement apartment by herself, and her daughter often visits and takes her out for a drive or to have lunch together. Before moving into the apartment, her life was occupied with caring for her ill husband, who eventually passed away a few years ago. While she was caring for her husband, she said she deliberately maintained a distance from her
daughter in order not to interfere with her life. Wakae now applies this practice to herself. Although the retirement home provides basic care such as instrumental care and physical support as needed, she insisted that she does not want to receive any help. As our conversation went on, the reason for it became clear. She does not want to cause her daughter to worry about her. She stated:

My daughter tells me that I’m too reserved. She said, ‘it’s natural to rely on someone when you get older. So count on me’. But so far, I’m resisting it [her offer]. It’s fine that my daughter takes me out for drives [for fun]. But I don’t want to ask her to drive me to a hospital because of the reason that I’m sick. I said [to my daughter], I can catch a taxi. Then, she told me, ‘even so, you should call me’. … One reason [that I don’t want to rely on my daughter] is that she is our only child and married to a man who is the oldest son. Since she got married, I always think that she should prioritise his parents over me. My daughter said, ‘you don’t have to be so stubborn’. But this is my belief.

Wakae’s comment highlighted the Japanese traditional role of wives who are married to eldest sons. That is, the wives are expected to look after their parents-in-law. In fact, the government policy on elderly care used to be based on this traditional care role of wives (Yamato, 2006). Wakae believed that if she became a burden on her daughter, she would carry the double burden of looking after both Wakae and her parents-in-law. She is even afraid that this situation might cause a conflict in her daughter’s family. Wakae’s insistence on being independent is to avoid this situation happening. Wakae might believe that by maintaining the ability to look after herself, her daughter could maintain harmonious relationships with her husband and parents-in-law. Considering her daughter’s happiness may be what she wants to prioritise, and this contributes to her psychological wellbeing. This situation is different from Australian participant Rowena’s thoughts on being independent, which includes the notion of individualism in older age. In addition, it is interesting to note that despite Wakae’s desire not to
become a burden on her daughter, her daughter seems happy to offer assistance. The daughter thinks that it is natural for her mother to rely on her when she gets older. As suggested in previous studies, this shows that some adult children in Japan might still believe that caring for their parents is not a burden but rather it is normal (e.g. Someya and Wells, 2008).

Many Japanese participants who strive for independent living articulated a different rationale to that of the Australian participants. They did not necessarily connect their aspiration for independence with a fear of becoming a burden on their children. In other words, unlike Catherine and Rowena, they did not show fear of or aversion to becoming dependent on their children. It did not mean, however, that they were willing to become completely dependent on their children or that they expected to receive support from them when they get older and frailer. Rather, many Japanese participants used the words, ‘I don’t want to cause trouble to others’. ‘Others’ here referred not only to their children, but to their spouses, relatives, friends and any people related to them. This can be explained by Ueno’s (2009) analysis that many Japanese elderly are unwilling to become a ‘powerless self’ who has to be looked after by others. One of the reasons for this is ‘consideration for care-givers who will be inconvenienced’ (Ueno, 2009: 215). This shows that if they are in a position of needing assistance, Japanese elderly feel guilty for troubling care-givers. Reluctance to cause trouble to others may have motivated Japanese participants to strive for independence through taking care of themselves.

In addition, nearly half the Japanese participants believed that their sense of independence could be achieved in interdependent environments with their adult children. This was demonstrated in their positive attitudes towards co-residency with their children. They did not consider this as becoming a burden or dependent on their children. Rather, they believed that it would enhance their quality of life. When the interviews were conducted, five Japanese participants were living with their children, and others expressed the wish to live with their daughters in the near future. Setsuko (70), a widow who lives with her daughter, said: ‘we [I and
my daughter] share everything’. This means that Setsuko and her daughter share not only household chores, but also finances. In this circumstance she maintained a sense of independence. Moreover and more importantly, she benefits psychologically from the reciprocity. Setsuko continued, ‘If I lived by myself, I would sometimes feel lonely eating dinner by myself’. As a widow, living with her daughter helps reduce a sense of loneliness, which is important to achieving quality of life (Bowling et al., 2003).

Similarly, some other Japanese participants, including Sanae (62), Taeko (64) and Mitsue (69), believed that living with their children (along with their spouses) and helping each other would increase their happiness and enjoyment of life. In this circumstance their primary concern is the maintenance of good health, because with ill health they would not be able to reciprocate help and support. Taeko stated:

In general, I like looking after people including my children. My children are kind enough to care about me luckily. My son gives me a lift to go shopping. We sometimes go shopping together because some stuff is too heavy for me to carry like dog food. As long as I am healthy, we [I and my children] can cooperate with each other and live happily together.

Clearly, Taeko was motivated to be well in order to maintain harmonious mutual relationships with her children within the same household. Chen and Silverstein (2000) suggest that mutual support in intergenerational relationships can improve morale among older individuals in cultures where filial obligation is practised. With this notion, it can be considered that for some Japanese participants the sense of independence could be sought within interdependent living environments with their adult children.

Such perceptions were noticeably different among the Australian cohort. When I asked Australian participants what they thought about living with their children in
the future, almost all of them immediately reacted negatively to the idea. For example, Barbara (77) responded: ‘No way. No no no no, I don’t like the idea’. Moreover, Catherine (76), Ryan (67), Farren (74), Newton (84) and Peter (80+) responded in exactly the same way, ‘That’s not gonna work’. As discussed earlier, independent living is highly encouraged in Australian society. Living with their adult children is not a social expectation for elderly Australians (Plath, 2008, Powel, 2005, Rowland, 1991).

While not all Japanese participants shared the same meaning of independence in old age, unlike the Australian participants, most of them did not perceive a loss of independence or the fear of becoming a burden on their children. Rather their understanding of independence was largely influenced by the culturally-embedded practice of elderly care—filial piety. Many Japanese participants shared the idea that if they lost the ability to look after themselves, this would cause inconvenience to care-givers, including their children. Here, ‘not troubling others’ was the main motivation to be independent in old age. Moreover, several Japanese participants believed that their sense of independence could be preserved within mutual interdependent relationships with their adult children.

7.4.3 Summary

The meanings ascribed to independence by the Australian and Japanese participants were based on their differing cultures. The former emphasised the importance of independence in relation to their children, primarily in order not to become a burden on their children. Here, independence was understood as living independently and looking after themselves. It also contained a sense of autonomy: taking initiative in their lives and a desire to maintain dignity within the family. The Australians were particularly afraid of violating harmonious relationships with their children if they lost the ability to be independent. Reflecting this, Rowena used the word, ‘fear’ to describe her strong aversion to a loss of independence in relation to her daughter, with whom she had established a ‘friend-like’ relationship. It was clear that Australian participants strived for good
health by using anti-ageing medicine and believed that it allowed them to live independently, resulting in the maintenance of good intergenerational relationships.

By contrast, the meanings of independence held by Japanese participants were largely influenced by the traditional Japanese view of intergenerational relationships, namely filial piety. Moreover, they varied depending on the participants’ living circumstances. Unlike the Australians, all but a few Japanese participants did not show much antipathy towards becoming a burden on their children. Rather, many of them shared the concern that they did not want to trouble others by losing the ability to look after themselves because it would cause inconvenience to care-givers (Ueno, 2009). Moreover, nearly half the Japanese participants believed that a sense of independence could be preserved within interdependent environments with their adult children, as long as they could look after themselves and maintain reciprocal relationships. In this context, independence was understood as one’s ability to maintain mutual interdependent relationships with their adult children.

Australian and Japanese participants strived for independence for different purposes. They were addressed in culturally-specific ways. For the Australians the cultural practice of individualism had a great impact on their understanding of independence. By contrast, many Japanese participants inherited the cultural understanding of old age within intergenerational family contexts. These findings support Gilleard and Higgs’ (2013) argument that older individuals seek culturally-oriented desirable selves through various kinds of body work. Anti-ageing medicine was used to help both Australian and Japanese participants to seek independent selves, albeit influenced by differing cultural definitions of independence. It was clear that for both Australian and Japanese participants, anti-ageing medicine was edible health insurance that provided them with a sense of protection or a sense of security in what they want to do and what they want to be.
7.5 Conclusion

It is clear that the relationship between the use of anti-ageing medicine and the participants’ perceptions of ageing well was closely linked. Both Australian and Japanese participants believed that without good health, ideal ageing is not achievable. They considered anti-ageing medicine as edible health insurance that helps to prolong health expectancy, allowing them to have continuity in life. The concept of continuity in life contained two themes: (1) continuous engagement in everyday activities and (2) maintenance of independence. With regard to the first theme, both Australian and Japanese participants showed the same aspiration for active, continuous engagement in various activities including daily chores, paid and un-paid work, hobby activities and community participation. These activities were perceived as important to achieve quality of life. In order to carry them out for as long as possible, they understood the importance of acknowledging a natural functional decline in old age. Accordingly, they have adjusted their ways of conducting these activities. I argue that continuity in life is important for the participants because it gives them a sense of continuity not only in what they do, but also in their senses of self. Quality of life in old age can be attained through maintaining their biographies and coherent selves.

Not much difference was seen in perceptions of ageing well in the two cultural settings until participants talked about their desire for independence. It was clear that differences in the understanding of independence originated from the societal emphasis on individualism in Australia and the traditional view of interdependent, intergenerational relationships in Japan. Many Australians had a strong association between a sense of independence and relationships with their adult children. Specifically, avoiding becoming a burden on children was a strong force that has caused them to strive to remain independent. In contrast, Japanese participants did not show such intense feelings regarding the idea of becoming a burden on their children, although many of them hoped to avoid such a situation happening. They were motivated to be independent because of their unwillingness to cause inconvenience to caregivers, who are likely to be their children. Moreover, nearly half the Japanese talked about the importance of independence
within reciprocal relationships with their children. By living together, they and their adult children could provide mutual physical, mental and financial support for each other. They believed that independence in such circumstances would facilitate reciprocity that could benefit both themselves and their children.

Although Australian and Japanese participants showed different rationales for the importance of independence in old age, these were culturally accommodated according to Australian and Japanese norms. In other words, they embodied the cultural values acquired by both sets of participants throughout their life course. Giddens (1991: 75) argues that self-identity can be continuously rewritten within a trajectory of one’s life as a reflexive project in which ‘we are, not what we are, but what we make of ourselves’. Participants in this study aspired to be independent in older age in culturally-specific ways and believed that this would lead to the socially-oriented, desirable self. As Gilleard and Higgs (2013) suggest, self-care using anti-ageing medicine as embodied practices assisted them in becoming what they wanted to be in old age.
Chapter Eight: Conclusion
Anti-ageing medicine helps Australian and Japanese older adults to construct ageing identities

This study set out to explore the motives and beliefs attached to the use of anti-ageing medicine among older individuals living in Australia and Japan in relation to their perceptions of ageing well. In particular, it sought to discover how culturally-embedded health beliefs and values, as well as cultural ideologies of old age, influenced the perceived importance of anti-ageing practices among Australian and Japanese older adults. Anti-ageing medicine was defined broadly in this study to include hormone replacement therapy (HRT) and/or dietary supplements that conceivably have positive effects on ageing bodies in postponing or relieving the effects of biological ageing. They may also be considered effective in ‘treating or eliminating the diseases’ associated with ageing (Vincent, 2006a: 196-7). While most existing social research on anti-ageing medicine approaches this issue from the Foucauldian viewpoint, this study showed that embodiment approaches—that is, the idea that self-care reflects one’s lived experiences—was advantageous in examining how participants acquire strategies to manage their own health. Three research questions were asked in order to seek an in-depth understanding of Australian and Japanese older individuals’ health practices:

1. How did Australian and Japanese older adults define and perceive their self-care practices using anti-ageing medicine?

2. How did culturally-shaped health beliefs and health practices influence Australian and Japanese older adults’ use of anti-ageing medicine?

3. How did Australian and Japanese older adults conceptualise their use of anti-ageing medicine in relation to their perceptions of ageing well?
The findings revealed that both Australian and Japanese participants considered anti-ageing medicine as edible health insurance, meaning a necessary investment made to prolong health expectancy. It was believed that, as health insurance, it provides them with ontological security for their future lives. This ontological security meant for them that they could carry on, as far as possible into the future, behaviours and lifestyles established throughout their life courses and enjoyed as younger adults. In other words, the aim was to maintain coherence in life. Doing so further enables them to construct ageing identities. The findings of this study coincided with the definition of self-care adopted in the study: a health practice that ‘involves the attempt to re-establish a sense of wholeness, to regain the ability not to attend to inconsistency, present or potential, in one’s life’ (Dill et al., 1995: 35). Cultural differences were evident across the Australian and Japanese contexts in two ways. First, Australian and Japanese older individuals were guided to anti-ageing medicine use in culturally-specific ways. Second, although both Australians and Japanese believed independence to be an important contributing factor to ageing well, an in-depth investigation into their perceived meanings of ‘being independent in old age’ showed different perspectives.

In this chapter, I first provide a summary of findings that answer the questions above. In this process, significant concepts and themes are revisited. The findings are then integrated into the theoretical framework I developed in Chapter Two. Finally, I discuss the implications of this study for political orientations and suggest the importance of understanding culturally-influenced ways of getting older. In particular, the findings of this study allow a critical analysis of policy contexts such as healthy ageing, active ageing and successful ageing.

8.1 Anti-ageing medicine as ‘edible health insurance’: a necessary investment made by Australian and Japanese older adults in the maintenance of healthy lives

This study of the lived experiences of 42 older adults (21 older adults each from Australia and Japan) as narrated through in-depth interviews has provided
significant insights into how the self in older age is sustained or even constructed through active management of ageing bodies through the use of anti-ageing medicine. While much sociological scholarship views anti-ageing medicine in a critical manner, this study revealed that both Australian and Japanese older adults attached positive meanings to it.

The Australians and Japanese in this study understood anti-ageing practices as managing the deterioration in health (possibly) caused by ageing. Health management was categorised by them into three practices: 1) preventing occurrence of age-related diseases, 2) maintaining current good health conditions and 3) treating existent age-related health problems. These distinct practices largely—though not exclusively—reflected these older adults’ physical conditions. They actively made sense of the limitations of their bodies or bodily functions due to ageing, and the perceived pain presumably caused by age-related illness, and tried to fit them into these categories. Through anti-ageing practices, many participants experienced noticeable changes, even subjectively, in their bodily sensations; in other words, they noted the positive effects of anti-ageing medicine on their bodies. For example, they felt that knee pain reduced, eye conditions improved and energy levels increased. In the process of anti-ageing practices—proactive engagement with ageing bodies—almost all participants had developed the belief that using anti-ageing medicine to manage ageing bodies was a necessary investment made in order to prolong health expectancy. In this context, Australian participants, Rowena (67) and Anthony (75) coined the expression ‘edible health insurance’, which refers to ‘health insurance’ that helps maintain good health conditions inside the body.

Anti-ageing medicine as edible health insurance was believed to provide the protection of physical health as well as psychological health. More specifically, both the Australians and the Japanese said that it allows them to seek optimal health, and simultaneously to reduce unnecessary worry about their future health. For example, they felt that their health was protected by anti-ageing medicine. This indicates that they had developed a sense of psychological security through
taking these medicines. This is represented in Sanae’s (62) words, ‘they [supplements] are like a talisman’. The word ‘talisman’ implies a level of trust or reliance on anti-ageing medicine with regard to her future health. Capturing this, some other participants considered that to stop taking anti-ageing medicine would be risky, and even just imagining stopping their anti-ageing practices evoked feelings of fear. It was clear that in the process of managing their own health by using anti-ageing medicine, the participants had established a certain faith in anti-ageing medicine.

A prominent cultural similarity was that all participants have developed their own repertoires based on their health conditions, and have attached beliefs and values to anti-ageing medicine. However, cultural differences were noted in the ways Australian and Japanese older adults approached anti-ageing medicine. Kleinman (1978) argues that health care systems should be understood as cultural systems, and this was apparent in this study. Culturally-embedded health beliefs and health practices had a significant influence on their decisions regarding the use of anti-ageing medicine. In Australia, where health has been conceptualised through the lens of biomedicine, it is predominantly regulated by Western medicine and medical doctors (Foucault, 1991a). Accordingly, medical doctors are regarded as responsible for regulating health among the elderly by providing them with useful health information (Sim et al., 2009). Reflecting this, Australian participants showed an expectation that their doctors would support them in managing their age-related health issues. Their lived experiences of interacting with their doctors had a profound impact on why they decided to use (or continue using) anti-ageing medicine. While for some participants, their anti-ageing practices were encouraged by their doctors, many of them decided to use anti-ageing medicine because they were not satisfied with the medical intervention they had received for age-related health issues.

Several Australian participants were taking advantage of their doctors’ advice in their self-care strategies. Some decided to take certain supplements based on their doctors’ recommendations. These doctors acknowledged the benefits of dietary
supplements for specific age-related health conditions, and incorporated them into their medical practices. For others, the role of their doctors was important because they were supportive of their anti-ageing practices. These doctors did not critically judge how their patients (some Australian participants in this study) observed their own ageing bodies and established their own anti-ageing practices. In such cases, the doctors gave continuous encouragement by providing useful medical knowledge regarding their anti-ageing practices. In both cases, these Australians built confidence around understanding and managing their own health in conjunction with their doctors’ professional knowledge. This relationship follows the model of constructive medicalisation (Broom and Woodward, 1996). In particular, ageing bodies are medicalised in a way that older people are encouraged to practise agency in actively negotiating with their doctors in seeking the best treatment for their health conditions.

Other Australians were doubtful about the efficacy of medical practices for their age-related health issues. This doubt was largely derived from their past experiences of care by physicians who did not adequately treat their illnesses or by doctors who did not take seriously the impacts of side effects caused by medications. They certainly experienced negative feelings such as frustration, disappointment and anger regarding these medical actions. Such experiences became powerful mediating factors that empowered them to actively seek alternatives to treat their own age-associated health conditions. In this process, some of them encountered CAM health professionals who recommended particular supplements or herbal medicines for their health issues. Some were studious in conducting their own research into the effectiveness of various supplements, and selected particular varieties according to what they believed the requirements of their bodies to be. Although the intake of supplements in many cases was initiated as an experiment to see if there were any positive effects on their bodies, these Australians were satisfied with the supplements, and had not returned to their doctors for practical health advice on their anti-ageing practices.
Among the Japanese participants, there was little connection made between decision-making about the use of supplements and the role of medical doctors and their practices, with the exception of one instance. The fear of having surgery for age-related symptoms was the only theme shared with some Australian counterparts. In other respects, they showed indifferent attitudes regarding the benefits of doctors’ intervention in their self-care practices. Moreover, the Japanese did not associate medical errors with their own health behaviours, which was a big theme in the Australian context. This resonates with Haug et al.’s (1991) empirical finding that Japanese elderly do not emphasise the importance of their doctors’ involvement in their self-care practices, while American cohorts considered it an important aspect of their self-care.

This study found that these Japanese participants’ attitudes towards their doctors in relation to self-care are derived from culturally-guided health beliefs. In Japan there has been a culturally-rooted folk practice of managing one’s health by self-medicating through diet, referred to as ‘shokuji-ryohou: 食事療法’: corrective diet. The main focus of this practice is the treatment and prevention of illness and disease through diet. This is officially recognised in Japanese society. The Japanese government has labelled specific foods as functional foods, which are medically and dietetically proven to have positive effects on reducing the risk of particular illnesses and disease, and in improving health (Enomoto, 2002). This culturally-embedded health practice enabled me to explain why Japanese participants chose to include anti-ageing medicines—and various supplements in particular—in their health practices. They frequently mentioned that nutrients contained in these supplements are hard to extract from food in large amounts and therefore it is beneficial to get these from supplements. To some extent, taking anti-ageing supplements was seen as an extension of corrective diet, and they did not expect their physicians to be involved in this practice.

This culturally-influenced health practice has caused Japanese participants (or perhaps, Japanese people in general) to attribute Western medicine a specific role: the detection and cure of disease. Accordingly, medical doctors’ advice on
managing health in older age (even based on the results of medical check-ups) made little contribution to the development of anti-ageing practices. While many Japanese participants did not seek medical help for their age-associated conditions or discomfort, such as knee pain, it also appeared that some doctors in Japan regarded age-related physical symptoms as a natural process of ageing. Hence specific medical advice on these issues was not provided to some Japanese participants, or they were not encouraged to seek medical treatment for them. This implies the cultural significance of the medicalisation of ageing bodies. Lock (1993) argues that the medicalisation of symptoms of illness associated with ageing, such as menopause, is not a universal phenomenon, but rather it is culturally embedded. That is, it depends on how health is conceptualised within particular societies. Health in the West, including in Australia, is largely regulated within the domain of biomedicine, and therefore age-related health deterioration is mostly treated as a medical condition. This phenomenon was observed in the stories narrated by many Australian participants. However, it was not within the bounds of this study to conduct an in-depth inquiry into cultural comparisons in terms of the extent to which ageing bodies are perceived and treated as pathology by medical doctors and older individuals in Australia and Japan. This could be explored in future research.

Despite the fact that Australian and Japanese participants took distinct, culturally-guided pathways in initiating self-care practices using anti-ageing medicine, these practices were conducted with the same purpose in mind: that is, seeking good health in old age. As noted earlier, they shared a faith in the health benefits provided by anti-ageing medicine. In other words, it was regarded as health insurance that caused participants to feel that their future health was protected. All participants believed that achieving optimal health for as long as possible in old age was the foremost requirement for ageing well. While this finding coincided with much of the previous literature suggesting that health has become imperative in old age (e.g. Higgs et al., 2009), there was little empirical research that had qualitatively investigated older individuals’ lived experiences to establish the
reasons why this is so. This study sought participants’ beliefs regarding what good health means in old age by exploring in-depth their perceptions of ageing well.

It was clear from the findings that ageing well meant remaining physically and mentally active, and able to carry on in the future activities they had engaged in throughout their life courses. Here, continuity in life and maintenance of a sense of the self were emphasised. Continuity in life consisted of two components: 1) active engagement in life including domestic chores, hobbies, paid and unpaid work and community participation, and 2) maintaining independence. For the first theme, there were no substantial cultural differences observed between Australian and Japanese cohorts. It was clear that work brought those who are not yet retired vitality and contentment in their lives. Similarly, hobbies and community participation enabled those who are retired to have a sense of purpose and connectedness to society in their post-retirement lives. Social connectedness brought about by community involvement was of particular importance for widows, because it provides them not only with a sense of purpose and enjoyment in life, but also with physical and psychological support. Through social support, they have gained a sense of security.

The other component that constituted continuity in life—indepence and autonomy—was an important aspect of ageing well for both Australian and Japanese participants. However, there were substantial differences in the ways in which the two cohorts understand the meaning of independence. For the Australians, independence was considered particularly important in the process of ageing in order not to violate harmonious relationships with their adult children. They feared that ill health would undermine the ability to live independently, and this could cause interference in their children’s lives. This attitude was manifested in one participant, Rowena’s (67) words, ‘(M)y worst fear is that I’m a burden to our children’. The word, ‘burden’ was frequently used by the Australians. The maintenance of good health so as to avoid becoming a burden on their children was regarded as an absolute necessity.
This individualist idea of independence reflects the ideology of older age constructed by Australian ageing policies that promote ‘hyper-individualism’: that is, emphasising the importance of independence in later life through individual responsibility (Asquith, 2009: 260). This social expectation has caused value to be placed on self-reliance and independence in older age (Kendig and Rowland 1983). In this cultural context, instrumental dependency is not respected; rather it is considered that it will negatively affect intergenerational relationships. For example, it changes the power dynamic within them (Pyke, 1999). Loss of power in family relationships might in turn lead to a loss of autonomy. It could be argued that Australian participants felt that independence allows them to maintain a certain position within their family relationships—one that incorporates notions of power and autonomy.

Among Japanese participants, this individualistic idea of independence was not prevalent. They did not associate their desire to be independent with the fear of becoming dependent or a burden on their children. Rather, the meaning of independence held by Japanese participants reflected the culturally-constructed value placed on elderly care and reciprocity in interpersonal relationships (Ueno, 2009). Although previous literature has noted an attitudinal change in Japanese perceptions of ageing well from a culture of accepting dependency to one that strives for independence (Koyano, 1996, Kono, 2000, Hashizume, 2000, Jenike, 2003, Yamato, 2006), this study suggests that the traditional view of intergenerational relationships still influences Japanese participants to rationalise the importance of independence in older age. Often, they considered that if they lost independence it would cause ‘inconvenience’ to others, particularly their children. This was observed in several participants’ words, ‘I don’t want to trouble my children’. Simultaneously, many had an expectation that their children would provide help if they needed it in the form of instrumental support and support in decision-making regarding life choices, for example the decision to move to a nursing home. For them, maintaining independence may not only mean conducting daily activities on their own, but also being in a position where they can maintain reciprocity in interdependent relationships with others, including
their children. The Japanese believed that anti-ageing practices would allow them to maintain such a position within their families and society.

It was clear that obtaining good health has become an imperative among participants. In fact, it was almost synonymous with their understanding of ageing well, because they believed that ageing well would not be achievable without it. Overall, for both Australian and Japanese participants, ageing well meant the ability in the future to continue behaviours and life styles established and carried out throughout their lives. Anti-ageing medicine as ‘edible health insurance’ was believed to ensure that they could do and be what they wanted in old age.

8.2 Anti-ageing practices reflect older adults’ lived experiences

As discussed above, the influence of cultural beliefs in health, socially-constructed ideologies of old age, and their subjective experiences of their own health and getting older were of the utmost importance in understanding self-care practices using anti-ageing medicine among both Australian and Japanese older adults. There was no single theory or concept that satisfactorily explained their health behaviours; rather the reasons were complex and multi-faceted. The findings of this study show the important theoretical implications of embodiment approaches: that is, that the use of anti-ageing medicine reflects one’s lived experiences. This has been overlooked in the existing sociological literature on anti-ageing medicine.

In Chapter Two I argued that the Foucauldian understanding of self-care is useful in grasping how political strategies or social discourses impact on individuals’ decision making regarding the use of anti-ageing medicine. In this study it was apparent that Australian older adults understand and live up to the cultural expectation that emphasises the importance of independence in old age. They believed that this was possible through their own endeavours, particularly through the use of anti-ageing medicine, along with sensible choices regarding diet and exercise. In the existing sociological literature, this phenomenon is often
discussed in relation to Foucault’s idea of governmentality, technology of the self and biopolitics (e.g. Cardona, 2009, Lafontaine, 2009). However, this approach has limits because of its strong focus on societal control and regulation of one’s body, which leads individuals to feel responsible for managing their own health in order to conform to a socially-set standard. The Foucauldian perspective pays little attention to lived experiences—in other words, embodiment (Turner, 2004). This means that this perspective does not take into account how people’s behaviour and actions are learnt and created through their everyday experiences and interactions with others. This study suggests that self-care in older age is not simply influenced by government control and regulation, but is experientially formed through everyday life situations.

Turner (2004:170) explains embodiment approaches as looking into ‘the phenomenological subjectivity of the lived body in the life world’. This suggests that the self is formed through experiences of internal and external environments. As seen in the examination of the self in chronic illness, the self is vulnerable to bodily experiences of illness such as pain because these interfere with biography, which in turn negatively affects one’s sense of self (e.g. Strauss and Corbin, 1991). This notion has great relevance to Shilling’s (2008) view on ageing bodies. Shilling argues that ageing bodies are seen as a cause of crisis due to a natural decline in physical functions that makes it hard to carry out habitual actions. According to Shilling (2008), because habits and the self are closely interconnected, violation of them can quite possibly cause an identity crisis. As evidence of this, many participants (both Australian and Japanese) reflexively recollected their observations of ageing others who lost the ability to continue carrying out habitual routines. As a result, their sense of self was impaired and/or eventually lost. For these participants, such observations were precious because they made them realise that their sense of who they are is constructed through and sustained by what they have been doing in everyday life.

The analytical orientation derived from the discussion of ‘chronic illness management’ and ‘ageing bodies as a cause of crisis’ led to an important insight
that enabled me to understand how Australian and Japanese participants’ aspirations for continuity in life and their use of anti-ageing medicine intersect. Both Australians and Japanese engaged in their anti-ageing practices believing that such practices allowed them to continue carrying out habitual activities for as long as possible, as well as to continue good relationships with their friends and children. This in turn enabled them to maintain a sense of who they are.

Their anti-ageing practices coincided with Shilling’s (2008) idea of creativity. Shilling (2008: 19) explains that ‘creativity is associated with actions that alter certain aspects of oneself … in order to repair or enhance one’s embodied capacities for action’. With the bodily changes associated with ageing, such as experiences of limited capacity in bodily functions or lowered fitness levels, many Australians and Japanese in this study felt or anticipated that their ageing bodies would undermine their ability to keep doing what they want to do. This has encouraged them to use anti-ageing medicine to manage bodily capability in order to achieve a continuous engagement in life. This was observed in many participants’ comments when anticipating their future selves, ‘In ten years, if health permits, I should be probably doing what I’m already doing now’ (Angela, aged 64). Self-care using anti-ageing medicine is considered as a proactive, creative action that allows older individuals the possibility of maintaining the ability to conduct their daily activities.

Supplementing the above discussion, Gilleard and Higgs’ (2013) framework of ‘body work’ on ageing bodies as embodied practices is helpful in further explaining why healthy older individuals commit themselves to taking anti-ageing medicine. Gilleard and Higgs (2013: 159) refer to embodied practices as activities that ‘orientate the body toward distinct social, cultural and personal identities and their associated lifestyles’. Anti-ageing medicine, coined as ‘aspirational medicine’ by Gilleard and Higgs (2013:157), helps older individuals to seek ‘a new set of possibilities that allow for a more embodied subjectivity in later life’, rather than being constrained by declining bodily functions. Managing ageing bodies with anti-ageing medicine permits older individuals to seek a culturally-
oriented ‘new ageing identity’ as created by a consumer culture in which a particular ideology—virtue in youthfulness—has been produced and imposed on older adults (Gilleard and Higgs, 2013). Here, the meaning of youthfulness is not ‘youthful appearance’, but rather it represents the ‘choice, autonomy, self-expression and pleasure’ that ageing individuals have been enjoying throughout their adult lives (Gilleard & Higgs 2013: 160).

It was apparent in this study that the continuity in life that Australians and Japanese in this study believed to be achievable through anti-ageing practices allows them to experience independence, autonomy, self-expression and pleasure, all of which were considered the privilege of younger adults. They created various narratives to show that they have been enjoying these aspects through carrying out daily routines and participating in various activities such as work, community involvement and hobbies. Moreover, the narratives of desire for independence enabled me to foresee the negative attitude, or even fear—particularly among the Australians—of losing these privileges. It was clear that anti-ageing medicine as ‘health insurance’ played an important role not only in supporting the physical strength that permits participants to search for what and who they want to be, but also to reduce the levels of anxiety or fear caused by ageing processes. In this sense, it worked as ontological security that preserves a feeling of biographical continuity, an enduring conception of one’s aliveness and a stable sense of self-identity (Giddens, 1991).

8.3 Limitations of this study

The strengths of the methods used in this study could also be considered weaknesses. In particular, the small sample and the recruitment methods have placed limitations on this study. The use of qualitative methods employing in-depth interviews meant that the sample size needed to be small. This means that the findings are indicative rather than representative of the Australian and Japanese population as a whole. Instead, the study’s findings illuminated shared meanings and values held about health practices within specific groups of people.
Potentially, the findings of this study could be enhanced by a further study that investigated the motivations for using anti-ageing medicine and supplements among older individuals with cultural backgrounds other than those of Australia and Japan.

Second, the recruitment method I used in Japan: that is, sourcing participants through the social networks of my acquaintances including my family members and relatives, was likely to produce homogenous samples in terms of educational and socioeconomic status. Within his concept of habitus, Bourdieu (1986) argues that these aspects considerably affect people’s dispositions and taste. Consequently, the data derived from these participants could possibly have been biased. The use of a wider variety of sites to recruit participants, as I was able to do in Australia, is likely to alleviate this issue.

Finally, the participants of this study were relatively healthy and wealthy, and therefore the findings might not be applicable to people from lower socioeconomic class and less well older individuals. They might not be able to use same quality or quantity of anti-ageing medicine as the participants were taking because of financial constraint. Moreover, for those who are suffering health issues what they hope in their everyday lives might be different from the ones spoken by the participants. This may affect the in-depth meaning of ageing well clarified in this study. Including people from more diverse backgrounds, including class and health status, may be able to address these issues.

8.4 Lived voices of older individuals in ageing research and policy implications

In this study, with its use of the qualitative approach of conducting in-depth interviews, the central focus involved listening to participants’ lived experiences. I was interested in hearing their views on ageing, health and its management, as well as their wishes in relation to their older age. It is hoped that the critical analyses made possible in this study through the involvement of older people in
the research process will make a positive contribution to ageing research in both Australia and Japan.

It is argued that Australian sociological research involving the critical analysis of ageing policies is lacking in comparison with the U.S. and the U.K. (Asquith, 2009). This is because ageing research in Australia has been traditionally conducted within the frameworks of biomedicine and neo-liberal economic perspectives (Aberdeen and Bye, 2011). This has led to a lack of interpretivist and humanist approaches that integrate involvement by old people in the research process. This in turn limits the scope for understanding the ‘wide social forces, which shape the lives and diverse experiences of older Australians’ (Aberdeen and Bye, 2011:7). It has also been pointed out that within political contexts, analysis of the agency exercised by older individuals is largely absent from the literature (Conway and Kockey, 1998).

Recent social research conducted in Australia that targets or involves older individuals tends to focus on those in disadvantaged circumstances. Examples include issues surrounding nursing homes (Quine and Morrell, 2007), housing issues for the elderly (Bridge and Kendig, 2005), social isolation among the elderly (e.g., Findlay, 2003), relationships between ill health/disability and quality of life among the old (Kendig et al., 2000) and homelessness among the old (Rota-Bartelink and Lipmann, 2007). There are hardly any that focus on healthy older individuals who do not require societal support, but nevertheless would like to have their voices heard regarding the orientation of current policy. In essence, their voices are not heard.

The critique on Australian ageing policies argues that they have been formed according to political economic perspectives that see the ageing population as a problem that will impose an economic burden on the public health and welfare systems (Aberdeen and Bye, 2011). In order to avoid the negative consequences resulting from the ageing population, the Australian government has been promoting the individualised ‘responsibilisation’ of old age (Asquith, 2009). This
means that older individuals are expected to be responsible for their own ageing, so as not to become an economic burden on society. The idea of responsibilisation is prominently appeared in the 2015 Intergenerational Report Australia in 2055 released on the 5th of March 2015. In the report the Australian government encourages older Australians to remain in workforce for as long as possible and simultaneously, has proposed plans to reduce expenditure for an old-age pension and aged care in the future. This indicates that older Australians are encouraged to live independently and self-sufficiently without depending on the government support. This study found that to some extent Australian participants acknowledge the importance of self-responsibility in looking after their health. However, none suggested that their health practices are carried out so as not to become an economic burden on society. Rather, they were more concerned about the effect of their ageing on others, particularly their adult children. This may be because the Australians involved in this study are not economically disadvantaged. Nevertheless, the belief shared by all Australian participants was that good health in later life allows them to maintain or even protect the practices they have established throughout their lives, including lifestyles, activities, and good relationships with their friends and families that constitute a sense of self. This suggests that the focus of ageing policies may not be adequately addressing what older adults really want and need.

In addition, the cultural comparisons in this study have shown the different emphases of Australian and Japanese participants regarding perceptions of ageing well. This suggests that, because of the level of cultural diversity in Australia, Australian ageing research and policymaking may need to apply a cultural lens to understand ageing and its associated factors. Australians may be ageing differently based on their inherited cultural practices, and this tendency will become more obvious in the near future when many of the first generation of migrants—for example, the Vietnamese people who migrated during the Vietnam War—move into older age. Some studies have already pointed out the challenges faced by Australian society in terms of care and service provision. It is reported that ageing migrants have difficulties in finding culturally-appropriate aged care
and other support services provided by communities due to language and cultural barriers. This has resulted in their lower utilisation of home and community care services compared with their Australian-born counterparts (Rao et al., 2006). Consideration of culturally-influenced needs for older individuals may be necessary in order to successfully implement ageing policies for all Australians.

This study also has implications for Japanese policies on ageing, particularly the long-term care insurance system (LTIS): the new welfare scheme for older adults brought in by the Japanese government as a response to Japan’s rapidly ageing population. It is reported that the LTIS has changed the public discourse of elderly care from traditionally-practised filial obligation to one that is more modern—a discourse of professional and institutional care (Jenike, 2003). However, many of the Japanese participants in this study to a certain extent still hold a traditional view of intergenerational relationships. For example, some still reside with their adult children, or hope to live with them in the near future. The challenge for Japanese society in terms of elderly care provision may be related to how this modernised care provision can be integrated into culturally-shaped elderly care practices without affecting harmonious intergenerational relationships.

This thesis has contributed to a sound understanding of how older individuals perceived and understood their ageing processes in culturally-specific ways. It has also elucidated how their health management using anti-ageing medicine is integrated into their everyday lives. Anti-ageing medicine as edible health insurance was one of the options believed to help older adults achieve what they want to do and who they want to be in old age. It is an important investment that can provide them with a sense of security regarding their future health. These older individuals were, in one sense, ‘technogenarians’, a term coined by Joyce and Loe (2010) to describe those who creatively use technological artefacts to meet their health needs for quality of life. While most sociological literature views anti-ageing medicine in a critical manner, this study suggests that it can make a positive contribution to the social construction of ageing identities.
Reference List


Gastaldo, D. 1997. "Is health education good for you? Re-thinking health education through the concept of bio-power." Pp. 113-33 in Foucault,


Appendices

Appendix 1: Participants demographics and types of anti-ageing medicine they were taking

Table 1.1: Australian participants (N=21)

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Gender</th>
<th>Marital status</th>
<th>Occupation</th>
<th>Types of anti-ageing medicine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kyla</td>
<td>71</td>
<td>F</td>
<td>Widow</td>
<td>Retired</td>
<td>Calcium to prevent osteoporosis; fish oil to enhance functions</td>
</tr>
<tr>
<td>Joanna</td>
<td>58</td>
<td>F</td>
<td>Divorcee</td>
<td>Therapist</td>
<td>HRT to increase energy levels; CoQ10 for gum health; Gingko for good blood circulation; vitamin D&amp;E for general optimal health</td>
</tr>
<tr>
<td>Angela</td>
<td>64</td>
<td>F</td>
<td>Married</td>
<td>Yoga school owner and yoga teacher</td>
<td>HRT to improve thyroid problem and improve bone density; fish oil to treat hypertension</td>
</tr>
<tr>
<td>Dina</td>
<td>72</td>
<td>F</td>
<td>Married (to Bill)</td>
<td>Retired</td>
<td>Osteo-plus (a compound supplement) to prevent osteoporosis; glucosamine to prevent arthritis</td>
</tr>
<tr>
<td>Bill</td>
<td>74</td>
<td>M</td>
<td>Married (to Dina)</td>
<td>Retired</td>
<td>Osteo-plus (a compound supplement) to prevent osteoporosis; glucosamine to improve knee conditions; vitamin E for heart health</td>
</tr>
<tr>
<td>Ryan</td>
<td>64</td>
<td>M</td>
<td>Married</td>
<td>Retired</td>
<td>CoQ10 for heart performance; vitamin E for cancer prevention; glucosamine and fish oil for joint health</td>
</tr>
<tr>
<td>Barbara</td>
<td>77</td>
<td>F</td>
<td>Married</td>
<td>Retired</td>
<td>HRT to improve bone density and a depressive mood</td>
</tr>
<tr>
<td>Catherine</td>
<td>76</td>
<td>F</td>
<td>Married</td>
<td>Retired</td>
<td>Calcium to prevent osteoporosis; magnesium to prevent muscle spasm; silica to strengthen nails; glucosamine for joint health; vitamin E for general physical wellness</td>
</tr>
<tr>
<td>Rowena</td>
<td>67</td>
<td>F</td>
<td>Married (to Anthony)</td>
<td>Therapist</td>
<td>Glyconutrient to improve immune functions; anti-oxidant and multivitamins for general physical wellness; omega 3 for heart health and brain health</td>
</tr>
<tr>
<td>Name</td>
<td>Age</td>
<td>Sex</td>
<td>Married To</td>
<td>Occupation</td>
<td>Health Supplements</td>
</tr>
<tr>
<td>----------</td>
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<td>-----</td>
<td>-------------</td>
<td>-----------------</td>
<td>--------------------</td>
</tr>
<tr>
<td>Anthony</td>
<td>75</td>
<td>M</td>
<td>Married (Rowena)</td>
<td>Retired</td>
<td>Glyconutrient to improve immune system; anti-oxidant and multivitamins for general physical wellness; omega 3 for heart health and brain health</td>
</tr>
<tr>
<td>Natalie</td>
<td>62</td>
<td>F</td>
<td>Married (George)</td>
<td>Housewife</td>
<td>Fish oil to enhance immune functions; Chinese herbal medicine to prevent depressive mood (which she believed, is caused by ageing)</td>
</tr>
<tr>
<td>George</td>
<td>65</td>
<td>M</td>
<td>Married (George)</td>
<td>Retired</td>
<td>Fish oil to enhance immune functions; Chinese herbal medicine to treat prostate problem</td>
</tr>
<tr>
<td>Glenda</td>
<td>66</td>
<td>F</td>
<td>Married</td>
<td>Youth worker</td>
<td>CoQ10 to prevent degeneration of body cells; fish oil (omega3) and flaxseed (omega6) for heart health and general well-being; spirulina for general fitness</td>
</tr>
<tr>
<td>Priya</td>
<td>66</td>
<td>F</td>
<td>Married (Gavin)</td>
<td>Retired</td>
<td>Fish oil and glucosamine to treat an existing knee condition; a compound garlic and horseradish supplement to enhance immune system</td>
</tr>
<tr>
<td>Gavin</td>
<td>69</td>
<td>M</td>
<td>Married (Priya)</td>
<td>Retired</td>
<td>Fish oil and glucosamine to prevent arthritis; a compound garlic and horseradish supplement to enhance immune system</td>
</tr>
<tr>
<td>Newton</td>
<td>84</td>
<td>M</td>
<td>Married</td>
<td>Retired</td>
<td>Fish oil for heart health and to treat arthritis; vitamin E for heart health; magnesium to prevent muscle spasm</td>
</tr>
<tr>
<td>Farren</td>
<td>74</td>
<td>F</td>
<td>Married</td>
<td>Financial advisor</td>
<td>Fish oil to enhance immune functions; Osteo-plus (a compound supplement) and proto (prescribed mineral) to improve bone density; Bebeflex (a name of the product) for joint health</td>
</tr>
<tr>
<td>Jacquie</td>
<td>74</td>
<td>F</td>
<td>Married (Peter)</td>
<td>Retired</td>
<td>CoQ10 for heart health; vitamin B for energy boost</td>
</tr>
<tr>
<td>Peter</td>
<td>80+ (he refused to disclose his real age)</td>
<td>M</td>
<td>Married (Jacquie)</td>
<td>Retired</td>
<td>CoQ10 and vitamin E for heart health; vitamin B for energy boost; Ginkgo to support cognitive functions; magnesium to prevent muscle spasm; saw palmetto to treat prostate problem</td>
</tr>
<tr>
<td>Olivia</td>
<td>60</td>
<td>F</td>
<td>Married (Alan)</td>
<td>Artist</td>
<td>HRT for menopausal symptoms; various vitamins and minerals to enhance organ functions, hearth performance and</td>
</tr>
</tbody>
</table>

213
Table 1.2: Japanese participants (N=21)

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Gender</th>
<th>Marital status</th>
<th>Occupation</th>
<th>Types of anti-ageing medicine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yoshio</td>
<td>76</td>
<td>M</td>
<td>Married</td>
<td>Medical doctor</td>
<td>A compound supplement consisting of chondroitin and vitamin Bs to treat osteoarthritis</td>
</tr>
<tr>
<td>Tokiko</td>
<td>69</td>
<td>F</td>
<td>Widow</td>
<td>Former house wife</td>
<td>A supplement made of black vinegar for general physical wellness and also to treat hypertension</td>
</tr>
<tr>
<td>Takeshi</td>
<td>63</td>
<td>M</td>
<td>Married</td>
<td>Business owner (partially retired)</td>
<td>Ume (Japanese apricot) extract to improve blood circulation (for heart health and cancer prevention)</td>
</tr>
<tr>
<td>Yoko</td>
<td>65</td>
<td>F</td>
<td>Married</td>
<td>Business co-owner</td>
<td>CoQ10 to boost energy levels and physical performance</td>
</tr>
<tr>
<td>Wakae</td>
<td>79</td>
<td>F</td>
<td>Widow</td>
<td>Former house wife</td>
<td>A compound supplement that consists of DHA (docosahexaenoic acid), EPA (eicosapentaenoic acid) and sesamin for physical wellness; glucosamine to treat an existing knee problem</td>
</tr>
<tr>
<td>Setsuko</td>
<td>70</td>
<td>F</td>
<td>Widow</td>
<td>Former house wife</td>
<td>A compound supplement made of blueberry extract and others to prevent cataract; chondroitin to treat an existing knee problem</td>
</tr>
<tr>
<td>Fumiko</td>
<td>76</td>
<td>F</td>
<td>Married</td>
<td>Retired</td>
<td>A compound supplement made of calcium, magnesium and collagen to strengthen bones; the one made of blueberry and others to prevent recurrence of cataract; royal jelly for general physical wellness</td>
</tr>
<tr>
<td>Chizuko</td>
<td>66</td>
<td>F</td>
<td>Married</td>
<td>House wife</td>
<td>Glucosamine to treat an existing knee problem</td>
</tr>
<tr>
<td>Kazue</td>
<td>76</td>
<td>F</td>
<td>Widow</td>
<td>Yoga teacher</td>
<td>Glucosamine for joint health; a compound supplement made of minerals, vitamins and enzyme to prevent</td>
</tr>
<tr>
<td>Name</td>
<td>Age</td>
<td>Gender</td>
<td>Marital Status</td>
<td>Occupation</td>
<td>Supplement Details</td>
</tr>
<tr>
<td>------</td>
<td>-----</td>
<td>--------</td>
<td>----------------</td>
<td>------------</td>
<td>--------------------</td>
</tr>
<tr>
<td>Reiko</td>
<td>62</td>
<td>F</td>
<td>Divorcee</td>
<td>Owner and ballet school and ballet teacher</td>
<td>Oxidisation of body cells; compound liquid that contains DNA, RNA (brewer’s yeast extract) and collagen to improve metabolism. Chondroitin and collagen for joint health; a compound supplement that contains placenta, DNA and a swallow’s nest for menopausal symptom; multivitamins for general physical wellness; the one with lecithin and some fatty acid for her higher levels of cholesterol.</td>
</tr>
<tr>
<td>Shizuko</td>
<td>74</td>
<td>F</td>
<td>Widow</td>
<td>Former house wife</td>
<td>A liquid type of supplement that contains royal jelly, collagen and hyaluronic acid for joint health.</td>
</tr>
<tr>
<td>Mitsue</td>
<td>69</td>
<td>F</td>
<td>Married</td>
<td>House wife</td>
<td>Glucosamine and chondroitin to treat knee pain; enzyme extract to improve bowel functions; royal jelly for general physical wellness.</td>
</tr>
<tr>
<td>Saki</td>
<td>58</td>
<td>F</td>
<td>Divorcee</td>
<td>Sales manager</td>
<td>CoQ10 for heart health; polypore mushroom extract to enhance immune functions and cancer prevention; amino acid to support body recovery from fatigue.</td>
</tr>
<tr>
<td>Tatsuya</td>
<td>60</td>
<td>M</td>
<td>Married (to Saki)</td>
<td>Business owner</td>
<td>A compound supplement made of hyaluronic acid, collagen and others to prevent osteoarthritis.</td>
</tr>
<tr>
<td>Seiko</td>
<td>61</td>
<td>F</td>
<td>Married (to Tatsuya)</td>
<td>House wife</td>
<td>A compound supplement made of hyaluronic acid, collagen and others to prevent osteoarthritis.</td>
</tr>
<tr>
<td>Akira</td>
<td>68</td>
<td>M</td>
<td>Married</td>
<td>Business owner</td>
<td>Chlorella to improve circulatory system and organ functions; vitamin C to enhance immune functions; protein to improve metabolism.</td>
</tr>
<tr>
<td>Keiko</td>
<td>58</td>
<td>F</td>
<td>Single</td>
<td>Finance manager</td>
<td>Blueberry extract to treat cataracts; calcium and silica to prevent osteoporosis; CoQ10 and vitamin E to prevent oxidisation of body cells.</td>
</tr>
<tr>
<td>Sanae</td>
<td>62</td>
<td>F</td>
<td>Married</td>
<td>Business co-owner</td>
<td>CoQ10 to improve immune functions; magnesium to prevent muscle spasm.</td>
</tr>
<tr>
<td>Miyuki</td>
<td>67</td>
<td>F</td>
<td>Married</td>
<td>House wife</td>
<td>Glucosamine and chondroitin to treat knee pain; prescribed calcium to improve bone density.</td>
</tr>
<tr>
<td>Name</td>
<td>Age</td>
<td>Gender</td>
<td>Marital Status</td>
<td>Occupation</td>
<td>Supplement Description</td>
</tr>
<tr>
<td>-------</td>
<td>-----</td>
<td>--------</td>
<td>----------------</td>
<td>--------------------</td>
<td>----------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Taeko</td>
<td>64</td>
<td>F</td>
<td>Married</td>
<td>Youth worker</td>
<td>Liquid type of compound supplement made of multivitamin, amino acid, aloe vera extract and noni (that is a Polynesian fruit and contains various acids) for general anti-ageing.</td>
</tr>
<tr>
<td>Kazuki</td>
<td>67</td>
<td>M</td>
<td>Married</td>
<td>Retired</td>
<td>A compound supplement made of glucosamine, chondroitin and hyaluronic acid to treat existing knee pain; turmeric power for overall health (including physical and brain health)</td>
</tr>
</tbody>
</table>
Appendix 2: Ethics approval

To: Dr Deborah Dempsey/Ms Maho Omori, FLSS

Dear Deb and Maho

SUHREC Project 2009/290 Anti-Aging supplements and perceptions of ageing: A cultural comparison between Australia and Japan
Dr Deborah Dempsey FLSS Ms Maho Omori
Approved Duration: 12/02/2010 to 31/10/2012 [Adjusted]

Ethical review of the above project revised protocol was undertaken by Swinburne's Human Research Ethics Committee (SUHREC) at its Meeting 1/2010 held 12 February 2010.

I am pleased to advise that, as submitted to date, the project has approval to proceed in line with standard on-going ethics clearance conditions listed below.

- All human research activity undertaken under Swinburne auspices must conform to Swinburne and external regulatory standards, including the National Statement on Ethical Conduct in Human Research and with respect to secure data use, retention and disposal.

- The named Swinburne Chief Investigator/Supervisor remains responsible for any personnel appointed to or associated with the project being made aware of ethics clearance conditions, including research and consent procedures or instruments approved. Any change in chief investigator/supervisor requires timely notification and SUHREC endorsement.

- The above project has been approved as submitted for ethical review by or on behalf of SUHREC. Amendments to approved procedures or instruments ordinarily require prior ethical appraisal/ clearance. SUHREC must be notified immediately or as soon as possible thereafter of (a) any serious or unexpected adverse effects on participants and any redress measures; (b) proposed changes in protocols; and (c) unforeseen events which might affect continued ethical acceptability of the project.

- At a minimum, an annual report on the progress of the project is required as well as at the conclusion (or abandonment) of the project.

- A duly authorised external or internal audit of the project may be undertaken at any time.

Please contact me if you have any queries about on-going ethics clearance, citing the SUHREC project number. A copy of this clearance email should be retained as part of project record-keeping.

Best wishes for the project.

Yours sincerely
Keith Wilkins  
Secretary, SUHREC  

*******************************************  
Keith Wilkins  
Research Ethics Officer  
Swinburne Research (H68)  
Swinburne University of Technology  
P O Box 218  
HAWTHORN VIC 3122  
Tel +61 3 9214 5218  
Fax +61 3 9214 5267
Appendix 3: Interview schedule used for Australian participants

Section 1-Breaking the ice between the researcher and participants.

First, I’d like to start with asking you what interested you in this research topic?

Now, tell me a bit about your family background and living situation at the moment

   Probe –
   • Who do you live with?
   • Spouse or partner?
   • Children or grandchildren?
   • Brothers and sisters or other family members?
   • Are you working at the moment? How do you mainly spend your time?

(Note: keep in mind answers to questions here when reintroducing family relationship questions later in the interview).

Section 2- Perceptions about ageing

Now, I would like to talk to you about how you feel about getting older.

   • Do you think much about what your life or health will be like in 10/20 years?
     - If yes, what would it be like? Who will you be living with? How will you spend an average day/week? What do you hope to be doing?

   • Nowadays, you might have heard phrases such as ‘successful ageing’ in the media or even in government literature. What, does “ageing well” or “successful ageing” mean to you?

   • What, do you think, are the important aspects in “ageing well” or “successful ageing”?

      Probe — Is keeping healthy important for you? Why/why not?

      — Is “being independent” important for you? Why/why not? What does independence mean to you in the context of getting older? (probe different aspects, e.g. Living in your own home, doing own shopping/housework, etc.

   • What do you think these aspects (i.e., good health, independence and autonomy)

     would allow you to do in the future?
• If “ageing well” or “successful ageing” is important for you in the future, what, do you think, would be important things to do to achieve it?

Section 3 – Technological help to achieve “ageing well” or “successful ageing”

Now, I would like to move on to the topic of anti-ageing medicine/health supplements which could help you achieve “ageing well” even more (in terms of maintaining good health). You told me that you have been taking _________ (some type of anti-ageing medicine/supplements). I would like to ask you about more details about this.

• When did you start taking the medicine/supplement?
  Probe – How did you find about it?
    How did you hear about it?
    What did encourage you to take it?

• (Following the fact that you’ve kept taking it) What has driven you to keep taking it?
  Probe — Has it been effective to maintain your good health condition?

• Will you hope to keep taking it in the future?
  If so, can you tell me the reason?

• How do supplements fit with your idea of “ageing well”?

• What do you think getting older would be like if you didn’t take these medicines/supplements?

Section 4 – Relationships with others in order to achieve ageing well

You have already told me your perception of what is ageing well for you and how the usage of anti-ageing supplements facilitates it. I would like to ask about what would be an ideal relationship with others such as your families and friends to achieve ageing well and how the availability of anti-ageing medicine helps sustain the good relationships.

(If the participant doesn’t have a family, the word, ‘family’ will be changed into ‘friends or relatives’.)

• To achieve ageing well or successful ageing how much would your family or friends be important for you and why?

• What would be an ideal form of relationships with your families and friends in achieving ageing well?
Probe- What kind of support would you expect?

- How do you think usage of anti-ageing medicine will help you to maintain the kinds of relationships you want with (family or significant others in life)?

This is the end of the interview. Is there anything else you would like to tell me about?

**Questionnaire (to be completed separately by participant before the interview)**

Age:

Relationship status:

Number of children:

Gender:

City or area of residence:

Educational status: 1. Tertiary level or higher

2. Secondary school

3. Primary School or lower

Occupation:

(if you are a retiree, please circle here and also note the previous occupation)
Appendix 4: Interview schedule used for Japanese participants

セクション1: リサーチャーと参加者との距離を縮める
まず始めに、ご自身について少し伺いします。

- 何事でもっこうですので、自己紹介のような感じで、今のご自身について何かお聞かせください。
  探り-どのような環境でお暮らしですか？
  職業など、何をなさっていますか？
  誰と一緒に住んでですか？

- 現在の状況（何でもけっこうです。例えば、仕事、ボランティア、自身の健康、家族関係）を楽しんでらっしゃいますか？
  もしそうであるなら、将来どれくらいこの状況が続きばよいと思いますか？

セクション2: 「上手に歳を取る」又は「サクセスフル・エイジング」とは何か？
ここでは、「歳を取る」ということについてもうすこし詳しく聞かせていただきます。

- 10、20年後のご自身の生活、又は健康状態を想像したことはありますか？
  ハイ — それほどのものですか？現在では何を望みますか？
  ノー — 今ちょっと考えてみていただけますか？

- 現在、新聞やテレビで「サクセスフル・エイジング」という言葉を聞いたことがあるかもしれませんが、貴方にとって「上手に歳を取る」ということや「サクセスフル・エイジング」とはどういうことですか？

- どういうことが実際に「上手にを取ること」と「サクセスフル・エイジング」に不可欠だと思われますか？
  探り — 良い健康状態を保つことは重要だと思われますか？それは何故か？
  「独立」という言葉は重要だと思われますか？それは何故か？
  自立性（自ら自身の行動を規制する能力）を保つのは重要ですか？
  — 「独立」とはどういうことでしょう？

セクション3: テクノロジーの手助けによる「サクセスフル・エイジング」
ここで、アンチエイジングメディシン・健康維持のためのサプリメントの話題に移りたいと思います。ご自身も__________（サプリメントの名前）を摂取されていると言うことですが、そのサプリメントは「上手に歳を取るための」手助けみたいなのもだと思いませんか？
  それに関してももう少し詳しく伺いたいとお思います。

- いつ頃、それを取り始めたのですか？
  探り — どのようにそれを見つけたのですか？
  最初はそれはどのようなものだと聞いていたか？
  どういったきっかけで取ることになったのですか？

- なぜ今でも取っていらっしゃるのですか？
  探り — 今まで効果はありましたか？
セクション４：歳を取るプロセスにおいての家族との関係
先ほどご自身の現在の状況について話していただいたのですか、ここでは将来の理想的ご家族との関係についてお話しします。「将来誰の世話になりたいか」などというご自身の正直な気持ちをも踏まえて、お話を聞かせてください。

実際には考えられたことはありますか？

必要であるならば、家族のメンバー（配偶者又はお子さん）がご自身の面倒を見てくれることを期待しますか？

探り——将来、必要ならばお子さんの家族と同居することを望みますか？
どういったケアをしてもらうことを期待しますか？（例、自分の代わりに買い物に行ってもらう、など）。

（もし、本人に身内がいないようであれば、家族のかわりに友達や親戚についてたずねる）

歳を重ねていくというプロセスにおいて、家族とどのような関係を持つのが理想とされますか？

探り——ご自身の配偶者に頼るのはどうか？ 子供に対しては？
どの程度自分で自分の面倒をみる、いわゆる「独立した状態で居る」のは大切なことですか？

その「独立した状態」というのは、先ほどおっしゃられた「独立」と同じですか？

以上で、インタビューは終了となります。なにか他にお話になりたいことはありますか？

アンケートにご協力ください。

年齢：

性別：

最終学歴： 1．大学またはそれ以上
2．高校まで
3．中学まで、又はそれ以下
職業：
（定年されている方は「定年」と表記の上、差し障りがなければ以前の職業もお書きくだしい）
Appendix 5: Copy of form of plain language statement of this study
and informed consent form used for recruitment in Australia

**Project title:** Anti-ageing medicines & supplements and perceptions of ageing: A Cultural Comparison between Australia and Japan

**Investigators:** Maho Omori (principle investigator)
Dr. Deborah Dempsey (Thesis supervisor)

**Dear Participant,**
My name is Maho Omori and I am currently a PhD student in sociology at Swinburne University of Technology. I would like to invite you to take part in this research that I am conducting for my doctoral thesis. The thesis is supervised by Dr Deborah Dempsey and Professor Michael Gilding.

The aim of this research is to find out about cultural differences and similarities in Australian and Japanese people’s perceptions of ageing well and in the time of growing importance in preventive health, how the availability and usage of anti-ageing medicines or supplements has influenced this. Little research to date has explored how older adults in different cultural settings think about ageing and the perceived health benefits of taking anti-ageing medicines or supplements.

**Your Participation**
Your participation will involve taking part in one face-to-face interview with Maho. The interview should take one to one and half hours to complete. A follow up interview may be requested of you at a later date, in the event that Maho would like to clarify or find out more detail about something said in the first interview. The interview will be conversational in tone, rather than guided by a set list of questions.

Participation in this research is voluntary and you have the right to refuse to answer any questions asked of you, and to discontinue the interview at any time. With your permission, the interview will be digitally recorded so that I can ensure that I make an accurate record of what you say.

**Confidentiality and Anonymity**
The following steps will be taken to ensure your interview remains confidential and anonymous. The data collected from you will be reported in a way that protects your anonymity. Any references to personal, identifiable details that might allow someone to guess your identity will be removed. For instance, your name will be replaced by a pseudonym, and the names and ages of people you talk about in the interview will be changed. The recording of your interview will be erased after it is transcribed and the transcript checked. Transcripts will be stored in a locked filing cabinet and in a password-protected computer file and they are accessible only to Maho Omori and Dr Deborah Dempsey.

Should you require any further information, or have any concerns, please do not hesitate to contact either Maho or Deborah:
Maho Omori: 0415140838 momori@swin.edu.au or
Dr Deborah Dempsey: 61 3 92144374 ddempsey@swin.edu.au
This project has been approved by or on behalf of Swinburne’s Human Research Ethics Committee (SUHREC) in line with the National Statement on Ethical Conduct in Human Research. If you have any concerns or complaints about the conduct of this project, you can contact:

Research Ethics Officer, Swinburne Research (H68),
Swinburne University of Technology, P O Box 218, HAWTHORN VIC 3122.
Tel (03) 9214 5218 or +61 3 9214 5218 or resethics@swin.edu.au
Swinburne University of Technology

Consent Form

**Project title:** Anti-ageing supplements and perceptions of ageing: A cultural comparison between Australia and Japan

**Principal Investigator(s):**
Supervisors: Dr Deborah Dempsey, Professor Michael Gilding
Student Investigator: Maho Omori

**Agreement**

_I (name of participant) have read and understood the information provided in the form of disclosure. I have been provided a copy of the project information statement and this consent form and any questions I have asked have been answered to my satisfaction._

2. Please circle your response to the following:
   - I agree to be interviewed by the researcher **Yes**
     - **No**
   - I agree to allow the interview to be recorded by electronic device **Yes**
     - **No**
   - I acknowledge the information I provide can be used in publications such as journal articles and conference papers **Yes**
     - **No**
   - I agree to make myself available for further information if required **Yes**
     - **No**

3. I acknowledge that:
   (a) my participation is voluntary and that I am free to withdraw from the project at any time without explanation. In the event that I decided to withdraw from the participation, I am informed that the information I provided will be immediately destroyed and will not be used for this research;

   (b) the project is for the purpose of research and not for profit;

   (c) my personal information will be collected and retained for the purpose of carrying out this project;

   (d) my anonymity and confidentiality will be maintained.
By signing this document I agree to participate in this project.

Name of Participant: ............................................................................................

Signature & Date: ..............................................................................................
Appendix 6: Copy of form of plain language statement of this study and informed consent form used for recruitment in Japan

研究題目：日本とオーストラリアにおける文化比較
「サクセスフル・エイジング」とは何か？

私は大森真保と申します。現在オーストラリア国、ビクトリア州、メルボルン市にありますスウィンバン工科大学の博士課程で、Dr. Deborah Dempsey と Professor Michael Gilding の監修の元、研究を行っております。

私の『日本とオーストラリアにおける文化比較、「サクセスフル・エイジング」とは何か？』に興味を持ってくださったことに心から感謝しております。この研究の目的は、西洋と東洋の文化差から生じる、「上手に歳を取るというのはどういうことであるのか」という自己概念の違いを明らかにすることにあります。また、上記に加え、テクノロジーの進歩がどのようにその概念に影響を与えるのかを調査しております。

この目的を達成するために、55歳から70歳までの健康維持の為に何らかのサブリメントを摂取されている男性・女性で、この研究に参加してくださる方を求めております。

この研究に参加するお願いすることは、実際に私との1時間から1時間半程のインタビューに参加していただくことです。後々、私よりインタビュー時に頂いた情報について、より深く掘り下げる為に連絡を差し上げることがありますので、ご了承ください。インタビューは会話的であり、こちらから様々な質問で回答を誘導することはありません。

この研究における参加はあくまでもボランティアであり、こちらの質問に関して全てを答える義務はありません。更に、貴方の意思次第でいつでもインタビューを終了することもできます。貴方の許可を頂ければ、正確な情報を記録する為に、インタビューを録音させていただく場合があります。

インタビューにて集められた個人的な情報は一切他に報告されることはありません。又、研究レポートに載せられるいかなる個人的な情報に関しては、全て偽名や偽年齢などに変えさせて頂きます。またインタビューによって得られた大切な情報は全て匿名のデータとする保全上に保管され、この情報にアクセスできるのは私のみになります。

この研究に関する話題は個人的なものであり、時には貴方を不安にさせたり、ストレスを生じさせることがあるかもしれません。万が一そのようなことが発生した場合、ライフライン（www.lifeline-international.org/home 又は(03)5774-0992）にご連絡ください。

また、この研究プロジェクトに関してどんなことでもご意見・ご質問がございましたら、下記の連絡先までご一報ください。
この研究に興味をお持ちいただきましたことと、貴方の貴重なお時間をくださいましたことに、深く感謝をいたします。

大森 眞保　スウィンパン工科大学　社会学研究科大学院博士課程
Dr. Deborah Dempsey　Lecturer in Sociology, Faculty of Life and Social Science, Swinburne University.
同意書

将来へ向けての健康管理とサクセスフルエイジング
日本とオーストラリアにおける文化比較研究

監修：Dr Debora Dempsey, Pro. Michael Gilding

研究者：大森 真保

１．同意・承諾

私の（氏名）……………………………………………………………………………… は
この研究に関する情報を全て読み、理解いたしました。この研究に関する情報を伴った書類を提供してもらい、研究を行うにあたり、この同意書についてや私の個人的な質問に対して十分な説明を受けました。

２．次の事項に関して同意・承諾するものに丸をつけてください。

・ 研究者にインタビューされることに同意します。
・ インタビューが録音されることを承諾します。
・ 必要に応じてインタビュー後に研究者から補足連絡を受けることを承諾します。

３．私は以下の点を承諾しております。

(a) 私の参加はボランティアであり、いつでも参加の撤回をすることができます。その際、どのような説明も必要とされません。更に、参加の撤回を申し入れた際、私が提供した情報は全て破棄され、この研究に使用することはない趣旨の説明を受けました。

(b) このプロジェクトは研究のためであり、利益を追求するものではありません。

(c) 私の個人情報はこのプロジェクトを遂行する為に集められたもので

(d) 私の匿名、及び情報の秘密性は約束されています。

この書類にサインすることにより、私はこのプロジェクトに参加することを同意いたします。

サイン __________________________________________

日時 ____________________________________________
Appendix 7: Examples of poster advertising the study

[English version]

Anti-ageing supplements and perceptions of ageing:
A cultural comparison between Australia and Japan

Are you aged 55 years or older and taking any anti-ageing medicines or supplements such as Omega3, CoQ10 & anti-oxidants? If so, I would like to hear from you. This research is being conducted with adults in Australia and Japan and explores cultural similarities and differences in meanings of ageing.

Researcher: Maho Omori
Phone: 0415140838
Email: momori@swin.edu.au

This research will be conducted as a PhD project at Swinburne University of Technology, Faculty of Life and Social Sciences.
[Japanese version]

将来へ向けての健康管理とサクセスフルエイジング

日本とオーストラリアにおける文化比較研究

この研究に参加して頂ける方を募集しています！

60歳以上の健康な男性・女性で、健康維持の目的でアンチエイジング療法（例、ホルモン補充療法）を実施していたり、何らかのアンチエイジング・サプリメント（例、コエンザイムQ10、グルコサミン、コンドロイチン、DHA、ギンコ他）を摂取されている方、是非この研究にご参加ください。

この研究の目的は「理想の歳の取り方」という自己概念の裏側にどのような西洋と東洋の文化差が存在するのかを明らかにすることにあります。また、上記に加え、テクノロジーの進歩が自己健康管理に於いてどのような役割をはたしているのかを調査しております。

研究参加へのご質問等、お気軽にご連絡ください。

研究者：大森 智保
Eメール：momori@swin.edu.au　携帯：0804322537

この研究はオーストラリア、メルボルン市、スウィンバン工科大学の倫理委員会により正式に承認された研究として行われています。