Anthropology & Aging Quarterly

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Note from the Editor

Jason Danely, PhD
Department of Anthropology
Rhode Island College

As Editor-in-Chief of Anthropology & Aging Quarterly, I am proud to announce that our journal has finally completed preparation to take the bold step into the world of open-access digital publishing. Beginning with Volume 35 (the next issue), Anthropology & Aging Quarterly will be published by University Library Systems (a non-profit corporation) through the University of Pittsburgh. It will join other ejournals that our readership may be already familiar with in the D-Scribe Digital Publishing Program such as Ethnology and Health Culture and Society. We will work with the ULS and Pitt to partner with abstracting, indexing, and discovery service providers to increase our visibility.

Our contributors, peer reviewers, and staff all put a great deal of effort into the content of AAQ, and I am impressed with the quality of the results with every issue. One need only look at this current issue, featuring new contributions from three prominent anthropologists on three continents to find and example of the kind of rigor and dedication we value. This is work that can inspire anthropologists, social gerontologists, and others in related fields to engage as a community to expand our base of empirical knowledge on global aging, and explore new theoretical frames and concepts. We do this work because we believe it is important, and our new digital format will make this work freely available and readily accessible to the world. For more on open-access in social science research, I highly suggest the Society for Cultural Anthropology's free podcast "Can Scholarship Be Free to Read."

As we make our transition to this new format, many things will remain the same: our mission to create a global forum for the exchange of knowledge, our rigorous double-blind peer-review process, our commitment to publishing work that is original, diverse and engaging. Contributions will be protected under the Creative Commons Copyright attribution 3.0, and neither AAGE nor the University of Pittsburgh will have publication or reprint rights without author agreement. There will be no hefty publication fee as there are with many other open-access journals, but we will require all contributors to be members of AAGE.

Other things will change, beginning with the number of issues published per annum, and consequently the journal's name. Beginning with Volume 35, the journal will be published twice per annum, and will drop "Quarterly" from its title. In an informal poll of members, "Anthropology & Aging" was the most preferred new title. Other changes will include a streamlined review system, search functions, ability to include new forms of media, and greater interactivity. We have also expanded our editorial avisory board by seven members, including scholars based in Japan, Demark, Canada, and the US.

Finally, AAQ would like to encourage student readers to submit essays for the revived Margaret Clark Award . Anthropology & Aging will have the right of first refusal for the winners of this award, which, together with workshops and conference events, is a key way that the journal remains intertwined with the ongoing activities of AAGE.

To be sure, this new step means new challenges and a lot of work to be sustainable. AAGE members will remain key, but keeping the journal vibrant will depend on growing our network and building relationships. We hope that the journal will present new opportunities to meet our challenges and build our strengths.

Thank you to all who have helped AAQ reach this point. Looking forward to your submissions.

Jason Danely

Heterotopia and Illness: Older women and Hypertension in a Brazilian Favela

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Abstract

This article is about older women and the way hypertension is linked to their life in a favela, a "shantytown", in Rio de Janeiro. Inspired by Foucault, I suggest calling this complex phenomenon 'heterotopic illness'. By calling attention to the importance of place for understanding certain illnesses, the limited usefulness of some public health prevention campaigns is shown. Since hypertension can be considered a "disease of aging", it will be argued that some place-related stressors often have a greater impact on seniors than they have on younger adults.

Keywords: *Heterotopic illness, favela, Brazil, place, hypertension, aging.*

Mangueira, your scenario is a beauty*	*Mangueira teu cenário é uma beleza*
That nature created, oh oh...	*Que a natureza criou ô ô...*
The hill with its huts made of zinc	*O morro com seus barracões de zinco*
How splendid it is in the early morning	*Quando amanhecer que esplendor*

("Exaltação a Mangueira," Samba composed by Enéas B. Silva and Aloisio A. Costa, 1956; my translation)

* Mangueira is a well-known favela ('shantytown') in Rio de Janeiro

M-16P. G-3. AK-47	*M-16P. G-3. AK-47*
*Uzi. Glock***	*Uzi. Glock*
A missile is being fired (...)	*Fuzil lança rojão (...)*
To become stronger, to become stronger!	*Pra fortalecê, pra fortalecê!*

(Forbidden funk music about violence in a favela; quoted in: Barcellos 2003: 29; my translation) **names of weapons

Aging can be defined as the accumulation and embodiment of time, and the 'experienced body' of older individuals is spatially grounded in a number of ways. The link between certain spaces, sites or places[1] with health or illness may be obvious: for example, a hospital can be a site of healing and yet also a site of contagion and illness when understaffed or infested with a bacteria such as clostridium difficile. Other links between place, health and illness are more complex: Leon Eisenberg (2004), criticizing some forms of naive geneticism, states that, "nature and nurture stand in reciprocity, not opposition. Offspring inherit, along with their parents' genes, their parents, their peers and the places they inhabit" (Eisenberg 2004, 102; emphasis added). For older individuals, who experience more

restrictions in their mobility, sensoriality (vision, hearing etc.), and decision-making capacities (e.g., dementias), a variety of public, private, virtual, and actual spaces play a role in impeding or enhancing citizenship, comfort and well being.

Spatial dimensions of illness are often treated as a variable - in public health studies for example whereby the willingness of individuals to maintain and achieve their health depends on their access to certain facilities such as gyms and public markets. Social scientists (such as Williams [1999] who writes about "therapeutic landscapes") often concentrate on the impact of domestic or institutional environments on older people's well being (e.g. Wiles et al. 2012). These discussions can be diversified by applying Michel Foucault's concept of "heterotopia" to certain illnesses and inquiring how illness and place are entangled on multiple levels, often configured by issues of identity and power.

Foucault outlines an analytical framework for discussing "counter-sites" in his short essays on heterotopia.[2] Here, heterotopia refers to places that are exceptional to, or excluded from, mainstream society (cf. Foucault 2005, Sophia 2008, Elden 2001) or, "spaces of alternate social ordering" (Hetherington 1997).[3] Foucault was strongly influenced by Georges Bataille, who originally developed the concept of heterotopia in the 1930s, describing it as a "science of the other", concerned about "the 'garbage' of society, its outlaws, … mad laughter, the erotic, and violence" (see Chlada 2005, 13; translation mine). However, heterotopias are not conceived in opposition to mainstream society, rather site and counter-site are regarded as tightly interwoven in a very specific relationship:

But among all these sites, I am interested in certain ones that have the curious property of being in relation with all the other sites, but in such a way as to suspect, neutralize, or invent the set of relations that they happen to designate, mirror, or reflect. These spaces, ... are linked with all the others, ... however contradict all the other sites... [4] (Foucault n.d.; emphasis added; see also Sohn 2008, 44-45)

A counter-site – or, otherness as a mirror - is not necessarily negatively related to mainstream society. However, when applying it to illness – an analytical choice that makes only sense when illness is embedded in a particular place - the counter-site can be described as mostly pathogenic (contaminated, polluted, stressful, violence-stricken for example).

This article is based on ethnographic research on elderly hypertensive women who live in a well-known favela in Rio de Janeiro. For these women, their association with the favela – a kind of shantytown – defines their worth and determines which type of interventions (social, medical etc.) can be claimed from governments, non-governmental organizations (NGOs) and other institutions. This kind of spatial citizenship is more often found in counter-sites - heterotopias - because of the tensions that come with the "reverse side of society" (Sohn 2008).

Initially, I had intended to study dementia outside of the institutional settings of psychiatry and neurology (e.g., Leibing 2002, 2009). It was a surprise, then, that in the favela I had chosen, both patients and health professionals of the local health post deemed memory impairment, forgetfulness, senility and Alzheimer's disease as irrelevant to their reality. Instead, aging was firmly and repeatedly linked to hypertension, and the narratives about hypertension were embedded in the life in the favela.[5]

In Rio de Janeiro, favelas are often located on a hill (as in the classic film Orfeu Negro [1959]), associated with a high crime rate (as in the well-known film City of God [2002]), but are also invested cultural heritage and considered as the site which originated popular music such as samba (see Barke, Escanasy and O'Hare 2001). A favela is an "imagined community" in a double sense – it is the troubling shadow of modern Brazil, evoking counter-narratives of the nation (cf. Bhabha 1994, 13ff.), but at the same time an idealized site of authentic Brazilianness and, therefore a mirror of society, as per Foucault's conceptualization of utopia (e.g. Chlada 2005; see also Leibing 2001 on the "good bandit").

During one year my colleague Daniel Groisman and I followed every week two groups of older women (and one man) who visited the health post – the *posto*, as everybody called it - located at the bottom of the hill. Due to the advanced age of the women we worked with (approximately 25 women aged 57-83 years), we had suggested meeting on the hill in order to facilitate their participation. The women, however, insisted that the

health post was a safer place. But we also visited the homes of five of these women, who picked us up at the health post and carefully guided us into the favela, passing by the unofficial security people posted at the entrance, and through the meandering streets, paths, and staircases leading up the hill. In addition to the group meetings and the home visits, we conducted 10 individual interviews with group members, and five interviews, as well as regular informal chats, with the health professionals.

During the course of our fieldwork, we worked with two groups - each one for two hours every week. Different health professionals led the official "hypertension group," and we were allowed to pose some questions towards the end of each session. We led the second group, called the "memory group", because at the onset of our fieldwork, since dementia was not an issue, we were hoping to get at least some information on the concept of memory. This second group consisted of sessions based on themes pre-selected by members (some of the topics we discussed included: the favela versus the non-favela, women's everyday preoccupations and their life histories). This group was also made up of patients suffering from hypertension.

The favela, the non-favela and the health post in-between

Not all low-income communities in urban Brazil can be called favelas. This term generally refers to areas with illegal housing and is associated with a high prevalence of violence. Favelas emerged at the end of the 19th century as places of residence for newly-liberated slaves. Later they became the home for many migrants looking for work and a better life: An important period for the formation and expansion of favelas were the 1940s when, during the government of president Getúlio Vargas, people migrated to the Capital Rio de Janeiro and built their houses on the less valorized hills of the city. In the 1970s, another shift occurred when rural workers en masse moved into the big urban centers, most notably São Paulo and Rio de Janeiro, the two cities where by far the highest numbers of favelas exist (see for a more detailed analysis Valladares 2000, 2005, 2006; Valladares and Medeiros 2003; Zaluar and Alvito 2005, and many others).

Many Brazilians and foreigners consider favelas as dangerous areas associated with crime and illegality. Because of the high rates of violence in many favelas, constant distress impacts on health and well being of its inhabitants (cf. Epstein 2003; see also Duarte 1986). Life expectancy at birth can vary in Rio de Janeiro from 64.01 years in the poorer neighbourhoods to 73.25 years in the wealthier parts of the city (Sczwarszwald et al. 2000). However, a key factor responsible for the lower life expectancy in the favelas lies in the high rate of violent death among young men (Rocha 1998, Huguet and Szabo de Carvalho 2008).[6]

Not all favelas are violent and dangerous, but this reputation persists despite the attempts by non-governmental organizations (NGOs) and the State to alter that image (e.g. through the current pacification measures [see Schiller 2013], favela tourism [e.g. Hanrahan 2013]) and, indirectly, by turning illegal housing into a legal one (such as the huge slum-to-neighborhood initiative Favela Bairro; see RioOnWatch 2010). *Cidade de Deus* (City of God), for instance – well known from the movie with the same name by Fernando Meirelles (2002) – should not be called a favela, because it is a government housing project. However, this part of Rio de Janeiro is called a favela due to its high rate of crime. This misrepresentation is a vivid example illustrating that 'favela' is less a geographic notion, but first of all a strong moral and stigmatizing term.

Foucault describes a heterotopia to be a space of deviation, with ever-shifting points of reference. A widely discussed book in Brazil entitled *Cidade Partida* (The Divided City) argues that "[t]he City has been civilized and modernized by expelling its second class citizens to the hills and the periphery. The result of this kind of politics was a divided city… the choice was always the separation, or even a simple segregation" (Ventura 1994, 13). This description creates the illusion of a solid and unchallenged boundary between two discrete spaces, contrasting a modern city with a lawless periphery. More recent authors (e.g. Zaluar and Alvito 2005) point out that the notion of a divided city – the favela versus non-favela – is too simple for a complex metropolis like Rio de Janeiro.[7] Rather than two distinctly separate spaces, the favela and the 'asphalt' (*asfalto*) – as the non-favela is often

called - are linked by everyday practices in a globalized world, constantly creating connections and reinforcing boundaries (cf. Segre 2008, Porto 2000). As an example, during our fieldwork, we encountered women from the favela who had little formal education and very limited means who adopted a "successful aging" discourse and other key psychological concepts in the same manner as the women of a similar age, living outside of the favela. The social workers, doctors, and psychologists at the health post, along with the world of television, were responsible for transmitting a notion of self that needed to be active and in need of a double improvement: Through the working of self esteem being old and poor should become less disabling, mingling social, psychological and physiological factors contributing to hypertension, some of which will be discussed more in the section on 'risk talk'.

A *favelado* is often seen as a marginalized person and a favela is what Bachelard (1994) called a 'hostile space'. But this is only one part of the picture – a number of associations are positive, such as the roots of popular culture found in the samba singers, the queens and kings of carnival, and a notion of community-based life versus the individualized life generally associated with the big urban centers.[8] Many women expressed their preference for the favela (as one stated, "On the asphalt, when you die, you lay there in your apartment and people don't even notice"), but complained that the favela was becoming increasingly inhospitable with an increase of violence and the disrespectful attitude of the younger generation.

Nevertheless the favela is often contrasted with the asfalto – in strong dichotomies of good and bad – while the health post can be described as a real heterotopia because it is a site of convergence for site and counter-site. The health post was always described to us as violence-free, although a big part of its *raison d'être* was based on treating patients directly or indirectly hurt through violent acts. The clean and friendly environment of the health post rendered it an exceptionally positive space for many of its clients. The women valued the respectful manner they were treated and were deeply attached to the posto: "At the Souza Aguiar hospital," said one woman, "they treated me like a dog. Here we are all equal. A family." And another woman: "Here ("remocei") I became 10 years younger. This is better than my family. The family only likes us when we have money. Without this here [the post], we are nothing. First Jesus,[9] afterwards this here."

It is through the association with the health post and the psychosocial dynamics of the concept 'self-esteem' that the older women work on their citizenship, while both posto and self-esteem are tightly linked to their lives in the favela. The positive value given to self-esteem as a social factor that can be 'treated' through an originally psychological concept resembles the programs created by the State Assemblyman John Vasconcellos, who in the 1980s set up a task force on self-esteem in California. His argument was that "raising self-esteem in young people would reduce crime, teen pregnancy, drug abuse, school underachievement and pollution" (see Baumeister et al. 2005). In the case of the older women in our study, the complex interconnection of space, identity, and age can be translated, at least partly, into the language of hypertension.

Hypertension, aging and place

> Space is fundamental in any form of communal life; space is fundamental in any exercise of power. (Foucault 1984, 252)

The hypertension groups, alongside child health and pregnancy programs, were the main programs of the health post. The high profile of hypertension not only created something like a hypertension culture with its own language, slogans, and ideologies that was both incorporated and contested by the patients, it also showed the specificity of this favela as a hypertension-creating site.

The hypertension groups were organized almost like social clubs: one had access to a number of privileges after becoming a 'member' through referral by one of the doctors of the health post. If a patient was compliant (i.e. regularly attended the group sessions, took the medications as prescribed and sufficiently adapted one's diet to the doctor's recommendations), direct access to medical treatment was guaranteed and eliminated the need to wait in long lines in the early morning to receive clinical attention. Compliance was regularly measured after sessions by Dr Mariax,[7] one of the three doctors working at the health post and who was responsible

for the hypertension program: she was both feared as a controlling agent and gatekeeper and respected for her caring and sincerity. Leisure activities like bus excursions and parties were organized for the hypertension groups, while other afternoons were dedicated to health promotion activities, such as films followed by discussions; a number of conferences about blood pressure, aging and other health topics; and conscious-raising occupational therapy like the production of collages or paintings, some of which adorned the walls of the posto. Because of the importance given to self-esteem, group members were encouraged to attend the nearby State University of Rio de Janeiro, which had a Third Age University where some of the older women in the program learned how to read and write.

In 2010, the Brazilian Ministry of Health reported that 63% of the elderly suffer from hypertension (versus 24% of the adult population), with Rio de Janeiro leading the country's number of cases (Formenti 2010; Camarano 2002, 67).[11] Although not exclusively found within the elderly, hypertension can be conceived as a disease of aging. This is because there is a common notion that in most environments, blood pressure – both systolic and diastolic – generally increases up to age 60,[12] which, after the National Institute of Aging (2010) is due to a number of risk factors of which only some (when they are lifestyle-related) can be targeted by public health campaigns.[8]

The intersection of the "spatial" with the "biological" is especially apparent in hypertension studies, which report a higher prevalence of hypertension in lower-income groups compared to higher-income groups (e.g. Grotto, Huerta and Sharabi 2008). And since people generally gather together in places which are indicative of their economic situation – although there are exceptions to this – hypertension (as obesity and several other illnesses which are highly context-dependent) can be transformed into maps mirroring the interaction between poorer neighbourhoods and cardiovascular health (see the maps published by the Brazilian Institute for Geography and Statistics [IBGE 2009] showing the distribution of Brazilian seniors and several health-related issues). The apparent simplicity of this correlation, that can become an ecological fallacy - is being disturbed by studies that found no clear geographical relation between socioeconomic factors and the distribution of hypertension. For the Brazilian context, for example, a study by Campos et al. (2009) about seniors living in the medium-sized city Botucatu, in the state of São Paulo, shows that although the distribution of socioeconomic status and living area can be mapped as a direct correlation, the distribution of hypertension (and diabetes) could not. The authors think that the senior population in the city of Botucatu is much more homogeneous regarding lifestyle and ethnic origin than the socioeconomic differences seem to suggest.

The social sciences and the medical literature in the 1980s and 1990s, sometimes termed chronic health conditions such as hypertension as "diseases of civilization," linking them to specific ('industrialized') sites (e.g. Trowell and Burkitt 1981). James et al. (1991), for instance, noted that the Yanonami and other native Brazilian groups did not show the elevation of blood pressure with age found in many studies on industrialized places. And when these groups live in closer contact with more "mainstream" Brazilian culture, their mean blood pressure is significantly higher compared to those groups who live in more remote areas. This "native" phenomenon is a common finding in studies of indigenous groups around the world (e.g. Frohlich 1995; Rowe and Kahn 1998, 35f.). The explanation provided is generally a combination of genetic factors, diet (less salt and fat in native diets) and the common association of a less stressful life when compared to urban settings (e.g., Dressler 2004, Dressler et al. 1987, Kusuma et al. 2004, Steffens et al. 2006), which is of course a generalization that does not apply to all indigenous groups.[14] While these risk factors certainly play a certain role in the wider phenomenon of hypertension, reducing them to civilization-blaming "…still exercises a strong Romantic hold", remarked Roy Porter (1997, 599). He suggests that one looks critically at any such claim, because

> …with the spread of health education, with enlightened eating habits, …, it appears likely that today's so-called diseases of civilization are not in any straightforward sense the products of affluence, but rather diseases disproportionately afflicting the less privileged members of advanced societies" (Porter 1997, 598; see also Roelcke 1999, esp. chapters 1 and 6; Littlewood 2002, 74-93).

Another recurring theme in hypertension studies is the connection between race, ethnicity (sometimes including racial genetics) and hypertension. For example, a number

of studies show that African Americans have an earlier onset, a higher prevalence and more severe hypertension compared to non-Hispanic Whites (e.g., Kurdian and Cardarelli 2007). This generally accepted correlation is criticized by Thorpe Jr. et al. (2008, 1610) who conclude that the "socio-environmental context plays a substantial role in producing race disparities. ... Given similar socioeconomic status and similar socio-environmental conditions ethnic disparities in hypertension prevalence are substantially lessened." Thorpe Jr. et al.'s study raises the question whether a place like a favela, where a majority of its inhabitants has a darker skin, should be targeted by public health campaigns, when the target should not be the ethnic individual, but the stressful (in the widest sense) environment.

A further argument is related to the general increase of hypertension around the world. Some authors call attention to the fact that recent classificatory changes have lead to a more inclusive understanding of hypertension in direct relation to the marketing of hypertension drugs, such as Diuril (Lakoff 2007, Timmermann 2008). It is possible to imagine that due to changing inclusion criteria, new hypertension-related groups at risk can be detected and risk factors become more generalized, less specific. Different from the concrete example of the women's narratives located in a stressful favela (and validated by the health professionals), stress as a risk factor in biomedical reasoning is generalized ("a stressful life"), while intervention and prevention are dis-located and highly individualized: the American Heart Organization, for example, recommends that individuals become more joyful.[15]

Risk talk

The regular hypertension group meetings were held in the afternoon. Once the small room with the wooden benches placed around the walls became available, group members entered and waited for the social worker or psychologist who would lead that particular session. This was the opportunity for informal chatting, gossip, and news. The women's conversation frequently steered to the risk factors of hypertension. The women discussed their food-related transgressions and compliances, (such as celebrations with their inevitable fatty and sweet dishes), the difficulties in maintaining a diet whereby one had to avoid cheaper and less nutritious food when money was never enough for the whole month, along with the violence on the hill.

> Dona Elza: Sometimes I eat things that I am not allowed to, just because I have nothing else.
>
> Dona Oneide: I eat everything because I have no shame (de sem-vergonhice). When there is, for instance, a wedding I eat everything I can. It's hard to resist.
>
> Dona Teresa: She (Dr. Maria) told me that I can eat *javali*, wild pig meat – but where the hell do I find javali?[16]

Dietary restrictions are difficult - but not impossible – to follow, although most inhabitants of a favela have a limited income. However, the women who visit the posto do consider favelas are sites of violence that directly influence their well-being.[17] As the following excerpt illustrates, the women's regular exposure to violence explains the impossibility of controlling hypertension, but also the significance of the health post where they, at least for a short period of time, participate in a non-violent world (no assault of the post has ever been reported).

> Dona Elza: After 8 p.m., to leave the house - only with faith and following God… We live through our faith. This group gives a lot of support to our egos.
>
> Social worker: Yes, to take the medication right is very important, but – [she points to the two sides of her head] – it's a lot of pressure, gente (folks)!
>
> Dona Cecilia: And the police throw some drugs into your house, just to be mean.[18] One word of them is 20 times more valid than ours. One has to close the windows. They think that everybody here is the same [a bandit]. Policemen are liars.
>
> Dona Teresa: [She tells us that her son was shot by the police or by a bandit that was dressed like a policeman, she was not sure]. Who to trust? There is no heart that can withstand all this. The bandits do not bother the inhabitants. (…) But the police. People are [their blood-] pressure. The nerves control the pressure, the heart beats.

Crime is only one of the many forms of violence, which cause suffering for these women. Gender issues, generational conflicts, and other family controversies are equally responsible for the stress[19] they linked to hypertension.

> Dona Teresa: One lives oppressed inside the house. With my husband there is no dialogue. With him, everything is through fighting [na marra] ....While my husband was still working, we lived well. He arrived in the afternoon, drank a little and stayed the rest of the evening in bed [she imitates a drunkard]. Didn't bother anybody. Now it's different. He observes me all the time.

Violence has become a banal event, to a certain degree, among younger generations, and this aggravates the women's suffering, who perceive this generation gap as a sign of the noxiousness of the times they live in.

> Dona Teresa: My granddaughter saw a child dying in the street and while grandma [herself] cried, granddaughter said that that was banal, 'Death is like that'. So my pressure was gone already. I pray to God. These young people are not afraid. I cannot lock my grandson in the house. He does not obey anymore.

Furthermore, the women perceived themselves as more vulnerable now than they were at younger age.

> Dona Elza: After 40, we become more emotional, the older one gets, the more it is the emotional form of hypertension. The world became a violent world. Before, there existed love, friendship.

The vulnerability of the aging body that provides less protection against a violent world, in the case of hypertension is being translated into a specific language of numerical relations.

Embodying risk and hypertension: living by the numbers

Although the women we worked with each had a different history, they identified themselves as 'hypertensives', creating a kind of biosociality (Rabinow 1996) that structured a great part of their life, in which the social and the biological were fundamentally intertwined. As 'hypertensives,' the women's entire lives were transformed into what Rayna Rapp (2000) calls "living by the numbers". Numbers helped articulate a great part of their identities and well-being. For instance, during the meetings, women frequently responded to greetings of "How are you" by scaling their degrees of hypertension with the degree of experienced violence: "Yesterday [after the shooting] I was 17:12, today I feel better, probably 14:10." In their everyday banter in the group, the degree of violence - whether domestic or on the hill - was directly related to the numbers indicating the degree of hypertension and for some, the higher the hill (where the poorer people lived), the higher the hypertension. The geographical attributes of the favela reflected the favela's built hierarchy as related to health. Accordingly, the physical and concrete materiality of the hill became central to our thinking early in our ethnographic research. At the beginning of the group sessions, we asked the participants to describe their social networks on the hill. Rather quickly, a pattern emerged with living areas located most high on the hill being related to the severity of one's hypertension. Generally speaking, poorer individuals lived high on the hill, while more well-off ones resided at the bottom. Violence is more accentuated higher on the hill, and the houses here, with their thinner walls, did not always offer suitable protection against the bullets, according to the women. "I think there are a few simple and exceptional examples in which the architectural means reproduce, with more or less emphasis, the social hierarchies," writes Foucault in Space, Knowledge, and Power (1984, 255).

The professionals at the health post made a similar link between violence close to their patient's living quarters and the degree of their hypertension. As Dr. Maria explained to us:

> …There are many problems. A new cycle of violence has just started. Only last week we had ten deaths on the hill. And I can tell you, when they come afterwards to check their blood pressure, it is high – when I hear the shooting, I know already – they will come and their pressure will be terribly high. I hear the machine guns and in front of my eyes I see numbers [indicating the blood pressure]. It's war…

For Dr. Maria – as for the women - it was clear that hypertension is to a large degree a symptom, an idiom of distress linked to violence. The distress was felt, measured and categorized through the bodies of the women who lived that particular favela.

There were also numerical, interpersonal adjustments. For instance, the very fact of being an older individual was perceived as numerical: the older a person, the more vulnerable she was to the violent environment and everyday worries (the "emotional" form of hypertension).

But being old also meant to have a certain power: for the older women, self-esteem as a means to citizenship had a specific currency. The women were very clear about the fact that money played a major role in their family relations. Since most elderly now receive a State pension (see e.g. Simões 2000), and because often younger family members were unemployed, the older individuals gain the status of the head of the family that they had lost due to their age in a country that values youth and the youthful body to a significant degree (e.g. Leibing 2001, Leibing and Collin 2013, Edmonds 2010).

As the excerpts above show, conversations revolved around two of the three main attitudes for a good hypertension management and the difficulty of avoiding certain foods and life's stress and strain when one is poor and lives in a violent environment. The third factor, hypertension medication, did not elicit much discussion. Because they were poor and part of the hypertension program, the women had free access to medications and therefore took them for granted. However, health professionals brought up issues of non-compliance by discussing how some women changed the dosages of their medicine according to their daily circumstances – taking higher doses in response to negative life events or special occasions with forbidden food, and maintaining or reducing their dose when they perceived their life to be uneventful.

Furthermore, hypertension medications are "prescribed by numbers" (cf. Greene 2007) – that is, prescribed by diagnosing illness on the basis of numerical deviations from a norm established by more or less neutral experts and now often treated on a preventive basis before any sign of illness has developed. At the same time, patients were self-dosing by numbers: since the dose of medication and severity of hypertension can both be measured and related to each other, the language of numbers and its apparent objectivity is self-evident.[20]

Another medication group, tranquilizers, were prescribed to one third of the women. Dr. Maria was aware of the profoundly troubling environment of the favela, but this did not translate to possible treatment options:

> Dr Maria: So there is the medication. They have to take care of what they eat; and self-esteem is also an important point. (...) Here, there is a lot of stress, what can one do? I try to give as few tranquilizers as possible. It is wrong to prescribe them to these people, but I often have no choice. It's either that or nothing. It is like [artificially] transforming the lion into a little mouse. And the groups help. The groups work like a valve and there is a lot of solidarity. The high stress level of modern life brings with it all these diseases. Stress is the biggest problem.

To a certain degree, treatments and the discourse of risk also undergird the need for more nuanced understanding regarding the medicalization of poverty. Borrowing the words of Nikolas Rose (2007): medicalization is not simply a "recoding of misery," but involves "delicate affiliations" between complex matters such as the politics of identity and the moral economics of inclusion. Dr Maria's statement that "[t]hese women have always been treated badly by the public health system. I try to really look at them, to touch them – that's important" demonstrates her awareness of her role in acknowledging the citizenship of individuals who, for a long time, were invisible in public discourse unless they were depicted in extreme or stereotyped manners: on the one hand, part of the violent image of a favela, the criminals with their negative media, or, on the other hand, part of the positive favela of famous samba dancers or singers or, close to the elections, as voters.

The mouse and the lion

Place is not always significant when talking about health and illness (although all practices related to health happen somewhere), yet I suggest that there are some forms of suffering which reveal the interconnectedness of place, the (aging) body, identity, and power, and may be understood as heterotopic illness.[21] I focus on counter-sites - taking Michel Foucault's reflections regarding heterotopias as an inspiration – because these spaces generally create tensions by by inverting what is taken for granted – something that is felt most acute by those who suffer from place-related distress. The concept of heterotopic illness helps to pose questions, which challenge one to go beyond too easy recipes of self-care.

Heterotopic illnesses, in this specific context, is critical of health promotion activities which reinforce the moral economy of neoliberal thinking by valorizing self-care. When illness is linked to place, hypertension is no longer

an illness/disease that can be centred on the individual. Accordingly, the hypertensive bodies of the older women discussed in this article form the basis for articulating a citizenship based on a place-linked identity - a mix of the favelado, the hypertensive, and the old as shared by all of them.

Nevertheless, Dr Maria continues to prescribe tranquilizers, and the question of how exactly the "lion can be transformed into a mouse" remains unanswered. While the concept of heterotopic illness does not prevent the practice of medicating social problems; it does help us better understand how using mouse-traps (here meaning all interventions ignoring heterotopias) – while useful for catching mice – are an inadequate solution for fighting the lion.

Notes

1. Like Foucault, I am using space, site, and place interchangeably in this paper, since in most cases it does not make sense to separate phenomenology and dimensions of place/space from each other. Many theoreticians distinguish among them. For example, Michel de Certeau defines space as the product of action and movement, while place implies stability (cf. Reynolds and Fitzpatrick 1999). Others define space as linked to the question of dimensions, while place is the lived space (e.g. Low 1996).

2. Heterotopia was first mentioned by Foucault in The Order of Things (1966). He rethought heterotopia in 1967, when he gave a lecture called "Des espaces d'autres" at the Cercle d'études architecturales in Paris. His discussion of heterotopia drew greater attention in English-language scholarship two years after his death in 1986, when his 1967 conference under the title of "Other Spaces" was published in the United States (Sohn 2008, Foucault 2005, Chlada 2005, 7-14). I have elsewhere applied the six principles through which Foucault analysed a heterotopia to a Brazilian favela (Leibing 2010). Because of the limited space of this article, I will just name them here: 1) heterotopias may be either based on crises or deviance; 2) the function of a heterotopia may change over time; 3) several spaces may be juxtaposed in a single heterotopia; 4) heterotopias are linked to 'slices of time'; 5) heterotopias have systems of opening and closing; and 6) they function in relation to all remaining space.

See also the critiques regarding heterotopias made by Lefebvre (1991, 3-4) and Giddens (1984, 145-161); see also Philo (2000).

3. Exclusion does not always have a negative connotation; it can be desired as in the case of exclusive spa sites or a university (comparable to Goffman's [1963] 'positive stigma'). As well, heterotopias are not necessarily spaces with a negative impact on individuals (as the most perfect heterotopia Foucault mentioned a ship), and such places can protect and enhance the well-being of its inhabitants or just have a neutral effect on people's health.

4. My reading of the text on heterotopia stems from Foucault (2005). For the quotes (the English translation) I used http://foucault.info/documents/heteroTopia/foucault.heteroTopia.en.html

5. We tried to find out about this curious fact. It seemed that the older women strongly stigmatized people who showed the symptoms of dementia. At the time of fieldwork two famous members of the community were suffering from dementia (it had been reported in the media), and by using these concrete examples it became clear that the symptoms were associated with unpredictability and madness, and some of the women strongly condemned the antisocial behavior of these individuals. The health professionals thought that there might be some older individuals on the hill who suffered from a dementia. However, they did not see those patients and did not know what happened to them. Their central health concern when treating their older clientele was hypertension.

6. There are many studies that link violence to hypertension (see, for instance the American Institute of Stress http://www.stress.org/) that I am unable to address here.

7. This notion dates back at least to the Bohemian journalist João do Rio (1881-1921).

8. A certain paradox exists, since the carnival is produced by « favelados », but the key roles are increasingly taken by starlets and mannequins. The authenticity stemming from popular culture rooted in a low-income community has been questioned by many since the official carnival has been rigidly pressed into the sambodromo, an open space made of concrete and separated from the public, and has become an investment that a poor community could never produce without sponsors (who, for many years, have been the powerful bosses of the illegal "animal lottery"; see Cavalcanti 2006).

9. The majority of the women we saw in these groups were Catholic. Although the new evangelic churches are now dominating low-income communities in Brazil (Arias 2004), many older individuals seem to stay committed to the Catholic church. The women's participation in Afro-Brazilian religions, such as Umbanda, was not discussed in the group sessions, although we did broach the subject.

10. All names used in this article are pseudonyms.

11. For the State of São Paulo Zaitune et al. (2006, 285) conclude: "Hypertension prevalence [in the elderly] was 51.8% (46.4% in men and 55.9% in women) and was higher among the elderly with less education (55.9%), immigrants from other States (60.2%), and the overweight or obese (57.2%)".

12. After age 60, the systolic pressure might still increase, but diastolic pressure tends to stabilize or decrease

13. The NIH (National Institute of Health 2010) lists the following risk factors associated with hypertension: 1. older age; 2. race/ethnicity; 3. overweight or obesity; 4. unhealthy lifestyle habits (salt, alcohol, not enough physical activity, smoking…); and 5. other risk factors (such as family history, long-lasting stress, and so on.).

14. Although limited to a journal with a specific scope – Psychosomatic Medicine – Engel (1998) showed that all articles that appeared on blood pressure between 1939 and 1997 talk about hypertension as reactive to the environment in which a person lives. We are not able to outline here or even mention all discussions regarding risk factors for hypertension, such as physical activity or genetic-environment interactions. See also Sapolsky (1992), who relates stress (and hierarchy) to the aging brain.

15. (see http://www.heart.org/HEARTORG/Conditions/HighBloodPressure/Prevention%20TreatmentofHighBloodPressure/Stress-and-Blood-Pressure_UCM_301883_Article.jsp). Conceptualizing hypertension as a heterotopic illness can resemble what some authors have called ´structural violence´. Many people living in low-income neighbourhoods such as the favela clearly suffer from what Farmer, Nizeye, and Keshavjee (2006, e449; emphasis in the original) explain as "arrangements [which] are structural because they are embedded in the political and economic organization of our social world; they are violent because they cause injury to people (typically, not those responsible for perpetuating such inequalities)." Heterotopic illness is not necessarily associated with victims. Good and bad, victim and masters, here and there are not predefined, but mingle and overlap. This way of perceiving social relations as related to counter-sites can avoid what Loïc Wacquant (2002) rightly condemns as "moralism" in some studies on low-income communities.

16. Dr Maria denied that she had recommended wild pig meat, but perhaps she had mentioned it as an example of a lower fat meat when compared to commercial pork. However, the example of 'javali' was well remembered by the group and was repeatedly referred to, becoming the symbol of the impossibility of respecting the nutritional prohibitions.

17. Anthropologist Cornelia Eckert (2002) shows how older women in Porto Alegre link their life histories to the city, and how violence and chaos influence the way the women's auto-biographies are constructed.

18. The negative image of the police cannot be deepened here (see Leibing 2001), but many studies have shown this (e.g. Gonçalves 2000, Antunes, Conti and Marqueiro 2000).

19. We adopt here the common meaning of stress to refer to any stressor that affects an individual's well-being. For a critical history of stress see, for instance, Viner (1999).

20. See Greene 2007: chapters 1 and 2 on hypertension medications as a 'therapeutic embrace'.

21. Although Foucault did not make an explicit link between heterotopias and health he must have known the medical term "heterotopia", which indicates the displacement of an organ or cells from normal positioning in the body (see Sohn 2008).

22. Brazilian social epidemiologist Cecilia Minayo (2006, 380) observes: "The greatest difficulty lies in convincing a sector deeply marked by biomedical reasoning to accept in its model and dynamics complex problems of social character and not diseases. Many times I ask myself: 'Does one die more when dying from AIDS or cancer than when dying from a traffic accident or murder?'"

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Aging, Gender and Sexuality in Brazilian Society

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Abstract

Drawing on the interplay between gender, aging, and sexuality, the aim of this article is twofold: (1) to show how Brazilian gerontologists treat gender differences and sexual activity in old age; (2) to analyze the ways discourses regarding the aging body and sexuality are perceived and evaluated by older women and men . I argue that attempts of gerontologists' to eroticize old age have to contend with the widespread notion that the desire for sex is inevitably lost with age. Thus, in the retiree associations that were studied, men had a tendency to assume they are not 'old' because their erectile function was still in good condition, and divorced or widowed women, in senior citizen associations, tend to regard themselves as happy due to having freed themselves from the sexual obligations imposed by marriage. In both cases, the dominant belief that there is a loss of sexual desire in old age was reproduced.

Keywords*: sexuality, gender, aging, Brazilian gerontology, sexology*

Introduction

Is old age a developmental phase of degenitalization of the body when the two ideal bodily forms, two ideal morphologies-- the male and the female – should be dismissed? This question, inspired by the work of Judith Butler (1990, 2004), has guided my reading of the interplay of gender, aging and sexuality in texts produced by Brazilian gerontologists. These Brazilian gerontologists and sexologists argue that decreases in sexual activity in old age are, in fact, replaced by a unique and intense sexual pleasure, based not so much on genitals, but rather on a more holistic bodily experience. The aim of this article is to show how women in senior citizen clubs and men in retiree associations react to the discourses of these specialists.

Prescriptions by gerontologists and geriatricians for 'successful' aging in Brazil tend to eroticize old age, simultaneously reproducing a gender-based sexuality (Foucault 1990). One of the ideas they specifically promote is the degenitalization of male sexuality. That is, these experts insist on the importance for older men to explore new areas of their bodies to increase sexual pleasure, similar to the more diffuse notion of female sexuality. In the case of older women, sexual activity is often linked to the questioning of a restrictive moral code interconnected with male domination (Bourdieu 2001), which supposedly forms the basis of their sexual learning. Older women are stimulated by these professionals to delink the practice of sex from their partner's desires, and instead to focus on

their own. This suggests that old age also brings with it the possible freedom from concerns over children, as well as from judgments of society. Thus, aging can create a space for women to actively engage in their sexual interests, openly assuming their interest in sex.

The pervasive dogma that guided studies in gerontology starting at the beginning of the 20th century considered aging to be a homogeneous experience, as the problems faced by the elderly were so similar, and prominent in the public sphere; consequently, differences of ethnicity, class, gender and religion were minimized. Some analysts assumed that the later stages of life would be characterized by androgyny. Gender roles would become less sharply defined: older men would begin to show increasingly more affective, nurturing tendencies, while older women became more independent and assertive than their younger counterparts (Gutmann 1987). Some researchers report that the traditional domestic division of labor into female and male tasks tends to diminish with age (Sinnott 1977; Arber and Ginn 1995); this convergence of gender roles is explained, by some researchers, as a product of hormonal changes (Gutmann 1987). Social roles, values and attitudes considered typically masculine or feminine tend to mix in old age. Or, aging involves a masculinization of women and feminization of men, so that gender differences would dissolve in the "unisex normality of old age" (McGee and Wells 1982; Marshall and Katz 2006).

A central part of my argument is that the efforts of gerontologists to eroticize old age contend with a double reaction: 1) sexual function promotion campaigns, particularly marketing by the pharmaceutical industry which have been widely disseminated through the Brazilian media in the last decade and which directly link sexuality to the erectile function; 2) the common Brazilian assumption that the decline in desire, loss of physical attractiveness and the virtual erasure of sexual identity are among the leading marks of old age. This view leads to a widespread disgust and fear of bodily degradation, along with the well-known positive evaluation of youth in Brazilian society. Interestingly, both of these tendencies reinforce each other, as the marketing campaigns coincide with these much older conceptions that characterize Brazilian culture along the axis of race, gender, and social class.

Methodologically, I juxtapose content analysis of texts produced by gerontologists with an ethnographic account that was undertaken in senior citizen clubs or third age programs which are primarily enrolling a female audience, and in retiree associations which are attended mostly by males.[1] I show how the elderly participating in these various contexts react to the Brazilian gerontological assumption that in old age the decrease in sexual activity is compensated by sexual pleasure of an amplified intensity. This article thus seeks to demonstrate the difficulties faced by gerontologists in promoting a gratifying sense of sexuality in old age, while operating within a complex culture that is dominated by a cult of youthfulness and corporal beauty in which old age is inextricably linked to a loss of libido.

The Third Age Programs and the Retiree Associations in Brazil

Third age programs[2] can be understood as leading a fight for cultural change in the sense that they struggle against prejudices and stereotypes and celebrate the elderly and the aging process. Within this context, older adulthood is considered a privileged moment in life and one where one's personal fulfillment, satisfaction and pleasure are in full swing and are experienced in a more mature and fruitful way.

Participation in programs for the third age is quite insignificant when we take into account the Brazilian population of elderly women as a whole, just as male participation in the associations is modest when compared to the total number of retired people in the country. In 2013, Brazil had 201,032,714 inhabitants. The population over sixty was 24.85 million (12.6% of the total), the great majority of whom live in urban areas (20.94 million). Of these, 13.45 million are women (The Brazilian Institute of Geography and StatisticsIBGE 2013). However, the proliferation of general ideas from these third age programs cannot be underestimated, and they continue to reach a wider population through dissemination in the media.

The women I interviewed showed enthusiasm about the recent changes in the experience of aging in Brazilian society. They stress that, unlike their mothers

and grandmothers, they no longer have to wear black or stay at home waiting for the children and grandchildren to visit. They believe they are enjoying unprecedented liberty when compared to the elderly of the past, and furthermore, that they have more freedom than younger women. Their participation in third age programs is an expression of this and an opportunity for these women to engage in motivational activities, expand their group of friends and their repertoire of skills, and explore new identities and lifestyles.

When asked what they understood by the expression "third age," the women enrolled in the University of the Third Age in Campinas, São Paulo State replied:

> I find the third age to be an innovation, the best thing possible for the elderly, because it leaves us in total freedom. You know, it's a great pleasure.
>
> I felt that, despite my age, I could still be someone, still a soldier in battle.
>
> For me, the third age is a beginning, there must be some better things there for me that I don't know and need to know. Life is an experience that is renewed every day.

Dona Lázara, a 62-year-old seamstress who participated in a recreational group for the third age engaging in dance, singing, and yoga, can be considered an embodiment of the way these new images of aging are promoted. She made the following comment:

> My big transformation began when my daughter gave me an unexpected gift: she signed me up for a workshop on dance and corporal expression. I was 49 years old and had never worn shorts. In the first classes, I felt ridiculous, old, and awkward. I continued and my mind opened – it opened to the world. I lost weight and began to feel alive.

These feelings were very common among participants in third age programs.[3] They clearly show that well-being, as defined by these women, is not dependent on references to an active sexual life.

The women had difficulty in explaining the lack of male participation in the program. The men themselves, who comprised a small part of these third age programs, were the ones more concerned with pointing out the role of women and in explaining the lack of male participation. As some of the men said:

> Men are more proud. They don't want to give in to those who know more. It seems that the world is now turning to the side of women. We have to give way to those who have it by right.
>
> Women are getting much more involved in everything. After women's liberation, things have changed and I think it's better.
>
> I don't know whether men are more inhibited, or they think that they're better. (They are) Machos who think they know it all, but they don't know what they're missing.

In the retiree associations,[4] men were less optimistic about social change. They claimed that young people no longer respected the elderly, which consequently undermined their status. They challenged stereotypes related to aging by criticizing governments, politicians and the media, demonstrating their mental agility and lucidity. Many were critical of the third age programs, denigrated by some as the "playground of the old," which diverted retirees and pensioners from their real interests and their true consciousness. These men considered the exploration of new identities and the intense experience of leisure activities offered by third age programs as a form of infantilization of citizens, a kind of denial of masculinity. These views help to explain the lack of men in these programs. As a colleague of mine studying masculinity noted: "men suppress their emotions so they can play the role expected of them in our society: provider, protector, and creator." To the elderly in third age programs this masculine ethos is denied, and instead, they are encouraged to view old age as a time to rethink life, remake projects, and develop new relationships.

Women are excited about the changes associated with aging experiences and men are vividly concerned to protect and improve retiree's rights. However, they both react to gerontologists' attempts to eroticize old age, as shown below.

Sexology and Gerontology

Sexology is the scientific study of sexual interests, behavior, and function. As a clinical discipline, its therapeutic strategy includes the use of medicines and other interventions, such as educational techniques of behavior modeling, and use of the body in order to promote a better functioning sex life. For the elderly the goal, in most cases, is to "maximize" or "optimize" their sexual activity.

The new generation of Brazilian gerontologists are eager to emphasize the advantages brought by the aging process. Inspired by international gerontology (Katz and Marshall 2003), this new generation opposes the more traditional Brazilian gerontology that characterized old age as a state of physical decline and loss of social roles. When addressing aging and sexuality this generation enthusiastically adheres to the assumptions and empirical tradition of sexology, and further, they promote active sexuality (narrowly defined in terms of heterosexual intercourse) as a signal indicator of positive and successful aging (Brigeiro 2000).

Additionally, a statement on the nature of sexuality in old age commonly accompanies this generation's new commitment to reconceptualizing old age. Despite the decrease in its frequency, which is acknowledged empirically, these gerontologists emphasize that sexuality can be expressed in a myriad of ways other than sexual intercourse. A book, published by the University of the Third Age at the Catholic University of Campinas, written by Sá (1991: 20), concisely summarizes this new vision of the advantages of old age:

> Passions and lust are replaced by more refined pleasures. The sexual issue is resized in the sense of love, warmth, sharing, touch of intimacy between people.

Gerontologists challenge assumptions of older people as asexual beings by proposing a reversal in the conventional depictions of female versus male sexuality in old age, or by uncoupling genitalia from sexuality. Old age seems to give rise to a new phase in the course of one's sex life; this assumption can be verified not only in the discursive reiteration of the prolongation of sexuality, but also in the description of the sexual problems faced by men and women in old age – as well as in the specific technologies produced as part of the solution. The advice regarding therapy and sex education, for example, suggests a shift of sexuality from the genital area to diverse "erogenous zones" of the body. This amplification is of such an order that there is no part of the elderly person's body that is not a potential source of pleasure. Consequently, there is a transcendence of the very notion of 'zone' from that of the specialists' understanding, to one where there are no limits or demarcations. This shift is very well illustrated by the words of psychoanalyst Sueli Souza dos Santos, whose book about sexuality and love in old age has inspired a reflection amongst professors and coordinators of third age programs.

> Recovery of an elderly person's right to a sex life implies being able to think of love in its forms of libidinal transformation, that is, other forms of love, including tenderness, physical contact that eroticize the body, such as looks, touch, the voice, rediscovering the human being's first forms of love. (…) With aging, when the organic functions suffer loss of sexual performance, the libido(...) returns on its investment in other areas of the body, marked in the first experiences, returning to the pleasure found in other erogenous forms, such as touch, looks, the delicateness of all the sensibility. (...) It is the prejudices that make one think that the so-called andropause in men and the menopause in women are responsible for sexual difficulties. Hormone loss modifies the mechanism and frequency of erection, and also alters vaginal lubrication, thus hindering coitus. This seems to decree that penetration is the only pleasure-producing source and that the absence or difficulties in these functions incapacitate the elderly person as a sexual being (...), what interferes in his/her sex life is of a psychological and social order (Santos 2003:22-30).

In the literature analyzed, this amplification of the erogenous or pleasure zones often appears through the accounts given by the elderly themselves. However, it is above all the specialists who advise or prescribe a new sexuality. In words loaded with humor, the social psychologist, José Carlos Ferrigno – who for more than a decade, coordinated the programs conducted for the third age in SESC (Serviço Social do Comércio) in São Paulo – observes that degenitilization seems to be especially associated with men.

> [Elderly men and women] They report a different experience with their own bodies, the partner's body, and in the relationship itself. No longer is there preeminence of the 'big bang' of the orgasm, no longer principally among men, erotic sensations concentrated only in the genitals, but rather full eroticization of the entire epidermis, sex throughout the entire body and permeating the whole spirit. Sex without haste. No longer is it the 'hamburger with chips' greedily devoured during youth, but rather a dish carefully prepared and delicately savored. (Ferrigno 1988: 16).

Women are generally encouraged by gerontologists to assume their interest in sex; in the process, all associations that limit their experimentation are disrupted – be it subordination to the will of the male partner, or concerns regarding children or other family members and society

in general. For men, Ferrigno proposes that they discover different parts of their bodies to experiment with sexually, thus making their corporal sexuality more diffuse, an aspect normally attributed to women.

This insistence by gerontologists and sexologists that sexuality among the elderly encompass far more than genital-based pleasure as it includes multiple "erogenous zones" of the body is contradicted by the messages put forth by powerful actors in the marketplace, such as the pharmaceutical industry, which persists in overstating the importance of genital based pleasure, subsequently reducing male sexuality to erectile function. In this way, the drug Viagra, which has been popularized worldwide, transforms impotence into the medical condition of "erectile dysfunction", thereby challenging the social and psychological factors related to aging (Brigeiro and Maksud 2009; Bozon 2004).

One of the difficulties in the study of sexuality, as shown by Luiz Fernando Dias Duarte (2004), is the tension between, on the one hand, "an incitement to talk about sex" (Foucault 1990), and on the other, a movement that renounces this talk or even reflection on the theme, given the correlation between sexuality, intimacy and privacy. This tension leads to a separation between two levels of experience: a sensorial pleasure of sex (termed sensual) and a sentimental affective pleasure (corresponding in our culture to the ideology of love). It is appropriate to establish a correlation between the sensual and the male, and between the affective and the female. This correlation tends to be redesigned and inverted when one thinks of sexuality and old age. Psychoanalyst Otto F. Kernberg, professor of psychiatry at Weill Cornell Medical College, draws upon his clinical experience to demonstrate the inversion of supposedly male and female sexual traits that occurs in old age:

> In the light of the observations of love relations of older couples, I suggest that this development continues into old age, with surprising role reversal. Men falling in love and establishing a passionate love relationship at late stages of their lives frequently have the exhilarating experience that their intense love for a woman transcends their erotic desire in new ways, so that love becomes the bridge to sexual intimacy. In their fusion with the woman they desire, they experience a sense of total security and certainty about their love and an overwhelming gratification at having found the love object of their lives. Love, it would seem, becomes a means for the achievement of erotic desire, replicating, we might say, the early maturational characteristics of younger women. Women who fall in love in later stages of their lives, on the contrary, experience a freedom of sexual desire that becomes the bridge to love for the men they have found. One male patient in his sixties said jokingly to his new girlfriend: "I fear, at times, that you are only treating me as a sexual object and that my feelings and personality are of no relevance to you (Kernberg 2001: 183-184).

Kernberg was president of the International Psychoanalytical Association from 1997 to 2001. He was in Brazil on numerous occasions and is widely respected among Brazilian psychoanalysts. However, his enthusiasm with the potentialities of sexual life in old age does not seem to have reached the representations that most elderly men and women have about sexuality.

The Obligation of Having Sex

A survey carried out by Datafolha, one of the most important Brazilian survey agencies, in November 2008, interviewed 1,238 respondents aged 60 or over in different Brazilian cities. Seventy eight percent of the male respondents declared having a normal sex life, and one quarter said they had sex once a week. Twenty four percent of the female respondents aged 60 or over declared they were still having sex.

The claim made by gerontologists that sex life does not cease with old age was manifested in the views of the married women, but this was contradicted in the views of the unmarried women in the third age program I researched. Among the elderly, topics of sex generated jokes and much laughter. Expressions like: "Heaven forbid! Get a boyfriend now at 65!" caused enthusiastic agreement among them. Among married women, sex and love were indissolubly linked; personal statements by the women reflected notions of the advantages of sexuality in old age, as it is espoused by program conferences and lectures given by the coordinators of the group. In the words of a married woman whom I interviewed after a conference on aging and sexuality at the Catholic University of Campinas in 2011: "I find it much better now without all the overexcitement-- less quantity and more quality"; "true love between two persons at our age is much more beautiful, it's fantastic..." and "at

this stage, there are no worries, it's much better, more tranquil". These considerations – which are quite in line with the gerontological discourse – were rejected by most unmarried, separated or widowed women whom I interviewed in the same third age program. These women mocked the supposed advantages of sexuality in old age which were affirmed by both the coordinators and the married participants in the program.

Unmarried women didn't miss an opportunity to show how husbands imposed work on their wives, citing duties such as, "providing meals," "dealing with the laundry,"and being "always willing and in a good mood". In their view, sex was just one more marital obligation from which widowed and divorced women are relieved. In this sense, they vehemently expressed how male dominance has had a specific configuration on their lives, including their sexuality. It should be noted that being free from marital obligations did not lead to a negligence of their physical appearance. On the contrary, the women interviewed show great concern for their physical appearance, but these beauty concerns were not necessarily linked to sexual activity or sexual seduction:

> I want to be beautiful, but we know that our bodies are no longer the same. So, what to do about it?", asked one of the women after the conference regarding old age and sexuality; lowering her hands in front of her breasts as if she wanted to show that these parts of the body inevitably droop, she continued, "men are only interested in older women when they need someone to do their housework.

The senior men in the associations of retirees seemed to wholeheartedly agree with the discourse of pharmaceutical marketers: they valued sexual expertise and their performance was strongly determined by expectations for intercourse, depending on their erectile capacity. They all reported an interest in maintaining an active sex life, but did not seem overly influenced by the gerontological discourse that sexuality is broader than genital-based pleasure. Most of them stated that their sex lives were currently limited to the marital context.

Arthur, who at the time of the interview was 72 years old and who had been the director of a retiree association, made the following statement, very common among those interviewed:

> It is not the same as when I was 30. The liveliness and the rhythm are not the same (…) but I am always up for it, I never lost interest. I have been married for 40 years now. That initial enthusiasm softens a bit, there is a tiredness that is natural, but the love never ends (…). We need sex to live (…) it does us a lot of good.

It is difficult for a female researcher to talk about sex with older men. They prefer to talk about national and international politics and make criticisms of those retirees who have a hard time supporting their families and maintaining decent living standards. It is mainly through jokes, never told in the presence of a woman, that these men express the importance of sexuality in their lives. These jokes, which discuss the erectile difficulties of elderly men, were told under one's breath, and were heard by my male research assistant . :

> After 30 years of marriage, a couple was having sexual difficulties. They decide to consult with a specialist, who says: "Many couples like you have solved their issues with a prosthetic penis."
>
> The husband asks: "Really? And how much does it cost?"
>
> "I charge 30,000 Reals for a small size prosthesis, 40,000 for a mid-size, and 50,000 for a large-size new penis."
>
> The husband turns to his wife: "What do you think, honey?"
>
> The wife thinks for a minute, then says: "Well, if I'm going to spend 50,000, I'd prefer to redecorate my kitchen."

Another joke similarly makes fun of the assumed inactive sexual life of the elderly:

> Two elderly men are speaking:
>
> -"Do you prefer sex or Christmas?"
>
> "Sex, of course! Christmas happens every year, I get bored of it.

Through playful performances, jokes, and funny stories, men express the importance of sexuality in their lives, which is divergent from the notion of a reconceptualized sex life proposed by gerontologists. For men in this study, the importance of sexuality is linked to traditional values of masculinity and to a resistance towards old age, which is assumed to be a phase of life with diminished lucidity, less self-control and the loss of a rewarding sexual life. In short, they validated the negative stereotyping of the elderly in Brazil. Most of the women I interviewed, on the

other hand, assumed that a rewarding aging experience was independent of a gratifying sex life. For them, the aging body cannot be seen as an object of sexual desire, and they consider that only elderly women who have lost their lucidity can imagine having an active sex life. Thus, the elderly respondents in my research did not reproduce the arguments put forth by gerontologists and sexologists pertaining to the broader, more corporal nature of human sexuality. On the contrary, they articulated a proliferation of divisions, thus creating greater differences among themselves.

This article discussed how transnational discourses take on specific articulations in local contexts and how specific groups react to these discourses. In Brazil, a country where the cult of beauty, youth and sexuality is seen as one of its most prominent cultural characteristics, sexual function has become central to contemporary gerontological conceptions of well-being, the good life and happiness in old age. Our interest in the subjective accounts of older adults pointed to ways in which old age can be negated by older men, alleging that their erectile function is in good form, or that old age can be conceived by some women as one of the best moments in their lives because they have been exempted from the obligations of sex.

Notes

1. Research funded by the Fundação de Amparo a Pesquisa do Estado de São Paulo (FAPESP) and by the Conselho Nacional do Desenvolvimento Científico e Tecnológico (CNPQ).

2. About the emergence of the category "third age" see Laslett (1987); on new images of old age see Featherstone and Hepworth (1989) and Featherstone (1992).

3. On womens' positive view of third age see the comparative study by Cachioni (2003) on third-age universities in different regions of the country; Debert (1999) on third age programs in São Paulo; and Cabral (2002) on third age programs in Paraíba State; Motta (1998) study on a group of lower class elderly in Porto Alegre, Rio Grande do Sul State; and Motta's (2001) study on forms of sociability among the elderly in Bahia State. Studies on the subject can be found in the volume edited by Barros (1998) and by Goldenberg (2002).

4. It is possible to identify four types of retired peoples' associations: (1) associations connected to state companies that have their own welfare funds, offering their workers supplementary retirement benefits and a series of other advantages; (2) labor union associations that bring together the retired of the professional category they represent; (3) eclectic associations that gather people of different professional categories; (4) associations born of political interests. These are ineffective and short-lived associations, generally organized at election time through candidates' initiatives or campaigners seeking votes. On the different types of associations of retirees, see Simões (1996).

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Surgery-for-Life: Aging, Sexual Fitness and Self-Management in Brazil

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Abstract

This article draws on ethnographic fieldwork on plastic surgery to explore tensions in aging norms and ideals for women in Brazil. I situate my analysis in relation to debates about a "de-chronologized life course." Some scholars argue that the life course in late capitalism has become less standardized. In this account, chronological age diminishes in importance as consumers are defined by life style choices available to all ages and the period of youth extends into middle age and beyond. In Brazil consumers embrace plastic surgery as a means to "manage" aging, mental wellbeing, and reproductive and sexual health. This promise of a flexible and optimized aging trajectory seems to echo the notion of a de-chronologized life course. I argue, however, that medical discourse and patients' accounts show ambivalence about aging and conflicts in the ideal of medically-managed sexual fitness for women. Drawing on analysis of changes in family structure and women's health regimes, I argue that passage through the life course, rather than becoming more flexible, is in some ways becoming more rigidly defined by biological processes.

Keywords: Aging, plastic surgery, de-chronologized life course, sexual fitness, self-management,

Introduction

> Nelson [Rodriguez, the playwright] said to me, 'Tatiana, only assholes age. Everyone else becomes wiser.' This is very true. If you are super happy, have an active life, and a wrinkle bothers you, why not do something about it? That's different than having plástica out of bitterness. Aging is not cool.
>
> -- Tatiana, Brazilian plastic surgery patient

Such a breezy acceptance of "*plástica*" has become common in Brazil as the country experiences a boom in cosmetic surgery. Tatiana's comment that "aging is not cool" also points to new ideals of aging that have been popularized in industrialized societies since the 1980s. The terms "successful aging," "new age," and "third age" reflect an optimistic view of aging as a process that can be managed to maintain not just physical health but also mental wellbeing, social engagement, and sexual fitness. This vision of aging has been described as an inspiring ideal that enables the elderly to counteract social isolation -- but also as an ideology that masks structural changes in the life course in late capitalism, not all of which are positive. In this article I draw on ethnographic fieldwork on plastic surgery to explore tensions in ideals and norms of aging in Brazil.

I situate this analysis theoretically in relation to a debate in gerontology about the "de-chronologization" of the life

course. Scholars have argued that passage through the life course in late or post-Fordist capitalism has become less standardized (Debert 2011, Macmillan 2005, Moody 1993). The thesis of a "de-chronologized life course" builds on research analyzing historical changes in the life course in western societies (Brückner and Mayer 2005, Kohli 2007, Held 1986). In the transition from a pre-modern to modern period the life course became more standardized, or in the expression of Kohli and Meyer (1986), there was a "chronologization of life." This was a multidimensional transformation in the structures and experiences of aging. Mass education and an industrial labor market divided the life course into distinct phases: student, worker, pensioner. Identity became less defined by family position than by rights and duties specified by the state.

The modern life course, some argue, has now been superseded by a "postmodern life course" in "which chronological age loses its relevance" (Featherstone and Hepworth 1991, Debert 2011, 6). Periods of work, leisure and education become intertwined as workers adjust to a dynamic labor market. The consumer is defined more by lifestyle choices available to all ages than by an aged-defined role in the productive order. Sexual norms have become less linked to age with the rise of serial monogamy and divorced men and women who date in middle and old age (Bruckner and Mayer 2005). Youth extends into middle age, middle age blurs into old age.

In this article I analyze the thesis of a "postmodern," de-chronologized life course in light of the experiences of Brazilian plastic surgery patients. Consumers from a broad socioeconomic spectrum embrace plástica as a means to manage psychological and women's health. Some patients view it as a way to correct aesthetic damage attributed to childbirth, breastfeeding and menopause. Other women say it enables them to "look as young as they feel," manage sexual relationships, and maintain a youthful lifestyle throughout their lives. Plastic surgery's promise of a flexible and optimized aging trajectory seems to reflect the notion of a de-chronologized life course. One problem with the term "postmodern life course," however, is that it mirrors the ideal of successful aging that is promoted by the anti-aging industry. While plástica generally has a "sex positive" discourse, a closer look at medical practices shows major tensions in new aging and sexual norms.

A rich literature in symbolic anthropology has explored how initiations, marriage ceremonies, funerals and other rites of passage "move" individuals and groups through life stages in ways that culturallly meaningful. In Brazil and other industrialized countries there are of course many such rites and ceremonies, often with Christian roots but distinctly secular expression: such as the 15th birthday party, weddings, baby showers, and increasingly since it was legalized in 1976, divorce. The experience of passage through the life cycle, however, I argue is becoming mediated by medical practices that are used to manage women's reproductive and sexual health. I analyze how plastic surgery contributes to a biologized experience of aging that radically reduces the social persona to a sexual, reproductive and aging body defined in physiological terms.

This article explores the dialectic between the erasure of biological aging and its inscription on the body. I discuss how plástica addresses an "aging subject" made responsible for managing psychological health and well being through aesthetic and therapeutic techniques. But while this medical practice seems to promise an extension of youth into middle age and beyond, it also makes the "problem of aging" start early in life as younger patients plan "preventive surgeries." While it inspires affects like hope and happiness, aging continues to provoke anxiety and disgust. Plastic surgery is not just a means of self-management, but a way to manage sexual relationships as family structures change. Some women see themselves as competing in a market where youth is sexual capital that continually loses value. In this medical and social context passage through the life course, rather than becoming more flexible, is in some ways becoming more rigidly defined by biological processes.

Plástica, Rejuvenation and the "Mask Of Aging"

Brazil is the world's second biggest cosmetic surgery market (after the US). Mainstream news media, telenovelas, blogs, and entertainment magazines widely endorse plástica and present it as a routine consumer service. In the private sector cosmetic surgery became more available to a growing middle class after the stabilization of inflation in the 1990s. Remarkably, plástica has also come within reach of patients from across the socioeconomic spectrum. Credit

plans allow patients to make small monthly payments and some are marketed to "maids and secretaries" (the latter are often paid a very low, subsistence wage). Some hospitals in the ailing public health system also offer free cosmetic operations.[1] While the SUS (public health care system) did not directly authorize comsetic surgeries (except for a few procedures), chief surgeons in some hospitals were able to successfully argue that residents-in-surgery need training in cosmetic techniques. Some doctors also maintain that both reconstructive and cosmetic surgeries are a powerful means of psychological healing and thus should be offered to what they call the *povão*, the "common people." Surgeons from Latin America, Europe and elsewhere come to train in these residency programs where long lines of patients provide opportunities for intensive practice.[2]

I undertook ethnographic fieldwork in plastic surgery clinics, interviewed surgeons and patients from a range of socioeconomic backgrounds, and researched sites that play a central role in the production and consumption of beauty, such as television studios and advertising agencies. This research was conducted primarily in Rio de Janeiro intermittently for approximately two years. I have given a fuller ethnographic account of this fieldwork and the lives of patients and surgeons (see Edmonds 2009, 2010). Here I explore what plastic surgery reveals about changing aging and sexual norms in Brazil.

Many operations are seen to "work" on the aging body. Surgeons present facelifts and eyelid surgery as "rejuvenation" – even if a few doctors are critical of this promise. One senior surgeon became so exasperated by patients with "unrealistic demands" that he complained: "If I operate on a woman who is old and ugly, she is going to continue old and ugly, but with her skin stretched. 'How many years am I going to rejuvenate, doctor?' they ask me. And I say, 'I'm not going to operate on your heart, operate on your liver, I'm not going to operate on anything, I'm going to stretch the skin of your face!'" Operations performed on the body are also seen to counter aging effects. Abdominoplasty, breast and buttocks lifts, liposuction, and genital surgeries "correct" changes blamed on childbirth, breast feeding or menopause, and thus "reverse the clock" – a frequent metaphor used to describe plástica's effects. A few surgeries are motivated primarily by dissatisfaction with the size or shape of a body part, and are thus not directly linked to aging (such as rhinoplasty or some kinds of breast surgery). But even breast surgery -- both enlargement and reduction procedures -- often aims to project the breast and counter perceived effects of aging. The goals of aesthetic improvement and rejuvenation are also intertwined since women's beauty norms strongly stress youthfulness.

Surgeons and patients view the rejuvenating effects of plástica as a powerful means of improving psychological well being. A key term in medical discourse and patients' testimonials is *auto-estima* ("self-esteem"). Regardless of whether patients said they had "good" or "bad" auto-estima, they saw plástica as a legimate means to boost it. One woman I met in a public hospital said simply: "It's psychological. I think that for any woman who does plástica these days, it's more psychological than anything." While patients gave different reasons for "low self-esteem," many said they felt their outer appearance did not match their sense of self. Glaucia was as comfortable discussing plastic surgery as Lacananian psychoanalysis. In her early 50s, she has two adult children and a *namorado* (boyfriend). She described the effects of her multiple operations: "The moment you see that you're young again is really good, because in reality the spirit of a person does not age. What ages is the shell (*caraça*), nê? If you have a young spirit and have those aging problems, it's terrible. I'm young, I'm a girl (garota)."

Similarly, Lídia, a middle-aged facelift patient, said:

> Every time that I got up and looked at myself in the mirror I had this desire [for surgery] because I said, "It's not possible. Ah, to wake up with this face, I don't want to wake up anymore, no." [laughs] Because when I put on make-up everything's more . . . but it's the moment when you wake up, nê?

For Lídia a facelift did not reflect a desire to "be someone else," but to "look like herself."

In Freud's (2003) account, recognizing oneself in what at first seems to be a strange image in a mirror or photograph elicits an "uncanny" feeling. This uncanny double recalls Lídia's experience of not recognizing herself in the mirror, as if the aged face confronting her was both familiar and monstrously unfamiliar. For some patients their "naturally" aged appearance can seem more foreign to them than an "artificially" enhanced one. One critique of plastic surgery is that it distorts identity or causes self-alienation. But for many patients aging itself is a form of self-alienation, which plástica can correct.

For some women aging not only creates a gap between an ageless self and an aged body, but also pushes them into a new social role that they reject. Tatiana said that already in her 50s she was being called "minha senhora," a more formal form of address:

> There are men with white hair, for example, with the biggest charm, but women . . . they already become "minha senhora." This is crazy. Women they develop earlier. This is something genetic . . . Women become sort of matronly, they get fatter, here [in Brazil]. At 13 years old they're already menstruating, with a woman's body . . . Because women are the generators of life, they have a hormonal factor, a different physical formation.

While she acknowledges a social double standard for men and women, her account of women's aging stresses biological differences (genetics, menstruation, reproduction, hormones), which in turn require more medical management.

Medical discourse sometimes stresses that historical changes have made aging a more problematic domain of psychosocial life. Dr. Barretto argues that medical progress expanded the life span from 35 years a century ago to between 80 and 90 today, which in turn has caused a "disequilibrium" between the mind and body. Plástica can correct this historically "new" problem: "It's more than normal to try to make the physical organism fit our interior youth, which is becoming more and more prolonged" (Plástica & Beleza, May/June 1999, 203). Plástica is often presented as a new technology that enables women to negotiate the specific challenges presented by contemporary life.

This medical discourse recalls the representation of experiences of aging in "postmodern" societies made by some scholars. Featherstone and Hepworth (1991) describe a "mask of aging," a kind of self-alienation where the inwardly young consumer ceases to identify with an outwardly aged appearance. Similarly, Katz and Marshall (2003) discuss how new aging ideals address a "timeless" consumer who is trapped in an aging body (Katz and Marshall 2003). Plastic surgery could be said to reflect aspirations for a more "plastic" sense of identity not defined or limited by processes of biological aging. In the next sections I explore tensions in this psychotherapeutic project. I first discuss the social forces that address an "aging subject" made responsible for maintaining a state of pyschological, reproductive and sexual health with a focus on aesthetics.

The Psychological Subject of Anti-Aging Medicine

Brazil's rise to "empire of the scalpel," as a news magazine boasted, coincided with larger changes in social constructions of aging in Brazil beginning in the 1980s. Imported from abroad, the terms "third age" (terceira idade) and later "successful aging" refer to the ideal of a sociable, healthy, productive lifestyle for the elderly (Leibing 2005, Debert 2011). More generally, a youthful lifestyle is being defined as a norm for an expanding portion of the population. "Successful" aging can refer not just to the avoidance of disease and infirmity but rather the active pursuit of health through a variety of therapeutic techniques.

As we've seen, plastic surgery is one such technique used to remedy low self-esteem and a disjuncture between appearance and the self. However, the psychological problems patients report can also be linked to a psychological subjectivity that has emerged as aging norms have changed in Brazil. Once a "young country," over the past fifty years Brazil experienced a rapid demographic transition. The percentage of elderly doubled as Brazil's fertility declined in the 1960s and 1970s and life spans were extended (Leibing 2005, 17). While the population aged, the elderly were also made socially visible as a population in new ways. For example, pension funds began conducting market research that contributed to the notion of a "gray market" with political and consumer muscle (Debert 2011).

Annette Leibing (2005) argues that beginning in the late 1970s aging has been removed from a Christian moral framework that emphasized a simple, ascetic life as the key to longevity. Seniors instead were constituted as a "national problem" as social workers and psychologists provided new interventions. New models of aging stress, though, that the elderly should not become wards of the state, but rather remain active in order to avoid biological decline and depression (Leibing 2005). New aging ideals have sparked a social movement and reflect new social and politial aspirations of the elderly. However, the promise of liberation from (internalized) ageism is potentially undermined by new forms of self-monitoring.

Positive aging, of course, presumes an opposite: negative aging. Avoiding this fate – and the mental health problems that come in its wake – requires self-management. Leibing points out that messages about "positive aging" involve "techniques of the self" and a "psychologization" of daily life (Leibing 2011, 25). She argues that the notion of "self-esteem" (auto-estima) figures as a key term in pastoral programs aimed at seniors. Keeping sociable as well as thinking positively are recommended as a means to age well. Conversely, psychological problems are said to "accelerate aging" (Leibing 2011, 24). Plástica discourse reverses this formula: beauty work that slows aging becomes a means of avoiding psychological problems. The psychotherapeutic benefits of surgery are available throughout the life course, as a "Miss Third Age" beauty contest made clear. The rationale of this event was to "augment the self-esteem" of the elderly. The 1996 winner was "judged by her plastic surgery, elegance, and empathy with the audience" (among the prizes was additional plastic surgery) (Leibing 2005).

The rising popularity of plástica thus reflects the growth of a psychotherapeutic worldview and "psy-" institutions (Cruikshank 1996, Rose 1996). The notion of self-esteem can be seen as a "therapeutic technology" in that it morally authorizes the healing of healthy patients. Elizabeth Haiken (1997) points out that in the U.S. plastic surgeons in the early 20th century scorned "beauty" doctors in a bid to legitimate the specialty. The eventual acceptance of cosmetic surgery depended not just on improved surgical technique but also on psychological notions such as the "inferiority complex," and later self-esteem. From a technical term used in psychological research (Ward 1996) the term self-esteem entered into a range of everyday uses: self-help manuals, black social movements, mobilization around third age, and beauty industries (Edmonds 2009). In Brazil, for example, in the 1990s new magazines oriented towards "black" beauty practices and celebrities began to speak of "rescuing the self-esteem of the black Brazilian" (Filho Dias 2006, 4; Fry 2002).

In Brazil the term auto-estima, like "third age" and "successful aging," was originally imported. Its foreign status does not mean it was inauthentic, but differences in class, education and religiosity have shaped the dissemination of a psychotherapeutic ethos (Duarte 1986). Among the middle class and elite plástica is thriving in the "ruins" of psychoanalysis, and is often combined with, or else replaces, the older talking cure. In public hospitals the psychotherapeutic rationale for plastic surgery was also prevalent. Sonia, who was waiting on line to have abdominal plástica, said, "I think my "I" is going to really improve, because the important thing is your interior. If your head is good, you're going to look at yourself and feel good." She also, though, added another reason: "We [*a gente*] want to be beautiful for the husband, nê?" Like many women in public hospitals she often used the pronoun "*a gente*" (we) in place of the "*eu*" (I) more commonly used by middle class women. Other patients were not fully conversant with the psychological idiom of plástica, or else doubted or mocked it. Janaina had worked as a "*mulata*" (in her account a job description not a color term) in a samba show. When I asked her why she wanted liposuction, she said, "Look, I'm going to do this surgery not because I'm bad in the head, but because I'm bad in the body . . . I looked at myself in the mirror and I saw that I was a pig [porcaria]. It doesn't do to look at myself and say, 'hum, I'm sexy [gostosa]' if my eyes fight with my thoughts." Other women simply said that plástica was a "woman's thing" or "women's vanity." Some patients, like Dona Firmina, an illiterate woman in her 50s, showed up to consultations with a picture of an *artista* (celebrity). Such patients could discomfit surgeons who worried that patients "did not have the culture to understand that plastic surgery is a medical procedure."

Thus, while psychological rationales for having cosmetic surgery were widespread, patients also had many other concerns that entered into their decision-making. Some worried about getting fired because they were "old" or feared losing a partner. Others were motivated by modest aspirations to break into the service economy and escape their mother's fate of "working for a family" (a euphemism for employment as a maid). Some psychologists employed by surgeons to screen candidates (to turn away those suspected of being too emotionally disturbed to be satisfied with results) were concerned that women were replacing psychotherapy with plastic surgery. Yet plastic surgeons simply said that their techniques were more "effective" than the talking cure. And as one psychologist acknowledged, many working class patients – for whom talk therapy is not an option – simply "prefer surgery" (Edmonds 2010).

Coached by surgeons, psychologists, or other patients, surgery candidates come to replace "bad" motives – such as the desire to look like an artista or secure a marriage – with "good" ones, such as "boosting self-esteem." Interactions in the clinic thus are didactic in that they train patients to describe "defects" in clinical terms. But they also teach a psychotherapeutic rationale for surgery and "open up" the body as a terrain of self-management. Plastic surgery is thus not only a socially validated means to heal the suffering psyche, it also reflects a notion of appearance as a psychic domain requiring therapeutic management. Yet while plástica promises to liberate the timeless consumer from what Glaucia called the "shell" of the body, it can also reinforce awareness of aging as inexorable biological decline as it becomes embedded in the female life course.

Surgery-for-Life: Plástica and the Female Life Course

One of the most significant and problematic aspects of cosmetic surgery is that it is often a lifetime therapy for women. It was rare to encounter a patient who had had only one operation or was not already at the time of her first surgery planning additional ones. Around 70 percent of patients are women, but plástica is also highly gendered in that surgeries are often timed to female lifecycle events.

A former president of the Brazilian Society of Plastic Surgery sketched out a "typical timetable" of surgeries that begins in adolescence:

> Age 15 to 20: Breast reduction surgery
>
> Age 20 to 25: Liposuction, even before marriage
>
> Age 25 to 35: Breast-lifting and liposuction, to correct the sags and bulges that can come with child-bearing
>
> Age 35 to 43: She waits a while and goes back to the academia (gym) for exercise
>
> Age 43 to 50: Facial surgery, taking the opportunity to have some 'freshening' done on the body ("War on Fat: Rio Cultists: Good Looks at the Beach," Los Angeles Times, 8/15/87).

However, patients often discussed their operations not only in relation to a "need" defined by chronological age but in relation to significant age-related milestones: "becoming a woman" (in Brazil often celebrated at the 15th birthday party); childbirth and breast feeding; decisions to end reproductive life (often by tubal ligation); divorce; and menopause.

Plástica is often given to teens as a birthday present, especially the festa de quinze anos. While a variety of operations aim to make patients look younger, ironically women are rarely considered "too young" to have plástica. Carlos Garcia, ex-president of the Brazilian Society of Plastic Surgery, argued that at the age of 16 the body is already "formed" and "nothing prevents adolescents from seeking a new appearance. It's in the physiology text books" ("Reino das Formas Perfeitas," Época, 6/19/00). Another surgeon said that liposuctions "should only be performed four years after the first menstruation."

The ideal of successful aging holds out the promise of extending a youthful lifestyle into middle age and beyond. Yet, plastic surgery also pushes the "need" to manage the aging body into early adulthood. Surgeons say that younger patients are "better patients." Younger skin means a smaller chance of complications and better aesthetic results. At a plastic surgery conerence in Rio de Janeiro, a surgeon told me that "the wrinkles of the future are not going to be the wrinkles of the present, that is, very deep wrinkles . . . plastic surgery is becoming more preventive." The rise in "preventive surgery" and higher numbers of adolescents and women in their 20s having surgery have likely contributed to a drop in the average age of the patient. In 1980, the average age of the cosmetic surgery patient was 55 years. Ten years later it had dropped to 40 and by 2000 it was only 35 ("Os Exageros da Plástica," Veja, 3/6/02). There are also few upper age limits for plastic surgery. Imagining a skeptical reader asking why an eighty year old would elect to have plástica, one surgeon asserted "to simply feel better, younger, a little over sixty perhaps." Rather than being presented as an "artificial" prolongation of youth, plástica is often seen as a "natural" means – provided it's done well – to age in a modern world.

Both facial and bodily surgeries are also linked to menopause. Márcia had been waiting ten months to have a second facelift. She discussed her motivation to have the operation: "When I began menopause three years ago, everything fell, fell really fast. Women age more quickly . . . menopause, hormones, breast feeding, giving birth, everything deforms the stomach, your body . . . and domestic life too is wear and tear, stress. And also men demand more of us." While Márcia mentions gendered social roles, she stresses that plástica is a means of

compensating "damage" blamed on women's "quicker" aging.

But the most important lifecycle events mentioned in relation to plástica are pregnancy, childbirth and breastfeeding. Breast surgery, abdominal surgery, and liposuction are said to correct flaccid skin or localized fat or else "lift" areas of the body described as *acabado* (finished), *caído* (fallen) or *murcha* (shriveled). This language reflects a clinical gaze – sometimes taken on by patients – that fragments the body. While the field of "aesthetic medicine" presents aging as a holistic biosocial process, clinical practices instead localize aging in body parts, some of which become pathologically or prematurely "aged." Plastic surgery, however, is often used not just once to correct a "defect," but is integrated into a larger management regime for reproductive and sexual life.

Now in her mid-40s, Cecilia lives a comfortable life in a condo in the South Zone of the city. She grew up, though, in one of the poorest Rio suburbs, raised by a mother who gave birth to her at age 15, never learned to read, and converted from Catholicism to an evangelical church. Cecilia studied psychology in university and has tastes she considers "*moderna*," which run from a love of French cinema to a simple and "relaxed" (in her mother's words) sense of fashion. On her living room book shelf stand the entire collected works of Freud, translated into Portuguese. She is now separated from her husband, a self-made man with whom she had three children. Talking about her multiple surgeries she often mentioned her reproductive and marital life.

While her mother blamed her for the end of her marriage -- "you let yourself go" (se largou) – Cecilia simply said, "We had grown apart." It was at this time, when she was in her late thirties, that she decided to have abdominal surgery and liposuction on her thighs and abdomen (followed by an additional liposuction operation some years later). She explained how the operations were designed in part to "correct" the effects of her three Caesarean births:

> I did it on my belly, which had a very flaccid part due to the cesáreas. . . . And the doctor made a cut a little bigger than the Caesarean scars, and took out that piece of meat that was really flaccid, without life, and then he sewed it up, and did the liposuction.

She explained that when she was pregnant with her third child, she began to think about having surgery. She wanted to combine the birth, which like the others would be a Caesarean, with a tubal ligation and a correction of abdominal "flaccidity." As with many other women, Cecilia timed her surgeries to the end of her reproductive life (due to tubal ligation) in part because of a concern that becoming pregnant again would "ruin" the effects of surgery. After her gynecologist told her, however, that he couldn't "fix her belly" during the birth since he was already "tying the tubes," she decided to postpone the plástica. A few years later she had combined liposuction and abdominal surgery to "repair" the Caesareans and reduce "localized fat" she had gained during her pregnancies.

Cecilia was not considered "vain" by family or friends and in any event, vaidade (vanity) has a neutral or even positive connotation of "self-care" in Brazilian Portuguese. Rather, her medical history reflects a more widespread, sometimes routine use of plastic surgery to manage reproduction and aging. Ob-Gyns refer patients to plastic surgeons after giving birth, reinforcing the idea that cosmetic operations are a "normal" aspect of women's health. Vaginal birth is said to cause sexual and aesthetic damage that can be avoided with Caesarean sections, which comprise more than 70 percent of births in some private hospitals (Rebelo et al. 2010, Carranza 1994).[3] Plástica is also used to correct iatrogenic damage from C-section, but also to "compensate" for medical suffering since it is "good for the self." Women who are unable to acquire a C-section are often given episiotomy,[4] an incision made in the perineal muscle during delivery, and later followed by the *ponto de marido*, the extra "husband's stitch," which aims to correct "vaginal trauma" (Diniz and Chacham 2004).[5] Other women giving birth in public hospitals who are "denied" C-sections are offered cosmetic vaginal plástica as a "proxy" C-section, Emilia Sanabria (2011) found. Links between Ob-Gyn, plastic surgery -- and sometimes endocrinology too -- have helped to routinize an aesthetic approach to managing reproduction and aging within a highly interventionist medical culture (Edmonds 2010, 2013a).

Clinical practices themselves contribute to "producing" the age-related defect and a consciousness of aging as biological decline. The surgeon measures defects with surgical instruments or discusses them in technical language with the patient, which can lend them an

objective existence. In public hospitals discussion of defects is often a pedagogical exercise performed for a room filled with residents. A senior surgeon will (gently) pinch the nose, pull the skin on the forehead, pick up and drop the breast to test for skin elasticity. Surgeons also use digital photography to measure the size of asymmetries or defects. In private clinics too surgeons frankly describe defects. Lídia spoke of one consultation: "I went with my sister. I said to the doctor I'm thinking of a lift. He said, 'you have to do it, you have to do it now.' He took me into another room and with a pincer, showed me all I had to do. He said 'Our Lady, you're finished [*acabada*].' The clinical description of defects though is often "softened" by gallant praise. When Lídia said she had told him she was afraid of having a "stretched face," he replied, "No, you're a beautiful girl [*moça*], it will be good."

I found it difficult to understand the effects of plástica on its ostensible therapeutic object: self-esteem. Some patients used superlatives, describing how they felt "marvelous," "super-happy," "super-woman." Others spoke in a more restrained manner of a boost to self-esteem. But many patients came back for repeat surgeries, to correct complications, for retoques (touch-ups), or simply because their aesthetic expectations were not met. Those who were satisfied often had additional surgeries later, either to counter new effects of aging or because they had perceived new defects. Ironically, their interactions in the clinic could also create a heightened awareness of flaws. Some surgeons said correcting one defect can accentuate another one, for example, a breast reduction can make the belly appear to protrude too much. In other cases the expert simply points out an asymmetry the patient had never perceived, but quickly learns to "see."

Patients and surgeons view plástica as a powerful means to overcome limits imposed by aging. Yet the "operable body" is embedded in the female life course as patients time surgeries to biosocial events. Thus, while plastic surgery reflects a view of the body as "plastic" – malleable, manageable, improvable – it can heighten awareness of aging as a biological trajectory. In the next sections I explore this tension further by analyzing the use of medical therapies to maintain or enhance sexual well-being throughout the life course.

Menopausal Playboys: Sexual Rights and Duties in Middle Age

New models of aging have, of course, not simply replaced older ones. Positive images of the elderly are often presented with an underlying irony, Leibing (2011, 22) points out. For example, activity is represented as a sign of successful ageing, but activity among the elderly is often seen as "empty bustling." Contradictions in new ideals of aging are particularly salient in the area of sexual health and sexual "fitness."

The ideal of successful aging validates to some extent sexual activity among middle aged and older women as "healthy." For example, the Ministry of Health announced that "86 percent of Brazilians are sexually active between 41 and 55, a higher proportion than the 66 percent among youth from 16 to 25 ("Sexo depois dos 40," Veja, 24/5/2000). An article in Época claimed that over the last 30 years women have "succeeded in transforming their bodies into sources of pleasure" ("Sem Medo dos 40," Época, 9/27/99). Celebrities too have played a role in defining a more "liberated" sexual norm for middle-aged women (Goldenberg 2002, 19).

The new media interest in what one magazine article termed "sex after 40," however, coincided with heavy promotion of medical or quasi-medical sex and beauty treatments. For example, a Veja news article on the "arsenal of middle age" touted the benefits of a range of therapies for "him and her": from Viagra and antidepressants to aphrodisiacs that "combat frigidity" to cosmetic surgeries. Such techniques enable the middle aged to have a "much more active sexual life" than their parents did. Plástica is sometimes explicitly presented as erotic enhancement for middle-aged women. For example, actress Ângela Vieira – who like many celebrities has publicly discussed her surgeries -- appeared nude in a magazine and was dubbed a "menopausal playboy" ("Sem Medo dos 40," Época, 9/27/99).[6]

Flávia, a working class woman in her 20s, is one admirer of such images. She said that she "loved" to read magazines like Playboy because she "loves to see the body," i.e. the nude bodies of female models. Plástica is sometimes positioned in this visual culture as way to achieve sexual fulfillment. Flávia's mother, Bete, said men "flirted" more and that they had more *tesão* (desire)

after she had several plastic surgery operations. These assertions of sexual agency, however, contrast with the disgust, contempt or even fear expressed by male peers, husbands, partners, and sons of female patients. One TV viewer said he felt repulsed when he noticed the contrast between a 40-year old face and an "old, wrinkled hand." Another man was outraged by a patient who said she had decided not to breast feed in order not to "ruin" her breasts. Even positive depictions of sexuality in "older" women (where older is a category that encompasses ever younger women) often have an ironic tone. The term menopausal playboy is partly humorous, as is the separada malhada, a separated woman with toned muscles.

Katz and Marshall (2003) analyze how sexual fitness has become a "pivotal sex/age body-problematic" in the new ideal of successful aging. They argue that a more standardized life course has given way to a "postmodern life course" in which "timeless consumers" become responsible for transcending sexual decline. Men have recourse to Viagra and testosterone therapy while women have access to various hormonal therapies, and perhaps eventually, an arousal pharmaceutical. They conclude that "the discourses of positive aging have created the sexy ageless consumer as a personally and socially responsible citizen" (Katz and Marshall 2003, 12).

This ideal of the "sexy, ageless consumer," however, involves very different therapeutic techniques for men and women. Sexual fitness for men is often focused on "performance" and erectile function through diet, exercise and drugs; sexy means in this context, "feeling like having sex." Sexual fitness for women – perhaps especially in Brazil – has a remarkable focus on beauty; sexy means here "sexually desirable." As in other Western countries, women's magazines in Brazil are filled with tips on erotic techniques. However, sexual fitness is often "aestheticized" in that it focuses on the technical management of attractiveness throughout the life course.

Some patients see plástica as a means to explicitly enhance erotic allure. Many operations that make relatively minor changes promise to project the breasts or "contour" the waist, hips and buttocks to create a more "*gostosa*" (sexy) figure. One female surgeon was distressed to see more clients in their 20s who "were already beautiful" and wanted to become "more perfect." An aestheticized approach to sexual fitness is also apparent in the marketing of cosmetic genital surgeries. Medical discourse claims that these operations enhance women's sexual pleasure (by correcting "vaginal widening" following normal birth) (Cirurgia Plástica Íntima, 2006). This reasoning, in ways similar to discourses surrounding C-sections, promotes a view of childbirth as a process that puts women at sexual and aesthetic risk. Marketing discourse also claims that "aesthetic aspects" of the genitals are "increasingly important for self-esteem."[7] Sexual fitness is thus a complex ideal and norm. It aims not only to boost self-esteem and libido, but also entails a norm of medically-managed, "aesthetically pleasing genitalia" (McCallum 2005, 226). Some patriarchal sexual norms -- such as the ideal of pre-marital virginity -- are in decline. On the other hand, these sexual norms resurface in an "aestheticized" form in re-virginization genital surgery or in a management regime that views reproduction as a sexual and aesthetic threat.

To some extent anti-aging medicine seems to take seriously the sexual concerns of middle aged and elderly women, reflecting a shift from an older medical assumption that sexual decline was an inevitable and natural part of the life course (Marshall 2009). In Brazil it also, however, often normalizes beautification as a health aim throughout life course. Teenagers have access to the same techniques of self-optimization as adults. Women in their 20s, 30s, and 40s are "already" ageing and need preventive medicine. And all adults are potentially "falsely aged," requiring therapy to look as young as they feel. The liberatory promise of anti-aging medicine thus coexists with a new "positive" morality that makes sexual fulfillment a right, but which also entails a duty to medically maintain attractiveness to preserve family relationships, self-esteem, and even health itself.

"Mom is a Snapshot of Me in the Future": Aging in the Family

I have discussed tensions between the promise of a liberation from an aging body and a biologized experience of passage through the life course. I explore this point further by examining how women see themselves as being linked to female kin through a genetic inheritance that creates shared medical "needs." Plástica is often represented as a personal choice undertaken by the patient in private consultation with a physician. But during

fieldwork I was struck that plastic surgery was often a family matter. Surgeons acknowledge that the most effective means of marketing is *boca a boca*, word of mouth, which is often from kin to kin. Mothers, grandmothers, aunts, sisters, daughters and cousins recommended surgeons to each other or accompanied each other during multiple visits to the hospital.

I met Flávia and her mother, Bete, at a private clinic. Both women live in a working class neighborhood in the Zona Norte. Now in her mid-20s Flávia was having a breast lift and liposuction to "correct problems" she attributes to childbirth. She said she could never afford the clinic's prices, but got a heavy discount through a personal connection. She spoke of the influence her mother had on her when she was a small child:

> My mother here already had four plásticas, and so since I was really little I lived with plástica in the family, nê? Because she did her nose, she did her eyes, she did the same breast surgery and lipo I am doing now. And I was with my mom through all these procedures.

Mothers can provide "inspiration" to have surgery, but they can also "map out" the daughter's future aging. She said: "I usually say to men, look at your mother-in-law to see what you're buying, taking home. Mom is a snapshot of me in the future."

Like many unmarried women, Flávia lived with her mother. Both women were separated from the fathers of their children and in Flávia's words were "in the market" (of dating):

> In the past, a 40 year-old woman felt old and ugly. And she was traded for a younger one. But not these days. A 40 year-old is in the market competing with a 20 year-old because of the technology of plastic surgery. She can stretch [her skin], do a lift, put in silicone, do a lipo, and become as good as a 20 year old.

This description echoes the collapse of generational differences analyzed by gerontologists. Plástica "allows" women of different ages to enjoy sexual freedom, making chronological age less relevant. Figueira argues (1996) that in consumer capitalism family members become less identified with age-defined roles. For Flávia, rather than being defined relationally through different rights and duties, mother and daughter become "equal" sexual beings, though situated in different moments of the aging process. This equality between the 40 year-old and 20 year-old though also puts them in a competitive relationship in a market, a point I return to below.

This mother and daughter pair stress the importance of "support" (força or apoio) they receive from each other.[8] Having plastic surgery can be seen as a kind of rite of womanhood, especially when it is linked to a key life event. Other kinds of beauty work, such as wearing make-up or dressing up, can be seen as form of passing on the "arts" of femininity across generations and perhaps a form of bonding between kin. But plastic surgery also targets a notion of "beauty" that is defined biologically -- in terms of anatomy, reproductive processes, hormones, and secondary sexual traits (Edmonds 2013b). The mother "maps" the future because she provides the example of how to successfully manage aging, but also because, Flávia said, their bodies age in similar ways.

Patients spoke too of inheriting from kin combinations of ethnic traits that require surgical correction. For example, some women who identified as *branca* (white) or *morena* ("brown" or "brunette") said they inherited the shape of their nose from an Indian or black grandparent or great-grandparent. They sought rhinoplasty to narrow their nose and make it more in "harmony" with their face. Their comments point to the "plasticity" of Brazilian constructions of race and color, as well as color hierarchies that value white, or relatively white, *brancina*, facial features (Edmonds 2010: part II, Goldstein 2003). They also show how generations are linked through genetic inheritance that creates particular medical "needs."[9]

Plástica also mediates the kin relation by making generational gaps less apparent, or even invisible. Flávia and Bete mentioned being mistaken for siblings. Flávia hoped that when her five-year old was grown up, strangers too would assume they were sisters: "Because my body will be so well-treated, so conserved, like my mom's is now." While the age gap separates mother and daughter into different family roles, aging also in a sense links them in a biological process that requires management.

Patients spoke of plástica in terms that echoed the postmodern life course, and seemed to support the thesis of a "de-chronologized life course." But one problem with this thesis – which some argue is a more general problem plaguing postmodern theories – is that it mirrors new ideologies about the social phenomena it depicts. Successful aging is promoted by plastic surgeons. Yet patients, not surprisingly, also had more ambivalent attitudes towards the psychosocial effects of aging and the

possibility of managing them medically. Flávia saw Bete's surgeries as an "inspiration," yet her mother's aging is also a sign of her own inevitable decline. She said in front of Bete: "Aging is horrible. I try not to even think of how I'll be at 50." Mothers not only map the daughter's aging body, but also possible futures of relationships. Divorce and separation rates have been rising since divorce was legalized in 1976 in Brazil. The number of men aged 40 to 59 marrying women in their 20s doubled from 1978 to 1996 (Veja, 24/5/2000). Plástica was also practiced by women in happy marriages, where it could provoke "jealousy" in the husband. But in intimate conversations women often expressed anxieties about current relationships or hinted at hopes that surgery would rekindle a marriage.

Lídia said she had "done one plástica with each husband, this is now my third." While Flávia seemed reassured that plástica can make a 20 year-old woman as "good as" as a 20 year-old, Valéria -- who was divorced -- joked about men who "trade one woman of 40 for two of 20." Luisamar spoke more despairingly about the breakdown of relationships: "In the past man didn't separate. He had his lover, or lovers, but the family was sacred. This is changing . . . Everyone separating. I think it's absurd, a man living 40, 50 years with a woman, and then leaving her. It's a kind of cruelty. 40 years of marriage, and they marry a 20 year-old." Other women viewed plástica as a "compensation" for the loss of love or inability to have more children due to the end of a relationship. The self-work in plástica is thus not just a "private" therapeutic technique for calibrating mind and body, but also transpires in a world of uncertain familial and sexual relationships.

Plástica is not the only medical therapy used to manage sexual and "aesthetic" anxieties. In her ethnographic work in Bahia, Emilia Sanabria (2010, 2011, 2012) found widespread experimental uses of sex hormones. Compounding pharmacies offer hand-crafted implants that combine a variety of hormones, including testosterone. These are used for off-label indications: menstrual suppression, coping with work difficulties, and regulating mood, libido and sexual disposition, *disposicão*. Dubbed "beauty chips" by the media, implants are also said to have "aesthetic" effects, such as diminishing cellulite, improving skin elasticity, and avoiding weight gain. These therapies are presented as a means to greater "freedom." However, Sanabria argues, this promise is subtly blurred with the duty to maintain disposicão and diminish periods of sexual unavailability to partners. What appears to be a technique for sexual self-optimization can also be a means for managing sexual relationships.

Tensions between reproductive and sexual rights (and duties) also surfaced in conversations with plastic surgery patients. Tatiana saw plástica as a way to "have it both ways," enabling her to enjoy breast feeding (without worrying about "damage") while boosting libido. Maria José said that after becoming a mother, the "role of woman becomes secondary" – a problem again that can be solved with plastic surgery (her comment was taken from an interview in Ribeiro and Aboudib 1997). In these accounts plástica is a kind of modern technology that allows women to overcome the "split" between motherhood and sexuality, which Sandra Bartky (1990) argues characterizes patriarchal society. The highly interventionist approach to women's health in Brazil can also reinforce this split as it normalizes a view of reproduction and aging as biological processes threatening sexual and "asthetic" integrity.[10]

Conclusion

This article has approached plastic surgery as a window on tensions in aging and sexual norms. I began with a discussion of the thesis that the life course has been de-chronologized in contemporary societies. To some extent plastic surgery patients live in social circumstances that support this thesis. Women are postponing motherhood in Brazil (as in other industrialized societies). Across the socioeconomic spectrum they are less defined by domestic and reproductive work as Brazil's economy grows and gender norms shift (to give just one example, while the vast majority of older surgeons were male, young residents in surgery are about half female). In consumer culture youth is an ever-expanding category -- a lifestyle more than a stage in the life course. And medical discourse portrays aging as a process that can be limited or transcended with the right psychological, health, and beauty work.

I have argued, however, that in some important respects the life course remains "chronological" as plastic surgery and other therapies are medically authorized as management techniques that accompany a woman through the life stages of adolescence, birth, breast feeding and menopause. Patients embrace plástica as a means to bridge the gap between a youthful interior and aged exterior; yet

also compete in markets of sexual relationships where youth is a form of capital. Medical discourse valorizes "sex after 40" and women's sexual pleasure; yet practices focus on a notion of sexual fitness that emphasizes the technical control of "aesthetic damage." The timeless consumer can transcend some limits of the standardized life course, yet also have a heightened awareness of biological aging. Some patients praise plástica as a way to manage conflicts between maternal and sexual roles; yet these conflicts also contribute to the pursuit of health practices which have health risks.

The goal of successful aging is thus often shadowed by the prospect of a failed rejuvenation. Self-tinkering reinforced by medical authority has the potential to make patients even more conscious of aging as biological and aesthetic decline. It's true that some patients experience therapeutic effects from both cosmetic and reconstructive surgery. Medical treatments (e.g. cancer surgeries, gynecological surgeries, psychotropic drugs) often cause sexual and aesthetic damage, thus it is arguably more legitimate to correct such damage. However, the medical and psychological management of aging comes with considerable risks. Perhaps the greatest is that plástica often becomes "surgery-for-life": a therapeutic process that is entangled with life course events and necessary for healthy aging, healthy reproduction, and healthy sex.

Acknowledgements

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Notes

1. One major plastic surgery center is located in Santa Casa de Misericordia hospital, which is run with a mix of charity funds and state subsidies. Unlike fully public hospitals where all medical services are free, it offers free reconstructive surgery, but charges a small fee to cosmetic surgery patients to cover costs of medical materials and anesthesia (surgeons receive no payment). Both Santa Casa and public hospitals attend mostly working class patients.
2. Price competition between surgeons in a crowded market – combined with an international reputation for quality – also attracts medical tourists (Edmonds 2011).
3. A meta-study concludes that there is no evidence that "elective" C-sections, compared to vaginal birth, protect sexual health or result in a speedier return to sexual activity (Barrett et al. 2005).
4. Demand for C-sections, as well as for plastic surgery, is partly fueled by class dynamics since both these therapies are considered in some contexts as "modern" medical goods that have been normalized in healthcare for middle class women (Béhague et al. 2002, Edmonds 2010).
5. Medical studies dispute that the routine use of episiotomy has any health or sexual benefits (Belizán and Carroli 1998).
6. The news article held up the actress, a 47 year-old divorced mother, as an example of a generation of middle aged women who "give a new meaning to the phrase *coroa enxuta*" (literally "a crown in good shape," that is, a well-preserved, middle aged person).
7. Herbenick and Reece (2010) claim to have developed a new psychological research tool, the "Genital Self-Image Scale."
8. Similarly, another working class patient, Sonia, brought her teenage daughter, Taís, with her to the hospital. Sonia was waiting for abdominal surgery and at first I thought her daughter was there to give her moral support. Discussing her decision to have the operation, she said that her husband "supports" her just as she supports her daughter's decision. "It's her 15th birthday present, the nose. She doesn't want a party, she wants to make a "book" [in English, a fashion modeling portfolio] with a nose that makes her feel good."
9. Surgeons too reinforce a "racialized" aesthetics of aging. They argue that 'pure whites' have skin that ages more rapidly, while women with some African descent have a tendency to gain weight more easily.
10. Tensions between maternal and sexual roles have historical roots in modernity, perhaps especially in Latin societies that have been described as having a "Madonna/whore complex" (Yalom 1997). But this "complex" takes a specific form in Brazilian medicine. When an Ob-Gyn says to a woman after she has her first child, "You don't have to look like that," sexual fitness is reinforced as an aesthetic norm attainable through proper management.

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Argentine Tango

social dance health 'to' you

Text and Photographs by Jonathan Skinner

Argentine Tango: social dance health 'to' you

These three photos evoke the plaint of life. They are a static portrait of Argentine tango dancers mid-movement. This is life and action frozen and memorialized from a long-awaited Christmas party in Belfast, Northern Ireland. Unlike Julie Taylor's (2001) succession of mini-tango moves in her ethnography of tango and Argentina, a choreography by flipping, there is only the hint or trace of movement in these photos: the legs in open position with torque on the body, a shoelace working its way free; couples in closed embrace, the leader with motility, the partner with either open or closed eyes, primed to follow their initiations. There is longevity in the pictures from the detail of the marriage rings to the wrinkles on faces solemn with the dance, concentrating but also flowing with solace – 'relaxed responsiveness' as Richard Powers (2013) puts it.

Dance - described by Spencer (1) as that 'nonutilitarian patterned movement' - can be cathartic, controlling, competitive, communitarian as well as sustaining, maintaining and self-generating. There is solidarity amongst dancers, regularity in the order of attending, learning and performing a dance, and mutual self-affirming of an ontology of being-in-the-world each night when one dons one's dance clothes and horns a pair of dance shoes. Leslie Gotfrit (1988) speaks to the nostalgia and longing of a bygone body in women reclaiming theirselves on the boogie floor. The same can be said of the tango couple, rejuvenating under the Christmas decorations. There is familiarity and comfort in the sociality of the Other in one's arms, often a life partner of decades moving with you, reassuring walking as one. "I dance to you": the 'to' a linking narrative and a metaphor for corporeal intimacy in the eyes of Judith Hamera's (2001) appropriation of Irigaray-ian philosophy.

'Indistinction' is how Jonathan Bollen (2001) phrases it as the dancers lean in, support each other, and begin to move in an improvised script to a music from a far-away land and a far-away time. In this case, social dance transports us to Argentina in the 1940s. In the beating of the hearts, and the fleetness of the feet, and the alert anti-clockwise lead around the room, there is wellbeing. Solace seeps up through the motile feet and calm descends from a labile imagination. Argentine tango, a self-selecting social dance, affects the dancers – variously, an anti-psychotic (Anon. 2013), a stabilizer for Parkinson's (Hackney et al 2007), an omni-therapy (Woodley and Sotelano 2011). These are just some of the benefits of this genre of social dancing. Other social social dancing such as ballroom dancing also has its strengths as a form of 'serious leisure' (Stebbins 2006) – a personal vehicle for successful ageing (Skinner 2013) - and can retain muscle density and stave off social isolation amongst other benefits. But Argentine Tango has the 'Healing Embrace' (Berve 2008): it is a resting place for the active. Those interested in more tango visuals and in following up on the worth of tango in the medical setting can follow this link to the annual 'All of Us Are Crazy for Tango' programe put on by Hospital Borda in Buenos Aires.

Wherever danced - from Buenos Aires to Belfast, and carrying whatever condition - from physical to mental health issues, this dance addiction can become a boon and adjunct to other fracturing and faltering rhythms in life.

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Book Reviews

Lynch, Caitrin & Danely, Jason, Eds. Transitions & Transformations: Cultural Perspectives on Aging and the Life Course. New York, NY: Berghahn Books. 2013. ISBN978-0-85745-778-3 272 pp Price $95.00/£60.00 (Hardback)

Transitions & Transformation: Cultural Perspectives on Aging and the Life Course, officially launches Berghahn Books new book series, entitled Life Course, Culture and Aging: Global Transformations (series editor is Jay Sokolovsky), that proposes to focus on aging and the life course in anthropology. This is a welcome addition to the growing literature on cross-cultural aging that applies creative and multifaceted approaches of anthropological analysis and inquiry to the wonderfully complex subject of age. While firmly situated within the global urgency of burgeoning numbers of aged individuals worldwide, the chapters in this volume resist the panic trope so often summoned in usual representations of the squaring of age pyramids and ominous dependency ratios that preference doom and ruin over dynamic cultural identities and innovative human strategies. The anthropological stance is uniquely well suited to tackling individual and larger social issues embedded in changing cultural norms and practices, and nuanced treatments of aging across the globe are featured in this volume. Focusing on on-the-ground situations within specific cultural contexts, important issues are discussed in the well-written, lively and varied collection of articles displayed here. How to embed meaning, recognize personhood and respect relationships in later years is a strong theme of the volume.

In the initial section that introduces the essays of this book, the editors describe their dynamic approach of "transitions and transformations." In the papers that follow, relationships and changes, the interactions of individual, family, and society through time and flux are highlighted. The chapters claim a connection with earlier anthropological collections that focus on diversity and creativity; at the same time, the articles purport to depart from "reductionistic uses of cultural diversity as points on a scatter-plot" (p 5) and argue for enhanced cross-disciplinary inquiry. Organized in sections titled, "Frameworks," "Bodies," "Spatiality and Temporality," "Families," and "Economies," the chapters consider an important variety of issues and provide insights to extend the existing literature. An Afterword by Jennifer Cole that focuses on importance of including cross-generational analysis rounds out the volume.

"Frameworks" includes the introductory chapter by the editors that describes the approach of the book, places the volume in historical context of anthropological writings on age, highlights the importance of the "life course" approach to studies of age, and provides brief summaries of the chapters and their relationship to the unifying thread of the book. Following this introduction, Mary Catherine Bateson updates Erickson's developmental stages with "Adulthood II," a phase of life she characterizes as showcasing "active wisdom." She considers the necessity of this stage in light of global aging and the expanded period of time of healthy aging so prevalent today in industrialized nations. Many of the chapters in this volume echo Ericksonian principles of development and psychological growth over time.

Section II contains chapters that explore the notion of "Bodies" by presenting varied and lively accounts of different subjects rooted in universal biological processes and situated in specific cultural contexts. These chapters examine how individuals cope with chronic pain at different ages in a clinic in the United States and use strategies to construct continuity challenged by the disruption to identify caused by pain (Lindsey Martin); how Chinese middle-aged women construct their experiences with menopause (gengnianqi) to explain and protest through "irritability" and "venting anger" their individual perspectives on growing older in a rapidly changing China (Jeanne Shea); and how men both young and older describe reaction against and identification with traditional and changing notions of what it means to be masculine and Mexican in a rapidly modernizing Mexico (Emily Wentzell).

Section III, "Spatiality and Temporality," explores the intersection of time and identity and notions of place in relation to individual aging. Jessica Robbins examines the intimate and intricate connection between the national and personal "moral ideal" of identity in Poland, how suffering in old age is entangled with victimization throughout Polish history, and the relationship between kin nearby and abroad. Frances Norwood uses the Dutch window bridging the public and private spheres of life as a metaphor to showcase cultural notions and intense "euthanasia talk," inspired by the rarely enacted legal choice to die. Jason Danely's treatment of the temporal world of older Japanese notes individuals' connections "involving mutual recognition with unseen spirits and invisible worlds that structure memories, aspirations, and emotions" (p109). Narratives of older Japanese individuals as well as various common phrases and sayings emphasize interdependence and exchange across

time and place.

The fourth section of the book focuses on "Families," and its three chapters explore caregiving by Azorean women in Brazil (Diane De G. Brown), Puerto Rican grandmothers who care for their grandchildren in Boston (Marta B. Rodríguez-Galan), and how in Sri Lanka, complex notions of reciprocity in debt and obligation among generations are displayed in changing and discrepant attitudes about using care institutions for older individuals when they become dependent. These chapters, like others in the volume, include vivid quotes, elicit cultural values, provide national context and specific circumstances, and situate the authors in their ethnographic accounts.

The final section, called "Economies," includes chapters on the conflicting meanings attributed to the rise of eldercare institutions in India (Sarah Lamb), how best to provide seva (respectful service or care) to elderly individuals and manage the dilemmas of these sparring narratives embedded in "the project of being human" (p177). Membership and mattering are prime concerns of the elderly factory workers discussed in Caitrin Lynch's lively chapter. These workers choose to continue to work, maintain friendships within the factory and thereby preserve a viable identity that seems to cushion old age. It is reminiscent of my ethnographic exploration of elderly New York diamond dealers who find satisfaction and meaning by working whenever possible into their 90s (Shield, 2002). The fascinating chapter by Jane Guyer and Kabiru Salami describes notions of indebtedness and responsibility examined from the perspectives of their separate studies over decades in rural Nigeria. Again, mutuality and interdependence are stressed in how changing contexts reframe the meanings of finances, old age, and worth. Finally, Jennifer Cole's "Afterword" explores the important notion of generations within the heterogeneity of age and youth. She warns against the "synoptic illusion" and reductionism of definitional shortcuts that stereotype and damage dynamic differences among ages.

This volume is full of good writing, lively situations, some wonderful photos, revealing quotes and stimulating ideas. Its readability makes it appealing as a text to be used widely in the undergraduate/graduate classroom. A brief introduction to each section would have been a good addition as another opportunity to remind the reader of key unifying themes. Still to be explored by anthropologists are their own relationships to their aging and the subjects with whom they interact, a point I've argued elsewhere (Shield 2003). A concern is that the volume claims a radical distinction from prior anthropological works on aging considered static and totalizing in contrast. This argument privileges new contributions without fully recognizing some important precedents such as the "life's career-aging" examination by Myerhoff and Simić (1978), for example. Here the authors attempt "in their analysis of aging to reconcile its culturally stable aspects with its dynamic dimensions conceiving of each particular cultural niche as a distinct and unique resource subject to manipulation and individual interpretation and misinterpretation" (1978: 231). Of course, each generation has the challenge of recognizing its own myopia in thinking itself unique as it discovers and rediscovers these insights. These concerns aside, the current volume makes for excellent reading and launches the new Berghahn book series admirably.

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Chang, Heewon, Faith Wambura Ngunjiri, and Kathy-Ann C. Hernandez. Collaborative Autoethnography. Walnut Creek, California: Left Coast Press. 2013. ISBN 978-1-59874-556-6 200 pp. Price $34.95 (paper)

Heewon Chang, Faith Wambura Ngunjiri, and Kathy-Ann Hernandez have collaborated to produce Collaborative Autoethnography. Collaborative Autoethnography (CAE) is a further elaboration of Autoethnography (AE). Researchers in both approaches see themselves as both the subject/informant of the research and the analyst of that research. In CAE, the researcher/subject is part of a team that collects and analyzes her/his data. This book is a review of past research in terms of methodology and a handbook on how to do collaborative research.

The authors place CAE and AE in terms of an evolving field of theoretical interest. Researchers themselves have personal and professional lives that are situated in their institutions and culture(s). AE (as well as CAE) allows the researcher/subject to turn a lens (p.22—their word) on her/his own life as well as the larger society.

AE has addressed abortions, pregnancy, death and grief, and sexual

abuse, among other topics (pp.19-20.) The book's authors agree with other students of AE that while rich in data, more can be gained by a more collaborative approach. Collaborative approaches allow for more depth as well as personal and community building. At minimum, a collaboration can be two people—the researcher/subject and another researcher. They propose an ideal team of at least one more member.

CAE can focus on traditional academic concerns, with a single or several research focuses. It can also extend to performance art, wherein "… autoethnographies are written as theater scripts… [or as] a series of poetry, or performance narratives… (p.51.)" In terms of AAGE's mission on aging, I can see many places where CAE can be used. A few "personal" examples come to mind. People are doing "Story" projects in many communities. Often located in museums or libraries, a person tells her/his story. Teams of collaborators, whether professionals and/or non-professionals trained by professionals, can engage a person or several people to tell their life stories in greater depth. Several years ago I taught a discussion class on "Generations" through our local junior college's Older Adults Program. The discussion group was based in a nursing home. It could have easily been based in a senior center as well. The participants reviewed their lives, providing wonderful information on their similarities and differences according to all our "standard" kinds of foci—gender, class, education, region, job, religion, sexual preference, and so on. The data were rich and could easily be used to add to histories of different periods. Moreover, the data were enriched by each participant's interaction with the others when they questioned or reaffirmed or remembered something or some events another had not. Hopefully, we can find issues worthy of study that we had not expected as well.

As for academic collaborative teams, the authors contend that they work best when the participants are located where they can have continued social interaction. They are located in the same city. They meet for coffee, lunch, dinner, and other events and they meet over time. In terms of proposed methodologies, they suggest different models of collaboration, which can offer differing degrees of complexity. It would be interesting to see what kinds of data and studies can be gained by on-line collaboration or a mixture of the two. As noted above, it may be possible to add that to the repertoire of CAE for older people that they can do by themselves or with some help.

As they lay out their models for research and their places in theory, they note that many of the studies involve women in the academy, immigrant experiences, and people of color. They situate themselves in all the above ways and especially in terms of motherhood (pp.185-6.) The authors build upon both feminist theory and feminist critique and the whole field of qualitative research. The ends they seek say it all: "It [CAE] is a transforming process that allows scholars to build community, advance scholarship, engage in social activism, and become empowered in their social context (p.148.) What makes this book even more interesting is that as the authors lay out their formulations, they share relevant anecdotes about their own lives.

The authors also address some of the dilemmas this kind of fieldwork entails. One always has to ask: How much should I reveal about myself? How much should I reveal about others—especially without their consent? How should I present my data? They recognize that collaboration helps reveal issues that are not always apparent to the subject (p.28.) Lastly, they see the research process as supportive for the person studied as she experiences or re-experiences trauma or a difficult situation (p.30.)

I have several suggestions for the book. First, I think the title should have been Collaborative Autoethnography: A Handbook. That makes it clearer as to what the book is about. Second, the authors should tie their research into other related research about the psychology and anthropology of fieldwork experiences, (cf. Davies and Spencer 2010.) Third, in terms of my self-disclosure about my comments, I am an anthropologist as well as a licensed psychologist. I would have liked to see much more of a discussion of the handling of trauma and denial, among other psychological issues (e.g., p.29.) In sum, I would strongly recommend this book for those unfamiliar with this emerging field and who want to do this kind of valuable research.

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Richard Zimmer
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Ulsperger, Jason S. and Knottnerus, J. David. Elder Care Catastrophe: Rituals of Abuse in Nursing Homes & What You Can Do About It. Boulder, CO: Paradigm Press. 2011. ISBN 9781594519079, 222 pp.

Price $ 28.95 (Paper).

As the population rapidly ages and people are living longer, today's Boomers are faced with the complex decision of determining who is going to provide proper care for their elderly parents. Dependent upon medical, financial, physical, mental and other specific needs, some individuals may decide to care for their parents on their own while others seek out long-term care facilities such as assisted living, adult day care, respite care or nursing homes that provide optimum care. While finding a facility takes time and much thought, the complexity of the issue lies in finding long-term care where elders are treated with kindness, respect, and cared for as human beings; not abused, neglected, ignored or treated as "impersonal, material items" (84).

Authors Jason Ulsperger and J. David Knottnerus investigate the root causes of abuse in nursing homes and other long-term care facilities based on systematic research and sociological theory to help one understand the different types of nursing home maltreatment. The book is divided into nine chapters. Beginning with identifying the bureaucracy that encompasses today's nursing homes and other long-term facilities, the text transitions into the history of nursing home care. Final chapters focus on the organizational dynamics and everyday rituals that can unintentionally lead to elder abuse and neglect.

Although present in the 1960s, nursing home care and maltreatment drastically emerged as a social problem and came to the forefront in the 1970s. This resulted in the establishment of the nursing home reform movement and efforts by organizations such as the National Citizen's Coalition for Nursing Home Reform (NCCNHR) to continue to assume important roles in the history of nursing homes. Interestingly as the authors point out, even with the development of the Omnibus Budget Reconciliation Act of 1987 (OBRA) also known as the "Nursing Home Reform Act" (59) elder abuse and maltreatment continued to plaque our nation and impact the care of aging adults. But why?

Bureaucracy and rules impact the overall care for our elderly. Rules replace compassion. Government regulations impact how assigned, everyday duties or "rituals" go unnoticed or undone due to daily tasks assigned to specific employees based on skill/knowledge levels. Simple things such as removing dirty dishes from the table in a resident's room or seeing a resident stranded in a hallway waiting for someone to roll them back to their room may not get done if top-level employees are the only ones available. I totally agree that in our complex world rules are a necessity. However environments where people are dependent on compassion and quality care at a time in their life when they are alone, afraid, and/or ill, rules can contribute to unethical and inhumane care.

This book addresses the core issues of elder abuse and maltreatment and provides case vignettes of everyday situations that long-term/nursing facility residents tolerate due to bureaucratic policies. I was angered when I read many of these short stories which depict bureaucratic induced dehumanization of care. The authors stress the need for culture change; shifting away from the traditional nursing home model (130) to a positive, "resident-centered care" model, thus transforming a facility into a home. The authors remind the reader to acknowledge the elderly for the human beings they are and not "unemotional work products" (83). Engage them, don't isolate and be responsive to individual needs. Hire employees who have the compassion and desire to care for the elderly and not just fill bureaucratic positions based on policies/demographics.

I would recommend this book to any lay person, healthcare provider, nursing facility employee; or anyone from the Boomer generation who may be faced with the decision of one day finding the proper home for a parent. This book should be required reading for anyone working in a nursing home or long-term care facility as a reminder how not to treat those they are caring for. Although a quick read, this book provides a wealth of advice and strategies for lessening elder abuse and maltreatment. In one of the chapters the authors compare today's nursing homes to zoos; stressing the point that residents who are unruly and labeled "troublemakers" are often tranquilized and restrained to protect themselves and those around them much like a zoo keeper would do to a wild gorilla. Both have staff ready to contain unruly creatures that cause disruptions throughout the workday, even if the physical welfare suffers.

Two other types of maltreatment the authors identify is "spoken aggression" and "infantilization" (122). Spoken aggression involves speaking to residents in an intimidating, cold tone or calling names (e.g., calling an older female resident a "mean old woman" or yelling at someone to "shut up and eat your dinner") (123). Infantilization is speaking in a *condescending way that reduces the status of the resident to a young child (117). Healthcare providers need to*

be attuned to the subtle nuances that can degrade the status of those they are caring for by treating them like children instead of the adults they are.

The world around us is aging and providing compassionate care is the model all facilities should strive toward. The authors summarize the book nicely by concluding that in order to provide such care, nursing homes must undergo culture changes that downplay bureaucracy, revise staff policies, counter loneliness and isolation from the inside, empower residents and respond to their individual needs.

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Sanjek, Roger. Gray Panthers. University of Pennsylvania Press. 320 pp.Cloth 2009 ISBN 978-0-8122-4137-2 , $65.00; Paper 2011, ISBN 978-0-8122-2191-6 $26.50; Ebook 2011, ISBN 978-0-8122-0351-6,$26.50

Studies of elder activism are rare indeed. Much more so the kind of rich and detailed account which veteran anthropologist and activist Roger Sanjek offers us here. Gray Panthers has much to give those interested in older people, not just because of the quality of the study itself, but also because the Panthers to whom we are introduced are themselves experts on aging from whom we need to learn.

Some professor once taught me that the test of a good ethnography was the degree to which the data it presented could enable another scholar to re-anaylze it to answer different questions. I was reminded of this criteria as I read Gray Panthers. The careful study of the emblematic activist organization is rich enough in data to speak to a dozen different research agendas: relating to the history of left politics in the United States, the activism of older people, social movement organizing, leadership and gender, ideas about older people, intergenerational politics, and insider anthropology, among others. The life history of a social movement, Gray Panthers traces the story of the eponymous organization from the moment of the group's inception in 1971 in a fight against mandatory retirement and the ageism it represented. The group grew to represent the interests of older Americans in a variety of ways: denouncing living conditions in nursing homes, unethical practices in the hearing aid industry (in collaboration with Ralph Nader), media portrayals of older people, for example. Yet, it has been much more than that. It's slogan, "Age and Youth in Action," signals the group's intergenerational philosophy. It took up pressing social justice issues of the moment, including the war in Viet Nam, public health care, sexism and racism. It is to this larger critique that the group owes its name, an intentional reference to the Black Panthers. The story spans several decades and many states, including specific chapters focusing on the Panthers in Berkeley, New York, and Washington. (Sanjek originally encountered the Panthers in Berkeley in 1977. He and his wife both became personally involved with the Panthers. The author only later took up the group as an object of study.) The account continues through the organizations various ups and downs, including internal conflict, and the death of its found Maggie Kuhn in 1995, to the time of writing.

For scholars interested in aging, the book is doubly fruitful. There is much to learn about how older people organize and do politics. Most striking perhaps is the symbolic politics which the Panthers were so good at: intentionally interrupting mainstream views of older people and aging by doing "outrageous" things. Another important question for older activists is time. In Gray Panthers, we see this particular relation to time in at least three ways. First, older people are often retired, thus have more time available to dedicate to their causes. Second, older people also benefit from long experience and extensive networks. Once and again in Gray Panthers we see how members make use of expertise and contacts acquired in earlier stages of their lives. One of the most personally compelling aspects for this reader was the way the Panthers connect us to earlier activist movements and political struggles that have been all but forgotten in US political memory -- in particular the pre-cold war left traditions. Third, the activists and their organization have to contend with the fact they are nearer the end of their lives, than the beginning. This can create a sense of urgency, that time is limited. It also creates practical challenges for political organizing. Experienced and knowledgeable members are more likely than their younger counterparts to be sidelined by illness, or even to die. The particular strengths of and challenges faced by the elder activists here can thus inform our understanding of the third age more generally.

In sum, Gray Panthers is a book that needed to be written. Evidently Sanjek was the man for the job. The Panthers have played an important role in *redefining what it means to be old. This book both describes and continues that project.*

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Haber, David. Health Promotion and Aging: Practical Application for Health Professionals. New York, NY: Springer Publishing Company. 2013. ISBN978-0-8261-9917-1, 536 pp. Price $90 (Paper)

Dr. Haber's text delivers exactly what the title says and more. Like most books on aging, this book begins with a demographic perspective of aging in the Unites States. It then moves onto a clinical perspective of the current state of health (or disease based on your perception) in older adults. The book continues with a frank discussion of how we as helping professionals should focus on wellness vs. health care (or disease management, again based on your interpretation of the health care system). The text provides examples of evidenced based practical applications of wellness that can be utilized by gerontologists, public health professionals and everyone in between who works with older adults. The book ends with a look at the ever changing public policies and programs for older adults such as Medicare, Social Security, and the Affordable Health Care Act. The final chapter provides words of wisdom, ideas, and hope for the future to continue to serve and care for the growing older adult population. One can only hope that policy makers have a copy of this book on their shelves and take Dr. Haber's words to heart.

Health Promotion and Aging is now one of my favorite books and I look forward to using it in class. It takes many of my interests in the professions of gerontology and public health and combines them all in one book. This is perfect for the jack of trades professional. Every health educator, health care administrator, and community planner could benefit from the research and application examples described in this text. This is the perfect "crossover" text for the public health professional who says they don't work with older adults and the gerontologist who says they don't focus on health care. This book provides a "big picture" look at our society and how we plan (or have not planned) to meet the needs of the fastest growing segment of our population. This would be an excellent text for an applied gerontology course. It provides valuable examples for future professionals in the world of recreation, wellness, and administration for older adults.

As a former senior center director, I particularly liked chapter 13, where Dr. Haber provides five unique career paths for students. The first one, being to redesign existing senior centers as wellness centers. This book would have been a great asset to assist me in new program development. As an instructor, this book provides examples for future service-learning projects. Dr. Haber provides ideas for new programs using evidenced based practices and a good amount of detail to write the policies and procedures (if not the actual procedure) to get a new project off the ground without having to reinvent the wheel. As a bonus, Dr. Haber provides suggestions on agencies for community collaborations.

I found the author's writing style particularly engaging. While reading the text, I felt as if Dr. Haber were speaking to me as if we were old friends or colleagues. I enjoyed reading his personal insights and thoughts even in areas of the text I would have been tempted to skim just to read what his impression was of a particular topic or situation.

There is a wealth of history along with current events described in the text. For those of us who have been around, I really liked how Dr. Haber provided "then and now" examples. For example in chapter five, Dr. Haber describes the USDA's new program MyPlate vs. MyPyramid in teaching about balanced meal planning. In chapter four he provides examples of the Surgeon Generals recommendation for activity that used to focus on targeted heart rates and now focuses on the accumulation of activity most days of the week and explains why we changed from one method to another. If there is a weakness in the book, I have not found it, unless you are not a fan of Dr. Haber's style of humor and blunt honesty.

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Anthropology & Aging Quarterly
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