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Feature

Reexamining the boundaries of the 'normal' in ageing

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Reexamining the boundaries of the 'normal' in ageing

Textbooks and policy documents tend to present the boundary between normal and abnormal ageing as natural and clearly demarcated. In this study, we trouble the notion of natural and clearly demarcated boundaries between normal and abnormal ageing by considering how these boundaries have been established and maintained in present-day Western contexts. We draw on both Canguilhem's discussion of the normal and the abnormal and Foucault's emphasis on the role of the sociohistorical context in the social practice of boundary generation. In doing so, we critically examine common conceptualizations of normal and abnormal ageing, including those found in antiageing science, successful ageing and healthy ageing policy discourses and in health education textbooks. We argue that the growing emphasis on 'healthy' ageing both reflects and shapes the societal views of those individuals who are not able to remain disease-free and represents a kind of mystification of ageing where ageing without functional or cognitive decline is instituted as the norm. Awareness of the role that the social context plays in shaping definitions of normal and abnormal ageing encourages critical consideration of the effects that Western conceptualizations of normal ageing may have for older adults who continue to age with cognitive or functional decline.

Key words: ageing, ageism, healthy ageing, normal, norms, successful ageing.

Older adults represent a growing proportion of individuals in Canada. By the year 2026, estimates suggest that adults over the age of 65 will represent one-fifth of the population (Government of Canada 2002). By the year 2031, the number of adults over 100 years of age will triple, totaling 14, 000 (Carstairs and Keon 2009). These sorts of numbers are often cited both as a source of alarm and as the grounds for action in policy, research, and practice. It is in part these numbers, but more so the ways they tend to be taken up, that compels a rethinking of societal understandings and responses to ageing as such. As people age, they experience a number of physiological changes that are usually considered, by lay people and health professionals, as a normal part of the ageing process, including decreased muscle mass, reduced visual and hearing acuity, and slowed reflexes (Aud 2001). Older adults are also known to be more likely to experience diseases such as diabetes, cardiovascular diseases, or dementia-related conditions (Mattson Porth 2005). Yet increasingly, these diseases are not considered an expected part of normal ageing but, rather, are seen as preventable (Aud 2001).

In this study, we critique the boundaries between normal and abnormal ageing by considering how these boundaries have been established and maintained as natural and clearly demarcated within present-day Western contexts, drawing on the seminal ideas of Georges Canguilhem and Michel Foucault, both influential twentieth-century French philosophers (Spicker 1987). Canguilhem was a physician and philosopher concerned with normality, the pathological, and the implications that common understandings of the normal and pathological have for the development of medical knowledge and the practice of medicine (Horton 1995). Foucault was a historian and philosopher who was influenced by Canguilhem's work, but his analysis placed more emphasis on examining knowledge development as a social

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practice embedded within a particular sociohistorical context (Bracken, Khalfa, and Thomas 2007). Taken together, Canguilhem's conceptualization of norms and Foucault's approach to understanding the construction of boundaries as a social practice, embedded within a sociohistorical context, supports critical analysis of the ways in which common, Western perceptions of normal ageing and disease shape *what we consider as acting for the good of older adults* in health practices, political responses to the growing ageing population, and the research agenda for ageing science. Instructional texts, policy documents, and scholarly research articles provide examples for exploring Western conceptions of normal and abnormal in ageing and disease, and the societal context in which these conceptions have developed.

In discussing the present-day boundaries of the normal and abnormal in ageing, we will ask how we, as healthcare providers and researchers, have come to promote the idea that normal ageing is or should be devoid of disease and abnormal (i.e., pathological) functional or cognitive decline. We will begin with a more detailed discussion of Canguilhem's and Foucault's work to introduce the ideas that are of assistance in exploring the current systems of thought within Western culture that, we will argue, support the use of a particular understanding of healthy ageing as normal ageing.

THE NORMAL AND THE ABNORMAL

Canguilhem (1991) differentiates between biological and social norms. Biological norms have commonly been defined in two different ways. A biological norm has been defined as a characteristic that originates from the observable features of the organism that correspond to the longest lifespan. As Canguilhem writes, 'an organism's norm of life is furnished by the organism itself, contained in its existence' (1991, 258). As such, biological norms represent innate characteristics of the organism; features of that organism that, when within normal limits, improve that organism's chances of survival. Each of the biological norms for an organism relates to another. That is, norms hang together, resulting in a cohesive biological system that results in the longest lifespan for that particular being.

In biology, norms are also defined by the frequency of a characteristic occurring within a population. Statistically, the norm is based on a normal curve on a graph that plots some characteristic against the frequency of occurrence of that characteristic within a given population (Woodward 2005). The point at which this graph peaks is the average or the value of that particular characteristic that is of the highest frequency within that population. Normal is not defined only by the average. In biology, it is understood that there will be some natural variation around this average and that it is the values that encapsulate 68.26% of the population that are considered normal (Canguilhem 1991). However, there are individuals who fall outside of this normal range and who do not actually experience any pathological effect. Given this, it is important not to confuse the statistical norm with the pathological norm as 'there is no clear dividing line between innate variations compatible with health, and acquired variations which are the symptoms of disease' (Canguilhem 1991, 268).

In contrast, social norms are *selected* by members of a society: 'social norms are to be invented, not observed' (Canguilhem 1991, 259). Or put another way, social norms do not exist for any natural reason; instead they are created (Mol 1998). As Mol argues, social norms mimic biological norms, where a large social organization is composed of a body of norms that are interdependent upon one another and coalesce in a coherent way. That is to say 'norms are relative to each other in a system (and) their correlativity within a social system tends to make this system an organization' (Canguilhem 1991, 249).

The identification of the abnormal precedes definition of the normal state. As such, a social norm is *the expression of a preference* for one state of being in light of evidence of the existence of another state of being deemed undesirable – the abnormal (Canguilhem 1991). In other words, human beings define normal because the state defined as abnormal is seen as an undesirable state within a particular societal context. In Canguilhem's terms, every preference for a possible order is accompanied, most often implicitly, by the aversion for the opposite possible order, and we are not indifferent to that which diverges – we are repulsed by it, hostile to it (Canguilhem 1991, 240). Distinguishing between normal and abnormal is not then a value neutral activity; rather, the norm acts to devalue the abnormal (Canguilhem 1991).

Canguilhem (1991) begins his essay *On Organic Norms in Man* with the statement that in the case of the health and disease of an organism, the therapist who attends to the ills of that organism will know 'in advance and without hesitation' the normal state that must be reestablished. Here, Canguilhem is drawing a clear distinction between biological norms and social norms. To Canguilhem, medical intervention that seeks to restore that organism (here, a human being) to their normal state of health is as straightforward as observing what the biological norms of that organism are and intervening in a way that supports the organism to return to that innately defined normal state. This distinction, so clearly drawn at the outset of this chapter, is blurred near the end of the chapter. For humans, norms are not only

means through which the biological human is governed in the physical environment; they are also shaped by that organism's 'possibilities for action in a social situation' (269). Unlike a 'law of nature', suggests Canguilhem, 'a norm does not necessitate its effects' (240).

In many cases, the two understandings of biological norms can coexist without contradiction. For example, most individuals within a population carry only two copies of chromosome 21 (Davis 2005). The presence of three copies is considered abnormal, as in Trisomy 21 or Down syndrome. Individuals with Down syndrome have a shorter lifespan than those with only two copies of chromosome 21. This provides a good example of a characteristic that is less frequent within the population and is also associated with a reduced lifespan. However, in older adult populations, there are many instances where there is a high frequency of characteristics that are not associated with the longest possible lifespan. We will expand on this idea throughout this paper.

Drawing distinctions around normal and abnormal is an ordering and boundary-drawing activity. Foucault (1970) discussed ordering practices in a way that can shed light on the distinctions made between normal and abnormal ageing. He argued that systems of ordering influence what is possible to think within a given culture. By examining the ordered bodies of knowledge, for example grammar, natural history, and biology, he analyzed the basis through which knowledge and theory were possible in a particular historical context. Foucault analyzed the distinction between the 'Same' and the 'Other' and upon which foundation or order those distinctions rely. In his analysis of ordered bodies of knowledge, Foucault's aim was to 'rediscover on what basis knowledge and theory become possible' within a particular culture at a given time (21). He is concerned with the conditions of possibility for knowledge, the particular configurations of thought within the '*space* of knowledge' which have produced present-day science. For Foucault, what we come to know is contingent upon the sociohistorical context wherein the knowledge was developed. Foucault's analysis of the sociohistorical contingency of human ordering practices and of boundary-drawing between the 'Same' and the 'Other' directs us to consider, in more detail, the factors that influence how 'normal ageing' is currently defined in Western culture.

To summarize, Canguilhem (1991) described two ways to define a biological norm: as the characteristic associated with the longest lifespan and as the characteristic that occurs most frequently within a population. There is also a social norm, which results from what Foucault (1970) describes as a human practice of boundary drawing within a particular sociohistorical context. Thus, social norms are contingent upon the context within which they were selected. Both Canguilhem and Mol (1998) caution us concerning the dangers of confusing social and biological norms in our practices. We will now consider the Western societal context, presenting first a brief description of the development of the Western understanding of health and illness before turning to Western definitions of normal and abnormal ageing.

CAUSES OF HEALTH AND ILLNESS

Definitions of health and illness have not remained static over time (Mattson Porth 2005). Human beings' understanding of what constitutes health and what causes illness has evolved largely due to new discoveries and the interpretation of those discoveries at a particular point in history. At one time, evil spirits or angry gods were thought to cause illness (Mattson Porth 2005). In stark contrast, the current Western approach, which has had influence across the world, operates under the belief that the knowledge of health and illness is developed by peering deeper into the organism. This has resulted in scientific discoveries, accompanied by technological developments – from the discovery of the cell in the sixteenth century to the development of kidney dialysis and transplant surgery in the twentieth century (Mattson Porth 2005).

These developments have also had a profound impact on the health concerns that Westerners face. No longer do we fear death primarily from infectious disease. Instead, with measures such as antibiotics, vaccinations, and widespread improvements to sanitation, we have a high probability of living well into older adulthood (Mattson Porth 2005). There remain a whole gamut of chronic diseases such as cancer, diabetes, cardiovascular disease, and arthritis that we may very well experience as we age (Government of Canada 2002). Is it, then, normal to age with chronic disease?

BIOLOGICAL NORMS: THE HIGHEST FREQUENCY

Canguilhem (1991) discusses biological norms as a characteristic with the highest frequency within a population. Thinking about biological norms of ageing in this way results in a particular interpretation of the relationship between ageing and disease. Statistics, for example, suggest that 80% of seniors who live at home 'suffer from a chronic condition' (Government of Canada 2002, 10). If the majority of seniors who reside in community live with chronic disease and this number would be even higher in long-term care or assisted living settings, then according to the highest frequency argument, normal ageing is ageing with a chronic disease.

Indeed, this is a conception of ageing that has permeated Western society in the past.

Western values and ageing as pathological

Vincent discusses several fundamental characteristics of Western culture that have influenced cultural beliefs about ageing including the valuing of individualism and a strong focus on the body in forming an identity (Vincent 2008). Similar to the focus on individuality, autonomy is a strong cultural value that minimizes the importance of interdependence between biological individuals (Becker 1994).

These foundational understandings of human beings—as autonomous individuals and with identities that are closely tied to the physical body—permeate Western culture and influence the meanings assigned to the ageing process (Mattson Porth 2005). The ageing process has been seen as a period of losses and decline in physical and mental functioning (Nygren et al. 2005) and as 'synonymous with disease, disability, and decline' (Becker 1994, 60). Ageing has been defined as 'the time-independent series of cumulative, progressive, intrinsic, and deleterious functional and structural changes that usually begin to manifest themselves at reproductive maturity and eventually culminate in death' (Arking 2006, 11). Here, the boundaries of the biological definitions of ageing rely on concepts of deterioration and decline (Vincent 2008), which may be a consequence of the Western approach to thinking about humans as physical, independent beings and by observing the high frequency of chronic disease within the population of older adults that can limit physical function and independence. The definition of normal ageing then arises from a biological norm as defined by the frequency of observing a particular characteristic within the population of older adults. However, the meaning attached to this biological norm is constructed based on reference to Western values of autonomy, practices of individualism, and a focus on the physical body. In Canguilhem's terms, qualifications are added to the norm but are made to appear intrinsic to it, disregarding the extent to which these actually require social and material practices to be made meaningful. That is, the normal becomes the norm in relation to practices, theories, and institutions that support a particular social ordering.

In Katz' (1996) analysis of the implications that Western medical practice has had on ideas of ageing, the ageing body would always be seen in terms of pathologic processes because the normal referent for health is the body of the mature, young adult. In comparison with the young adult, ageing represents a process of decline and degeneration from this peak, healthy state. The ageing process is seen as at once both pathologic and normal; the meanings that medicine imposes upon the ageing body result in an equating of 'pathological disease, decline, and incapacity with the normality of the ageing body' (Katz 1996, 47). This suggests that this understanding of normal ageing was, in reality, what Canguilhem would call a social norm rather than a biological norm, created to exist in a coherent relationship with the biological norms of the young adult.

Equating decline with ageing represents but one potential effect of social processes that define norms of ageing. We argue that the current discourse illustrates a rejection of this particular understanding of the relationship between ageing and disease because of the implications this relationship has for older adults. Yet, Western practices of focusing on the individual, highlighting the physical body, and emphasizing autonomy remain highly influential in determining what is currently defined as normal ageing.

BIOLOGICAL NORMS: THE LONGEST LIFESPAN

Disease has been defined as 'any deviation from or interruption of the normal structure or function of… the body that is manifested by a characteristic set of symptoms or signs' (Mattson Porth 2005, 13). As an organic norm, Canguilhem (1991) would say that restoration of the individual to a normal state is a relatively straightforward process, in contrast, for example, to trying to fix a problematic society. This is because the state that the organism would be restored to is evident within that organism, corresponding to the longest lifespan. Given this definition of a biological norm, disease would be an abnormal physiological process for human beings because it would shorten the natural lifespan of that human. This requires us to draw boundaries between those physiological changes that constitute normal ageing, that is, that correspond to the natural lifespan of the organism, and those that are characteristic of disease. This boundary-drawing process has occurred within the medical literature, shaping the generally understood relationship between ageing and disease. We argue later that the social context has a large influence on where and how these boundaries are drawn. Our intent is to make some of these contextual influences explicit.

THE INFLUENCE OF THE SOCIAL

Texts from the health sciences indicate that there are a number of 'normal' physiological changes that occur during the ageing process. These changes include decreased skin elasticity, diminished hearing acuity, increase in systolic blood pressure, and muscle atrophy (Aud 2001, 252). Changes that

are currently seen as normal (i.e., expected) physiological changes can change with time and technology. They are, as Foucault would say, contingent.

Antiageing

Proponents of antiageing science direct their research efforts toward a range of activities focused on decreasing the effects of the ageing process (Vincent, Tulle, and Bond 2008). These activities include explorations of ways to extend lifespan and of interventions to avoid the 'diseases and functional and cognitive decrements of old age' (Vincent, Tulle, and Bond 2008, 291). While some antiageing researchers expect maximum life expectancy to remain essentially unchanged once extended to 120 years, others envision a future where human beings would live as long as 240 years (Vincent 2008). In both cases, reduction in morbidity throughout the older adult years is a main goal (Vincent, Tulle, and Bond 2008). In antiageing science, there is a blurring of boundaries between what is a disease process and thus worthy of curative intervention and what is a 'normal' ageing process that should be left to unfold naturally. Indeed, in antiageing science, no part of the ageing process is, by virtue of its naturalness, safe from the work of health science researchers or intervention by healthcare professionals. In antiageing, the boundaries of normal physical ageing are diffuse and in constant flux.

The antiageing enterprise is explicit in its aims. But there are more common discourses on ageing that implicitly shift the boundaries of normal and abnormal ageing, while attempting to present these boundaries as clear, biological norms.

Healthy and successful ageing

A well-known recommendation thought to delay the onset of chronic disease is to make certain lifestyle choices such as exercising regularly, eating well, and not smoking (Aud 2001). As Heymann and Porth (2005) assert:

> We have become increasingly aware of the importance of preventive measures against non-infectious conditions…. There is no better way to prevent disease and maintain health than by living a healthy life, and increasingly, it will be the individual who is responsible for ensuring a healthy passage through life. (12)

Where once the gods caused illness, now the individual and their lifestyle choices are to be held accountable. Thus, the scientific explanation for the causes of illness that Western society emphasizes results in a dramatic shift in the locus of responsibility for disease prevention. Further, that the responsibility for disease prevention belongs to the individual further reflects the Western societal focus on individuality and autonomy. And importantly for our purposes, this understanding of the causes of disease shapes what is seen as an appropriate message to send to the public about ageing. Frequently this message appears paradoxical – the inevitability of decline and disease set against individual responsibility to prevent the same. This leads to a situation where even documents that recognize the ways ageism is perpetuated in social values and arrangements also identify 'healthy ageing' as a solution to this problem.

For example, a recent Canadian government document, *Canada's Ageing Population: Seizing the Opportunity*, reports the findings of a Senate committee tasked to examine a broad range of issues related to ageing in Canada and to review the resources available for older adults (Carstairs and Keon 2009). This document gives a sense of the broad mandates of the federal government and of the vision for the future of elder care, and puts forward a number of recommendations to improve the care and support that older adults receive in their communities. The authors highlight the problem of ageism, that is, 'discrimination on the basis of age' pointing out that Canada's Western, youth-oriented society undervalues older people (Carstairs and Keon 2009, 12). In Canadian culture, growing older is seen as something to be avoided, and if not avoided then to be kept hidden (Carstairs and Keon 2009). Similarly, international bodies have highlighted the issue of ageism and challenged the negative images imposed on older adults, including the view that older adults are a drain on society owing to increased utilization of healthcare resources (Madrid International Plan of Action on Ageing 2002).

Both the Canadian and the international documents cited earlier also discuss the importance of healthy ageing. Nationally, a main measure to combat ageism and the view of older adults as unproductive members of society is to 'lead an aggressive public relations campaign to portray healthy ageing and to present the benefits of staying active at all ages – in volunteer work, continuous learning, and physical activity' (Carstairs and Keon 2009, 16). Although it is argued that governments have a responsibility to provide a supportive environment to enable health and well-being in older age, it is also expected that individuals will take on the responsibility to live a healthy lifestyle (Madrid International Plan of Action on Ageing 2002).

Few could argue that maintaining a healthy lifestyle is a positive strategy and goal for individuals as they age. However, in this framework, is there room for the 'normal', physiological changes that occur as people age that may result in functional and cognitive decline, regardless of the individ-

ual's lifestyle choices? Certainly, the policy documents described earlier acknowledge that older adults will need equal access to preventative and curative healthcare services. But they heavily emphasize that health promotion and disease prevention activities are focused on maintenance of independence throughout life and prevention of disease or disability (Madrid International Plan of Action on Ageing 2002). And helping people to 'age well' through health promotion strategies intended to delay the onset of chronic disease, ultimately lowers costs for the healthcare system – which can only be a good thing (Carstairs and Keon 2009). However, as Dahl (2005, 56) argues in her analysis of this shift in discourse in the Danish context, while the change in focus may be good for older people who are active, healthy, and independent, it may bad for those who are fragile:

> One discursive threat is a retrenchment caused by the silencing of the fragile elderly person and his/her needs. Another threat becomes the extension of the regulation of the recipient since a new ideal of the 'good' recipient is generated. An ideal embodied by a capable and self reliant elderly person….

Dahl has also described this new imperative as a 'will to the pleasant', a movement away from the duty to relieve distress or loneliness to an increasing emphasis on supporting well-being and life realization.

These ideas are not just found in policy documents but are also in textbooks. In recent years, nursing and other health disciplines have carefully specified that ageing with illness is not normal ageing (Aud 2001; Mattson Porth 2005). Undergraduate nursing texts draw a clear boundary around normal ageing to prevent students from equating the ageing process with illness and decline and focus, instead, on ways to promote 'healthy' ageing (Aud 2001). Training of nurses and other healthcare providers is carried out in this way to counter stereotypes of ageing adults as sick, frail individuals with diminishing ability to contribute in a meaningful way to society – a goal very hard to argue with (Carstairs and Keon 2009).

However, this conceptualization of ageing without illness as normal ageing works to implicitly shift the boundaries of normal ageing. Although healthy ageing is discussed in policy documents and textbooks as though it is what Canguilhem would call an organic or biologic norm, a natural thing that corresponds to the longest lifespan of the organism, if only we would make the proper lifestyle choices, there is something unsettling about the way in which, in these terms, the majority of older adults become abnormal. Some would argue that, in challenging the association of ageing with illness and decline, ageism is actually perpetuated (Vincent, Tulle, and Bond 2008) because many older adults – those with physical and cognitive decline and who live with multiple comorbidities – come to be seen as not having fulfilled the mission of healthy ageing. As in the definition of normal ageing as pathological, this definition of normal ageing as devoid of disease remains a reflection of Western values, presenting physical and/or cognitive decline as a negative, undesirable by-product of ageing. While discussed in texts and policy documents as a biological norm, there is something much more social at work.

It is also important to note that, despite clear distinctions in medical textbooks, there are many cases where we do not actually know where the boundaries lie between improving normal function, treating symptoms, and preventing illness (Hyman 2006). Establishing a boundary between normal and abnormal ageing then seems a process as much influenced by the social context as by an inherent biological norm. Here, we will discuss cognitive impairment as a final example of the diffuse boundaries between the normal and abnormal in ageing.

Cognitive impairment

Mild cognitive impairment (MCI) is a relatively new category/diagnosis used to describe individuals who exhibit some cognitive impairment but do not meet the diagnostic criteria for dementia (Petersen et al. 1999). It is of interest to researchers and to clinicians because people diagnosed as exhibiting MCI are believed to be at higher risk of developing Alzheimer's Disease (AD) or other forms of dementia, and early intervention is hypothesized to slow this process (Katz and Peters 2008). However, critics suggest that because MCI has not been clearly found to be a pathological process, creating a diagnostic category, MCI, is characteristic of the medicalization of normal ageing and the blurring of boundaries between pathological processes and normal ageing (Katz and Peters 2008; Moreira and Bond 2008). Absent a clear distinction between normal brain ageing and MCI, the boundary between AD and normal ageing becomes more diffuse and expansive, and a larger number of people are drawn into the category of the diseased. Yet, research on AD and other dementia is still developing, and the causes of AD and other dementias remain poorly understood (Katz and Peters 2008). Even the final diagnostic criteria for AD remain problematic; on autopsy, the plaque characteristics of AD are actually present in many older adults without the symptoms of AD (Katz and Peters 2008).

How do healthcare professionals and researchers come then, to make statements that dementia is not a normal feature of ageing when we do not yet know what normal cognitive ageing is? Qualitative findings from research conducted

with individuals who work with or study older adults in clinical and scientific settings highlight the political factors that have been instrumental in the consensus definition of AD as different from normal ageing (Moreira and Bond 2008). As Moreira and Bond report, the political framing of AD was key to securing government support (i.e., funding) for research on AD as politicians were not interested in funding a 'hopeless quest'. Thus, a necessary distinction to make to gain government support was that AD was a disease and not normal ageing (Moreira and Bond 2008). Drawing boundaries between normal and abnormal cognitive changes appears to involve political and social considerations that impart meaning to what then come to be seen as natural processes of ageing.

SOME IMPLICATIONS OF WESTERN BOUNDARY WORK IN AGEING

Our beliefs are strongly influenced by our prior beliefs, which are themselves intricately connected to the historical, cultural, and social contexts we inhabit (Shapin 1994). These contexts shape how we, as Westerners, draw boundaries between normal and abnormal ageing, and this in turn influences what is seen as an appropriate response to the growing population of older adults.

The boundaries placed around normal ageing matter because they shape the messages that are delivered to the public around the experience and goals of ageing. Those who create such messages are also members of a larger society, and this societal context shapes their approach to framing the idea of normal ageing in social policy, public health, clinical management, and research. What are some of the implications of the current boundaries placed around different aspects of normal ageing?

In research, as with the government's focus on healthy ageing, there is an increasing emphasis on 'successful ageing'. Exploratory work has been conducted to determine the factors that contribute to successful ageing among older adults. Previous research has highlighted the importance of achieving meaning and purpose in one's life (Flood 2005; Sinnott 2009) and the integrative ability to achieve a sense of past, present, and future (Moore, Metcalf, and Schow 2006). Yet, these themes were uncovered by speaking with participants who had 'normal' cognitive function. If this is how successful ageing is defined, someone with cognitive changes who has difficulty remembering the past, a task seen as necessary to form an integrative self, or who could not articulate the meaning in their lives owing to loss of communicative ability, would not have aged successfully and would be excluded from research that wishes to examine determinants of successful ageing. As another example, research that examines ageing processes has identified potential positive aspects of ageing that can include continued intellectual and skill maturation (Nygren et al. 2005). Yet, even in trying to intentionally highlight positive aspects of ageing, this research identified factors that are value laden and are reflective of traits seen as positive within a society with hypercognitive expectations of its members (Katz and Peters 2008).

Successful ageing has been identified as more about how an older adult *should* age rather than how individuals actually age (Chapman 2005). Some have taken strong positions on successful ageing, stating that successful ageing is not ageing at all and that it would indicate that those who do display normal signs of ageing are in need of fixing (McDaniel 2005). This successful ageing discourse, similar to the healthy ageing discourse, results in an individual duty to age well (Rozanova 2010). Shifting our understanding of older adults from frail elders to healthy, active individuals who do not consume healthcare resources shapes our perception of those older adults who have not met this societal expectation. Within this discourse, they have not aged successfully and do not contribute to society.

We discussed previously how the definition of AD as a disease, and the consolidation of the category MCI as its early indication, has resulted in the funnelling of resources toward the search for a cure. The same can be said for other processes of ageing. The Institute of Ageing, the primary funding body for ageing research in Canada, focuses on healthy ageing in their mandate 'to support research, to promote healthy ageing and to address causes, prevention, screening, diagnosis, treatment, support systems, and palliation for a wide range of conditions associated with ageing' (Canadian Institutes of Health Research 2010, para 1). While they also support the study of the 'ageing person in an ageing society', the focus, as stated in their mandate, is largely on understanding the diseases that affect older adults. This perpetuates the idea that the questions that are most worthy of exploration are those associated with changing a pathological process by modifying risk factors and identifying a cure. The value of studying ageing is tightly linked to interventions to support healthy ageing (i.e., ageing without disease or disability).

We would suggest that these discourses around healthy and successful ageing, although important and in many ways compelling, fail to draw our attention to the needs of older adults in the here and now. That we must differentiate between normality and disease to justify something as worthy of societal attention is problematic. What will not improve with a narrow focus on healthy and successful ageing is our

pessimistic view of the older adults who experience cognitive and functional decline, regardless of their healthcare practices or the technological interventions of the time. We de-value older adults, even as we attempt to reduce ageism.

CONCLUSION

Western discourse on ageing is strongly shaped by social norms rather than by biological norms. That is to say, what is presented as normal, biological ageing is not the static reality of normal ageing; it is the fluid, contextual understanding of ageing, constructed within a particular society. While the dominant Western discourses support older adults to age well, the underlying message is that, to do so, one must avoid disease and disability. The boundaries, as currently drawn around healthy ageing as normal ageing, will continue to define the majority of older adults as failing to age successfully. The purpose of this study was to illustrate how the boundaries between normal and abnormal ageing are less concrete than they are often presented to the general public and in the training of healthcare professionals and that these conceptions are perpetuated for a variety of reasons that have cultural, political, and historical roots. The intent of this study was to make the contingent nature of these boundaries explicit and to ask the reader to consider the implications of these conceptions of normal ageing on older adults as we advance healthcare practice, research, and social policy.

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