Older Women, Power, and the Body

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Stereotypes about older people contain both positive (e.g., wise, sage, experienced) and negative (e.g., grumpy, lonely, senile) elements (Kite and Johnson 1988). The positive elements are more likely to be emphasized in collectivist cultures that recognize important roles for older people in society in general and in the family in particular (Calasanti and Slevin 2001). For example, powerful roles for women include grandmother and mother-in-law, and these roles are often especially powerful in cultures where younger women are treated with significantly less respect than men are. Women obtain some of the power associated with these roles through the body or in connection with others' bodies. Bearing children and raising them to adulthood, negotiating a good "match" so that one's children will produce children, reaching menopause, and sharing knowledge about recipes and herbs/medicines/treatments that keep the family healthy are all associated with wise and experienced older women who have proven themselves worthy of others' respect and admiration. Thus, the aging body can empower women.

Negative stereotypes of older people are more common than positive ones in individualistic, industrialized, Western cultures, which tend to be youth oriented. In these cultures, young adults and midlife men tend to occupy more powerful roles than midlife women and older people do. Older adults tend to be marginalized in both popular culture and in society in youth-oriented cultures (Lemish and Muhlbauer 2012; Robinson et al. 2009). Due to the double standard of aging (Zebrowitz and Montepare 2000), older women are generally portrayed more negatively than older men. This is because women's power in youth-oriented cultures depends to a large degree on the body, as attractiveness is a traditional source of power for women. Attractive women gain attention from powerful people, and beauty brings women into the orbit of the powerful (e.g., via relationships with wealthy and/or powerful partners, via well-paid careers that depend, at least in part, on women's self-presentation). The negative stereotypes of aging are often related to changes in the body that render it unattractive (e.g., wrinkled, grey-haired, ugly)

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or incompetent (e.g., weak, feeble, debilitated, disabled, dependent, ill). Thus aging bodies, especially women's bodies, can be disempowering.

Stereotypes of older people are not merely a matter of academic interest. They can have an important impact on older people's physical and mental health and well-being and on their social, physical, and cognitive competence. For example, in social psychology studies where older participants were primed (i.e., exposed to, usually in a surreptitious way) with words associated with either positive or negative stereotypes of elders, the negative priming led to worse handwriting (Levy 2000), stronger cardiovascular response (i.e., evidence of stress) when asked to solve verbal puzzles or do arithmetic (Levy et al. 2000), poorer performance on a math (Abrams et al. 2006) or a memory test (Desrichard and Kopetz 2005; Hess et al. 2003), lower willingness to take a risk, higher scores on a measure of loneliness, lower scores on a measure of perceived health, lower scores on a measure of extraversion, and more frequent requests for help (Coudin and Alexopoulos 2010). Participants who received the positive priming performed significantly better on all of the measures than those who received the negative priming. Thus, it seems that acceptance of the negative stereotypes (or the belief that others accept the stereotypes) that emphasize incompetence can be a self-fulfilling prophecy for older adults who come to embody those stereotypes, both literally and figuratively. The results of the studies suggest that negative stereotypes can actually contribute to dependency, weakness, and inability by disempowering older adults (Coudin and Alexopoulos 2010), and thereby reinforce those negative stereotypes.

In this chapter, we examine the ways that the body can empower and disempower older women. We consider ways that older women can see their bodies as potential sources of empowerment. Finally, given that most of the work on stereotype embodiment has been done in Western countries, we wonder how older women's self-perceptions and self-concepts might be different if they had regular access to positive stereotypes about their age mates.

Empowerment and the Exercise of Social Influence

Social psychologists define power as influence, that is, the ability to persuade other people to do or not do something (e.g., Cartwright 1959). Three types of power have been described: power over, power from, and power to. *Power to* over is the prototypical form; it is the ability to get other people to do what one wants them to do. *Power from* is the ability to resist the influence attempts of others; it includes the ability to say "no." *Power to* is the ability to control one's own thoughts, emotions, and actions in the service of achieving one's own goals (Hollander and Offerman 1990; Yoder and Kahn 1992). Empowerment includes all three types of power, but feminist activists tend to focus on power to—the ability to make change in the service of social justice (i.e., to improve conditions of life for oneself and others). Empowered older women have greater self-confidence, a stronger sense of self-efficacy (i.e., the belief that one can do what one wants to do), and a considerable

amount of social capital (i.e., connections in one's social network) and relationality (i.e., the ability to work with others to get things done) (Denmark and Klara 2007). Disempowered women are lower in self-confidence, self-efficacy, and social capital, and they are able to exercise much less power of all three types. It is important to remember that power only exists in relation to others; it is not a characteristic of individuals. Power is also a dynamic and contextual process; therefore, an older woman may be powerful in some circumstances (e.g., in the family) but not in others (e.g., in the public sphere).

In a classic essay, Bert Raven (1965) described six bases or styles that people can use to exert influence successfully: reward, coercion, referent, legitimate, expert, and informational. Reward power is the ability to offer resources to others in order to persuade them to accept one's influence. Typical resources used by powerful people include money, promotions, awards, and positive publicity. However, other rewards are body-dependent, and do not require wealth or position. Many people can be influenced by a hug or kiss, a warm smile, a pat on the back, or sexual activity, and older women use some of these rewards successfully every day with family and friends. Coercion power is the ability to confer (or threaten to confer) punishment on others in order to persuade them to accept influence. Coercion can include directly delivered punishment (e.g., violence, imprisonment, disinheriting someone) or the withholding of rewards (e.g., no sex, no smiles, no talking until the influence is accepted). Lysistrata showed the power of withholding body-related rewards when she and her followers stopped a war in ancient Greece by refusing to have sex with their husbands until peace was declared. Referent power is based on long-standing or strong relational ties (e.g., "Do it for me," "Parents ought to agree"). Friends, lovers, and kin earn the right to influence each other over time. Older women often have considerable social capital, some of it directly related to the body (through sexuality, birthing, and caregiving), which allows them to influence others they know well.

Legitimate power is the right to influence others based on one's social role or position in a hierarchy (e.g., corporals influence sergeants, religious leaders influence congregations, teachers influence students). Parents have the right to influence their children and their children's children, a form of legitimate power derived from the body. This form of power is what makes grandmothers and mothers-in-law so influential. Beautiful women are also shown in popular culture to be very influential; others want to please them and be seen with them. They have the ability (and "the right") to "turn men's heads" and to draw others' attention away from whatever they were doing. Physically ill, dependent, and weak people also have a legitimate right to influence others to help them or to take care of them. This may not be the most empowering way to deploy the body as an agent of influence, but it usually works, and older women have often successfully used illness and weakness as a claim on others, especially family members.

Expert power is the ability to persuade others to accept one's influence because of the special expertise one has. For example, most people willingly accept influence from doctors, plumbers, stockbrokers, and mechanics because they have specialized training most of us do not have. Informational power is the ability to persuade

others based on a solid argument that is convincing or because the persuader has access to information (e.g., through gossip) that is not generally available. Older women can have considerable expertise based on their profession, specialized education, or practical experience gained over a lifetime. They may also be good at explaining patiently to others why a particular course of action is the right one, and their wisdom and experience can back up their advice. Their social networks, which are often more extensive than men's, provide them with the opportunity to "hear things" or learn from others' experiences that can add to their arguments. However, these power bases have less to do with the body than others do, so we will not say much more about them here.

Aging Bodies and Power

There are three main ways that changes in the body that are related to aging can empower or disempower women. Those ways are changes in (1) beauty or physical attractiveness; (2) physical fitness; and (3) physical health and ability.

Physical Attractiveness

Both women and men are rewarded when they engage in activities related to gender roles and gendered expectations (Burgess and Borgida 1999; Rudman and Phelan 2008). Sports and leadership are expected of men, and men with talents in those areas have high social status and ability to influence others. Physical attractiveness is a primary way that women gain social status and earn rewards (e.g., "You're beautiful," "You look so young for your age"). For example, there are many studies in social psychology that demonstrate a halo effect for attractive people of both genders (e.g., greater likelihood of being hired, promoted, accepted into college, rented a desirable apartment, and lesser likelihood of serving jail time for a criminal infraction; see Fikkan and Rothblum 2012, or Saltzberg and Chrisler 1995, for a review). The rewards of attractiveness are even more obvious for women than for men, as studies show that men rate "attractiveness" a more important quality in a romantic partner than women do (Miller et al. 2007), and some well-paying female-dominated jobs are actually advertised with the qualification "must have front-office appeal" or FOA (in other words, must be attractive to clients and customers). The pursuit of beauty has become a key component of what is perceived as feminine behavior, and most women spend a lot of time, money, and energy to look as attractive as they can (Saltzberg and Chrisler 1995). Those who do not wish to engage in these pursuits are considered to be unfeminine and/or to have "let themselves go."

The current beauty ideal in Western cultures includes a youthful, thin body, with medium to large breasts, small hips and waist, toned muscles, and European hair and facial features (Brown and Jasper 1993; Smith 2008). Most Western women

do not measure up to this ideal (Saucier 2004), and this realization has led to what some call "a normative discontent" (Rodin et al. 1984, p. 267) with the body; however attractive women are, they are never attractive enough. One result of globalization is that images of these ideal women are seen around the world with such high frequency that it can be difficult for women to avoid them, and this means that the body dissatisfaction so common in the West is spreading to other cultures that previously had different beauty ideals. For example, in some cultures, fat women have been considered more beautiful than thin ones (especially where weight is a proxy for health), and in others, dropping breasts, facial scarring, and deformed feet have been greatly admired (Saltzberg and Chrisler 1995; Smith 2008). We know that Western media have changed others' beauty ideals because studies conducted in Eastern Europe (e.g., Forbes et al. 2004) after the fall of the Iron Curtain and in the South Pacific after the arrival of satellite television (Becker 2004) clearly show a rise in eating disorders as women have attempted to change their bodies to look more like the Western models and actresses they now admire.

The Western beauty ideal has become progressively more youthful in recent decades (Seid 1989), and many of the models who appear regularly in beauty magazines and fashion shows are adolescents. The slim, lean lines of "ideal" bodies are child-like, as is the smooth skin unblemished by any sign of lines or winkles, age spots, cellulite, or stretch marks. In addition to changes in the skin that signal aging, women tend to gain weight with each reproductive milestone (e.g., menarche, pregnancies, menopause); therefore, older women, on average, weigh more than younger women do (Rodin et al. 1984). Thus, no matter how near or far from the beauty ideal they started, women move farther away from it with age (Chrisler 2011). Because attractiveness (especially facial attractiveness) is an important component of social capital and interpersonal power (Hatfield and Sprecher 1986), bodily changes that move women farther away from the beauty ideal are disempowering, especially for women who were considered beautiful in their youth.

Although studies show that both female and male faces perceived as old are judged as less attractive than both female and male faces perceived as young (e.g., Kissler and Bäumi 2000; Wernick and Manaster 1984), older women are judged more harshly than older men (e.g., Foos and Clark 2011; Furnham et al. 2004; Harris 1994). In a particularly interesting study (Harris 1994) of 268 adult women and men (ages 18–80), women were significantly more likely than men to report that they use (or plan to use) products that conceal signs of aging (e.g., hair dye, antiwrinkle cream). The participants also read scenarios about midlife characters, who either did or did not use age concealment techniques. Even when the participants themselves favored age concealment, they judged the female characters who attempted to look younger more harshly than they did those who were content to look their age. That is, they described the age-concealing characters as foolish, vain, conceited, and pathetic. Thus, midlife and older women are damned if they do try to conceal their age, and they are damned if they do not.

The studies discussed above illustrate the double standard of aging (Sontag 1979). In the USA, men whose hair is beginning to grey are thought to look "distinguished," whereas women whose hair is beginning to grey look "old." Men with

lines on their faces are thought to look wise and experienced, but women, again, merely look "old." The virtual disappearance of midlife and older actresses from American films and television, whereas male actors continue to work much longer, sometimes playing romantic lead roles well into their 70s, is an expression of the double standard (see Bazzini et al. 1997; Lauzen and Dozier 2005a, b). Although in recent years, there have been several high-profile films starring older actresses (e.g., *Calendar Girls, Something's Gotta Give, The Mother, The Queen*), the positive roles those women played were white, higher-income, and attractive characters (Lemish and Muhlbauer 2012), who can hardly be said to represent the majority of older women. The typical older woman in film and television (rare as she is) is marginal to the plot and exhibits negative stereotypes of older people (e.g., lonely, irritable, senile; Robinson et al. 2009).

Although some studies have documented considerable body dissatisfaction among midlife and older women (e.g., McFarland 1999; McLaren and Kuh 2004; Platte et al. 2000; Wilcox 1996), others have found that older women seem to have a neutral, or even a positive, body image (e.g., Donaldson 1994; Deeks and McCabe 2001). The difference between these two groups of women might be how beautiful they were in their youth and/or whether they have internalized the Western beauty ideal as their standard. Older women who have internalized a youthful beauty ideal are at risk for body dissatisfaction, appearance anxiety, and lowered self-esteem as they are reminded of their aging bodies every time they look at a mirror (Hurd 2000; Saucier 2004). In interviews, older women have complained about grey hair, wrinkles, double chins, facial hair, loose skin on their arms and necks, sagging breasts, and weight gain (Clarke et al. 2009; Foerster 2001; McFarland 1999). Some women, who had previously felt empowered by their ability to turn heads, now feel sad that no one seems to notice them anymore, no matter how well-groomed and nicely attired they are (Chrisler 2007). Thus, women who were closer to the beauty ideal are likely to be disempowered by physical signs of aging, as they are no longer as easily able to exercise power over others and to use the legitimate and reward power bases. However, women who were farther away from the ideal may be empowered by signs of aging. They may be able to exercise power from—the ability to refuse to continue the pursuit of beauty, given that stereotypes of older women as frumpy and ugly are available. Some beautiful women may also feel a relief that could be seen as empowering, as they are freed from some constraints now that their aging bodies are no longer sexualized and objectified by others, and they may be glad to have the opportunity to feel more authentic. Women in cultures that value older women come into power as they embody the wisdom and experience of elders. Thus, signs of aging do not carry the same meaning for all women.

Rather than relaxing into old age by giving up the pursuit of beauty, some women turn to age concealment techniques and attempt to "pass" as younger than they are (Ostenson 2008). Women can do this through the strategic use of fashion accessories (e.g. scarves to hide their necks) and clothing choices (e.g., longer sleeves, looser blouses), through diet and exercise, through the use of cosmetics (including hair dye) and cosmeceuticals (i.e., cosmetic products with biologically active ingredients, which are purported to have medical benefits), and, for those who can afford

it, through cosmetic surgery (e.g., face lift, breast lift) and other medical procedures (e.g., Botox, dermabrasion) (Clarke and Griffin 2007, 2008; Clarke et al. 2009; Clarke and Korotchenko 2010). In interviews, women often express ambivalence about age concealment products and techniques and recognize them as inauthentic, ageist, sexist, and risky, yet many still choose to use them to enhance their self-esteem, relieve body dissatisfaction and anxiety about aging, reduce the risk of age discrimination at work, or because of perceived sociocultural pressures (Clarke et al. 2007; Muise and Desmarais 2010). Indeed, "antiaging" products and cosmetic surgeries are advertised so frequently in the media that their use has become normalized, almost mandated (Brooks 2010; Clarke and Griffin 2007), in the sense that those who can afford to use these techniques are expected to do so.

Recent studies in Australia (Slevic and Tiggemann 2010), Canada (Muise and Desmarais 2010), and the USA (Chrisler et al. 2012) show high interest among midlife women in cosmetic procedures and cosmeceuticals. One third of 57 American women surveyed by Chrisler et al. (2012) had had at least one cosmetic procedure, and 81 % said they would like to have one or more procedures if they could afford them. Although it is certainly true that cosmetic procedures skillfully done can permit women to pass as younger than they are, thus, re-empowering them and shoring up their self-confidence, these gains can be fleeting, as age catches up with the women in other ways or the need to repeat the procedures begins to feel oppressive (Dingman et al. 2012). We have seen women whose smooth faces do not match the loose skin on their arms or necks and women whose face-lifts left their skin so tight that they appear to be wearing plastic masks. These examples of age concealment gone wrong could be among the reasons that Harris' (1994) participants described women who try to pass as "pathetic," "vain," and "foolish"; failed age-concealment techniques certainly do not help women to feel empowered.

Women who want to resist sociocultural pressures to try to erase signs of aging can try to reinterpret their bodies' changes in ways that are empowering. Stretch marks, sagging breasts, and extra pounds are evidence of having birthed and nursed children. Grey hair and lines on the face are marks of experience and suggest wisdom well earned. If grey hair and lines are distinguished in men, why not in women, too? Many people think that photographs of the writer Susan Sontag, with her streak of grey hair, and the artist Georgia O'Keefe, with her deep wrinkles from years of painting outdoors under the desert sun, are beautiful and show Sontag's and O'Keefe's strong character and individualism. Sexiness derives as much from self-confidence and experience as it does from attractiveness, and sexiness is a way to exercise power over, as well as reward, coercion, and legitimate power. Age-peered romantic and sexual partners know that their own bodies are not what they were, and they do not expect the ideal from each other. Women who are concerned about men's reactions to their aging bodies might be comforted by the results of two recent studies. In a study of attractiveness ratings of women's faces (Foos and Clark 2011), it was younger men and women and older women who rated the older faces harshly. Older men rated both younger and older women's faces as attractive. In a study of midlife married couples (Markey et al. 2004), wives thought that their husbands were dissatisfied with their bodies, but the husbands reported that they

found their wives attractive. Women might feel more comfortable with their aging bodies if they watched fewer films from Hollywood and more from other cultures where older women are still seen as sexy or are portrayed as playing powerful roles in society.

Physical Fitness

The process of aging invariably involves changes in the body that can leave older women less physically fit than they once were, and this transition can be disempowering. During the aging process, cardiovascular and respiratory capacities tend to decrease, and muscle fiber count and bone density also diminish (Hamberg-van Reenen et al. 2009). Aging is associated with a decrease in skeletal muscle mass, which accelerates after menopause (Janssen et al. 2000). By age 65, a woman's muscle strength is, on average, 75–80% of her lifetime maximum muscle strength (Hamberg-van Reenen et al. 2009); how serious a problem this is depends, of course, on how much muscular strength she developed in her youth and maintained through midlife (e.g., through manual labor or athletics). A decrease in the elasticity of muscles and tendons can limit a woman's range of motion, and the natural changes in collagen tissue that come with aging leave many older women with decreased flexibility (Jorgic et al. 2013). In part due to these changes in flexibility, range of motion, and other changes in the musculoskeletal and sensory system, the ability to maintain balance significantly decreases over a woman's lifespan (Isles et al. 2004; Jorgic et al. 2013). These factors lead to an increased risk of falling, which is one of the most common, serious, and potentially incapacitating dangers for older adults (Zhang et al. 2006).

A number of negative stereotypes of aging (e.g., ineffective, dependent, less physically active, weak; Robinson et al. 2009) are related to physical ability and fitness. Although the age-related changes described above mean that older people slow down their physical activity with advanced age, there is considerable variability in how much energy, stamina, balance, and cardiovascular and muscular fitness people have at every age. Men's levels of physical activity tend to be greater than women's throughout the lifespan, but the gap is wider in older cohorts (Bassey 2000; Chen et al. 2012). In some cultures, girls and women are discouraged (or even forbidden) to engage in sports and exercise routines that take them out of the house, involve revealing or form-fitting clothing, or require them to compete with or against boys and men. In some cultures, women who live in rural areas may not engage in sports, but develop strength and fitness through manual labor, including long walks to markets or wells, heavy lifting, and aerobic activities (e.g., sweeping, hoeing). In the USA, where a "fitness boom" began in the 1970s, the women who are most involved in fitness activities are circumscribed by class, culture, and cohort (Chrisler and Lamont 2002). Demographic predictors of a sedentary lifestyle in US adults include being older, female, and African American and having less

education, more body weight, and a lower level of physical activity in childhood (Blair et al. 1993).

It is important to consider women's lower levels of activity from a power perspective. It is easier to control women and to keep them in "their proper sphere" if they are less physically fit and more aware of their lesser physical strength and underdeveloped physical abilities (Chrisler and Lamont 2002). Many older women were raised to believe that sports and exercise may be fine for children, but are not appropriate for adult women. The beliefs that it is unfeminine to develop muscles or to sweat are common among older women, as well as among some class and cultural groups, even in developed nations (Hayes 1999; Nelson 1998). Many girls have been discouraged from participating in team sports and told that individual sports that emphasize gracefulness (e.g., figure skating, gymnastics) or involve the use of "light" objects (e.g., racquets) are more feminine than those that require physical force or the use of "heavy" objects (e.g., weights, boats; Hall 2008). In the USA, prior to the enactment of Title IX in 1979, it was difficult for girls to find opportunities to participate in team sports, even if they wanted to do so, which means that older cohorts of women have less experience with physical activity as "fun" and a greater sense of it as an unpleasant "duty" that their physicians have recommended. Barriers to exercise among older cohorts of women include social anxiety (e.g., people will laugh at her because she is unfit or does not know how to use the machines in the gym), lack of free time (e.g., family, work, and volunteer roles keep her too busy to exercise), unsafe public spaces (e.g., too dangerous to walk in the streets or nearby parks), concern about physical appearance (e.g., if she sweats, she will ruin her hairdo), body shame (e.g., she is too fat or too old or too clumsy), gender role constraints (e.g., exercise is a masculine activity; if she takes time to exercise, people may see her as selfish, ambitious, or competitive), and fear of falling and breaking a bone (Chrisler and Lamont 2002; Marcus et al. 1995; Nelson 1998; Vertinsky 1998; Zhang et al. 2006).

Those barriers make it difficult to encourage older women to exercise. However, physical fitness is widely seen as crucial for healthy aging; the American College of Sports Medicine recommends that older adults engage in regular aerobic and strength training exercises (Lemos et al. 2009). Even minimal physical activity can have significant effects on the health and well-being of older adults. One study (Sundquist et al. 2004) showed that those who participated in occasional physical activity had a 28 % lower mortality rate than those who were physically inactive; those who were physically active at least once a week had a 40 % lower mortality rate. Older adults who were physically active in midlife, as well as in later life, tend to live longer and suffer from fewer disabilities than their sedentary peers (von Bonsdorff et al. 2011). Women in developed countries who perform blue-collar jobs that require manual labor do not have lower mortality rates than women who perform white-collar jobs, but they do have higher rates of disability, perhaps due to the combination of the increased physical and mental strain (e.g., sexual and gender harassment) and the decreased resources that blue-collar workers face (von Bonsdorff et al. 2011).

Physical activity can increase independence and functional capabilities, and it can reduce the risk of falling (Lemos et al. 2009). The ability to navigate through one's community independently is critical to maintaining a sense of independence and autonomy; thus, mobility can help women maintain a sense of empowerment over their own lives and a sense of self-efficacy. However, female sex and older age are both associated with decreased community mobility (O'Brien and Tan 2002). Moreover, older women are less likely than older men to exercise, and they tend to have poorer physical status than men their age (Chen et al. 2012), which results in more older women than older men with lower mobility and greater dependence on others. Although dependence provides older women with a way to exert the legitimate power associated with helplessness (e.g., she deserves help), it is a form of power that can breed resentment in helpers, and it can weaken self-confidence and self-efficacy in the long run. However, some women with disabilities find it empowering to voice their needs and name what they want from others (Julie Williams, personal communication). It is also empowering to focus on interdependence with others, rather than dependence on others, which is a way to gain or maintain connectedness (e.g., "You help me to walk or dress, and I help you to entertain the children or by giving advice"). Some women, who have worked hard all their lives and now are frail or disabled, may find "surrender" liberating; it may even feel good to "allow" others to help them (Williams, personal communication).

Physical activity has also been linked to a number of other psychological benefits for older women. Among frail older adults, exercise programs have been shown to improve global quality of life, including improved social and family relationships (Langlois et al. 2013). Other researchers have found similar results that suggest a causal relationship between physical activity and psychological well-being. A meta-analysis (Netz et al. 2005) of 36 experimental studies showed that physical activity leads to a decrease in anxiety and depression and an increase in self-efficacy and positive view of the self (e.g., self-worth, self-esteem, self-concept, body image, perceived physical fitness, sense of mastery, locus of control). Research indicates that these results hold constant regardless of the country in which the study took place or the nationality of the participants. For example, a study of Brazilian elders (Antunes et al. 2005) showed that, after a 6-month exercise regimen, participants in the experimental group demonstrated significantly lower scores on anxiety and depression and reported significantly better quality of life than did participants in the control group. A similar study of elders in Taiwan (Wang et al. 2011) showed that those who participated in a regular exercise program reported lower levels of depression than did those who exercised irregularly.

The positive psychological effects that exercise has on older women may be just as important as the physical effects in helping them to remain empowered. Both anxiety and depression are associated with decreased social interactions and reduced independence (Antunes et al. 2005), which is of special concern for women, given estimates that one in five women experience depression during their life (Mayo Clinic 2013). Risk factors for depression include stressful life events (e.g., bereavement), chronic medical conditions, lack of social support, and isolation—all of which occur at higher rates among older people (Fulbright 2010). Depression

can be a debilitating illness among all age groups as it leads to impaired functioning; however, in older adults it can be particularly dangerous as it is associated with functional decline, cognitive impairments, frailty, and increased dependency and disability (Antunes et al. 2005; Duckworth 2009). Further, depression is the most significant risk factor for suicide among older adults (Duckworth 2009).

Walking difficulty is associated with reduced activity, and thus, a decline in physical and social functioning (VanSwearingen et al. 2011). Low-impact exercises, such as walking or stair climbing, have been a prominent feature in recent interventions aimed at encouraging exercise among older adults (e.g., MacMillan et al. 2011; O'Brien and Tan 2002). VanSwearingen et al. (2011) evaluated a program aimed at increasing the efficiency of their gait among those with walking difficulty. Results indicated that elders who participated in "motor sequence learning" improved in gait speed, physical activity, and total physical functioning. Interventions that improve mobility could enable older adults to remain independent and active for longer; however, studies (e.g., Orsega-Smith et al. 2008) have shown that long-term adherence tends to be quite low. To resolve this problem, some researchers have suggested that sport leagues, which provide social support, competition, and recreation, might be a better strategy. Some research (e.g., Orsega-Smith et al. 2008) supports this hypothesis, as does a more casual observation of the growing number of older adult sport leagues in Western countries. Although these leagues might be of greater interest to men than to women, and of greater interest to the "young old" than to the "old" and "old old," given the cohort effects addressed earlier, we are inspired by the South African grandmothers who formed their own soccer league after having been told that it is undignified for them to wear shorts or run around. Those women have a newfound sense of physical and personal empowerment, and they have discovered the joy of sport (Dixon 2010).

VanSwearingen et al.'s (2011) study suggests that effective exercise programs can be created to meet needs of older women of various physical ability levels, yet many are nonetheless hesitant to participate; one of the main deterrents is a fear of falling. This creates an unfortunate paradox as physical inactivity is significantly associated with the likelihood of falling and regular physical activity can help to prevent falls (Lim and Sung 2012; Zhang et al. 2006). Although much literature on physical activity among older adults is focused on aerobic training, a growing body of research demonstrates the benefits of Tai Chi (Roppolo et al. 2012). Tai Chi, which was originally developed as a martial arts form in China, has been used for centuries as a form of exercise for older adults because of its low velocity, low impact, and focus on strength and balance (Zhang et al. 2006). Tai Chi techniques can easily be modified so that women of different fitness and physical activity levels can participate and benefit. A study of 74,941 middle-aged and older Chinese individuals (Birdee et al. 2012) showed that 28% of the women practiced Tai Chi as a form of exercise; those who did tended to be older and to suffer from chronic medical conditions. Studies have shown that Tai Chi improves flexibility, balance, and strength and decreases both the likelihood of falling and the fear of falling (Song et al. 2010; Roppolo et al. 2012; Zhang et al. 2006). Decreasing this fear is of critical importance in building older women's confidence in performing

various physical activities, including leaving home to attend social and cultural events, which in turn helps to keep women independent, mobile, physically functional (Zhang et al. 2006), and in touch with their social network. Yoga, swimming, and certain forms of dance are other examples of low-impact physical activity that might be appealing to older women.

There is a scant research on the physical fitness levels of aging populations in developing countries. For the first time in human history, those who survive childhood can expect to live past 50 in every country on earth (Ramashala 2001), but older adults who live in countries with widespread poverty face many more challenges than older adults who live in wealthier nations. In settings with limited healthcare resources (Ramashala 2001), older adults might be less likely to be able to maintain a level of physical fitness that renders them physically empowered and independent. On the other hand, a lifetime of physical labor might result in stronger bones and muscles in older age than are typically seen in developed nations with more modern conveniences and sedentary jobs. However, insufficient data exist to address this question. As the proportion of older adults increases across the globe, the physical fitness and empowerment of older women in developing nations should become an increasingly important area of research.

In the meantime, older women can be encouraged to engage in regular physical activity of whatever kind interests them and at whatever level they can manage. Older adults do not necessarily like to exercise with a mixed-age group (Beauchamp et al. 2007), thus organized groups of older people (e.g., walking clubs, Tai Chi, yoga, "senior swim time") would be more attractive to many. The sociability of group activities for older adults is another benefit. Those with disabilities that prevent most forms of physical activity should be encouraged to see a physical therapist and to procure mobility aids (e.g., walker, wheel chair, scooter, cane) in order to maintain greater independence, better ability to navigate their communities, and social ties. Reframing physical activity as a way to promote longevity and extend the time a woman can perform her family roles may be helpful in working with older women who see exercise as a masculine or selfish activity or one that interferes with the time she spends with her family (Cantu and Fleuriet 2008). Enhanced physical fitness will give women the energy, strength, and stamina necessary to exercise power over, power from, and power to; it will also improve women's quality of life and provide opportunities to exercise reward, coercion, referent, and other power bases that come from work or community roles (e.g., expert, informational, legitimate).

Physical Health and Ability

Women live longer than men in most nations: 11 years longer, on average, in Eastern Europe, 5 years longer in Northern Europe, 3 years longer in East Asia and North America, and 1 year longer in Sub-Saharan Africa (Lee 2010). Although people often assume that the gender difference in longevity has biological origins, many studies indicate that it can be accounted for in most cases by health-related

behaviors (e.g., social support, health habits, risk taking) that are influenced by sociocultural expectations about how women and men should behave (i.e., gender role-related behaviors; Lee 2010). Women usually report better health habits (e.g., smoke and drink less than men, see a physician more regularly), have larger and more reliable social support networks (i.e., friends and family they can count on for advice and assistance), and take fewer risks (e.g., wear seatbelts, wash hands more frequently) (Lee 2010; Taylor 2011). Learning about health and caring for ill people is also a part of the feminine gender role (Chrisler 2012); thus caring about health and knowing how to keep others healthy could also contribute to women's greater longevity.

Chronic illnesses are conditions that cannot be cured (e.g., hypertension, diabetes, osteoporosis) and whose symptoms require active management (i.e., self-care) by patients as well as medical professionals. Chronic illness is a highly variable category. For example, it includes cancer, autoimmune disorders, and heart disease, each of which is a high variable category itself. Some illnesses (e.g., hypertension, arthritis) can manifest as mild or severe, and others (e.g., multiple sclerosis, rheumatoid arthritis, heart disease) have forms that are progressively debilitating. Although the average age of diagnosis varies by illness, many are associated with older ages. The longer people live, the more likely they are to be diagnosed with chronic illness. Because women live longer than men, they are more likely to face their older years with one or more chronic illness (Taylor 2011). Furthermore, due to benevolent sexism (i.e., chivalry, solicitude; stereotypes of "sainted mothers" and "long-suffering wives"), including the belief that older women are too weak to withstand aggressive medical interventions, physicians may prefer to take a "wait and see" stance rather than "subject" older women to heart surgery or aggressive chemotherapy that they are more likely to order for men of the same age (Travis et al. 2012).

Although older women are hardly likely to be surprised to receive a diagnosis of a chronic illness (given that most older people they know have at least one), a diagnosis requires a series of adjustments. For example, it might be perceived as a sign that one is now officially "old." Regardless of age at diagnosis, chronic illness requires changes in identity (e.g., "I am diabetic," "I am ill"), body image (e.g., energy level, physical capabilities, physical comfort), future plans, and life goals (Carel 2008; Goodheart and Lansing 1997). It also requires a change in the way people think of being "ill." As Gordon (1966) described it, people with a chronic illness or disability must abandon "the sick role" and adopt the "impaired role." The sick role refers to appropriate behavior for people with an infectious disease: rest, obey "doctor's orders," get well. It may be appropriate to acknowledge weakness and dependence upon medical personnel when one is sick; however, because people with chronic illness will never "get well," they need to maintain normal roles and behaviors to the extent possible given their condition. Their role is not to recover, but to learn as much as they can about themselves and their illness and to discover what they can and cannot do under which circumstances. The sick role is a disempowering orientation for people whose conditions will not improve. However, the impaired role can be empowering; it results in the development of expertise, which

can be used as a power base in interactions with medical personnel and with family (especially in regard to power from).

Not all chronic illnesses are necessarily debilitating, but many can become so if they are not well managed. Patients must work with medical personnel as a team in order to manage symptoms and prevent deterioration of their condition. This is a new idea to those who have been healthy for most of their lives or have suffered only from short-term disease or injuries for which they relied on medical personnel to cure them. This teamwork might require patients to learn some medical techniques (e.g., test blood sugar, give self injections). The teamwork also requires keen observation (e.g., How do I feel today? What was I doing right before I noticed this symptom?) and self-discipline (e.g., exercise daily, take medications on time). Some chronic illnesses (e.g., diabetes) have complex treatment regimens that require a great deal of self-knowledge and self-discipline from patients. Physicians and health psychologists typically refer to the patient's role on the medical team as adherence (or compliance) with a treatment regimen. Nurses typically refer to the patient's role as self-care, which may be a more appropriate term to use with older women, who sometimes need "permission" to take care of themselves and put their own needs ahead of those of others. Self-care can be empowering in a number of ways, including power over (e.g., I can control my symptoms or keep them from getting worse), power from (e.g., This is "me time"; I have to take care of myself, so I cannot do what you want), and power to (e.g., If I care for myself, I will be able to care for others; If I work when I feel well, I can rest when I feel ill).

Chronic illness reflects several negative stereotypes of older people (e.g., weak, unhealthy, disabled), and it can be disempowering if it means that older women must give up favored activities due to fatigue, joint and muscle stiffness, difficulty breathing, or other signs and symptoms of chronic illness. Although many chronic illnesses can be improved by regular exercise, symptoms (e.g., stiffness, fatigue) and related concerns (e.g., fear of falling and breaking a bone) may lead patients to become more sedentary, thus making their conditions worse and contributing to the problems we discussed above related to physical fitness. Of course, chronic illness does allow for the use of the legitimate power base through the patient's weakness or helplessness, but, as Gordon (1966) pointed out, the sick/helpless role is not a good strategy for the long haul, and the helpers may begin to withdraw from the ill person's influence after months or years.

Although it seems counterintuitive, self-care and the impaired role can be empowering. As older women learn more about their illness, adjust their behavior accordingly, and become better at managing their symptoms, they gain self-confidence and self-efficacy, they feel that they have some control of their bodies and their lives (Leach and Schoenberg 2008), and they become able to exercise expertise and informational power in relation to their condition. Recent studies of older women with chronic illness illustrate a variety of ways that women can be empowered as they engage in self-care, despite the frailty they might experience.

Rather than giving up favored activities, women may modify the way they carry out those activities in order to continue them (Roberto et al. 2005). Pain and lower stamina or energy level can be accommodated by slowing down the pace of the

activity. Occupational therapists may be able to assist women in finding new ways to perform tasks that have become difficult (e.g., use of an assistive device to open tight jars). In her illness narrative, Carel (2008) spoke of learning to manage her poor lung capacity by learning new routes (so as to avoid walking up steep grades), allowing more time than she had needed before her illness to do most things, and changing her habits (e.g., limiting how many times she walked upstairs at home, carrying her phone everywhere). The use of assistive devices (e.g., canes, scooters, hearing aids) can also help ill or disabled individuals to maintain their activities, and these devices can become incorporated into the individuals' body image (e.g., "My cane is part of me"). Although some older women resist devices (or handicapped parking tags) because of embarrassment or concern about looking "old" and infirm, the devices, along with the other suggested modifications, can allow women to maintain independence and autonomy.

Older women often report spirituality as a source of strength and empowerment, especially in relation to living with chronic illness (Gallant et al. 2010; Harvey 2008; Leach and Schoenberg 2008; Shawler and Logsdon 2008). Praying for strength and courage to face illness is a favored approach. Meditation, communing with nature, or losing oneself in music or other art forms helps relieve stress associated with illness and can provide hope and a sense of being part of something larger than oneself. The belief that one is not suffering alone (e.g., that God, a guardian angel, a saint, an ancestor, a spirit, or a totem is always there) can contribute to self-efficacy and empowerment.

Emotion-focused coping techniques can help older women to maintain emotional equilibrium and avoid the depression that chronic illness may bring (Lonborg and Travis 2010). Use of positive self-talk (e.g., "I can do it!") and refusal to dwell on the negative aspects of one's situation are helpful (Shawler and Logsdon 2008). Relabeling emotions is another strategy that can be used to stay positive and empowered (e.g., "It's not anger, it's annoyance"; "I'm not depressed, I'm disappointed"). When anger or frustration occurs, it can be channeled into positive action (e.g., "Don't tell me I can't go out on my own, I have my scooter!"; "If at first, I don't succeed, I'll just try, try again"). Normalizing is another useful emotion-focused approach (Carel 2008; Leach and Schoenberg 2008); it refers to gently reminding oneself at frustrating times that this is the "new normal": One's body has changed, and accommodation must be made. Recollection of past competencies and accomplishments (both physical and professional) have provided comfort to some women (Shawler and Logsdon 2008), but others might find those memories distressing if they focus on their reduced capacity compared to the past.

Social comparison refers to the process of identifying others as standards against which to compare oneself. As we have discussed earlier, older women who compare themselves to a youthful beauty ideal are going to be disappointed. Similarly, disabled or chronically ill individuals who compare themselves to able-bodied or healthy individuals are also likely to be disappointed. Part of normalizing involves selecting a new comparison group. For example, we have heard older women say, "I'm doing fine for my age" or "I get around pretty well for someone my age." Upward social comparisons (i.e., to unreachable standards) are likely to be

disempowering, whereas downward social comparisons (i.e., to people in worse condition than the self) can be empowering. Some older women have reported that they maintain their self-confidence and positive feelings by helping others who are worse off than themselves (e.g., doing volunteer work in a nursing home) or thinking about others who are worse off (e.g., "At least I don't have dementia like poor Lucy") (Leach and Schoenberg 2008; Roberto et al. 2005).

Older women often rely on their social support networks to manage their chronic illness. Having a shoulder to cry on, a person who provides comfort and reassurance, someone who can help with practical matters (e.g., walk the dog, drive to appointments), someone who gives good advice, someone with the same chronic illness, and someone who has needed information (e.g., knows a good doctor or physical therapist) in one's social network is very helpful. When people know whom to call for what they need, and can feel fairly sure that they will get a good response, they feel more confident and in control of their circumstances. Social support has many well-documented positive effects, but sometimes it can have negative effects as well (Taylor 2011). For example, older women sometimes report that they get too much help, which is disempowering, or that they get the wrong help, or that their social network depends too much on them, which takes all of their available energy (Roberto et al. 2005). Some older women may hesitate to use referent power to call upon their social network for assistance for fear of "bothering" their friends and family or because they do not want to upset the power balance in their friendships. They may worry that the usual "give and take" in friendships will become "all give" on one side and "all take" on the other. However, that power balance can be preserved when tangible support is received from the healthy friend and emotional support is given by the ill friend. In collectivist cultures, and cultures where families often live in multigenerational homes, older women in need of help may not need to worry about exhausting their helpers. Their years of caring for and giving to others activate the reciprocity norm: Younger family members expect to give back, see elder care as their duty, and may even appreciate the opportunity to show their affection through providing social support to their elders. However, in developing nations young people are increasingly likely to leave their home towns and villages to move to cities where there are greater economic opportunities. Elders who are left behind might find themselves without the support and care they had expected to receive from their children and grandchildren, and their situations may resemble those of older people in developed nations—but without government-funded agencies that can deliver needed services.

Finally, problem-focused coping is very helpful in managing chronic illness and/or disability. It refers to active attempts to manage a situation by gathering information, making plans, trying different strategies, and assertively asking for help needed from medical personnel or others in one's social support network (Lonborg and Travis 2010; Taylor 2011). The support groups (either in-person or online) can be good sources of tips and strategies for managing symptoms. Learning to solve problems related to one's condition is empowering and builds confidence and self-efficacy.

Thus, even when chronic conditions limit older women's ability and hence can be disempowering, they also provide the opportunity to learn to think about, and to use, the body differently in ways that can re-empower patients in the impaired role to get the most out of their lives. The quality of life of older women with chronic illness or disability can be much better than young, healthy people imagine it to be. Obviously, women with more resources and better health care options at their disposal will be able to manage their illnesses better than those with fewer and worse options, but many of the coping strategies discussed above can be used by anyone, anywhere.

Conclusion

Attractiveness, physical fitness, and health are common ways that bodies empower women, providing influence and ability to achieve plans and goals. In old age, those ways may be less available and cause women to feel disempowered. However, changing one's standard for social comparison, taking good care of the body, learning to manage chronic illness, and learning to use the body in different ways can all contribute to the continued use of the body as a source of personal and interpersonal power. Some women may turn to cosmetic procedures to erase signs of aging writ on the body; others may do better by remembering that sexiness has more to do with knowledge, skill, and confidence than with beauty. Most people's energy and stamina can be improved through self-care (e.g., adequate rest, good nutrition, regular exercise). Assistive devices and community services (e.g., van service for those who can no longer drive or walk easily) can empower older women by helping to maintain their mobility and independence, as can a focus on interdependence rather than dependence.

It is also helpful to remember that there are many sources of power outside the body for people of any age. Older women can often empower themselves and their social networks by sharing their wisdom and experience as mentors, volunteers, and activists (Denmark and Williams 2012; McHugh 2012; Wray 2003) or by sharing family stories with, and caring for, their grandchildren (Kulik 2007; Wray 2003). Although aging invariably leads to changes related to the body, the process of aging does not inevitably mean a decrease in empowerment; it might just mean a change in how and from where power is derived.

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