Decline or successful ageing discourses: When local knowledge and dominant discourses intersect to shape personal stories of ageing

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Abstract. The decline and successful ageing discourses are key contemporary discourses of ageing, which provide contrasting identities for older people. Although the successful ageing discourse now appears to be globally dominant in policy and beyond, people engagement with both these discourses varies by culture. People draw on discourses that are culturally available and legitimated in their contexts to produce ageing identities. This study aimed explores the interaction between local understandings and the dominant discourses of ageing, focusing on how these shape personal stories about ageing and the subject positions provided by the discourses among older people who need family care. Applying positioning-discursive analysis to the narrative data of older people and their family members who are co-resident in 11 multigenerational households in Bali, we identified culturally available discursive resources and their use in self-positioning and positioning by others. Four subject positions were identified, namely frail and vulnerable old person, disengaged and dependent family member, compliant patient, and unsuccessful ager. We found that both 'decline' and 'successful ageing' discourses were used to legitimate a positive identity for being an old person in decline. These findings contradict previous research from different socio- cultural context which described pressure and shame among older people who could not achieve successful ageing ideals. The policy implications and the importance of a life-course preventive approach to facilitate ageing well are discussed.

Keywords: ageing identities, cultural knowledge, decline discourse, positioning – discursive analysis, successful ageing.

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Introduction

Globally, ageing is framed by two dominant and oppositional discourses: the decline discourse and the successful ageing discourse (Fealy et al., 2012; Sandberg, 2013). The decline discourse is part of a more established and common-sense way of understanding the life course. It is essentially deficit focused, emphasising increasing physical frailty, mental deterioration, non-productivity, passivity, and dependency (Rowe & Kahn, 1987; van Dyk, 2016). In contrast, successful ageing emerged in response to the deficit view of the decline narrative, and highlights activity, autonomy, and responsibility (Caddick et al., 2018; Sandberg, 2013). From the early 1980s, scholars in ageing began pointing out the disadvantages of the decline discourse, which cohere around its deficit focus. They argued that discourse exaggerates the negative aspects of becoming old and categorises older people as non-productive and a social and economic burden, encouraging their dependency on public provisions (Rowe & Kahn, 1987; Townsend, 1981). Ultimately, this discourse has been shown to be disempowering, limiting possibilities in later life and contributing to social stigmatisation of older people (Caddick et al., 2018).

To challenge the decline discourse's deficit view—and its resultant ageist constructions, stigma, and disempowerment—the successful ageing discourse was developed to focus on the positive aspects of ageing (Rowe & Kahn, 1987, 1997). While the decline discourse imagines older people as passive and dependent, the successful ageing discourse facilitates identities centred around the importance of healthy life, social contribution, and autonomy. While The decline discourse envisages loss of agency, the successful ageing discourse sees the older person as agentic, in control of their body and life (Jolanki, 2009; McGrath et al., 2016). Given these positive associations, the notion of successful ageing has been seen as beneficial to older people and also to countries seeking to reduce the negative impacts of population ageing (Bülow & Söderqvist, 2014; van Dyk, 2014). It has therefore been promulgated widely through public policy and the media (Breheny & Stephens, 2019).

Although successful ageing discourse offers more positive social identities than the decline discourse, several disadvantages have also been highlighted. Chief among these is the construal of successful ageing as a personal responsibility and, in turn, the inability to achieve successful ageing is considered an individual failing (Bülow & Söderqvist, 2014). This discourse highlights individual choice, planning, and positive health-related behaviours, but without consideration of the context of older people's lives (Rowe & Kahn, 1997). What is not recognised is that successful ageing is only available to those who are *able to* maintain a healthy life. The physical and material resources needed to age successfully are not equally available to all older people (Breheny & Stephens, 2019). Successful ageing discourse can therefore have marginalising effects on those who do not meet its criteria, because they do not have the means to age successfully, such as ill or disabled older people, those already requiring care, and those with fewer economic resources (Baars, 2017; Stenner et al., 2011; van Dyk, 2014, 2016).

Both these dominant ageing discourses (decline and successful ageing) circulate in society and are available for people to draw on when making sense of their and others' experiences of ageing. These discourses act as resources for constructing contrasting identities for older people. However, understandings of ageing are also shaped by local cultural understandings of ageing (Andrews, 2009; Corwin, 2020). For instance, research indicates that some cultures focus on individual responsibility for maintaining well-being in later life (Bennett et al., 2017; Caddick et al., 2018; McGrath et al., 2016; Pack et al., 2019), while others emphasise interdependency and accept decline (Jolanki, 2009; Pfaller & Schweda, 2019). In doing so, people identify with discourses that are available within and legitimated by their socio-cultural context (Andrews, 2009; Liang & Luo, 2012). The decline and successful ageing discourses may co-exist, working in tandem with localised meanings to shape ageing stories (Calasanti, 2016). Accordingly, there are always diversity in people's understandings and accounts of ageing (Andrews, 2009). However, research has tended to study the decline or successful ageing discourses independently from one another, paying little attention to how they interact with localised cultural understandings of ageing, and to what effect.

Addressing these oversights, we consider the interaction of local understandings of ageing with dominant ageing discourses (decline and successful ageing) and explore how they are drawn on in personal narratives about ageing recounted by older Balinese people and the family members who care for them. The Balinese is a useful case example because the decline and successful ageing discourses coexist in Indonesian regional ageing policies (Lestari et al., 2021, 2022). The Indonesian Government has followed global trends by incorporating successful ageing ideals while also preserving cultural understandings of ageing and family, which largely cohere with the decline discourse (Lestari et al., 2022). Balinese consider old age (*bhiksuka/sanyasin)* as a life stage centred on disengagement from the mundane world to focus on the spiritual (Sukerni, 2018; Suteja, 2018). Older family members relinquish power and responsibility to the younger generation, remaining as dependents requiring family care (Geertz & Geertz, 1964).

In the context of Balinese cultural values, and Indonesian regional ageing policy, the ways in which the decline and successful ageing discourses are taken up in personal narratives on ageing was examined. The accounts of both older people and their families were included to illuminate how older people who need family caregiving are positioned by themselves and others, and to highlight the rights, obligations, and expected behaviours attached to those identity positions.

Methodology

The approach used was a narrative inquiry that draws on positioning theory (Davies & Harré, 1990) to investigate the socially situated production of identity (e.g., Bamberg, 2004; Currie et al., 2007; Taylor & Littleton, 2006). Smith and Sparkes (2008) have named this a 'storied resource' approach in which "people do things with words, and they do things with narratives…Through them they construct their own lives and those of others…Such accounts are certainly not private, and they do not yield accounts of unmediated personal experience… [and therefore] we need to analyse them in terms of the cultural resources people use to

construct them" (Atkinson et al., 2003, p. 117). Accordingly, both discourses and localised meanings are considered discursive resources that are available for narrating experiences and constructing identities (Bamberg, 2004).

In the storied resource approach, the concept of positioning is used to connect the social construction of identity to larger discourses (e.g., ageing discourses) and dominant cultural storylines (e.g., Balinese life stages, including *bhiksuka/sanyasin*) (Morison & Macleod, 2015). According to this perspective, people "draw from a cultural repertoire of available stories larger than themselves that they then assemble into personal stories. [In so doing] …constructing certain kinds of selves and identities in specific social contexts" (Smith & Sparkes, 2008, p. 19). In this way, people negotiate their identity in everyday talk, including the context of the research interview (Breheny & Stephens, 2019; Morison & Macleod, 2015). How people talk about and make sense of experiences of ageing depends on the available discourses in their social milieu (Allen & Hardin, 2001; Hardin, 2001). Moreover, culture legitimates specific discourses per others (Andrews, 2009). Hence, people take up the subject positions provided by discourses (Wetherell & Edley, 1999) that fit to the cultural expectation of ageing (Pfaller & Schweda, 2019).

In the context of ageing, individuals negotiate multiple and contradictory discourses in everyday life that make various, sometimes contradictory, positions possible (Allen & Hardin, 2001; Fealy et al., 2012). For example, decline and successful ageing discourses position older people in opposing subject positions: passive/active, dependent/autonomous, and frail/fit (Fealy et al., 2012). Each position includes certain rights, obligations, and expected behaviors (Breheny & Stephens, 2019), so that ultimately the discourse facilitates or constrains what can be said and done by older people (Katz, 2000).

Since individuals usually negotiate a position that provides a positive identity in a specific context and certain situation (Currie et al., 2007), certain subject positions can be taken up or resisted. Moreover, one is positioned by others *and* can actively position oneself; selves and identities are therefore conferred *and* actively claimed and contested (Breheny & Stephens, 2019; Smith & Sparkes, 2008). In this study, interviews with older people and their family members were used to identify culturally available discursive resources and their use in self-positioning and positioning by others.

Participants and data collection

Interviews with members of 11 Balinese multigenerational households were conducted by the first author. Participants were recruited through a hospital, community health services, and private practices. Among the participants, 14 individuals are the members of the first generation (grandmother and grandfather), 19 individuals within the second generation (son, daughter-in-law, and niece), and 16 individuals as the third generation (grandchildren and grandchildren-in-law) who were co-residents. All members of the first-generation experienced declining health and received care from the second and third generation.

Table 1. Structure of participating families

Family	1st generation	2nd generation	3rd generation	Primary caregiver	Health and mobility
1.	Grandmother (80)	Son (45) Daughter-in-law (43)	Two Granddaughters (21 and 17)	Son	Limited mobility due to decubitus ulcer
2.	Grandmother (72) Grandfather (75)	Son (44) Daughter-in-law (37)	Granddaughters (18)	Daughter-in-law	Frailty Cardiovascular
3.	Grandmother (75) Grandfather (75)	Son (53) Daughter-in-law (45)	Two Grandson (25 and 21)	Son	Frailty Hearing loss, Visual Acuity
4.	Grandmother (75)	Son[a] Daughter-in-law (42)	Granddaughter (18) Grandson (23)	Daughter-in-law	Diabetes Mellitus, Hypertension, Frailty
5.	Grandmother[b]	Son (54) Daughter-in-law[a]	Two Grandson (27 and 20) Granddaughter in-law (24)	Son	Parkinson Frailty Decubitus ulcer
6.	Grandmother (90)	Son (53) Daughter-in-law (53)	Granddaughter in-law (27)	Daughter-in-law	Diabetes Mellitus
7.	Grandmother (75)	Son (45) Daughter-in-law (40)	Grandson (23)	Son	Kidney diseases
8.	Grandmother (95)	Son (56) Daughter-in-law (52)	Grandson (20)	Daughter-in-law	Frailty
9.	Grandmother (80)	Son (49) Daughter-in-law (47)	Grandson (16)	Daughter-in-law	Obesity, Mobility disability
10.	Grandmother (80) Grandfather (81)	Son (42) Daughter-in-law (43)	Grandson (20)	Grandson	Kidney diseases Vertigo
11.	Grandmother (76) Brother (66)	Niece (44)	Granddaughter (17)	Niece	Vertigo Respiratory diseases Frailty

Note: [a] was not interviewed, [b] died after the initial meeting

The first author provided and explained information sheets describing the study to older people and their caregivers attending public healthcare facilities. In private practices health workers provided the information sheets to potential participants. Initial consent was followed by a meeting with the family members to explain the study. Private interviews were conducted with each family member after gaining consent from all family members.

The interviews were held at the participants' house or office or at the hospital. Narrative interviews involved inviting the participant to share their own stories about family caregiving, for example: "Can you tell me about your life and experience as an older person/caregiver in your family?" Thereafter, prompts were used to probe participants' stories. The anonymised interviews were transcribed in Balinese and Indonesian by the first author and a professional transcriber. Interview segments were back-translated for quality assurance.

Data analysis

The first author read and reread participants' interview transcripts in Balinese and the Indonesian language. She marked interview segments in which participants provided personal narratives about ageing and caregiving for an older family member, identifying how they those drew on the decline or successful ageing discourses. Identification of discourses involves noting patterned ways of talking represented by recurrent words, phrases, metaphors, imagery, and statements. For example, a decline discourse was identified by the use of words such as 'old', 'physically decline', 'dependent', 'emotionally vulnerable', 'limited mobility', 'frailty', 'high risk', 'memory decline', or 'deteriorated'. Whereas, the use of a successful ageing discourse, was identified through descriptors such as 'active', 'productive', 'healthy', 'autonomous', 'financial contributor', and 'socially active'. The authors then focused on positioning, exploring how older participants positioned themselves or were positioned by others within the identified discourses, which positions were taken up and resisted by older people, and how older people and their families viewed ageing from the vantage point of those subject positions.

Findings

The analysis demonstrated the dominant use of a discourse of decline in older people's stories about their ageing and caregiving experiences. However, the successful ageing discourse was also drawn upon so that decline and successful ageing discourses were often used together to construct participants' stories. This section describes how the decline and successful ageing discourses were drawn on by participants to position themselves or their older family members as older people in ways that accord with local cultural and medical knowledge. Overall, it was found that both decline, and successful ageing discourses were used to legitimate subject positions that allow older people to be passive, dependent, and accepting their limitations. Table 2 provides an overview of the positions that were identified within each discourse.

Decline discourse

Participants drew on a decline discourse in constructing their stories about ageing, living with illness, and family caregiving. Older people positioned themselves and were positioned by others as a person subject to decline both in their physical functioning and their contribution to society. According to this construction, physical and productive decline are inevitable.

Supporting the decline discourse, participants drew on local cultural knowledge of ageing and their health providers' advice to construct their narratives of decline, showing the role of culture and medical institutions in promoting the decline discourse among our participants. Older people were positioned/positioned themselves in two common ways: (1) as a frail and vulnerable person, and (2) as a disengaged and dependent family member. Each position is discussed in turn below.

Table 2: Subject positions, discursive functions, and effects

Discourse	Positions	Discursive function & effect
Decline discourse	1. Frail & vulnerable old person	Legitimates a positive position as a care recipient within the family and can allow person to secure ongoing care by younger family members without negative identity (burden, drain on family, slack etc.)
	2. Disengaged and dependent family member	
Successful ageing discourse	1. Compliant patient	Reinforces subject positions provided by decline discourse and allows older people to accept their limitations.
	2. Unsuccessful ager	

Frail and vulnerable old person

Drawing on a decline discourse, older people positioned themselves as frail and dependent, as shown in an extract provided by Tuniang who relates her physical decline to her age.

> Extract 1: My daughter-in-law always goes to Banjar for doing exercise and aerobic. I have never participated, I couldn't do physical exercise, I am old. I stay at home, never go anywhere. At home, I make offerings from coconut leaves. If I have strength and energy, I will finish making the offering. If I don't feel well, I take a rest and do nothing. I can't do anything about it, my condition has started to deteriorate. Sometimes I have an appetite, sometimes I don't (Tuniang, Family 3).

Rather than illness, old age is drawn on here to explain physical limitations and poor functioning. Tuniang positions herself as weak and physically frail (lacking strength and energy, needing rest). This construction of ageing aligns with the dominant Balinese cultural storyline in which the ageing person withdraws from society ("never participated", "stay at home, never go anywhere") and responsibilities ("Rest and do nothing). Here withdrawal is explained in terms of bodily decline and physical limitations (weakness, lack of energy, illness, deteriorating condition).

This positioning becomes more salient when older people are similarly positioned by the family. The extract below shows how a son positioned his mother as physically and emotionally vulnerable due to old age.

> Extract 2: For example, when my mom fell down, my brothers and sisters scolded Mom thinking that she was strong. When you are old, the stress level is high. If we respond angrily, she will be even more disappointed. I usually make her happy first, then I advise her to be careful in the future, so that she won't fall again (Tutde, Family 8).

Tutde draws on the decline discourse in constructing his narrative about ageing and care provision. The positioning of his mother as a vulnerable person requires Tutde to adjust the way he interacts with her, for example, providing a careful and gentle approach, in order to support her. The subject position not only determines his mother's rights, but also obligations and expected behaviors of the family members. Consequently, he criticises his siblings for failing to recognise and meet their mother's needs as an ageing person.

Beyond family, in the public domain, the medical institution legitimises the primacy of a decline discourse and educates participants accordingly. Medical discourse constructs ageing as a disease by associating old age with illness. For example, Pakde described how health personnel talked about his mother's illness:

> Extract 3: The doctor said the illness is because of her age, "She is already old". For me, she is only 76 and many people in her age are still active if they are healthy (Pakde, Family 5).

In this extract, Pakde describes how the doctor accounts for his mother's illness and inactivity as related to her age. This example shows how health personnel may use ageing as an explanation of ill health, excluding older people from the category of healthy people. The label of 'old' that the health personnel attached to older people's illness was also experienced by Mardika.

> Extract 4: My doctor said that stress causes illness. It is the major cause of every type of illness, especially when you think too hard about something. My doctor said, "You are already old, do not think too much unless you want to get S3: 'stress, stroke, and setra (cemetery)', don't you?". I think it is true (Mardika, Family 2).

Mardika repeats a joke told by his doctor about old age and stress which positions older people as susceptible to stress-induced illness and needing to take it easy. Agreeing with the doctor, he takes up a position of being "already old" and vulnerable. His extract shows the marginalization and exclusion of older people from being positioned as strong, active and resilient persons. They are expected to be passive by following the prescription of "do not think too much" if they want to avoid worsening their medical condition.

The position of being old ("already old" or "you are old") was repeated across data, both in older people's self-positioning and family and medical authorities' positioning of older people, in a way that was synonymous with physical decline, frailty, and vulnerability. The

physically declining subject position excludes older people from social categories such as a healthy fit person and one engaged fully in society. Some older people accepted this subject position, accepted the medicalised view of ageing as a disease, and conformed with expectations around the disengagement of older people.

The disengaging and dependent old person

Decline discourse includes expectations of disengagement from many social roles and responsibilities in later life, aligning with Balinese understandings. Participants understood ageing as a period of inevitable disengagement from active life while shifting responsibilities to the younger generations. Being dependent on the children and family is expected as one aged. For example, in the following extracts Luhtu and Sadhu explicitly use the words 'old age' to position themselves as someone who is disengaged from activities and dependent on family support.

> Extract 5: My life now, as I said earlier. I'm old, I can't work anymore. My life now depends on my sons and daughters-in-law. Since I'm no longer working, I don't hesitate to depend on my children, whatever they provide for me (Luhtu, Family 4).

> Extract 6: Now, I do not have anything to be worried about. I only think about eating and sleeping, nothing more than that. My children and grandchildren are already mature and independent (Sadhu, Family 6).

Both Luhtu's and Sadhu's accounts describe the shifting responsibility and reciprocity between older and younger generations in Balinese culture. As people age, it is time for them to be dependent on their successors. Their identity changes from provider to being provided for and from caregiver to care-recipient. Emphasising the normality of this ('I don't hesitate') in her account of family support, a disengaged and dependent subject position secures rights to family provision for Luhtu that she is able to depend on unreservedly and without guilt. Likewise, Sadhu perceives her later life as a detachment from responsibility which allows her to be a passive person who does not need to think about anything serious. This subject position is situated within the Balinese cultural ideal of older people as those who need care and local narratives of family caregiving that emphasise family obligations to care (blinded for review).

Family members also drew upon the decline discourse to position older people in terms of their role in the family. For example, a brother explains in the following extract how the older person in the family should be less dominant and more dependent as they age.

> Extract 7: She was interfering. She's never positioned herself as an ill and old person. She did not understand the current situation, still she always interferes. … But because her hobby is making offerings, she felt that she has to follow her hobby. Even though she does the work, but still this becomes a burden for our family […] As a parent, I am ready to lose my role. For example, for kitchen matters, whatever my daughter-in-law serves for my

> meal, I accept it. I am ready (Suandi, Family 11).

Suandi positions his sister as a troublesome older person who would not follow the cultural norms, therefore, creating trouble through her interference in family matters. He invokes the Balinese cultural norms (*bhiksuka/sanyasin*) that dictate the appropriate behaviour of older people as stepping away from important family roles and positions his sister as an older person who contravenes this norm, as she should now allow the younger generation to lead. Instead, his sister still tries to engage in the household affairs. Contrasting his sister's behaviour with his own, Suandi positions himself as passive and "ready to lose [his] role" of having a say in the household, relinquishing responsibility, and control to the younger generation. He invokes the cultural ideal of disengagement and dependency to describe his own position as one who conforms to culturally expected behaviours.

Participants frequently constructed old age in terms of decline and disengagement, both in terms of physical activity and social roles. They positioned themselves as functionally declining persons and did not expect to be as active and fully contributing as to their earlier lives. Responsibilities were shifted from the older to the younger generation. Disengagement and dependency in late life, which were prominent in the participants' narratives, are supported by Balinese cultural values regarding older people's roles in the family and society.

Successful ageing discourse

Although the decline discourse is dominant, successful ageing discourse is also publicly available for participants to draw on. This section demonstrates how successful ageing discourse was drawn on by some participants, mainly in discussions of health and healthy lifestyles. Most older participants did not position themselves as successful agers. Rather, they were positioned by others as responsible for their own health in older age. We identified two further common positions that are resourced by the successful ageing discourse: (1) compliant patients who participate minimally in successful ageing, and (2) unsuccessful agers.

Compliant patients with limited engagement in successful ageing

Participants drew on the successful ageing discourse when describing medical advice about needing to maintain vitality and social participation when experiencing illness. We provide two extracts that illustrate participants' adherence to medical advice that drew on successful ageing discourse. Although these participants were excluded from successful ageing by their actual physical health decline, they were expected to engage in exercise and social activities.

> Extract 8: "You have to do more exercise, 30 minutes per day, to keep healthy, and maintain your stent, that is my doctor's advice. So now, I go to the rice fields only to maintain my vitality. Maximum one hour, can't do more than that. After that, I immediately go home and take a shower. The goal is only to maintain my vitality. I do not think about revenue and loss. In fact, I lost a lot (Mardika, Family 2).

> Extract 9: I sit down nicely in Banjar and watch my friends do activities. I have never joined the exercise. My doctor told me that the importance of attending the community activity is for refreshing and meeting with friends. If I can do the activity, I do it, if I can't, I just keep quiet and watch. Because if I fall, no one can help me (Luhtu, Family 4).

Mardika describes how he follows the doctor's advice to participate in health promoting activity following surgery. However, emphasising that he engages in work "*only* to maintain vitality" and repeats that 'the goal is *only* to maintain my vitality'. He therefore positions himself as still withdrawing from the world of work and commerce by emphasizing 'I do not think about revenue'. Similarly, Luhtu describes her doctor's advice about maintaining social inclusion in old age, which is part of the successful ageing discourse. Her extract shows how successful ageing discourse has penetrated the community and individual levels via health personnel and the community programs. Like Mardika, Luhtu follows her doctor's advice, while making it clear that she is not able to participate fully because of her physical decline.

For both Mardika and Luhtu, by focusing on the main goals of successful ageing (maintaining vitality and social engagement), they have positioned themselves as older people who obey the advice of their doctors, while at the same time, recognizing and accepting physical decline. These extracts demonstrate how successful ageing discourse is publicly available and provides expected behaviors that are articulated in medical advice and community programs. They show that while medical advice included engagement in successful ageing activities, participants accept their productive or physical limitations.

Unsuccessful agers

Participants sometimes used the successful ageing discourse, particularly its construction of unhealthy lifestyles, to make sense of their illness rather than using the decline discourse and its notion of 'old age'. In this section we demonstrate how successful ageing discourse, especially related to healthy ageing, was drawn on in participants' narratives. The emphasis on personal responsibility for healthy behavior as investments in successful ageing can lead to self-blaming and blame by others when older people are seen as ageing unsuccessfully. Successful ageing discourse emphasises personal responsibility for staying physically fit in later life. and participants drew on these constructions when they referred to being 'naughty', 'snacking too much', or their poor 'eating habits' as reasons for their declining health and drew on health promotion discourse to explain their present health. For example:

> Extract 10: Smoking is the cause. I quit smoking after I got a heart attack. I was hospitalized in the ICU for three days. I was naughty, I smoked, drank too much coffee, gambled, and enjoyed cockfighting. I joined cockfighting everywhere. Because of my illness, I stopped cockfighting, quit smoking, did less travelling. In the past, before my illness, I joined cockfighting in the morning and gambled at night. Non-stop (Mardika, Family 2).

In constructing his illness narrative, Mardika described his previous "naughty" lifestyle and attributes his subsequent heart attack to smoking and other poor ("naughty") health habits. He therefore positions himself as personally responsible for his poor health. Mardika's extract provides an example on how the successful ageing discourse works with health promotion discourse to construct illness as personal failure.

Other family members also drew on the successful ageing discourse positioning their older family members as unsuccessful agers. References to medical professional's advice lent authority to this positioning. Older people were therefore blamed by others for their poor health (becoming "overweight", frail, and diabetic) because of their bad habits (e.g., snacking, unhealthy food consumption) and not monitoring their health practices. Older participants themselves also recounted how others positioned them in this way. For example, Luhtu recalled her conversation with her doctor who drew on past unhealthy lifestyle to make sense of her current chronic illness.

> Extract 11: My doctor asked me, "Grandma you used to be a seller, right?" I was surprised how my doctor knew what my previous job was. My doctor later said that most sellers have diabetes because they snack too much. I used to be like that, I bought whatever I wanted. There were many food sellers around me, and I had money to buy them (Luhtu, Family 4).

Here, Luhtu accepts the doctor's explanation about the cause of her illness and so takes personal responsibility for her 'bad' behaviour and its consequences, saying "I used to be like that".

In contrast, for the younger generation the successful ageing discourse was used to construct healthy ageing as a lifetime investment and result of a healthy lifestyle.

> Extract 12: That's why I always pray, I don't dare to be fat, because I don't want to be like my mother-in-law who can't walk. If possible, I want to be autonomous. If it is possible, I don't want to get sick, that's all. But by staying up late until 12 (midnight) my husband has started to worry because it is not good for health (Ayas, Family 9).

In extract 12 Ayas positions her mother-in-law as a dependent older person because she had failed to maintain a healthy life when she was younger. She draws on the successful ageing discourse to emphasize autonomy (rather than dependence), which counteract traditional Balinese ideals of old age rooted in the decline discourse. She constructs poor health behaviours as a barrier to achieving health and successful ageing, which then compels her toward self-regulation (i.e., monitoring weight).

The co-existence of successful ageing and decline discourses in the participants' accounts provides insights into the multiple subject positions that must be negotiated by older people when they position themselves or are positioned by others within these two discourses.

However, although some older participants did draw on the successful ageing discourse, it did not necessarily change their identity. In fact, successful ageing discourse was often used to reinforce the subject positions provided by the decline discourse. Extracts were used from Mardika and Luhtu as examples of both discourses used at different times for different discursive purposes. Both Mardika and Luhtu used decline and successful ageing discourses in their stories about ageing. Drawing on decline discourse, they positioned themselves as older people who are frail, disengaged, and allowed to be dependent on the younger generations. Drawing on successful ageing discourse, they positioned themselves as compliant patients, while maintaining a declining identity.

Discussion

Participants in this study mainly drew on a decline discourse to construct narratives about ageing and family caregiving. Beyond their own experience of bodily decline, the local culture, family, and medical institutions contributed to the construction of an inevitably declining older person. This construction fits with Balinese local knowledge on family caregiving in which dependency and disengagement is the accepted default position for older people (Lestari et al., 2022). It is also important to note that healthcare provider often use 'old age' to explain older people's health which is an aspect of the medicalisation of ageing (Estes & Binney, 1989; Robertson, 1997). The danger here is that old age is constructed as a process of decremental decline which must be controlled by biomedicine (Estes & Binney, 1989), and structured into social institutions and daily life (Calasanti, 2016).

The findings contradict previous research which described pressure and shame, felt by older people when positioned as a frail and vulnerable old person (Bennett et al., 2017; Caddick et al., 2018; McGrath et al., 2016; Pack et al., 2019; Phoenix & Smith, 2011). From the perspective of Balinese cultural mores of family caregiving, self-positioning or being positioned as a declining older people is not necessarily negative. Drawing on decline discourse legitimates dependency, in which older people's need for help has positive connotations and there are no demands for older people to keep active and productive (Jolanki, 2009). The findings have been supported by many studies which reveal situations in which decline is seen as a meaningful process (Corwin, 2020), old age is associated with privilege (Isopahkala-Bouret, 2017), and disengagement in late life is accepted as a sign of wisdom (Katz, 2008). Seeing illness and decline as part of a natural ageing process has also been found to facilitate older people's acceptance of poor health conditions (Hudson et al., 2015).

At policy level, the decline discourse and its subject positions are supported by regional initiatives that promote the key role of family in providing care for the older generation. The subject positions provided by the decline discourse allow older people to be dependent on their family in meeting their needs. From the family's perspective, the decline discourse strengthens the obligation to care. However, the ageing population in Indonesia does provide challenges, both for family and the government in meeting future care needs which has led Indonesia to include successful ageing ideals in regional ageing policies (Chomik & Piggott, 2015; Do-Le & Raharjo, 2002; Mi et al., 2018; Niehof, 1995). Successful ageing is believed to be a solution for decreasing the burden experienced by the country in financing the Indonesian

older generation (Ananta, 2012). However, despite these potential advantages, successful ageing also has limitations.

The aim of medical advice that draws on successful ageing discourse.is to increase healthy life expectancy and older people's quality of life (Calasanti, 2016). While older people in this study adhere to this advice, they are also aware of their actual physical limitations. Some studies conducted in clinical populations of older people found similar patterns (e.g., Caddick et al., 2018; Hudson et al., 2015). Caddick et al. (2018) highlighted the dangers of 'life-as-normal' successful ageing advice for older people with illness and disabilities where it, provides stress and pressure. They suggested activities that offer less physical demand and focus more on increasing social participation among older people. A focus on personal responsibility for health and financial consequences from a successful ageing perspective also means that physical decline may be regarded as a personal failure (Baars, 2017; van Dyk, 2014). The findings show that illness and incapacity can result in blaming ourselves or others.

Drawing on successful ageing discourse that emphasises preventive health behaviours among the younger generation may be more positive. Certainly, the younger generation in this sample drew on this discourse in constructing their future ageing. A preventive health system is considered by public health proponents to be a good solution to decrease health expenditure in the long run (Agustina et al., 2019; Biggs, 2014). Successful ageing requires adequate financial, social, cultural, and physical resources (Jolanki, 2009) and a life-course approach, which is integrated with several policies (e.g., health, educations, economics, labour) and promoted earlier in the human development stages (Walker, 2013). From a future oriented perspective, a successful ageing approach may provide more Balinese and Indonesians in general with an opportunity to age successfully in the longer term.

Conclusion

For Balinese older people and their families, both 'decline' and 'successful ageing' discourses were used to legitimate a positive identity for an older person who needs care and support. This study has demonstrated ways in which ageing discourses interact with local knowledge to provide valued identities. While a decline discourse is supported by the Balinese culture, family, and medical institutions, successful ageing has been promoted through medical advice and community programs. The two discourses were generally drawn upon to promote a culturally appropriate identity as an older person who is expected to physically decline, should resign from family responsibilities, and deserves care and attention from their children. Successful ageing was drawn upon by the younger generation to resist a future in which they declined physically like their parents and to include health promoting behaviour when they talked about their own future ageing. Rather than focusing on such successful ageing ideals which affects the behaviour of older people who need care now, it will be fruitful to integrate a preventive approach across social policies to lifespan development that facilitates ageing well for future generations.

Limitations

It is important to note that the participants in this study were all older people (and their families) who were recruited from medical centres and accordingly were receiving medical attention for physical illness. Therefore, having a bearing on the kinds of stories participants told. A cohort of healthy older people may have engaged differently with dominant ageing discourses and local narratives. Further study that includes stories from older people who are functioning well, will deepen the understanding of the primacy of decline discourse in the context of Balinese culture and the influence of material and social resources in ageing well. In addition, it could be valuable to consider healthcare worker's perspectives in greater depth too. While some examples were discussed of subject positioning by health personnel these were recounted by the participants and not first hand. Further studies are needed to understand how discourses of decline and successful ageing are integrated into the medical approach and are part of the relationships between patient and doctor and what implications this has for older people to receive family care and live well.

Finally, the data set was limited to individual interviews, which has both advantages and drawbacks. An advantage is that of probing and discussing personal experiences, which participants might be reluctant to do in other forms of data generation, such as focus groups or family interviews. However, other forms of data, such as, focus group discussions and conversations are able to capture everyday interaction between older people and others, so that interactive and reflexive positioning may be examined in more everyday situations.

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