Journal of Cross-Cultural Gerontology **13:** 81–98, 1998.

Localizing senility: Illness and agency among older Japanese

JOHN W. TRAPHAGAN
Population Studies Center, Univesity of Michigan, Ann Arbor, Michigan, USA

Abstract. For many Japanese, fear about senility is not primarily expressed in relation to pathological conditions like Alzheimer's Disease (AD). Instead, as people grow older, their concern focuses on a widely recognized category of decline in old age which, although symptomatically and conceptually overlapping with AD and other forms of senile dementia, is distinguished from unambiguously pathological conditions. This article examines the meaning and experience of this condition, known as *boke*, and shows that senility in Japan is culturally constructed in a way distinct from the clinical biomedical construction of senility-as-pathology which has become increasingly the norm in North America. Rather than being a disease, *boke* is viewed as an illness over which people are believed to have some degree of agency in relation to its onset – through activity, particularly within the context of groups, it may be prevented or at least delayed. The data discussed also suggest the importance of culture in defining the meanings of normal or abnormal aging. While from a clinical perspective it may be clear where the line is to be drawn between what is normal and what is pathological aging, from the perspective of older people, the basis of what is considered normal or abnormal aging may not have a direct link to disease.

Keywords: Japan, Aging, Senile dementia, Alzheimer's Disease, Ethnomedicine

Introduction

In Japan, as in North America, there is great concern over the increase in cases of senile dementia that accompanies population aging. Results of studies published concerning Alzheimer's Disease (AD) and other forms of dementia in Japan suggest that, in conjunction with the tremendous speed with which the Japanese population is aging, the number of cases will rise more sharply than in any other developed country over the next twenty years (Ineichen 1996: 170). Unlike North America, however, fear about senility[1] is not primarily expressed in relation to pathological conditions like AD. Instead, as people grow older, their concern focuses on a folk category of decline in old age which, although symptomatically and conceptually overlapping with AD and other forms of senile dementia, is distinguished from unambiguously pathological conditions. This category, known as *boke*,[2] differs from biomedically defined forms of dementia in its lack of precise definition and its rather diffuse scope of meanings including, but not necessarily limited to, conditions that may arise in old age.

Two questions will be considered in this article. The first is primarily of ethnographic interest in relation to aging in Japan: How is *boke*, as a form of senility, culturally constructed? This question emphasizes the importance of understanding senile dementia from culturally specific perspectives (Cohen 1995; Henderson 1997; Henderson & Gutierrez-Mayka 1992; Herskovits 1995). For the most part, *boke* is expressed through symptomatic features that tend to be associated with patterns of diminished cognitive status in nondemented older adults. Although these may be precursors to or very early stages of pathological conditions among those same individuals, *boke* itself is not usually presented as symptomatically representing pathology in the way that AD or other forms of dementia do. Instead, *boke* is viewed as an illness in the sense, indicated by Fabrega (1975), that it is defined in sociocultural rather than biological terms. The onset of *boke* is constructed in terms of the level of activity of the individual who has it or who potentially could experience it. As such, *boke* is differentiated from AD or other disease-driven forms of dementia on the basis that people have some degree of agency in relation to its onset – through activity, particularly activity within the context of groups, it may be prevented or at least delayed.

Agency is important in understanding why *boke* is the focus of attention when Japanese people think about senility and why control over its onset or progress is profoundly meaningful for older Japanese. Agency in relation to the onset of senility makes room for the possibility that, as one grows older, one can continue to engage Japanese normative values that emphasize: (1) avoidance of burdening others and (2) moral constitution of self within the framework of reciprocal obligations (Kondo 1987, 1990). Both of these ideas represent central normative themes in Japanese culture, and consideration of their relationship to the aging process can help in explaining the culturally specific reasons behind Japanese fears of senility (whether AD, other forms of dementia, or *boke*).

The second question with which this article is concerned is of an ethnological or comparative nature: What are the implications of the Japanese case for our understanding of normal and pathological aging? As Robert Atchley has aptly pointed out, the term normal aging usually refers to commonly encountered patterns of aging – the changes in body and mind that all people experience as they grow older. Normal aging is distinguished from pathological aging "by a lack of physical or mental disease" (Atchley 1989, 183). Atchley indicates that there may be social expressions of pathological aging (Atchley 1989: 184) and, thus, pathological aging needs to be interpreted within the framework of norms and values that characterize a given cultural milieu, but the basis of defining pathological aging remains fundamentally biological.

Using passages from the extensive literature on *boke* that has emerged in Japan over the past twenty-five years, and the narratives of four older Japanese, the meaning of senility will be localized as it is expressed through Japanese culture. By examining the meaning and experience of *boke*, it will become evident that senility in Japan is culturally constructed in a way distinct from the clinical biomedical construction of senility-as-pathology which has become increasingly the norm in North America (Cohen 1995: 315). Senility in Japan takes on a range of meanings which are often ambiguous and complex and which blur the lines between what is considered normal, as opposed to pathological, aging as defined in biomedical discourses. For those who are in the midst of experiencing changes associated with old age, the definition of what is normal or abnormal aging may well be quite ambiguous. Thus, while from a clinical perspective it may be clear where the line is to be drawn between what is normal and what is pathological aging, from the perspective of the social formulation of disease and illness the basis of what is considered normal or abnormal aging may not be clearly delineated (Fabrega 1975: 969).

Data upon which this article is based were collected during two periods of ethnographic fieldwork. The first was a pilot study conducted over three months in the summer of 1994, which led to an eighteen month period of fieldwork from the beginning of 1995 until mid-1996. Fieldwork took place primarily in a hamlet of about 410 people in an agricultural town in Iwate Prefecture at the northern end of Japan's main island of Honshu. The data discussed here were collected as part of a larger project aimed at producing a community study of how older Japanese living in a rural area manage the transition from early to later old age (Traphagan 1997, 1998). Data were collected through participant observation of activities that are primarily intended for older people, ethnographic interviews with approximately fifty older residents of the hamlet, and numerous casual conversations. Throughout these activities preventing *boke* arose as the central leitmotif directing many facets of older people's behavior.

What is *boke*?

Dementia, or the "failing brain" as it has been called, is generally presented in biomedical discourses as a "clinical syndrome characterised by persistent impairment of multiple cognitive capacities" (Cummings 1995: 1481). Dementia is arranged into two broad categories: Alzheimer's Disease and brain disorders causing cognitive deficits associated with other conditions such as Parkinson's disease, vascular disease, or depression (Cummings 1995: 1481–1482). The emphasis in this schema is on AD and other dement-

ing disorders of old age as being "caused by specific pathological conditions" and, hence, they fit within the rubric of abnormal cognitive function and pathological aging (Khachaturian & Radebaugh 1996: 4). As such, dementia is distinguished from characteristic changes in domains of cognition associated with normal aging that affect memory, abstract reasoning and problem solving, complex attentional processes, and visuospatial abilities – changes that are viewed as not caused by specific diseases, producing little disability, and thus are not pathological (Cummings 1995: 1481).

In the North American context, unambiguously differentiating normal and pathological aging has been deemed highly important in helping doctors assess conditions and avoid erroneously attributing normal age-related change to underlying pathologies (Beall, Baumhover, Maxwell & Pieroni 1996). But when considering dementia as a syndrome of brain dysfunction with various causes, it becomes difficult to define the threshold between cognitive impairment and cognitive changes associated with usual aging processes. Furthermore, physiological and psychological factors such as nutrition or educational attainment tend to blur the lines between what is considered normal and abnormal cognitive function (Morris 1996: 76).

The biomedical establishment in Japan follows a similar approach to categorizing cognitive impairment and decline in old age. Alzheimer's Disease, known as *arutsuhaimâ* (a direct borrowing from English) and *chihô* (dementia) are causally linked to diseases of old age and are placed into the general category of *rôjinsei chihô* or dementias of old age (Kikkawa 1995: 188). Unlike North America, however, where senility has become increasingly medicalized and associated primarily with AD as a clinically constructed form of pathology (Cohen 1995) among lay people and medical professionals alike, in Japan *boke* exists as an additional category of senility which is usually distinguished from the pathological conditions of AD and *chihô*.

From a biomedical perspective, *boke* tends to be associated with simple memory loss and reduced physical capabilities, rather than more diverse loss of mental functionality connected to disease-driven dementias (Ikeda 1995: 23). In the words of one Japanese doctor writing about the definition of *boke*:

> With *boke*, there is feeling of ease, a humorous feeling, an impression of softness, but as a medical term it is unsuitable, I think. For example, If you say dementia (*chihô*), without question there is a sense of disease, an *abnormal* condition being exhibited . . . (Ikeda 1995: 26, emphasis added).[3]

Although those who view themselves at risk for the condition see *boke* neither as humorous nor soft, Ikeda's comments clearly highlight the differentiation

of *boke* from pathological aging that exists within the medical professions. There is, no doubt, good reason for this because the term *boke* can be used in a strikingly broad range of situations. In its most general usage, *boke* conveys a degree of disorientation that, although often associated with old age, is not necessarily limited to old age. For example, jet lag in Japanese is *jisa boke*, which literally translates as "difference in time (*jisa*) disorientation (*boke*)".

The specific attachment of the term to old age has been contested by some. One author, a retired doctor writing on the subject of avoiding *boke*, rather emphatically argues that, "there are phrases like 'Old person *boke*,' 'the dotage of old age'; to say that only old people become *boke* – that's offensive!" (Hayakawa, 1992: 204). The author goes on to discuss other forms of *boke*, including "infant *boke*" in which an infant lies in bed and has no control over bowel movements, or "playing *boke*" such as when one is using a personal computer with friends and forgets the time. Hayakawa believes that even the feeling of waiting and waiting for a friend with whom one has made an appointment, but who is late, can be a kind of *boke* (Hayakawa 1992: 202–207). In Hayakawa's formulation, as with Ikeda's, *boke* does not fall into the framework of pathological aging or dementia, nor, for that matter, is it even specifically linked to the aging process; *boke* is categorized within the realm of normal aspects of human behavior that can occur at any time in life, albeit for different reasons.

Hayakawa's objections to the association of *boke* with old age notwithstanding, in contemporary Japan the term, as a free-standing noun, has come to be associated with a state of mind and body that most likely arises in old age, rather than a particular feeling such as jet lag. Heightened awareness of *boke* as a feature of old age originated with the publication of Ariyoshi Sawako's highly successful novel *Kôkotsu no hito* first published in 1972 (the title literally translates as "person of ecstasy", and was published as *The Twilight Years* in English translation) (Ariyoshi 1984). Following Ariyoshi's work, several novels and personal stories related to the care of older parents have been published, and these often become widely read. A recent example is Sae Shûichi's *Kôraku* (golden decline), a personalized account in which the narrator deals with the difficulties caused by aging parents who are becoming *boke* (Sae 1995). Fictional stories and personal accounts of caring for a *boke* parent or in-law have contributed to generating a broad atmosphere of fear among older and middle-aged Japanese about its potential onset.

This fear is evident in the spate of volumes on maintaining general health in old age, and prevention of *boke* in particular, that focus on how to avoid a gloomy old age. Such books often suggest that for many, the stereotypical image of old-age is one of a time in which people make weekly hospital visits, experience physical frailty, extensively use prescription drugs, and particu-

larly for men, have limited social interaction. Take, for example, this passage describing a hospital waiting room from the introduction to Hayakawa's book *Boke nai hanashi, rôke nai hanashi* (Talking about not being *boke*, not being old):

> Old men sit leaning against the wall or in chairs, awaiting their turns. They wait taciturnly. Although they wait next to each other, they do not speak. With sullen faces, they wait one hour, two hours . . . (Hayakawa 1992: 7–8)

The men in this picture well fit one pattern of behavior that is commonly associated with becoming *boke*; they sit next to each other but are not active at a social level. Men are viewed as being at particularly high risk of becoming *boke*. This is attributed to Japanese patterns of extreme devotion of time and energies to work, which are abruptly ended with mandatory retirement (although many continue to work in some capacity after "retirement"). Earlier in life men do not have sufficient time to develop a hobby or interest to take them into post-retirement years. To borrow Atchley's theoretical approach (Atchley 1993), Japanese men are viewed as lacking a domain of continuity of interest on which to draw as they move from middle age to old age and this puts them at higher risk for becoming *boke*. Women, by contrast, usually have established hobbies and interests earlier in life and can draw on these activity domains as they move into old age, thus reducing the risk of becoming *boke*.

Kikkawa indicates that some people in Japan simply equate *boke* and *chihô* (1995: 188), an equation against which he argues emphatically (1995: 203). Although finding much in common between *boke* and *chihô*, he emphasizes the difference between the two concepts as being expressed in the more precise, technical nature of *chihô*, invoking DSM-III (*Diagnostic and Statistical Manual of Mental Disorders*, 3rd ed.) as an expression of how *chihô* is clinically defined. *Boke* he argues, is considerably more imprecise in meaning than *chihô*. He offers his own definition of *boke*, in which he states that a person's perception becomes dull or vague. For Kikkawa, the *boke* person has entered into dotage (*môroku*) and may come to be in a dream-state in which he or she forgets him- or herself (*muchû ni naru, ware o wasureru*). While this may sound much like aspects of AD as understood in North American biomedical discourses, there is no sense of disease here. In fact, Kikkawa (1995: 213–214) differentiates *boke* from *chihô*, which, by contrast, is precisely defined as a "blockage of intellectual abilities" that is attributed to some form of disease and which is irreversible. Indeed, in writing about *chihô* Kikkawa presents it as a clinical concept, whereas he does not do so when referring to *boke*.

The ambiguity in defining *boke* is particularly evident when comparing the works of Hayakawa and Kikkawa. Hayakawa, on the one hand, emphatically states that *boke* is not to be described as dotage, whereas Kikkawa, on the other, uses the Japanese term for dotage when defining *boke*. Both, however, agree that whatever *boke* is, it is very diffuse in meaning. Furthermore, these books, as do many others focused on *boke*, while expressing a certain degree of fatalism about *chihô* and AD, present *boke* as something which may be preventable, delayed, or may even respond to rehabilitation. The prescription for successfully coping with or combating *boke* is invariably being active physically and mentally, particularly in hobbies and games that involve social interaction.

Experiencing *boke*

The distinction between *boke* and medicalized conditions of dementia is also expressed by lay people when they are asked about the meaning of *boke*. In order to investigate this more deeply, it will be helpful to consider the cases of four older individuals three of whom have a direct experience with *boke*. The following are narratives expressed by two women and two men during conversations in which the main focus of discussion was the worries people have about old age.

Narrative 1: Mrs Yoneyama. Mrs Yoneyama was sixty-eight at the time of our conversation. She lives alone and spends much of her time gardening and chatting over tea with the five other widows who are her immediate neighbors and other friends who occasionally visit. Mrs Yoneyama also tends a very small convenience store in the front of her house, a hang-out for a few of the neighborhood boys who come to play the arcade games that occupy a section of the room. The following is taken from a semi-structured interview in which she and one of her neighbors participated together. When asked about what worries her most as she grows older, Mrs Yoneyama, with the strong agreement of her neighbor, spontaneously raised the issue of *boke*.

> *Mrs Yoneyama*: I worry about living too long. If I live too long, then what will I do if I get sick? If I live too long, I might become *boke*; I don't want that because that is a very unhappy and lonely life.
>
> *JWT*: How would you describe the characteristics of being *boke*?
>
> *Mrs Yoneyama*: The characteristics of *boke* are things like forgetting where you put things or what you did with something. It's not only forgetting things, however. Also, *boke* is doing things like accusing someone of taking something that is yours when it is actually right next to you. You

tend to invent things that are not real. It is completely different from senile dementia (*chihô*). You are more able to talk when *boke* than when in a state of senile dementia. My mother-in-law was *boke*. It was really quite embarrassing. Once she told us that the police had come to take her and they wanted her bureau, so she brought all of the drawers of the bureau to the entryway of the house. She said that she needed to go with a futon and rice, so I made them up for her. Grandma put them on her back, but then said it was too heavy so she didn't need them. Grandma would also sometimes say that we needed to get rice when we had lots of rice around the house.

Another time, I went to get the phone and I thought that Grandma was in her room and was o.k. While I was talking on the phone, I noticed that Grandma was not in the room. I hung up and went into the kitchen when I found all of Grandma's clothing, including her underwear, on top of the stove, which, fortunately, was turned off. The door was open so I ran out and found Grandma half way to the tobacco store across from the park – stark naked. This sort of thing went on for ten or eleven years.

The concern I have is that I do not want to become a burden to my children (*meiwaku kaketakunai*). I would rather die before that. The best way to die is to die suddenly (*pokkuri*). I do not want to be a burden.

Mrs Morita: That way of dying is best. I would rather just go suddenly. The ideal death is to have had tea with a friend the previous day and spent time laughing together. The next day my friend comes to the house and finds me dead. That's the best way to go. I want to die while I am still able to enjoy life. I don't want to be burden on my children. They are busy working.

Narrative 2: Mrs Wakida. Mrs Wakida lives with her son and daughter-in-law in the home which has been in her family for ten generations. She was seventy-two at the time of our conversation, which took place in the living room of her house overlooking the formal garden which her daughter-in-law tends. Mrs Wakida enjoys international travel, but, like Mr Ueda to be discussed below, is concerned about physical problems preventing her from traveling in the future.

Wakida: The only worry I have is about my health. I do not want to become dependent upon my family. I hope that I will not become *boke* and that I can continue doing the things I like such as poetry writing.

JWT: What does *boke* mean?

Wakida: Well, in Japan there are a lot of meanings, aren't there. It's certainly different from Alzheimer's Disease. The first thing that occurs

is that you begin to forget things about yourself and in general. Also, you tend to have hallucinations (you experience things that are not there). There are various things.

[In order to avoid *boke*], living alone or as an elderly couple is not so good, it's best to live with family. It is also important to have a hobby. If you do not have a hobby or interest . . . well, if you have a hobby, your will not grow old. I often say that youth is not limited to the young. If you have a young way of thinking, that is youth as well. Elderly people often say that it is not good to behave or feel like you are young. The purpose of hobbies is to have contact with other people and to make friends to go out into society. For example, with the poetry, there are people who send their books all around the country without knowing other people and they get to know each other. Travel is like this. You go out with people and become friends. It allows you to enter into society. By participating in hobbies, your experience of society becomes wider. Also, it is important not to develop a feeling of just staying in the house and not going anywhere. After I was sick [she had kidney disease], I thought, "I have to get well quickly so that I can go out and do things again." I do not want to feel that I am old and cannot do anything. When you get old it is really important to have some sort of interest. You have to have something that makes you think and use your head. Definitely, in order to avoid becoming *boke*, you have to have an interest and you have to be doing something.

I don't want to be a burden to my family, but I really do not want to die in a hospital. Maybe the best way to go is to be at home and sick in bed for a week or ten days and die with your family around you. I want to die naturally. I want to live normally without becoming *boke*, and then die.

Narrative 3: Mr Murata. Mr Murata is an avid participant in a game known as gateball, one of the most popular activities in which older Japanese participate for the purpose of avoiding becoming *boke* (Kalab 1992; Traphagan 1997). On the walls of the small room in which he greets guests and customers to his tailor shop hang several framed certificates and two trophies from his participation in gateball tournaments. There is also a large group picture that includes Mr Murata and the other players of a team that went to the national tournament. Mr Murata is highly devoted to the game; although his hamlet team only practices twice a week, he visits other area teams so that he can play every day.

Although he does not describe himself as retired, business has not been good for several years, so he has time to devote to other activities. In addition to this, he and his daughter (who, with her family, lives with Mr Murata) care for his wife – who was diagnosed with AD about five years before the

interview. When asked to discuss his wife's condition, he answered in the following way:

> *Mr Murata*: My wife is not really able to do anything on her own. She spends most of her time watching the TV or sleeping. Her Alzheimer's is not always bad. She is fine some of the time and not good other times. She does not usually know what day it is nor what the date is. But maybe half the time she is o.k. Sometimes she remembers people's faces, sometimes not.
>
> *JWT*: Did your wife also work as a tailor?
>
> *Mr Murata*: No. She tried at first but was not able to get the hang of it. When we married I thought that she would also be involved in the business, but she wasn't ever involved in it. Using one's hands is the key to avoiding becoming *boke*. Because I have always used my hands because of my work as a tailor, I have avoided becoming *boke*.

Narrative 4: Mr Ueda. At 90, Mr Ueda seemed remarkably active. He is one of the most highly respected men in the hamlet in part because he was a town assemblyman and also because his family is one of the town's oldest. His ancestors came to the hamlet some 300 years ago as one of several samurai vassals connected to the castle that once stood nearby. At the time of the interview, Mr Ueda had just returned from a trip to Japan's southern islands (Ryukyus), although he indicated that this would be his last long trip. Travel is a central theme in his life; he has been overseas 27 times since his retirement from public service at the age of 55. Pictures from his travels to places like Egypt and Brazil adorn the walls of the room where he receives guests, and one of his great joys is to pull out picture albums from his various trips. Although, he recently returned from a trip, he sees himself as having reached a point where he can no longer be the sort of active person he was in the past.

> *Mr Ueda*: When I was younger, I didn't have any free time, but when you get older you have more free time and you might become *boke*. I am a *boke rôjin* [*boke* old person]. Because I am basically *boke*, I want you to consider what I am saying here and make your own judgments about it. In any case, I am very sorry about my speaking with the words of a *boke* old man. Because I am a *boke* old man, I am concerned that other people will not understand what I am saying and what I mean because of the way I say things and because I am *boke* . . . From the perspective of other people, I certainly look as though I am *boke*.
>
> *JWT*: You think others view you as *boke*?
>
> *Mr Ueda*: I do. Don't you think so?

JWT: How would you describe a *boke rôjin*?

Mr Ueda: Hmm, what would it be? In any case, the way I speak, well it doesn't go along straight like a tree, it wanders in different directions. I keep saying things that are unexpected. My hearing is bad, so I don't always understand others' questions clearly. Really, I apologize for my difficult to follow conversation.

The main theme that emerges from these narratives is that *boke* is a condition experienced in terms of others, particularly one's family. Specifically, *boke* is represented as causing a burden to those people with whom one interacts. Mrs Yoneyama's mother-in-law behaves in a way that shows a lack of concern for or awareness of others. She accuses others falsely and does things that publicly embarrass her family. Mr Ueda presents his own experience of *boke* as an inability to control the course of his conversations with others. His deep concern that I understand, because he believes that due to his being *boke* it would be difficult for me to follow him, can be interpreted as an expression of a desire to avoid burdening others with trying to make sense of what he believes to be confusing conversation.[4] The avoidance of burdening others is the central theme in the narratives of both Mrs Yoneyama and Mrs Wakida. Both women indicate directly that one of their greatest concerns about growing older is to avoid burdening their children with extensive provision of health care, which is seen as an inevitable outcome of *boke*.

A second theme also emerges. For Mr Ueda, Mrs Wakida, and Mr Murata, the onset of *boke* is potentially avoidable or, at least, can be delayed. All three link the onset of *boke* to inactivity. Mr Ueda states that his inability to travel as he once did puts him at greater risk for becoming *boke*, and, indeed, he thinks he has already started along this path. Mr Murata invokes the importance of using one's hands as a means of avoiding *boke*, a behavior which is constantly stated by older people as one of the best ways to avoid becoming *boke*. In fact, there was a subtle sense in the tone of Mr Murata's comments about his wife's failure to become involved with his tailoring business which implied that his wife's inability or unwillingness to do things with her hands contributed to her current condition. The tone of his voice suggested a lament that she had not managed to take better care of herself. Finally, Mrs Wakida emphasizes the importance of having hobbies, particularly those which require one to socialize, as keeping one from becoming old and, thus, *boke*.

A further point that arises in Mrs Yoneyama's and Mrs Wakida's narratives is the differentiation of *boke* from pathological forms of dementia such as Alzheimer's Disease. Repeatedly in the course of interviews and conversations with lay people, the idea that *boke* is different from AD and *chihô* arose when older people defined the nature of *boke*. This may, in part, be

attributable to the fact that most older people read books such as those cited above, and, thus, are attuned to public discourses informed by biomedicine. Although some informants were not clear on how the categories actually differed, for most the dividing line rested in the ability of an individual to respond to the onset or potential onset of the condition. With AD or *chihô*, there is a strong sense of fatalism. These are diseases that one contracts and, thus, has little control over without the direct intervention of a doctor (and unlikely even with that intervention), and in the case of AD or *chihô* the inability to cure these diseases underscores the fatalistic attitude toward their onset. When talking about AD or *chihô*, informants often said, "*shô ga nai*" (there's nothing one can do). Furthermore, as a result of lacking agency in relation to these conditions, informants indicated clearly that they are not a source of embarrassment to the family because the individual who gets AD, for instance, does not have any control over its onset.

Alzheimer's Disease and *chihô* are like cancer. They are disease one may contract regardless of what one does to prevent them. There is, of course, some ambiguity in this because, as is evident in Mr Murata's case, the two are sometimes used in ways that overlap with *boke*. But when thinking about senility, older Japanese generally draw a line between what is caused by disease and, thus, out of their direct control, and what is susceptible to human manipulation or preventive action. *Boke*, for the most part fits into this second category. As one seventy-five year-old man put it:

> There are ways to avoid becoming *boke* or to fight it and if you do not, that is embarrassing because you were too lazy to have avoided it. Being *boke* is something that I think about and am trying hard to prevent. For me, participation in the hamlet ground golf team, reading out loud for at least thirty minutes a day, and working in my garden and rice fields are ways I am trying to avoid becoming *boke*.

This informant stated that by reading aloud he gives his brain more exercise than by reading to himself silently, because he is more conscious of the content of the text when he reads aloud. Ground golf (another game largely played by older people) provides a way to exercise his mind through social interaction and his body through walking, and gardening and farming help him to keep physically healthy.

It is important to recognize that older people do use the three terms somewhat interchangeably and it seems that there is a sense that *boke* may ultimately become *chihô* or AD. The dividing lines between these categories of senility are fuzzy, not only from the perspective of an observer, but also in the minds of older Japanese themselves. Nonetheless, there is a taxonomic division in how older people think about senility. Older Japanese base their

ideas about senility upon two overarching categories which shape behavior: agency and non-agency. Older people differentiate between conditions unambiguously related to disease and, thus, not within the realm of human control (non-agency), and the broadly defined symptoms that are not necessarily clearly linked to disease and over which individuals may have some degree of control – the ambiguous forms of decline that are subsumed under the rubric of *boke*.

Conclusions

As Margaret Lock has noted, in Japanese society the inability to perform one's role in a given group adequately generates a sense of not only having let oneself down, but of having let down the group as a whole. This can stimulate strong feelings of guilt, whether the group is one's family, co-workers, or others (Lock 1980: 248). In addition, it has been stressed repeatedly in the ethnographic literature on Japan that one of the fundamental values of Japanese society is a principle of reciprocity, by which people engage in practices of balanced giving and returning. This is evident in specific behaviors such as reciprocal gift giving (Befu 1967), or more generalized cultural concepts that socially and morally bind people together in relationships of interdependent obligations (Lebra 1976: 90–109). Reciprocal obligations are expressed very directly in the parent-child relationship in terms of inheritance and provision of health care. Although the situation appears to be changing, in many Japanese families (particularly those in rural areas) only one child receives the majority of inheritance and takes on the position of head of household (often, buy by no means always, it is the eldest son). This, however, comes with the expectation that the inheritance will be reciprocated in the form of provision of health care, a place to live, and economic support as needed in old age (Traphagan 1998). As a consequence of this reciprocal relationship, older Japanese often are able to legitimately expect to depend upon at least one child for social support in old age (Hashimoto 1996).

These characteristics of Japanese behavior and social organization help to clarify why *boke* is feared by many Japanese. In the above narratives, two of the informants (Yoneyama and Wakida) expressed their concern about not becoming *boke* directly in terms of the importance of not burdening their children. The ability to legitimately depend upon children for social support in old age is tempered by Japanese social norms against burdening others (Traphagan 1998). I suggest that it is this tension between legitimized dependency and avoidance of burdensome behavior that is at the basis of why *boke* is feared. To become *boke* means to place undue burden on family members. More importantly, in spite of the fact that people go to great lengths

to avoid or delay *boke*, there is considerable uncertainly and even a degree of fatalism about whether, having started down the slope to becoming *boke*, one might ever improve. Hence, the onset of *boke* carries the moral implication of burdening family members without the possibility of ever being able to reciprocate the care one receives.

This brings us to the crux of the meaning of senility for many Japanese. In order to explicate this meaning, it is helpful to employ Horacio Fabrega's ethnomedical approach in which he draws a distinction between illness and disease. Illness, according to Fabrega, is a category which refers to socio-culturally defined departures from normal health. Disease, by contrast, is a category defined by members of the biomedical community (Fabrega 1975). Employing this distinction in the Japanese context it becomes clear that from an ethnomedical perspective *boke* for the most part is perceived as an illness, while *chihô* and AD clearly fall into the category of diseases. What is important in understanding Japanese ideas about senility is that the notion and experience of illness, and not disease, forms the predominant way in which Japanese conceptualize the meaning of senility.

The differentiation between *boke qua* illness and dementia *qua* disease lies in attitudes toward human agency in relation to the onset and progression of the two conditions. To put it rather simply, the term *boke* implies a potential for individual agency. The limits of personal or human control come at the point where the condition becomes unambiguously linked to a disease (Long 1997), where there is a biomedically defined cause; at this point there is no or little potential for agency on the part of the individual. This should not be taken as suggesting that people do not take steps to avoid the onset of the biomedical conditions. They do. And as noted above, the dividing line between *boke* and biomedical forms of dementia is hazy. The activities aimed at avoiding or delaying *boke* are seen as being generally good for maintaining health, thus other conditions are not necessarily excluded from the purview of their influence. It is at the point where ambiguity dissolves to clarity, at the point of a diagnosis, that older people shift to a sense of resignation – *shô ga nai* – that as a disease, rather than as an illness, senility is beyond a person's ability to direct or control (Ohnuki-Tierney 1984). Indeed, this may well explain why Japanese people focus so intently upon the notion of *boke*, because as long as there is ambiguity there is hope that one can take steps to prevent or delay the onset of senility and, thus, remain a viable social entity.

To become senile is at a fundamental level to disengage from the inter-dependencies that characterize human nature and society and, thus, to become depersonalized because it is these interdependencies that fundamentally define one as human in the Japanese context (Plath 1980: 217). Senility means one has started a process of entering into a relationship of increasingly

unilateral dependency with a care provider and, thus, disengagement from the relationships of reciprocal interdependency which are considered to be socially normative. To become senile is to fall into a position where one's behavior is at odds with the needs of the group – specifically, one's family. While the person experiencing any of the three categories of senility faces the potentiality of this form of dissociation, the causal link to disease which defines AD and *chihô* mitigates the sense that one might have been able to do something to prevent these conditions and, thus, mitigates the moral implications of contracting the conditions. The moral weight of *boke* arises because, unlike unambiguously pathological forms of dementia, individuals may have some degree of agency in terms or preventing or delaying its onset. In short, *boke* symbolically represents Japanese concerns about being dissociated from the framework of interdependencies and reciprocal obligations that define one as a moral being (Traphagan 1997: 265).

Some caution in the degree to which these conclusions can be generalized in the Japanese context is worth heeding. The general availability and effectiveness of medical technology and treatments in Japan and widespread trust in the validity of medical knowledge have meant that the biomedical model has become increasingly influential in shaping how Japanese think about the process of aging (Lock 1993). A shift in emphasis, similar to what has happened in the USA over the past thirty years, to a more medicalized conceptualization of senility may well be happening throughout Japan. Nonetheless, *boke* remains at this point in time the primary category through which Japanese think about senility, and it is reasonable to conclude that, given the importance of the category as a focus upon which to enact human agency, it will remain important for the foreseeable future.

The study of *boke* and other folk categories of senility is intrinsically interesting from an ethnographic perspective, but it also has important consequences for gerontological research more generally. There is no clear-cut way to categorize *boke* as either normal or pathological aging in the sense understood through biomedical categories, because many Japanese people (at least those not tied into the biomedical establishment) do not think about the aging process in terms of an oppositional relationship between *disease* and normality, but of *illness* and normality. Even with a sense of resignation that if one lives long enough there is a good change of becoming *boke*, the enormous efforts made by older Japanese to avoid the condition strongly suggest that they do not see it as a normal outcome of the aging process. Although *boke* in its earliest stages may be seen as a more or less normal aspect of the aging process, as the condition progresses and is increasingly viewed as an illness, it is categorized as abnormal because it represents socially aberrant behavior. The *boke* person is ill, but not diseased. From a biomedical perspective, *boke*

is not defined as pathology in Japan, but from a social perspective it can neither be understood as normal aging.

This raises a final point concerning the significance of this study for the cross-cultural examination of senility or dementia. Application of the biomedical conceptualization of senility in terms of the opposition of normal and pathological forms of aging may well overlook significant – in the Japanese case the most significant – conceptualizations of senility and functional decline in different cultural settings. What I suggest in closing is that cross-cultural studies in gerontology can profit from a broadening of the definitions of normal and pathological aging to encompass the emic perspectives of those who are in the process of experiencing later life. Cultural values are an inevitable part of how people in different settings perceive of the aging process and the features to be considered normal or abnormal in relation to that process. The centrality of these values in defining what is normal or abnormal limits the possibility of employing a universally applicable definition. There is a need not only for localizing the meaning of senility, but for understanding the social norms that define the meaning of normal and abnormal processes of aging.

Notes

1. I have chosen to use the term senility here as opposed to dementia because the later expresses biomedical meanings not necessarily evident in the Japanese context. When I use senility, I mean forms of cognitive decline inclusive of both biomedical and ethnomedical categories.
2. This term *boke* is pronounced in two syllables – bo•ke – with the "e" pronounced as a short vowel sound.
3. All translations from Japanese texts used in this article were produced by the author.
4. It is worth pointing out that his family and peers, in contrast to his opinion, do not regard him as *boke*. Many informants indicated that one who is aware of the possibility that he or she is *boke* cannot actually be *boke*, because such people are not aware of their own behavior.

References

Ariyoshi, S. (1984). *The twilight years* (Mildred Tahara, trans.). New York: Kodansha International.

Atchley, R. C. (1989). A continuity theory of normal aging, *The Gerontologist* 29: 183–190.

Atchley, R. C. (1993). Continuity theory and the evolution of activity in later adulthood. In J. R. Kelly (ed.), *Activity and aging* (pp. 5–16). Newbury Park: Sage Publications.

Beall, C. S., Baumhover, L. A., Maxwell, A. J. & Pieroni, R. E. (1996). Normal versus pathological aging: knowledge of family practice residents, *The Gerontologist* 36(1): 113–117.

Befu, H. (1967). Gift-giving in a modernizing Japan, *Monumenta Nipponica* 23(3–4): 445–456.

Cohen, L. (1995). Toward an anthropology of senility: Anger, weakness, and Alzheimer's in Banaras, India, *Medical Anthropology Quarterly* 9(3): 314–334.

Cummings, J. L. (1995). Dementia: the failing brain, *The Lancet* (North American Edition) 345: 1481–1484.

Fabrega, H. (1975). The need for an ethnomedical science, *Science* 189: 969–975.

Hashimoto, A. (1996). *The gift of generations: Japanese and American perspectives on aging and the social contract*. New York: Cambridge University Press.

Hayakawa, K. (1992). *Boke nai hanashi, rôke nai hanashi* [*Talking about not being senile, not being old*]. Tokyo: Shôgakkan.

Henderson, J. N. & Gutierrez-Mayka, M. (1992). Ethnocultural themes in caregiving to Alzheimer's patients in Hispanic families, *Clinical Gerontologist* 11: 59–74.

Henderson, J. N. (1997). Dementia in cultural context: Development and decline of a caregiver support group in a Latin population. In J. Sokolovsky (ed.), *The cultural context of aging: Worldwide perspectives* 2nd edn (pp. 425–442). Westport: Bergin & Garvey.

Herskovits, E. (1995). Struggling over subjectivity: debates about the 'self' and Alzheimer's Disease, *Medical Anthropology Quarterly* 9(2): 146–164.

Ikeda, H. (1995). *Rônenki chihô no korin de fusegeru ka?* [*Does choline from egg yolks protect against senile dementia?*]. Tokyo: Kodansha.

Ineichen, B. (1996). Senile dementia in Japan: Prevalence and response, *Social Science and Medicine* 42(2): 169–172.

Kalab, K. A. (1992). Paying gateball: A game of the Japanese elderly, *Journal of Aging Studies* 6(1): 23–40.

Khachaturian, Z. S. & Radebaugh, T. S. (1996). Synthesis of critical topics in Alzheimer's Disease. In Z. S. Khachaturian & T. S. Radebaugh (eds.), *Alzheimer's Disease: cause(s), diagnosis, treatment, and care* (pp. 3–12). New York: CRC Press.

Kikkawa, T. (1995). *Hito wa naze bokeru no ka: Boke no genin to keaa* [*Why do people become senile? The causes and care of senility*]. Tokyo: Shinseidehansha.

Kondo, D. K. (1987). Creating an ideal self: Theories of selfhood and pedagogy at a Japanese ethics retreat, *Ethos* 15(3): 241–272.

Kondo, D. K. (1990). *Crafting selves: power, gender, and discourses of identity in a Japanese workplace*. Chicago: University of Chicago Press.

Lebra, T. S. (1976). *Japanese patterns of behavior*. Honolulu: University of Hawaii Press.

Lock, M. (1980). *East Asian medicine in urban Japan: Varieties of medical experience*. Berkeley: University of California Press.

Lock, M. M. (1993). *Encounters with aging: Mythologies of menopause in Japan and North America*. Berkeley: University of California Press.

Long, S. O. (1997). Reflections on becoming a cucumber: Images of the good death in Japan and the U.S. Unpublished paper presented at the Center for Japanese Studies, University of Michigan.

Morris, J. C. (1996). Diagnosis of Alzheimer's Disease. In Z. S. Khachaturian & T. S. Radebaugh (eds.), *Alzheimer's Disease: Cause(s), diagnosis, treatment, and care* (pp. 76–84). New York: CRC Press.

Ohnuki-Tierney, E. (1984). *Illness and culture in contemporary Japan: An anthropological view*. New York: Cambridge University Press.

Plath, D. W. (1980). *Long engagements: Maturity in modern Japan*. Stanford, CA: Stanford University Press.

Sae, S. (1995). *Kôraku*. Tokyo: Shichôsha.

Traphagan, J. W. (1997). *In the shadow of Obasuteyama: Old age and the disembodiment of social values in a Japanese town*. PhD Dissertation, University of Pittsburgh.
Traphagan, J. W. (1998). Contesting the transition to old age in Japan, *Ethnology* (in press).

Address for correspondence: John W. Traphagan, Population Studies Center, University of Michigan, 1225 S. University Ave., Ann Arbor, MI 48104–2590, USA
Phone: (313)998–8698; Fax: (313)998–7415; E-mail: jtrap@umich.edu