The Experience of Self-Perceived Social Death Among Older Persons in the City of Bamenda, Cameroon

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Abstract: **This qualitative study, undertaken in the city of Bamenda, North West Region of Cameroon, explores from a symbolic interactionist perspective, the experience of social death among older persons. Its context is specially interaction within the social environment. Data was collected through in-depth interviews and focus group discussion. In the narratives of the participants, the principal pathways to the experience of social death included: the loss of the sense of self and identity, disintegration of the body and agonising concerns about body image, inability to participate in community and social events, increasing dependence on others, isolation and loneliness, ageism and discriminatory language. This paper draws attention to the fact that, apart from their material sustenance, older persons have psychosocial needs which are crucial to their emotional and psychological wellbeing and quality of life. Fostering a spirit of respect, empathy, appreciation, solidarity and social integration by the younger generation will greatly improve the sense of satisfaction of older adults, and help them to lead fulfilling and meaningful lives.**

Keywords: **experience, ageism, social death, community, interaction, meaningful life.**

1. Introduction

Generally, Africans lay claim to a communal way of life, pinned on sociological and moral categories, according to which a person is defined in terms of a network of social bonds (Daly, 1994), a kinship-oriented social order marked by an ethic of reciprocity (Gyeke, 1987, 2002), a collective existence and intersubjectivity (Khoza, 2005:266), mutual concern and special commitment to one another (Ramose, 2002),. Today, this claim is being constantly challenged by current experiences of older persons who feel or are actually neglected, abandoned, despised and forgotten in the hopelessness of their vulnerable conditions. The world population is ageing at unprecedented rate. The United Nations (2001) defined older persons as "persons aged 60 years and over." People aged 60 years and older make up 12.3% of the global population, and it is expected that by 2050, it will rise to almost 22% (UNFPA, 2023). In Sub-Saharan Africa, this segment of the population was 4.7% in 2005, and is expected to rise to 5.5% in 2030. In 2023, the population of Cameroon was estimated at 28 647 293 persons, with persons aged 60 years and older constituting 3.5%. The

needs of this bracket of the population are often multiple and complex. Apart from their material wellbeing, older persons have psychosocial needs. Confined to their homes either by the sheer weight of old age or the debilitating effects of illness, their needs include among other things, psychosocial and affective support, social recognition, material support and tangible proofs of the fact that they are cherished and still have a role to play in the society. When these comforting and assuring signs are absent, many feel that their page has been turned and they are socially non-existent, socially dead.

Several studies have noted an increase in negative attitudes towards older persons over the years (Nelson, 2005; Scharlach et al. 2000). The researchers, North and Fiske (2012) have observed the younger generation now exhibit more negative views and attitudes towards older persons than was previously the case. This qualitative study, undertaken in the city of Bamenda, the regional capital of the Northwest Region of Cameroon, explores from symbolic interactionist perspectives, the experiences of social death among some 120 older persons. Following Kalish's (1968) distinction between "self-perceived social death" and other-perceived social death", our focus is on the former, the experience of persons who have the feeling or are actually excluded as to feel socially dead. Our context is specifically the domain of interpersonal relationships as opposed to government policies on the care of older persons. We are interested in their interaction with their social environment. Special attention will be paid to the sociocultural and personal factors which shape the experience of social death. We shall also seek to account for differences in the intensity of the agony

2. The Concept of "Social Death"

The multidimensional concept of 'social death' was introduced to the literature on elderly people by Miller and Gwynne (Miller & Gwynne, 1972:80), in the context of their critical study of residential care. They drew the conclusion that:

To lack any actual or potential role that confers a positive social status in the wider society is tantamount to being socially dead. To be admitted to one of these institutions is to enter a kind of limbo in which one has been written off as a member of

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society but is not yet physically dead. In these terms the task society assigns - behaviourally though never verbally - to these institutions is to cater for the socially dead during the interval between social death and physical death.

In the wake of the research of Miller and Gwynne (1972), the concept of 'Social Death' has been used in a wide range of contexts, including grave medical conditions, old age, slavery, social exclusion, banishment, and imprisonment. In all these contexts, it depicts a human condition marked by a feeling of exclusion from the community (Noys, 2005), loss of social connectedness and loss of social roles (Guenther, 2013), loses associated with the disintegration of the body and stigmatisation (Goffman, 1961; Agaben, 1998; Hockey & Draper, 2005), and vulnerability (Biehl, 2004). Broadly, the term "Social Death" refers to a situation in which old and or terminally ill persons who are clinically and biological alive are treated as if they were already dead, or are neglected and abandoned. It is often characterised by the loss of social identity or personhood, the loss of social connectedness and losses associated with the disintegration of the body (Kralova, 2005).

In his seminal work, *Life and Death: Dividing the Indivisible,* Kalish (1968) conceptualised death as physical, psychological, sociological and social, and made a distinction between self-perceived social death, where a person believes that they are good as dead, and other-perceived social death, where it is others who classify the person as such. The term social death was introduced into the social sciences with Sudnow's (1967) study of the processes surrounding death. Based on observation in hospital settings, he made a distinction between clinical, biological and social death. Glaser and Strauss (1966) described how the awareness of person's dying due to poor prognosis determines social interaction with others. Applying the term to the terminally ill, social death is said to occur when people begin to withdraw from the terminally-ill person and to dehumanise them by ignoring them, taking decisions without consulting them, and imposing unwanted procedures (Ibid). Antecedents of this application are found in Goffman's (1961) essays on the social situation of long-term hospitalisations of mental patients which result in disculturation- removal of persons from their natural setting, causing them to lose their social roles, stripping them from social support and exposing them to a "series of abasements, degradations, humiliations and profanations of self" (Goffman 1961:24; 1963). Similarly, Biehl's (2004) study of a rehabilitation centre for drug addicts and alcoholics, the "vita" in Southern Brazil demonstrates how social death occurs at a community level. Employing such terminologies as "ex-humans" to describe the very poor inmates with disabilities, HIV/AIDS and terminal diseases, he paints a vivid picture of their deprivation, how they have been excluded from the wider community to experience social death, stripped of their humanity and terminally excluded from reality, so that they experience social death before biological death (Biehl, 2004:476, Borgstrom, 2015).

Recently, Brannelly (2011) applied the concept of social death to HIV/AIDS and cancer patients in irredeemable conditions who may find that friends, family members and healthcare professionals pay only sparse or no attention to their condition; they spend less time with them, talk less about their condition. Other applications of the concept have been made by Card (2010:237) who applies it to slavery, banishment, disfigurement, illness and even self-chosen isolation. Refugee studies have also highlighted feelings of displacement, social exclusion, loss of citizenship, economic vulnerability, and loss of protection as aspects of social death (Kralova, 2015; Guenther, 2013; Steele et al., 2015).

3. Methodology

A. Study Design

This study adopted a qualitative approach based on case study. This approach was preferred because it focuses on meaning making and allows for rich descriptive accounts from the participants' subjective point of view (Denzin & Lincoln, 2011; Bryne, 2001). In qualitative research, a case refers to a particular instance of a phenomenon of interest to the research (Gall, Borg & Gall, 2007). Case study research is an "empirical enquiry that investigates a contemporary phenomenon within its real-life context" (Yin, 2003:13). In-depth interviews and focus group discussions conducted in participants' homes enabled us to share their lived experiences, which were interpreted from a symbolic interactionist perspective. According to the basic premises of symbolic interactionism, as stipulated by Blumer (1969), humans interact with things based on meanings ascribed to those things; the ascribed meaning derive from our interactions with others and society, and the meanings of things are interpreted by a person when dealing with things in specific circumstances. As Charon (2004) has observed, human interaction is not only interaction among individuals but also interaction within the individual and the definition of the situation. These elements contribute to the definition of the self and identity, with questions about how I see myself and how others see me structuring the experience and perception of social death (Millward and Kelly, 2003).

B. Research Setting

This study was conducted in the City of Bamenda, Capital of the North West Region of Cameroon, with a population of 393 835 people. Although there is paucity of reliable data on the growing population of old and very dependent persons in the North West Region, the general statistics for the country is indicative. Statistics published by the Ministry of Social Affairs on the occasion of the 30th edition of the International Day of Old Persons on 1st October 2020 reveal that persons age 60 years and above was 1.143 691 in 2015, with the majority being women (52%). Data was collected mainly in the urban area, between January and August 2023.

C. Research Participants

A total 120 participants (52 men and 68 women) were sampled for this study. They were selected by purposive sampling, based on their living conditions and lived experience. The research participants were heterogeneous with regard to their ages, gender, and health and material conditions, as represented in Table 1.

Table 1
Demographic data (n = 120)

Characteristics	Categories	Frequency (%)
Age		
	65-70	30 (25%)
	70-75	32 (26.7%)
	75-80	36 (30%)
	Above 80	22 (18.3%)
Sex	Male	52 (48.3%)
	Female	68 (56.7%)
Education	No Formal Schooling	22 (18.3%)
	Primary School	38 (31.7%)
	Secondary School	42 (35%)
	Higher Education	18 (15%)
Occupation	Public Service	26 (21.7%)
	Farmers	36 (30%)
	Business	27 (20%)
	Skilled labour	12 (10%)
	Labourers	22 (18.3%)
Religion	Christians	70 (58.3%)
	Moslem	20 (16.7%)
	African Traditional Religion	22 (18.3%0
	Non Adherents	8 (6.7%)
Marital Status	Married	30 (25%)
	Widow	36 (30%)
	Widower	26 (21.7%)
	Divorcee	20 (16.7%)
	Single	08 (6.6%)
Mobility Rate	Bed-ridden	16 (13.3%)
	Able to circulate at home	46 (38.3%)
	Able to go out of the home With assistance	32 (26.7%)
	Able to go out of the home without assistance	26 (21.7%)

D. Data Collection Procedures

Two collection methods were used, namely, in-depth interview and focus group discussion. Each interview session lasted between 45 and 75 minutes. Before each interview, the purpose of the research was carefully explained and participants were assured of the confidentiality of their information and the strict respect of their anonymity if they so wished. Babbie (2013) maintains that respect for people is the recognition of participants' rights, including the right to be informed about the study, the right to freely decide whether to participate in a study or not and the right to withdraw at any time without penalty. This is the implication of informed consent which, as Patton (1990) insists, should be given only after the potential informant has fully understood the purpose of the research. All the participants gave their oral consent, and permission was also obtained to use a tape recorder during the interviews, so that as Creswell (2003) argues, no relevant data would be lost and the accounts will be faithfully rendered. For greater accountability for all the information provided by our informants, we made use of a notepad to take down relevant methodological, descriptive and analytic notes. Apart from 6 participants who spoke only in their dialect and for whom we employed translators, the rest perfectly understood and spoke Pidgin English. Mindful of the fact that the focus group discussion often generates information and insights that might not be gained from an individual interview, and that it allows participants to talk freely about the subject being studied and to generate information on collective views, and the meanings that lie behind those views (Bernard,

2006; Holloway & Wheeler, 2002; Morgan, 1998, we organized two focus groups discussions. Each focus group had 7 participants and lasted for 75 minutes.

E. Data Analysis

We opted for a thematic analysis, which according to Green and Thorogood (2004) is essentially a process in which various accounts are compared with each other to classify themes that recur or are common in and across the data. We found five of the six steps in thematic analysis as outlined by Braun and Clark (2006) very useful. These include: 1) Familiarising oneself with the research data through listening attentively and repeatedly to the audio-taped interviews, reading the interview transcripts several times in order to get a feel for the data in its totality, and noting initial ideas and key concepts as they occurred to me; 2) generating initial codes by systematically coding of all interesting features across the data that capture the perspectives of the participants; 3) searching for themes through a review of all the quotations of the identified codes and grouping the codes into potential themes; 4) reviewing the themes by ensuring that the data within the themes coherently fitted together by revising all the extracts and making sure that each accurately reflected the overarching theme; 5) Defining and naming themes to demonstrate what each theme entails.

4. Research Results

A. Characteristics of Participants

A total of 120 participants took part in the study. Their ages ranged between 65 and 88 years. Women were the majority (56.7%). While 25 % (n=30) of the participants were living in a marital situation (both spouses alive and living together), 75% were without a spouses, as a result of death (51.7 %; n=62), divorce (16.7%; n=20) or have been single (6.6%, n=8). Mobility rates decreased with increasing age, and while 13.3% (n=16) of the informants were bed-ridden, 48% were able to go out of their homes, with 27.7% of them needing assistance. All the participants aged above 70 years had health conditions ranging from arthritis, diabetes, cardiovascular disorder, renal dysfunctions, and mental problems such as dementia. Although old age is not an illness (Erdemir et al., 2011), old age is often characterised by a complex health status with vulnerability as an outcome (WHO, 2016, 2015).

B. The Experience of Social Death

As intimated much earlier, our concern was with self-perceived social death, the perception or feeling of being socially dead, as opposed to other-perceived social death (Kalish, 1968). We set out to gather ethnographic data on what constitutes the experience of the phenomenon of social death among the older persons in the city of Bamenda.

1) The disintegration of the body and concerns about body image

The body's disintegration and disfigurement were major contributors to the feeling of social death among at least 35% of the participants. Concerns about the appearance and functionality of the body deeply impacted the assessment of the quality of life in terms of being socially alive or dead. Left with

bodies that are powerless, wizened and disfigured by old age and illness, some participants viewed themselves as shadows of what they used to be. Body dissatisfaction grew as those in these situations compared themselves with other members of the society who were of the same age with them and even older than them, but whose bodies were looking and functioning better. This perception was well-articulated by a 78 years old woman, whose body has been disfigured by cancer, hypertension and diabetes:

The last time I looked at myself in the mirror, I saw something of an empty shell, a scarecrow. This is not me. I am only skeleton of what I used to be. I am not the oldest person in my family. My elder sister looks a lot better and can still take care of herself. I am as good as dead.

The foregoing narrative highlights the role of the body in the construction of social identity, the loss of which is a key component of the experience of social death.

2) Inability to participate in community and social events

While a limited number of participants accepted decreasing rate of activity with advancing age as a matter of course and the inevitable lot of humanity and were reconciled to it, the majority (77%) considered the inability to a play a role in societal events as "fading out of existence". This feeling was particularly acute among those immobilized either by the sheer weight of age or some debilitating illness. Becoming increasingly cut off from the routines of conventional life - unable to work, spend time with family and socialize with friends – a good number of informants saw both their social sphere of influence and their physical space tremendously reduced. The following statements made by one of the informants exemplify this feeling and way of thinking:

My world has been reduced to my home; I crawl around here, imprisoned in my little cell; days come and go. I miss the parties, community celebrations and going to church. This is no life. It is just stale and empty.

In the common understanding of the people, doing as opposed to being, conveys the perception of an effective presence, the manifestation of the vital force and the actualization of the human potential and mission. A person, who is rendered incapable either by old age or illness, feels somehow diminished by the inability to do the things that are meaningful to societal expectations and standards of social classification. This feeling of loss resonates in the following narrative of a 70 year old informant:

Throughout my life, I loved attending weddings, parties, meeting friends and dancing. I was a good dancer and everyone admired me. I always returned home with prizes. This put me on the social pedestal, in the limelight which I so much enjoyed. Now, I am at the rear of things. Who sees me here? I am just a shadow of myself.

Generally, among more than 60% of participants, the loss of the ability to perform certain social activities which had become habit and from which they drew meaning and happiness in their lives – *singing in the choir, attending prayer meetings, travelling, etc.*- contributed to the feeling of misery and vulnerability which are among the pathways to self-perceived social death. While the impact was more acute among those who have been socially active throughout their lives, it was far less among those who had lived a socially-detached and more individualistic life. For 35% of the informants, especially those above 70 years of age, there was a significant association between the ability to work and economic status. This was particularly the lot of farmers, traders and labourers, and most especially, those who lived a hand-to-mouth life, and had no insurance policy or substantial financial reserves to sustain them.

3) Increasing dependence on others

The loss of the sense of autonomy and control was found to be an important dimension of self-perceived social death among 60% of the informants. The burden of this feeling was common, especially among those who were bed-ridden and those with limited mobility within their homes. The bed-ridden were completely dependent on caregivers for their physical and material needs. This came with a sense of resignation and a feeling of being useless. Their predicament was articulated in statements like *"I am being carried around like a piece of wood that can be dropped at any time"*, *"I feel like a toy"*, *"I am alone all day, forgotten like a stone"*, and *"the world goes on as if I did not exist"*. Those with very limited financial resources faced a situation in which they were left alone, locked up at home, because the caregivers and others must go out in search of the daily bread. A victim of a massive stroke articulated his plight as follows:

I am left alone here when everyone goes to school, farm and work; no one to share my pains with or ask for help from. This is not life at all. I have to be bundled up and carried around like a thing, and hear of decisions that are taken for me. I have become a shadow of the very active and self-willed man who made things happen. I am just hanging in here; I do not even know how to describe myself.

Restrictions on diet and elaborate treatment protocols all generated among some participants a gnawing sense of loss of autonomy and self-hood. The prohibition of alcohol, smoking and some meals were interpreted by some informants as *"emptying life of an important ingredient and leaving it tasteless.* These and similar restrictions made some participants to feel very miserable as to invite physical death to close the cycle of a meaningless life.

4) Isolation and Loneliness

The feeling and perception of isolation and loneliness as expressions of social death resonated among 55% of the participants, especially among those whose mobility is drastically impaired. For most of them, the absence of visits and phone calls were clears signs that they are no longer alive in the world of their close ones. Participants, especially those above

the age of 75 years, whose children have moved away from them and who have lost touch with friends and have difficulty getting out of their homes, were more deeply affected by the absence of visits and phone calls than those who could still go out and meet people. This feeling was however modified by a good number of variables. Older couples who were still living together provided much needed companionship to each other. The feelings of isolation and loneliness were less among people who had been single and lived a more or less isolated and independent life. One of the six single participants, who were childless, said: *"I have learnt how to be alone and find joy only in my God. I know that I will die alone."*

5) Ageism and Age Discriminatory Discourse

Ageism refers to the negative attitudes, stereotypes, and behaviors directed toward older adults based solely on their perceived age (Butler, 1969). The majority of the participant, especially the beneficiaries of secondary and higher education, were sensitize to any derogatory and stigmatising language used by the younger generation and which seemed to suggest that the time of the old people has passed and that they have little or nothing to offer in a modern and technological age. Stereotypes used by younger individuals, such as *"senile", "old fashioned", "forgetfulness and mental deficiency",* when referring to the old and sick, generated negative expectancies for older adults, and fuelled the feeling of self-perceived death. The association of such words as "elderly" with vulnerability and the consideration of wrinkles and grey hair as ugly blemishes to be removed, were part of the societal discourse about old age as less desirable. The complaint by a 77 years old woman embodies the experience of ageism:

The new technology makes us fill obsolete. Today, even the media keep talk about modern approaches and solutions and we see around us gadgets which we cannot use. Even our ideas on social and moral issues are often very quickly dismissed as obsolete and we at times feel really out of place.

Ageism and the use of derogatory and discriminatory language when referring to the old and their inabilities were very effective in causing a feeling of self-perceived social death.

5. Discussion

The foregoing ethnographic data presents some themes which are of interest to anthropologists and other social scientists. The phenomenon of self-perceived social death was viewed in a symbolic interactionist framework, whose principal focus is meaning-making. We sought to explore the ways in which the old and sick interpreted the actions and non-actions of others and their own inabilities to construct their experience of social death. A basic premise of symbolic interactionism states that the meanings of things are interpreted by a person when dealing with things in specific circumstances (Blumer 1969). Human interaction, as Charon (2004) has observed, is not only interaction among individuals but also interaction within the individual and the definition of the situation. These elements contribute to the definition of the self and identity,

with questions about how I see myself and how others see me structuring the experience and perception of social death (Millward and Kelly, 2003). Three main themes of interest to anthropologists and social scientists will retain our intention in this section, namely, the loss of a sense of self and social identity, the formative influence of stigmatising language and concerns of about body image, as constitutive of the experience of social death.

A. Shifts in the Sense of Self and Identity as Key Dimensions of the Experience of Social Death

Cultural assumptions and expectations about self, identity and roles influenced the meaning and experience of social death among the participants. The majority of participants (85%) reported a host of changes in their way of life and the way they viewed themselves and interacted with others. Old age and attendant illnesses were interpreted as disruptive and intrusive occurrences, which led to numerous physical, psychological and social role changes that challenged their sense of self, identity and capacity to live a meaningful and happy life. The loss of agency, the capacity to act independently and make free choices (Emirbayer & Mische, 1998; Ortner, 2006) emerged as a key dimension of the experience of social death. Many participants premised the interpretation of their condition on a distinction between what they were prior to the emergence of old age (capable, strong, provident and industrious) and their current state marked by all forms of inability and dependence. It can be seen that expectations of the expression of self and identity are codified in social roles. Human beings are relational or communal beings and their decisions and actions are heavily influenced by social and mutual obligations, and the fulfillment of the expectations of the group (Oyserman et al., 2002). Not being able to perform culturally assigned roles that correspond to one's state in life as an adult, parent, member of the community or professional can injure a person's sense of self and the way society views that person. In performing these roles, relating with others and actively responding to changing circumstances, the self and identity are revealed in an interactive process.

According to the anthropologists Morris (1994) the self is not an entity, but a process that triggers an individual's personal experience as a result of which he or she becomes self-aware and self-reflective about his or her place in the surrounding world. It is the individuals' mental representation of his or her own person, a self-representation. The self is experienced as a core inner presence. Similarly, Charon (2004) has observed that human interaction is not only interaction among individuals but also interaction within the individual and the definition of the situation. Participants actively analysed the actions or neglects of people within their social networks as evidence of whether they were valued or not and also made judgments of their own inabilities in terms of having no impact, a total absence comparable to death. Our identity refers to the way others see us and it is developed and maintained through social relationships. Giddens (1993) has persuasively argued that identity is a matter of rational action and being dynamic. He maintains that identity is to be considered as a "symbolic

construction" which helps people to find their own place in time and preserve continuity. The reactions of others can impact one's sense of self and identity, and so it is understandable that people act as to present an image of themselves which fits the community values as far as possible. In keeping with the predictions of Giddens (1993), the sense of self and identity of old and sick participants was dynamic, changing with the evolution of their condition and the social contexts in which they were embedded. Social reality, physical reality, and personal reality interact simultaneously to form one's cumulative perception of what is real (Gamson et al., 1992:374; Huber & Gillapsy, 1996). Identity projections are always dependent on social recognition, evaluation and affirmation. Identity is dynamic and is grounded in the social context or space with others (Taylor, 1994, 1995). One's knowledge of self in relationship requires being able to participate in action involving others (Wertsch, 1991). In the narratives of some participants, one could easily discern the fact that their sense of "self" kept evolving and in many cases a different "self" emerged when faced with constraining changes in physical health, and when they reviewed their interests, roles, values, and philosophy of life. Even body parts could no longer be relied upon and ordinary processes of life that were taken for granted now required much caution.

Man is essentially a social being, and interaction with others and the performance of roles constitute an integral part of his social existence (Kralova & Walter, 2018). The reality or feeling of being socially detached and neglected is likely to ignite a crushing sense of vulnerability that adversely affects the quality of life, self-esteem, personal identity, and social status (Steele et al., 2015). Although the degree of loss of the sense of self and identity differed among participants, it stood out prominently as a vital component of their experience and the meaning which they gave to their condition. Describing themselves as "shadow of myself", as a result of some inability or response to some of the stereotypes and attitudes of others, the feeling of loss of society's esteem remained a formative element in the social construction of self-perceived social death. This was especially the case in worsening conditions when participants became increasingly dependent.

B. The Role of Stigmatising Language and the Construction of Self-Perceived Social Death

Some participants actually felt devalued by the derogatory and mocking use of such phrases as "Your time is over", "You are out of touch with reality", "Your ideas are obsolete." Social scientists have demonstrated the enormous capacity of societal discourse and particularly the use of discriminatory language to regulate and form experiences and perceptions of reality (Goldstein et al., 2003, Parker 1992). Language is often used to promote and reproduce dominant ideologies held by particular groups (Mills 2004; Lupton 2003). Stereotypes that associate old age with the less productivity and what is less desirable usually create the feeling of being "useless" and absent. Stigmatising language, for example, stereotypes and separates through labelling, leading to rejection, exclusion and discrimination (Link and Phelan, 2001; Sartorius, 2006).

Stigmatising language links a person with characteristics that are undesirable and through it one group sees the other as abnormal (Jones, 1984, Ahearn, 2001). A key to the effectiveness of the stigmatising language was the fact those who experienced social death as a result of its use by others, had some sort of concern for what others thought or said about them and internalised the social expectations to which they failed to conform. According to Charon (1992), reality is composed of societal definitions and interactions (1992). Aging is a challenging process during which many individuals lose their confidence and experience a loss of productivity (Schafer & Shippee, 2009). Many older persons become very sensitive to ageist messages which rudely remind them of this fact. An increasing number of studies have demonstrated the effects of ageism, the stereotyping, prejudice and discriminatory actions and attitudes based on chronological age (Iversen et al. 2009). It has been recognised as a risk factor associated with increased depression and lowered life satisfaction (Ayalon et al. 2019; Kim et al. 2018; Nelson, 2005), and a major contributor to the disruption of body esteem and psychological wellbeing (Sabik, 2005; Baker et al., 2005). Life may begin to fade when older persons are made to feel that they are considered passive recipients and a burden to the younger generation by discriminatory messages and attitudes (Hudson, 2013).

C. Concerns of About Body Image

Almost all the participants displayed curiosity about the deterioration of their bodies and what will be left of their social endowment when their body appearance is disfigured. The use of such adjectives as of an *empty shell*, *scarecrow* and *empty* by some participants to describe their condition, points to the role of the body as a constitutive dimension of the experience of social death. Body image, a multidimensional, subjective, dynamic and culturally specific concept (Gregans, 2001; Luskin & Mccann, 2011), refers to one's perception of one's body or of the bodies of others, and one's feelings about that perception. It refers to personal constructions and public projections of our body and body parts, often in attempted conformity with parameters of 'beauty' established in socio-cultural contexts. It is a multidimensional construct that comprises both cognitive and affective components. The cognitive component consists of perceptions of the appearance of the body. They include the perception of how one's body ought or should be (Barnett et al., 2001; Mills et al., 2012). The affective component deals with how people feel about their bodies. Several studies have demonstrated that a positive body image is related to better outcomes, such as happiness and life satisfaction (Tylka, 2011), while negative body image increases psychological and physiological agony (Cash and Smolak, 2011). This is so because our social identity is closely connected to, and enacted through our bodies (Hockey & Draper, 2005).

For close to five decades now, many anthropologists, following the work of Mauss and Elias, have adopted embodiment as a theoretical framework for the study of experience. Based on Merleau-Ponty's (1962) concept of embodiment (being-in-the-world as culturally constituted),

Csordas (1994) articulated a cultural and phenomenological approach which forged a synthesis of embodied experience and cultural meanings. Csordas (1993:135) emphasized the necessity of understanding the body as the existential ground of culture, and of taking embodied experience as the starting point for analysing human participation and experience, and for making-meaning in any given cultural world. In his ground-breaking work, *The Social Skin,* fruit of an ethnographic study carried out among the Kayapo of the Amazon Forest (in Brazil), the American cultural anthropologist Terence Turner (1980; 2012), depicts the surface of the body as the common frontier of society, the social self and the symbolic stage on which the "drama of socialization" is staged. The body mediates all reflection and action upon the world. It is the point of contact and interaction with society. Discussions of cultural representation of body and beauty are usually premised on a framework of difference, that is, in terms of differences in perception and modes of cultural expression or projection of body and beauty. In the study of vulnerability, Tombs (2006) demonstrated how physiological breakdown as a result of age and illnes threatens personal integrity of autonomy. Old age together with Illness always affect the capacity to be self-reliant, to act on one's own behalf. One becomes dependent on others. Dependence on others is perceived in many cultural settings as a weakness and one fears being a burden to others (p.126). The loss of autonomy is also profoundly threatening in the light of the cultural emphasis on "doing" as opposed to "being". A person who is unable "to do" feels diminished by the inability to continue projects that are meaningful according to societal standards. Bodily disorders also disrupt social roles causing the sick person to feel that he or she is failing to fully contribute to the welfare of the family and the society (p.128).

6. Conclusion

With ageing, our physical and mental capacities tend to decrease, which highlights the significance of attending to the psychosocial needs of the elderly population, in addition to their maternal sustenance.

Psychosocial needs include an individual's emotional and mental well-being, such as their sense of purpose, social interactions, and self-worth. While the government's social security and health policies may play a part in rendering their lives more enjoyable, understanding, empathy and social support in the networks of interpersonal relationships can make a major contribution to their psychological wellbeing and to the general quality of their lives. Within our families and communities, fostering a spirit of respect and appreciation among the younger generation in relation to older adults, is crucial to addressing the phenomenon of social death and to helping older adults to lead fulfilling and meaningful lives. This paper lends a voice to advocacy to prioritise psychosocial needs in the care of older persons.

The sample size of this study was restricted to few older persons. A similar future study will needs to be conducted on a larger section of the elderly population and may pay attention to the contribution of the differential contribution of gender and other factors to the experience of social death.

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