Psychosocial Development in Late Adulthood

CHAPTER 17

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Chapter Outline

Focusing Questions

- What is ageism?
- What is successful aging, and what contributes to it?
- What factors influence how retirees adjust to their new life circumstances?
- How does marital status affect well-being in late adulthood?
- Which relationships are significant in late life, and in what ways?
- Why is choice in housing critical in old age?
- How do the interests and activities of late life show both continuity and change?

On his eighty-fifth birthday, John Kenneth Galbraith, renowned economist, retired economics professor, former economic adviser to government agencies, and U.S. ambassador, reflected on modern attitudes toward old people that he had experienced:

> In my youth, the sensitivity of the old was greatly respected. One did not emphasize physical and mental decline, inevitable and apparent though these are. Now, I find, they receive daily, even hourly, mention. *"Still* getting that exercise," I hear when I go out for a walk. *"Still* lecturing," I hear when I give a talk. *"Still* writing," many say when I publish a book or even a review. *"Still* interested in politics," I'm told when I show up at a meeting. *"Still* imbibing," when I have a drink. *"Still* that way" someone observes when my eyes are seen to light up on encountering a beautiful woman. . . ." (*Harvard Magazine,* 1994, 96[3], p. 108)

Aging and Ageism

ageism Stereotyping of and discrimination against people because of their age.

Robert Butler (1993) coined the term *ageism* in 1968 when middle-aged citizens protested the building of a high-rise "luxury" apartment building for the use of poor older adults. **Ageism**, according to Butler, "can be seen as systematic stereotyping of and discrimination against people because they are old, just as racism and sexism accomplish this with skin color and gender." From the very beginning, ageism has been linked to social policy that is seen as potentially discriminatory and unfair in an egalitarian society (Kimmel, 1988). Distributing social services on the basis of age rather than need denies the diversity among people of the same age and promotes discrimination and prejudice. Ageism reflects tension about the growing number of older Americans in the population and the cost of entitlement programs that benefit them, such as social security, Medicare, and Medicaid.

In our society, prejudicial attitudes toward older adults abound; more stereotypes exist about old age than about any other period of life. Stereotyped images of older adults can be positive or negative, but because they are based on general characterizations of "old people," rather than on actual appraisals of individuals, they reflect preconceived notions or prejudices. Negative stereotypes of older adults, which are more abundant than positive stereotypes, include physical traits such as *slow* and *feeble,* as well as personality traits such as *cranky* and *repetitive;* positive stereotypes include *sweet, cute, pleasant,* and *storytellers* (Shenk & Achenbaum, 1993). In fact, anxieties about our own aging contribute to negative attitudes toward the aging (Martens, Greenberg, Schimel, & Landau, 2004). Stereotypes ignore the diversity of older adult populations (Adamchak, 1993). When college students are asked to describe a particular older person, stereotypes break down, and the descriptions often are of healthy, active individuals who happen to be older. Unfortunately, it is easy to consider older individuals who defy the stereotypes as exceptions, while continuing to hold the stereotypes (Shenk & Achenbaum, 1993). Additionally, the stereotypes that older adults hold about themselves have an impact on the perception and the experience of aging through the self-fulfilling prophesy (Bennett & Gains, 2010). Older adults who perceived aging in a positive light were more likely to report better physical health, mental health, and life satisfaction than those who held negative attitude (Bryant et al., 2012).

Ageism abounds among professionals as well. Nicknames such as "vegetable" or "Gork" ("God only really knows" the basis of the person's symptoms) are part of medical students' everyday vocabulary. Few medical students choose geriatrics as a specialty, and few doctors devote as much energy to their older patients as they do to their young patients (Butler, 1993). Clinicians prescribe drug treatments to older depressed patients more often than they refer them to psychotherapists because they assume that older people are too "stuck in their ways" to be introspective (Pasupathi et al., 1995). This is in spite of the fact that older adults prefer nonpharmacological treatments, such as cognitive behavioral therapy (Mohlman, 2012). K. Warner Schaie (1988) describes similar problems of ageism among psychological researchers who assume lowered competence in older people and fail to use proper comparison groups in their research. Because older adults are a heterogeneous group, health status, education, occupational status, gender, and race must be specified and generalizations to other populations made cautiously. Lars Tornstam (1992) criticizes gerontological researchers for their tendency to approach their work from a "misery perspective" (older people as a problem), rather than from a "resource perspective" (older people as a resource). Tornstam points out the common assumption that the processes of industrialization and urbanization distanced older people and their children from each other; however, as we saw in Chapter 15, older adults have close contact with their midlife children.

successful aging The maintenance of psychological adjustment and well-being across the lifespan. Characterized by maintaining physical and cognitive function, avoiding disease and disability, and staying engaged with life.

Personality Development in Late Adulthood

Successful aging, from a psychological perspective, refers to the maintenance of psychological adjustment and well-being across the full lifespan. Rowe and Kahn (1987, 1997) proposed three components necessary for successful aging: freedom from disability and

What Do You Think?

Discuss with your classmates the stereotypes you hold about aging and old people. Where did these attitudes come from? In what ways could negative stereotypes be overcome?

disease, maintenance of cognitive and physical functioning, and maintenance of social engagement. Recent research indicates that the vast majority of older men and women who are not cognitively impaired show considerable psychological resilience in the face of stress (Costa & McCrae, 1997). Although older individuals are less satisfied than younger adults with their health, they are more satisfied with most other aspects of their lives. Happiness is not correlated with age but appears to be a stable outcome of personality traits (Costa et al., 1994). Personality traits are remarkably stable in adulthood, as we saw in Chapter 15's discussion of psychosocial development in middle adulthood. Old age brings many adaptational challenges, including death of loved ones, declining health, and often, economic hardship. Older adults call on the skills and styles they have honed over a lifetime to adapt to these new situations.

Continuity and Change in Late Life

George Vaillant and Caroline Vaillant (1990) reexamined the lives of the men in the Harvard Grant study (see Chapter 13) to determine predictors of physical health, mental health, and life satisfaction at age sixty-five. In 1990 the 173 remaining participants were examined by an internist to assess physical health, given a psychosocial adjustment scale to assess mental health, rated on life satisfaction, and asked to rate themselves on life satisfaction. Because this was a longitudinal study begun in 1940, the investigators already had many measures of adjustment and experiences from earlier stages of life.

What did they find? The authors identify five variables that contributed to late-life adjustment: First, long-lived ancestors predicted physical health only. Second, sustained family relationships predicted physical and mental health. Closeness to siblings was a powerful predictor of late-life adjustment. More than half of the men with a lifetime diagnosis of depression were only children or estranged from siblings, whereas only 7 percent of the men with the best psychosocial outcome had such a family history. Third, maturity of ego defenses assessed before age fifty contributed to psychosocial adjustment at age sixty-five (see Chapter 13). Fourth, absence of alcoholism and, fifth, absence of depressive disorder promoted health. The use of tranquilizers before age fifty (indicative of both depression and alcoholism) was the most significant predictor of both physical and mental ill health at age sixty-five. While childhood strengths were positively associated with health in late life and difficulty coping in early life negatively affected both mental and physical health in late life, many variables often thought to be associated with adjustment in early adulthood were not linked to late-life adjustment. These included childhood socioeconomic status (SES), orphanhood, and college scholastic aptitude. More recently, findings from this study have suggested that utilization of adaptive defense mechanisms during midlife help in building and maintaining social support, which is linked to good physical health during late life (Malone et al., 2013).

Limitations of the Grant Study

While the Harvard Grant study provides longitudinal data into late adulthood, it has several important limitations. First, it includes only men. Second, the sample, selected as successful young adults at Harvard, was very privileged. Consider, for example, Vaillant and Vaillant's finding that SES during childhood was not associated with late-life outcome. These men represented a narrow range of SES; all were from families that had enough food, shelter, and medical attention. We cannot tell from this study how other levels of SES would affect late-life outcomes. The same criticism applies to the restricted range

The Grant study found that closeness to siblings is a powerful predictor of late-life adjustment for men. Although women were not part of the study, sisters often are close friends and companions to their siblings during late life.
Source: Rob Marmion/ Shutterstock.com.

of college scholastic aptitude: all of these men were successful enough to be admitted to Harvard. Third, sixty-five is only young-old age. What happens in the next twenty or more years? In summary, while the Harvard Grant study tells us a good deal about the aging of privileged men into young-old age, it does not answer questions about women, less privileged men, or people in old-old and very-old late adulthood.

The Berkeley Older Generation Study is a longitudinal study that includes women as well as men, has been going on for more than fifty-five years, and started out with a more representative sample than the Harvard Grant study. In 1928, about 420 young adult residents of Berkeley, California, were first interviewed. Every third child born in that city was selected for a child study, and these adults were their parents. Dorothy Field and Roger Millsap (1991) report on interview data collected from seventy-two survivors in 1969 (average age sixty-nine), when the respondents were young-old, and 1983 (average age 82.7 years), when forty-seven respondents were old-old (seventy-four to eighty-four years) and twenty-seven were very old (eighty-five to ninety-three years). The survivors—fifty-one women and twenty-one men—were educationally, intellectually, and financially advantaged (as survivors in longitudinal studies usually are because the less advantaged stop participating or die) and living in the community. All had been married at one time and had living children.

Stable Traits in Late Life

What does the Berkeley study tell us about stability and change in later life? Using statistical procedures to analyze ratings on twenty-one personality characteristics at each of the two interviews, Field and Millsap (1991) found five personality components that were stationary across the two time periods: intellect, agreeableness, satisfaction, energetic, and extraversion. If you look back at Table 15.2, you will see that four of these five components are similar to those identified by Paul Costa and Robert McCrae (1997), which we discussed in Chapter 15. *Intellect* represents cognitive functioning and open-mindedness. *Agreeableness* describes a person who is open-minded, cheerful, and accepting of his or her offspring and "things in general." *Satisfaction* describes a person with high self-esteem and life satisfaction. *Energetic* reflects activity and health and correlates highly with self-reports of health in the later years. *Extraversion* includes talkativeness, frankness, and emotionality. Field and Millsap found that four components—intellect, agreeableness, satisfaction, and extraversion—reflected enduring traits during the fourteen years between their two interviews. Notice that these are four of the traits that Costa and associates (1994) indicate are stable after age thirty. The trait that Field and Millsap add, *energetic,* showed low stability in their study, probably because it is linked to health and health declines for most individuals in old-old age. Change in measures of narcissism during adulthood among those from the Berkeley study was predictive of being maladjusted later in life (Cramer, 2011), and even though behaviors became more

adaptive throughout adulthood, that pattern of behavior shifted during late-late life with adults in this study engaging in maladaptive behaviors (Diehl et al., 2014).

When they compared the old-old with the very-old, Field and Millsap found that the very-old were less energetic than the old-old and were declining on this trait more rapidly. The very-old showed some decline in intellect, but this was unchanged for the old-old. The most stable trait they found was satisfaction. While most of the respondents showed no change on this trait, 20 percent went up in satisfaction. More than a third of the respondents increased in agreeableness. The investigators saw evidence of Eriksonian generativity (see Chapter 15) in the respondents' interest, concern, and care for their offspring. Extraversion showed a decline for both genders. The Berkeley data indicate that longitudinal change was more likely to be age related than gender related. Only one trait, satisfaction, showed a gender difference at both points of measurement, with men having higher ratings than women. The data show relative stability in satisfaction and intellect well into very old age, an increase in agreeableness, and a decline in extraversion. Certainly, this is a far cry from the stereotype of cranky, conservative old people. In fact, Field and Millsap saw considerable evidence for the development of integrity.

Integrity Versus Despair

Eric Erikson's eighth stage of life, **integrity versus despair**, describes the developmental task of late adulthood (see Chapter 2). In the face of the loss of loved ones, declining health, and loss of meaningful work that can lead to *despair,* can the individual find *integrity,* or "acceptance of one's one and only life cycle and of the people who have become significant to it, as something that had to be" (Erikson, 1968, p. 139)? Successful resolution of the previous stage, *generativity versus stagnation,* shifts the aging adult's focus from personal concern for self and family to altruistic concern for guiding the next generation. This paves the way for finding enduring meaning for one's life, or integrity, in late adulthood. Only in late adulthood can "the fruit of the seven stages gradually ripen" (Erikson, 1968, p. 139). The progression of Erikson's adult stages moves the individual beyond adolescent identity to include a significant other in early adulthood (intimacy versus isolation), expands to the next generation during middle adulthood (generativity versus stagnation), and expands further to the sequence of the generations (integrity versus despair) so that the person becomes what survives after death, faith, love, care, and wisdom (Erikson, 1968). In fact, the development of integrity can be viewed as a slow refining of identity at the end of life in response to late-life issues (Newton & Stewart, 2012).

integrity versus despair The eighth and final crisis of development in Erikson's theory, during which older adults assess the value of their life's work and fight the loss of hope about life in general.

According to Erikson, wisdom, which we discussed in the previous chapter as a late-life cognitive development, is born of the conflict between integrity and despair. Dorothy Field and Roger Millsap (1991) found a normative, developmental increase in agreeableness that they interpret as evidence for ego integrity. Though not representing "the breadth and subtlety of Erikson's life stage," agreeableness described "a person who is coming to terms with life and accepting what it has been" (p. 306). They also note that the old-old increased in agreeableness, which Erikson would expect, while the very old, who he would expect to have attained this stage already, held steady. Erik Erikson, Joan Erikson, and Helen Kivnick (1986) interviewed participants in the Berkeley Older Generation Study and found convincing evidence for the stage of integrity versus despair. Eugene Thomas (1991) also found clear evidence for ego integrity in a study of Hindu religious renunciates in India. The older men he interviewed accepted their past as "something that had to be." Thomas, however, points out the culture-bound nature of Erikson's formulation. These Hindus did not accept their lives as their "one and only life cycle" because of their belief in previous and future reincarnations as well.

Theories of Successful Aging

What makes for successful aging? Psychologists and sociologists have been interested in what older people can do and what society can do to promote successful aging. Since the 1950s and 1960s, several theories have been advanced that try to describe or explain how people adapt to the changes characteristically associated with aging. As Table 17.1 indicates, *disengagement theory* and *activity theory* take opposing perspectives on the problem of adapting to the loss of roles or activities that occurs in late adulthood.

TABLE 17.1 Activity and Disengagement Theories Compared

Activity theory and disengagement theory take opposing perspectives on adapting to the loss of roles or activities that occurs in late adulthood.

Disengagement Theory	Activity Theory
Older people have increased preoccupation with the self and decreased investment in society.	Older people have the same psychosocial needs that middle-aged people do.
Decreased social interaction in old age comes from mutual withdrawal of both the individual and society.	Decreased social interaction in old age comes from withdrawal by society from the aging person.
Optimal aging occurs when the aging person establishes greater psychological distance from those around him or her.	Optimal aging occurs when the person stays active.
Decreased social interaction should be expected.	Substitute activities should be found for those who are lost (e.g., for work at retirement).

Disengagement Theory

disengagement theory The theory of aging which views the reduction of older adults' social involvement to be a natural and mutual process between older adults and society.

Disengagement theory views the reduction in older adults' social involvement as the consequence of a mutual process between older adults and society. Proposed by Elaine Cumming and William Henry (1961), disengagement theory assumes aging individuals experience inevitable decline in abilities and, as a result, want to be released from societal expectations. As the older person retires and children leave home, his or her social circle begins to shrink. The individual anticipates, adjusts to, and participates in this shrinking. As people have fewer roles, their style of interaction changes from active to passive. Because they have become passive, they are less likely to be sought out for new roles.

Though disengagement occurs for some people, there is little evidence that it is normative. Reed Larson, Jiri Zuzanek, and Roger Mannell (1985) studied ninety-two retired adults who carried electronic pagers for one week. At randomly selected times throughout the week, a researcher would page the participants, and they would fill out a questionnaire about their companionship and internal states. From the 3,412 self-reports generated, the researchers found that half of the participants, waking hours were spent alone. Being alone, however, was not a negative or disengaged experience for most of them. When alone, they tended to do things that challenged them and demanded concentration. They reported feeling highly engaged, but in activities that were not interpersonal. In a sixteen-year longitudinal study of people who were over age fifty and living in the community when the study started, Robert Atchley (1998) found that functional limitation was responsible for all the cases in which dramatic decline in number and level of activities, or disengagement, occurred. Atchley found no cases of voluntary disengagement.

Activity Theory

activity theory The theory of aging that assumes that older adults who maintain social, physical and intellectual activity levels similar to those during middle adult year age more successfully than those who are less active.

As opposed to the disengagement theory, **activity theory** states that the maintenance of social, physical, and intellectual activity contributes to successful aging. This theory assumes that older people who are active will be more satisfied and better adjusted than those who are less active. When they articulated activity theory, Robert Havighurst, Bernice Neugarten, and Sheldon Tobin (1968) were presenting what has become both a dominant gerontological and commonsense perspective on aging. They proposed that unless constrained by poor health or disability, older people have the same psychological and social needs that middle-aged people do. Older people who are aging optimally stay active and resist shrinkage of their social world by maintaining activities or finding substitutes for the

Activity theory states that older adults who are active will be more satisfied and better adjusted than those who are less active. This older couple, along with their family, is volunteering to clean up a roadside, indicating both maintenance of physical activity as well as social awareness. While they might not have the same activity levels as when they were younger, they still remain active.

Source: wavebreakmedia/ Shutterstock.com.

ones they must give up. When disengagement occurs, it is because society withdraws from older adults, giving them gold watches and sending them home, rather than because older people seek this withdrawal.

As a test of activity theory, David Lee and Kyriakos Markides (1990) studied 508 older (age sixty or over) Mexican Americans and Anglos (whites) over an eight-year period to see if activity level would predict mortality. Participants were interviewed in 1976 and reinterviewed in 1980 and 1984. Activity level was assessed at each interview by means of a scale that asked questions such as "During the last two weeks, what was the farthest distance you traveled from your home (other than going to work)?"; "How often do you get together with friends or neighbors to play such things as bingo, cards, dominoes, etc.?" By the end of the study, 119 participants were confirmed to have died. The researchers found that activity level did not predict mortality or life satisfaction. Poorer self-rated health and advanced age did predict mortality. However, more recent research suggests that having quality social interactions is a better predictor of successful aging that simply engaging in activities (Litwin & Shiovitz-Ezra, 2006).

What the Theories Omit

Critics of both activity and disengagement theory point out that the theories place the burden of adjustment on aging individuals, independently of the circumstances in the world around them (Cutler & Hendricks, 1990; Marshall, 1996). One major reason older people change their activities is that they have reduced financial circumstances. Economizing to live within one's reduced retirement income often includes, for example, entertaining less often. As we saw in our discussion of leisure in Chapter 15, higher income, higher educational level, and higher occupational attainment all provide greater financial security and more options for leisure activities. In activity theory, we have the socially sanctioned value of productivity and keeping busy, prodding older people to "act middle aged." In disengagement theory, we have the acceptance of the stereotypes of passive, disengaged, decaying old people. Neither theory can account for the range of activity levels of successfully aging individuals; people have different levels of activity and life satisfaction based on their personalities and life experiences. Nor do these theories consider the role of social support in successful aging, which the research of Litwin and Shiovitz-Ezra (2006) suggests is important.

Selective Optimization with Compensation

A more comprehensive way to understand how older adults successfully age is to utilize a theory based in continuity theory—selective optimization with compensation (SOC) theory (Baltes & Baltes, 1990). This theory states that we select activities or domains that we prefer *or* choose based on the loss of alternatives. As we engage in the chosen activity

What Do You Think?

How have the ways people think of the older adults changed since disengagement theory was proposed in the early 1960s? Do you think this could influence how active today's older adults are? If so, in what ways?

or domain, we refine, or optimize, our skills, time, and resources, and finally, when we experience setbacks, loss of abilities, or loss of resources due to life changes, primary, or secondary aging, we overcome that loss by compensating (Freund & Baltes, 1998). In an examination of the measures of successful aging among older adults, it was found that those who utilized SOC were more likely to report that they were less lonely, less agitated, and more satisfied with aging (Freund & Baltes, 1998). In fact, there is evidence that many people choose careers in line with overarching life goals (selection and optimization) and that even after retirement, the work toward those goals continues, sometimes by utilizing bridge employment or by volunteering (compensation) similar to Neal, who is described in the next section (Baltes & Rudolph, 2012). Even if individuals' life goals are not tied to their career, the continuity of goals after retirement is important for life satisfaction (Baltes & Rudolph, 2012).

Retirement

What Is Retirement?

When Neal retired after twenty-five years on the police force, he didn't stop working. He began driving people to various places in their own cars and delivering packages. Because he knew so many people from his work on the force, his new business developed by word of mouth. He drives his regular customers to doctors' appointments, to the theater, and to and from airports. Often, he makes several trips in a day.

Continuous Work

Retirement often means departure from a *career job,* a job at which the individual has been employed at least thirty-five hours per week for ten or more years. Leaving a career job is a significant life event, but it does not necessarily mean leaving the labor force. In fact, the very definition of *retirement* may mean many things to different people: the cessation of work, reduced number of hours working, receiving pensions, or a career change (Wang, 2012). Shifting careers is known as bridge employment, and this continuous work, often in a different field, is often utilized for financial stability (Davis, 2003) or to contribute to feelings of generativity (Dendinger, Adams, & Jacobson, 2005). Retirement, then, may mean changed or reduced employment—not simply stopping work.

Discontinuous Work

Many adults, especially racial/ethnic minorities, never have held career jobs and thus never consider themselves retired. Only 5 percent of those who described themselves as retired in the AARP survey were African Americans. Rose Gibson (1993) found that many older African Americans did not define themselves as retired because they had discontinuous lifetime work patterns, thought of themselves as disabled, and felt economic need that pressed them to work from time to time. Perceptions of a discontinuous work life made the line between work and nonwork indistinct and created ambiguity of retirement status. Similar difficulties have been identified in defining retirement among Mexican Americans who often work, voluntarily or not, in part-time and seasonal jobs for much of their working lives. Because their lifetime work patterns have no clear line between work and nonwork, and because they lack access to private pensions, they do not define themselves as retired (Ralston, 1997; Saad-Lessler, Ghilarducci, & Richman, 2014). Additionally, due to lack of pensions and retirement funds, substantially larger

portions of "retired" African American (19.3 percent) and Hispanic (19 percent) older adults fall below the poverty line than white older adults (7.4 percent; Saad-Lessler, Ghilarducci, & Richman, 2014).

In terms of retirement, women face problems similar to those of racial/ethnic minorities. Although women's labor force participation has increased dramatically in the last several decades, many older women have been homemakers for most, if not all, of their adult lives. Consider Tom and Frances, who you met in the last chapter. When Tom retired at age seventy, Frances continued her homemaking tasks. Although she had held a small number of jobs over the years, they had always been part time, short term, and secondary to homemaking for her family of ten. As Tom naps in his recliner during the afternoon, she often asks herself when *she* will get to retire. Even women who have had more labor force commitment than Frances are less likely than men to be covered by pension plans because they are more likely to have held part-time jobs or taken leaves to raise children or to care for aging parents (Carp, 1997; Hatch, 1995). Mexican American women are almost five times more likely than Mexican American men to describe themselves as retired, but they are one-third as likely to be considered retired when in terms of receiving retirement income (Zsembik & Singer, 1990). In fact, Hispanic women and African American men face similarly disjointed employment throughout adulthood, and subsequently, similar disadvantages during retirement (Flippen & Tienda, 2000). This gender disadvantage is likely to change as younger cohorts of women establish steady patterns of labor force participation in jobs that provide retirement benefits.

Retirement Patterns

We see, then, that retirement is not simply a *yes* or *no* status; nontraditional retirement patterns are common among older Americans. Even those who retire experience different phases as they adjust to their new status, as Table 17.2 shows. Retirement is best defined by both substantial withdrawal from the labor force and receipt of retirement benefits (Atchley, 1997). White men are most likely to meet both criteria. Race/ethnicity, gender, and occupational level all affect retirement possibilities and choices. Examination of retirement earnings indicates the long-term costs to African American and Hispanic workers who work "off the books" without social security benefits or who hit the glass ceiling. The racial earnings gap is greater in retirement than it was in employment, which is reflected in the poverty statistics in Table 16.1 (Hogan et al., 1997; Saad-Lessler, Ghilarducci, & Richman, 2014). Therefore, it may be beneficial to utilize a continuity perspective and to view retirement as a process consisting of a preretirement planning phase, which begins as omnibus but becomes more specific as retirement nears, and an adjustment period (possibly including bridge employment) as people transition to and through retirement (Wang, 2012). Throughout this process, health and pension status are important both to the planning, timing, and experience of retirement.

Physical and mental capabilities interact with the demands of the job to influence retirement decisions. Sam, for example, was a pipe fitter who counted the days until he reached retirement age and would no longer have to bend and lift. His brother, a pharmacist, had less physically demanding work, but his health was poor, so he reluctantly retired. The third brother, a teacher, suffered small strokes that gave him episodes of incoherence that made continuing his work impossible. If there had been a fourth brother with an intellectually but not physically demanding job and no physical or mental health problem, he likely would have delayed retirement. People with poor health or physically demanding work are more likely to leave the labor force, as are those with pension benefits. Those who are healthy and those without benefits are more likely to continue working. Self-employed individuals are more likely to simply reduce hours on their current jobs. Other individuals will likely have to change jobs and take lower-status jobs to reduce work hours.

How much individuals enjoy their work also influences retirement decisions. Workers with boring, repetitive jobs, such as assembly line and office work, are likely to choose retirement as early as they can afford it. In contrast, workers with interesting jobs that give them high satisfaction are less likely to retire early and more likely to continue to

TABLE 17.2 Atchley's Phases of Retirement

Based on studies of people facing retirement, Robert Atchley and his colleagues identified phases through which the retirement role is approached, taken on, and relinquished. Phases are not tied to particular chronological ages, and individuals do not go through all of the phases.

Preretirement: People gear themselves up for separation from their jobs.

Honeymoon: New retirees experience a euphoric period of doing the things they "never had time for" before.

Immediate retirement routine: People settle into new routines. Those whose off-the-job-lives were full prior to retirement often find new routines more easily than those who have focused exclusively on work.

Rest and relaxation: Instead of a honeymoon phase, many people go through an initial period of inactivity or "taking it easy" after working for a long period of time. After about three years, activity levels return to normal.

Disenchantment: After the honeymoon is over and a routine is established, a small number of people feel let down or even depressed. They may have had an unrealistic fantasy of retirement or may have encountered a disruption in their retirement plans due to the death of a spouse.

Reorientation: Those who are disenchanted usually go through a process of exploring realistic choices and choosing a retirement routine that is satisfying. Friends, family, and community groups often help people to reorient.

Retirement routine: Whether they first go through the honeymoon phase, rest and relaxation phase, or disenchantment phase, most people master the retirement role and settle into a satisfying routine.

Termination of retirement: While some people return to a job, for many retirement is overshadowed by illness and disability, which gradually leads to the loss of independence.

Source: Adapted from Atchley (1997).

work. Well-educated employees are less likely to retire early than those with a high school education or less (Hooyman & Kiyak, 1993). However, there is evidence that those who retire early often do so out of necessity rather than choice due to ill health, therefore possibly putting those with less education (and likely less retirement) at higher risk for worse overall well-being (Bender, 2012). Perhaps for these reasons, early retirement is more prevalent among African Americans and Mexican Americans with career jobs than among whites (Gibson & Burns, 1991). Three-quarters of employees would choose to retire gradually, but few jobs make this option possible (Jondrow et al., 1987), and ill health may also be a factor (Bender, 2012).

Well-Being in Retirement

Although retirement is a major life transition, 60 percent of retirees are relatively satisfied and adjust well to their new life circumstances (U.S. Senate Special Committee on Aging, 1990). Health and financial security seem to be the major determinants of life satisfaction after retirement. Poor health, low income, negative attitudes toward retirement, difficulty making transitions, and inability to confront job loss have been found to make retirement adjustment difficult. Early retirement has more negative effects than later retirement (Atchley, 1997; Bender, 2012; Wang, 2012). Retiring early often results from ill heath, dissatisfaction at work, or involuntary job loss, which probably accounts for its negative impact. Workers forced into early retirement due to downsizing adjust the most poorly (Isaksson, 1997). Occupational status also predicts retirement satisfaction, with lower-status workers having more health and financial difficulties, and therefore less satisfaction, than higher-level, white-collar workers. Higher-status occupations are likely to provide options for nonwork pursuits throughout life, including retirement. Harold, for

example, recently retired at age seventy from his career as a college professor. He enjoyed his work and retired with a good pension. Because of his expertise, he is still sought after to lecture on trips and at special events, which provides opportunities for him and his wife to travel and enables him to continue to teach about the issues about which he has developed wisdom. In addition, Harold has research and writing projects that he never had enough time for when he was teaching. For those who, like Harold, have lifelong activities they can expand on during retirement, the transition is easier.

Retirement is just one of the role changes in late adulthood. Loved ones die and become ill; living situations must be adjusted to new physical, social, and economic circumstances. Physical and cognitive changes are a significant part of late adulthood as people adjust to and care for their aging bodies, but social changes are dramatic as well. Whether a person reduces his or her workforce participation gradually or abruptly, early or late, retirement leads to new options: leisure pursuits, community involvement, and adult education, to name a few.

Marriage and Singlehood

Older married people appear to be happier, be healthier, and live longer than widowed and divorced people of the same age (Blieszner & Roberto, 2012; Brubaker, 1985; Brubaker & Brubaker, 1995). Most older marriages have existed since early adulthood and, as we saw in Chapter 15, marital satisfaction generally increases among long-term married couples. Compared to middle-aged long-term marriages, old long-term marriages have reduced potential for conflict and greater potential for pleasure (Levenson et al., 1993; Orathinkal & Vansteenwegen, 2007; Ward, 1993). As older couples face retirement, relocation, and declining health, the marital relationship plays important support functions, especially for men. Marriage provides emotional intimacy, sexual intimacy, interdependence, and belonging. Men seem to depend emotionally on their spouses more exclusively than do women. While men and women are just as likely to consider their spouses to be companions, men are more likely to name their wives as confidants (Chappell, 1990; Gurung, Taylor, & Seeman, 2003). Married women are more likely to name a daughter or a friend as their confidants, either instead of or in addition to their spouses. Perhaps that is why while most older married people report satisfaction with marriage, men tend to report more satisfaction than women (Orathinkal & Vansteenwegen, 2007; Quirouette & Gold, 1995).

Both gender and race/ethnicity are related to marital status in later life. As Figure 17.1 shows, women over age sixty-five are much more likely to be widowed than men, especially in the oldest cohorts. Older African American women have the highest proportion of widows and are more likely to have never been married than other women (U.S. Census Bureau, 2012). African American women are more likely than white women to be divorced, with older Hispanic and Asian women reporting the lowest divorce rates (U.S. Census Bureau, 2012). White and Asian men are more likely to be married than Hispanic and African American men. Older widowed men are seven times more likely to remarry than widowed women (Longino et al., 1990). Divorced individuals are more likely to remarry than widowed people. Older women have fewer options for remarriage because they outlive men in their cohort and because older men tend to marry younger women. Widowed women may also find satisfaction in being single, especially if they have adequate financial resources, and may be reluctant to become caregivers to another aging husband.

Spouses as Caregivers

Declining health presents new challenges for older couples and brings changes to the couple relationship. Spouses serve as the first line of defense in coping with disease and disability. Spouses provide more hours of care and more personal care, and tolerate greater disability in their spouses for a longer period of time than do other caregivers (Stoller, 1992). Because caring for each other is a normative expectation of marriage, it is unlikely to stop until the caregiving spouse's deteriorating health prevents it. Caregiving spouses often report higher rates of depressive symptomology, more financial problems, and more physical burden

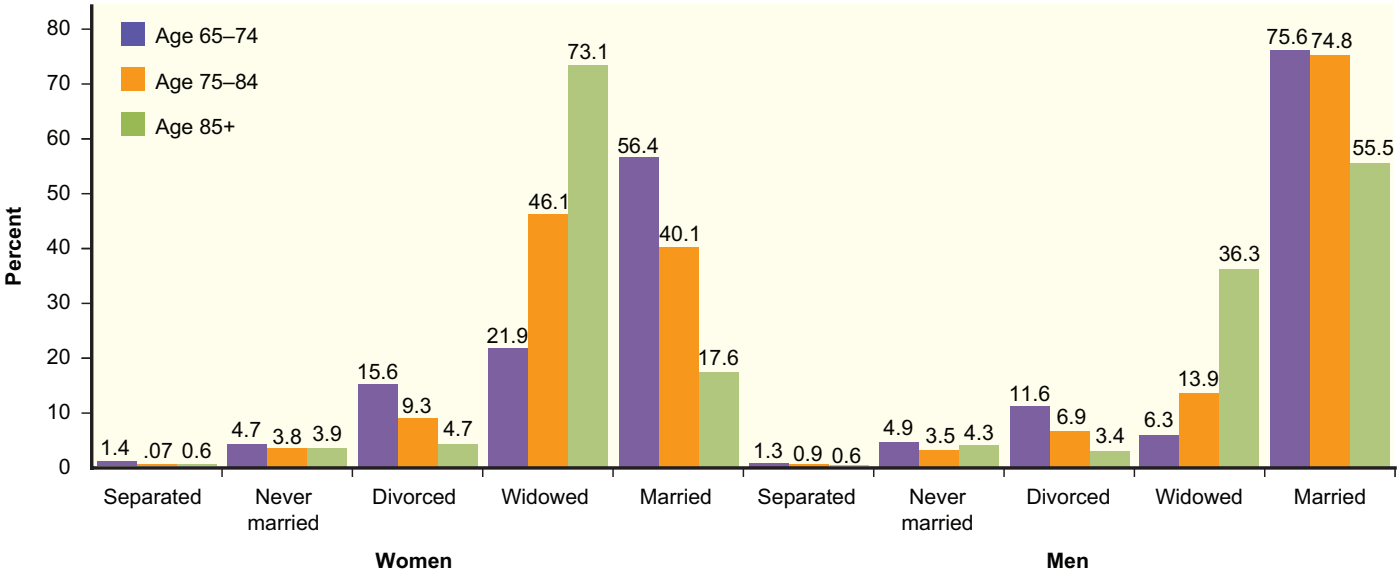


FIGURE 17.1
Marital Status of Older Adults by Age and Sex, United States, 2012

Women over age sixty-five are much more likely to be widowed than men, especially in the oldest cohorts.

Source: U.S. Bureau of the Census (2012).

than other common caregivers (Pinquart & Sorensen, 2011), which is of particular concern because high rates of burden and depression among caregivers is linked with decrements in quality of care provided (Smith et al., 2011). The rate of married older adults entering institutions such as nursing homes is about half that of never-married or previously married adults, even when the disability is extreme and the age very old (Stoller, 1992). Coping with disease and disability can increase closeness as the older partners express their love and gratitude by caring for each other (Ade-Ridder & Kaplan, 1993). The caregiving role is not limited to older spouses. Chronic illness and disability may strike in middle or even early adulthood, but it is more common in late life. Caregivers may receive satisfaction from working to maintain a high quality of life for their spouses, which seems to be dependent on the gender of the caregiver (women) and limited to caregiving tasks (Freedman, Cornman, & Carr, 2014). However, caregivers face burdens as well.

Psychosocial Aspects of Chronic Illness

As we discussed in Chapter 16, chronic illness generally begins with a crisis, such as a heart attack or a cancer diagnosis, and from that moment on the patient and his or her family face a changed future. Plans for daily living must be altered to include medical treatment and to revise exercise patterns, dietary practices, travel plans, and, perhaps, work and household chores. To adjust to chronic illness, patients must somehow integrate

Older married people are generally happier, healthier, and live longer than widowed and divorced people of the same age. Marriage provides emotional intimacy, sexual intimacy, interdependence, and belongingness as older couples face retirement, possible relocation, and declining health.

Source: WitthayaP/Shutterstock.com.

their illness into their lives. For example, a heart disease patient who continues to smoke or fails to exercise is a poor patient. Most patients cope with chronic illness in ways similar to how they cope with other stressful life events. Although most experience denial, anxiety, and depression as they adjust to the demands of the illness, many ultimately adopt active coping strategies, such as modifying health and lifestyle habits to reduce subsequent risk. In contrast to avoidant strategies, such as denial, active coping generally has been found to accompany good adjustment. In controlled studies, Ronald Grossarth-Maticek and Hans Eysenck (1996) have demonstrated that psychotherapy, behavioral therapy, group therapy, and self-instruction aimed at modifying vulnerable personality traits can effectively improve and prolong life for chronically ill individuals.

However, chronic illness can lead to interpersonal strains for patients and their families. Pity or social rejection may follow diagnosis, especially if negative stereotypes are associated with the illness, such as in the case of cancer (Rounds & Zevon, 1993). Cancer, Alzheimer's disease, and other chronic illnesses may cause fear and aversion in family and friends at the same time they call forth desire to provide social support. This ambivalence can lead to tense relationships and ineffective social support (Birditt & Wardjiman, 2012; Varni et al., 1992). Spouses, lovers, and other intimates may themselves be depressed by their loved one's condition (Stein et al., 1992).

Chronic illness also leads to positive outcomes. Patients report a greater ability to appreciate each day, to do things now rather than put them off, to put more effort into their relationships, to be more sensitive to others' feelings, and to be more compassionate (Taylor, 1998). They also report feeling stronger and more self-assured. People offset the negative impact of their chronic diseases by rearranging their priorities and extracting meaning and benefit from their experiences (Schaefer & Moos, 1992). It seems these benefits might be related to individuals' self-efficacy regarding their illness and the coping techniques being used, with problem-focused coping being most beneficial (Kristofferzon, Lindqvist, & Nilsson, 2010).

Problems of Caregiving Spouses

Spousal caregivers are subject to emotional, social, economic, and physical strain. Emotional stress results from concern for the spouse's physical and mental well-being, as well as from the need to establish new patterns of roles and responsibilities within the relationship. Not only is the caregiver likely to need to do more, but he or she is likely to get less. One of the most frequent problems of spousal caregivers is missing the way the spouse "used to be" (Chappell, 1990). Psychological reactions to many chronic illnesses, such as heart disease, stroke, and cancer, lead to decreased sexual activity (Taylor, 1998), and as noted in Chapter 16, chronic illness and worrying about a spouse's illness are two of the most common reasons older adults cease sexual activity (Waite et al., 2009). The disability of a spouse, especially if it entails cognitive impairment, removes emotional and social support and limits the personal freedom of the caregiver. Healthy spouses may restrict social activities to provide care and companionship or because they feel guilty enjoying themselves while their partners cannot. When Hassan became disabled, Minnah needed to assume all household and financial management. She also felt bound to the house to tend to his physical needs. When Minnah finally hired a nurse's aide to bathe him and watch him while she went for a walk or to the market, Hassan became upset and scared the helper away. As a result, Minnah left the house infrequently, only when responsibilities demanded it, and felt embarrassed to invite people in. Although financial strain was only a small part of Minnah's troubles, it often contributes to the caregiver's burden as the medical expenditures shrink the shared economic resources. The cost of nursing home care, which can lead to impoverishment, adds to the caregiver's desire to keep the spouse at home. These stresses may be greater for recently married older couples who do not have a lifetime of shared experiences to draw on.

Gender and Caregiving

Gender has a significant impact on the caregiving role. Because wives generally outlive husbands, more women than men provide spousal care. Husbands also appear to

Though spouses serve as the first line of defense in coping with disease and disability, having help from a child or other relative can relieve some of the caregiving spouse's strain.

Source: wavebreakmedia/ Shutterstock.com.

derive less satisfaction from caregiving (Freedman, Cornman, & Carr, 2014) and to be less tolerant of caregiving burdens because a higher percentage of married women are institutionalized, compared to married men, and married women spend more days in nursing homes than married men do (Bengtson et al., 1996; Freedman, 1993; Stoller, 1992). Eleanor Stoller and Stephen Cutler (1992) found gender differences in husbands' and wives' responses to their spouses' need for help among frail older adults. Still, more than one-third of spousal caregivers in the United States are men (National Alliance for Caregiving, 2009). There is evidence that men and women experience spousal caregiving differently, which may reflect the traditional division of labor within marriages among the now old. The way a relationship is organized before the disease or disability strikes influences how the couple copes with it (Grand et al., 1995). The quality of the relationship before caregiving also seems to be more important for men than women. Relationship quality was not a factor in female caregivers' desire to institutionalize their loved one, though it was for men (Winter, Gitlin, & Dennis, 2011). A lifetime of traditional gender roles leads wives more than husbands to be responsive to the physical and emotional needs of their spouses. Baila Miller (1987) found that caregiving wives paid closer attention to interpersonal situations and focused on the changes in the marital relationship, whereas caregiving husbands emphasized structural activities. Wives, for example, would devise explanations for hiring a helper when they went out so that their impaired spouses would not feel demeaned by having a "baby sitter."

Susan Allen (1994) found that wives provided about twice the hours of care husbands provided. However, it does not seem that men and women utilize support differently (Pinquart & Sorensen, 2006). In terms of roles, the incapacity of a husband means a wife must assume his responsibilities, and vice versa. Because wives already do most of the household tasks, the change is greater for caregiving husbands than for caregiving wives. Illness is the factor that causes the traditional division of labor to change in older adult households (Brubaker & Kinsel, 1988). Caregiving husbands are more likely to experience decline in social contacts because wives generally are the kinkeepers. On the other hand, men are acknowledged more for their caregiving because it is less expected of them. Although some studies show that men experience less caregiving stress, more studies report no difference between the genders (Miller, 1990; Pinquart & Sorensen, 2006; Stoller, 1992).

The impact of race/ethnicity is hard to determine because most of the available research has focused on white couples. In a large-scale study of caregivers of the aged, African Americans of both genders perceived higher rewards from caregiving than did whites because of the greater comfort they found in religion and prayer (Picot et al., 1997). However, minority caregivers are more likely to be an adult child or other family member than for white caregivers (Gelman, Tompkins, & Ihara, 2014). In a study of older inner-city African Americans and whites, Colleen Johnson and Barbara Barer (1990) found

that African Americans had more active support networks than did whites, and recent research has demonstrated that one important social network outside the family is their church (Gallant, Spitze, & Grove, 2010). Among Latino older adults, similar caregiving patterns emerge in which the primary support is the family, which is likely linked to the high prevalence of intergenerational families (Gallant et al., 2010; Gelman et al., 2014). However, it is likely that SES, extent of acculturation, length of time in this country, and circumstances in which the group or individuals arrived in this country are all factors that affect caregiving for minority older adults (Gelman et al., 2014; Lockery, 1991).

Widowhood

While illness of a spouse requires significant adjustment, the death of a spouse causes disruption to self-identity and relationships with others. The impact of widowhood depends on the age and social class of the widow. Older widows adjust better than younger widows. Becoming a widow late in life is "on time," whereas at younger ages, it puts a woman into minority status. Young widows are stigmatized and allowed to play the widow role for only a short time before they are considered single again (Lopata, 1973, 1984). However, for many people who have been widowed, life satisfaction may be impaired for a long period of time (Yap, Anusic, & Lucas, 2012). For most lower-SES women, widowhood means poverty, which results in lower social participation outside the home (Atchley, 1997), which may negatively impact subsequent well-being (Pinquart & Sorensen, 2000). Many studies have demonstrated that pre-widowhood social support is a predictor of well-being during widowhood; however, it seems that those with high life-satisfaction ratings before the loss of a spouse demonstrated significant decreases in life satisfaction during widowhood, regardless of social support (Anusic & Lucas, 2013).

Although far more women are widowed than men, in 2012, about 11 percent of males over age sixty-five were widowers (U.S. Census Bureau, 2012). Men often see their wives as part of themselves and rely more exclusively on them as confidants. This may be one reason why men report higher levels of depressive symptoms than women following the death of a spouse (Bennett, Smith, & Hughes, 2005). Because there are so many more older widows, women are likely to have friends with whom they can share activities, which can buffer the negative effects of widowhood (Subramanian, Elwert, & Christakis, 2008). A less established widowers' community is available for men to take part in. Widowers tend to be more cut off from families than do widows, although no apparent difference exists in the extent of older widows' and widowers' loneliness. Widows seem to expect more, get more, and want even more social interactions, whereas widowers expect little, get what they expect, and are satisfied (Atchley, 1997). Widowers generally have better financial resources than widows and greater opportunities for remarriage because there are more older women and because society is more accepting of marriages between older men and younger women than the reverse, for reasons presented in the "Focusing On" feature.

What effect does widowhood have on physical and mental health? Short-term problems and long-term recovery are common in both areas of health. Whereas the risks of negative health consequences are high immediately following the death of a spouse, the extended effects on health due to widowhood are minimal (Bradsher, 1997). In fact, mortality risk is substantially higher right after the death of a spouse and remains inflated up to ten years later, even after accounting for shared environment, a phenomenon known as the widowhood effect (Boyle, Feng, & Raab, 2011). Additionally, lower life satisfaction following widowhood can be long lasting—up to eight years among those who did not remarry (Lucas et al., 2003). Depressive symptoms associated with loneliness and grief are high during the first year of bereavement but return to pre-widowhood levels after that, although young-old widows (ages sixty-five to seventy-four) are particularly at risk of developing chronic depressive symptoms (Mendes de Leon et al., 1994). Widowhood does not increase risk of earlier mortality (McCrae & Costa, 1993).

However, widowhood has a significant impact on economic and social well-being. It is associated with a reduction in family income for both genders, but especially for women. The primary link between widowhood and depression among women is financial strain

Focusing On . . .

The Double Standard of Sexuality in Late Adulthood

Ageism makes being "older" difficult. We live in a youth-oriented culture. Youth is used as a metaphor for energy, mobility, appetite, and well-being. This makes us all aware of our age long before we approach old age. Men and women alike are made defensive about gaining years and losing the prestige of youth, but the glorifying of youth affects women much more harshly than it does men.

Women in our society are judged primarily on their physical attractiveness, whereas men are judged mainly on their accomplishments (Wilcox, 1997). Because the contemporary standard of female beauty is a slender and youthful one, as women age, they naturally move away from it; youthful appearance is something one outgrows, rather than develops, over the adult years. Accomplishments, in contrast, are achieved over time. As a man ages, he is more likely to be successful at work and gain money, power, and status. All of these things make him more attractive than he was before, despite his graying hair, wrinkles, and other signs of physical aging. Moreover, benefits such as wisdom among women are seen as not adding much to the perceived "women's intuition," whereas men's wisdom is perceived as valued (Saucier, 2004). The result is the *double standard of aging,* whereby getting older enhances a man's value but diminishes that of a woman. There are, of course, men who are not successful and distinguished, and many of them suffer profoundly in their middle and later years. All women, however, learn that they should hide their age by staying "thirty-nine" indefinitely and doing all they can to remain young looking. This is not a growth-producing or affirming process and puts women at a distinct disadvantage when looking for new sexual partners in their later years. Moreover, there is evidence that the beauty standards to which women are held negatively affects women's relationships with one another and, subsequently, their socioemotional well-being, particularly during late life (Gosselink et al., 2008).

Women are judged to be older than men of the same age. When asked to categorize photographs of men and women into adolescent, young, middle-aged, older adult, and aged adult, both men and women assigned the women to older age groups (Kogan, 1989). Wrinkles and gray hair, early signs of aging, are considered ugly on a woman. "Why doesn't she do something with herself?" people ask, meaning dye her hair, use cosmetics, or get a facelift. On men, however, wrinkles are considered "character" lines, and gray hair is considered distinguished.

Women are considered sexually unattractive at a much earlier age than men are. African American women are an exception. While young women can expect to attract men about their own age, middle-aged women have to settle for men who are considerably older. Older men, on the other hand, can date and marry women much younger than themselves. Films abound in which a young actress plays the romantic partner of an aging actor, and moviegoers find the pair quite believable. Imagine the age difference was reversed and the woman was twenty or so years older than the leading man. How would audiences react? In real life, older men often choose partners who are or look younger than themselves. We are used to this arrangement. We are not used to couples in which the woman is much older than the man, as was the case with Demi Moore and Ashton Kutcher, and research shows that people judge such marriages to be less likely to survive

(Umberson et al., 1992). For older adult widows, moving in with a family member provides a transition out of poverty (Dodge, 1995). For both recent widows and widowers, remarriage has been found to be one of the most important determinants of physical and economic well-being (Moorman, Booth, & Fingerman, 2006; Smith et al., 1991). In a longitudinal study designed to assess the effects of widowhood on health, ability to function, and well-being, Robert McCrae and Paul Costa (1988) found strong signs of psychological resilience from bereavement and the burdens of widowhood.

Dating and Remarriage

One type of resiliency is to form new intimate relationships in later life. Socially active older adults are more likely to meet people who are potential dating partners. Health, driving ability, organizational memberships, and contact with siblings are all positively associated with dating (Bulcroft & Bulcroft, 1991). Compared to younger daters, older ones are not experimenting with marital roles (because they have been married before) and place more emphasis on companionship. They date to select a marriage partner and

Focusing On . . .

The Double Standard of Sexuality in Late Adulthood *continued*

(Cowan, 1984). Older men marrying younger women leaves older women (and older-looking women) with few available partners.

Not only are older women seen as sexually unattractive; they are often thought of as not being sexual. Ageism includes the stereotype that old people are not interested in sex, that they are not sexual beings, and that sex is the province of the young, although half of older adults are sexually active and more would be if they had partners (Cutler, 1998). Because women are considered "old" sooner, they often fall subject to this prejudice when they are still in their middle years. Whereas people are likely to admire an old man's interest in sex, they see an old woman's sexual interest as being in bad taste. This is an extension of the sexual double standard, in operation during adolescence and early adulthood, that condones promiscuity in men but condemns it in women. Stereotypes and social expectations can affect how we think about our sexual feelings and make us feel guilty, ashamed, or inappropriate. Women more than men are subject to negative sanctions against sexual expression, and this situation worsens as they get older.

While the double standard of sexuality is apparent in late adulthood, gender stereotypes are changing, and hopefully, these changes will diminish it. As women have moved into the public arena in full force, their accomplishments have been mounting and receiving more recognition. As women devote their time and energies to being competent, strong, and accomplished instead of just nice, pretty, and graceful, we can hope that female desirability and self-confidence will be based on more than physical attributes, just as men's are. Sara Wilcox (1997) found some evidence for this. She measured body satisfaction of women and men, ages twenty through eighty, and found that women who were *exercisers* (regularly exercised no fewer than three times a week for at least twenty continuous minutes) increased in body satisfaction with age, whereas women who were *nonexercisers* decreased in body satisfaction with age. Men did not change in body satisfaction, whether they were exercisers or nonexercisers. Change is occurring, but slowly. Mid- and late-life women continue to be underrepresented on television (Saucier, 2004), and media outlets often focus on physical features of aging among female political candidates, such as Hillary Clinton, rather than focusing on the content of messages (Carlin & Winfrey, 2009). As women allow their bodies to age more naturally, without hair dyes and facelifts, they will gain self-respect, and perhaps that will lead to new standards of attractiveness for older women. Many older women are indeed quite beautiful, but not in eighteen- or twenty-five-year-old ways.

What Do You Think?

1. In what ways does the stereotype of sexuality in late adulthood contrast with the reality? (Look back at the section Changes in Sexual Functioning in Chapter 16 if you need to refresh your memory.)
2. Think of sexual stereotypes that people hold about adults your own age. Are they similar or different for men and women? Would you conclude that a *single* or a *double standard* of sexuality exists for your age group?

to maintain social activity. Older women report that dating increases their self-esteem because it makes them feel desirable. Older men report that dating gives them an avenue for self-disclosure. Both men and women expect the functions of dating relationships to include friend, confidant, lover, and, to a lesser extent, caregiver (McElhaney, 1992).

Marriage in later life is not uncommon, but it is likely to be remarriage. The major reasons for remarriage are companionship and economic resources. Older mate selection follows the same principle of similarity that we noted among younger adults (see the discussion of mate selection in Chapter 13), and this pattern of men seeking physical attractiveness and men seeking status stands even among older adults utilizing online dating sites (Alterovitz & Mendelsohn, 2009). Older adults choose mates who have similar backgrounds and interests; often they choose partners whom they have known for a long time. While older adults meet dating partners in public places or through friends, new spouses are more often known from the past (McElhaney, 1992). However, more recently, online dating has become a boon to older adults seeking a companion—between 3 and 6 percent of those in mid- or late-life had utilized online dating sites in 2005, which was before the advent of sites specifically developed for mid- and late-life adults (McWilliams & Barrett, 2014). Successful late-life remarriage is more

likely when there has been a long prior friendship, when family and friends approve, when the pooled financial resources of the new couple are adequate, and when the marriage partners are personally adaptable (Brubaker, 1985). Some older couples choose to live together without remarriage. Charlie, for example, became a widower shortly after he retired at age sixty-five. Just as he and his wife were preparing to travel and enjoy their leisure years, she discovered she had cancer and died in less than a year. Ruth had lost her husband a few years earlier. The two couples had been close friends for many years. Now Charlie and Ruth are together, although they have chosen not to remarry. They travel together and are accepted by each other's children, but they like things the way they are. However, it is important to note that it is less likely that older cohabitating adults will provide caregiving to their partner, but if they do, that care is equivalent to that of a married caregiver (Noel-Miller, 2001).

Older Lesbians and Gay Men

While most older adults are married and living with a spouse, an estimated 10 percent are lesbian women and gay men (Quam & Whitford, 1992). Long-term relationships are much more frequent among gay men and lesbians than is commonly assumed, as we discussed in Chapter 13. Based on his own research as well as a review of the literature, Douglass Kimmel (1992) found that "when matched on age and background, lesbian, gay, and heterosexual couples do not differ on standard measures of relationship quality or satisfaction" (p. 38). Older lesbian and gay couples, like older heterosexual couples, tend to be more content in their relationships than their middle-aged counterparts (Berger, 1982). The one place differences have been found are in that gay and lesbian couples often negotiate and share household chores (Peoplau & Fingerhut, 2007).

Although until June 2015, same-sex marriage was only legal in seventeen states, many had ceremonies to celebrate their partnerships and, in several municipalities, received "marriage" benefits, such as health insurance and bereavement leave (Kimmel, 1992). While having partial recognition in these ways did provide a sense of stability to relationships and, in some circumstances, has been related to higher life and relationship satisfaction, particularly when there is an informal ceremony (Fingerhut & Maisel, 2010), research conducted more recently has demonstrated the benefits of formalized marriage. Many same-sex couples note that marriage makes the relationship more "real" both to those in the relationship and to the public

Long-term relationships are much more frequent among gay men and lesbians than is commonly assumed. Older lesbian and gay couples, like heterosexual couples, tend to be more content in their relationships than middle-aged couples.

Source: Belushi/Shutterstock.com.

(Lannutti, 2009), and many couples shift the way they dealt with investments (Fingerhut & Maisel, 2010). Additionally, the legal bonds of marriage serve to stabilize the relationship by increasing relationship capital and making it more difficult to dissolve the relationship (Fingerhut & Maisel, 2010). Among gay men, having a domestic partner or legally recognized same-sex spouse appears to buffer the negative impact of discrimination and aging on mental health, with married couples benefitting the most (Wight et al., 2012).

In a survey of eighty gay men and lesbians ages fifty to seventy-three, respondents' areas of concerns were primarily the same as those for most aging adults: loneliness, health, and income (Quam & Whitford, 1992). They had additional concerns about being rejected by adult children (58.7 percent reported having children) and grandchildren when they "came out" to their families. Older gay men and lesbians are a diverse population. Some are in a couple, and some are not. Some are "out of the closet," and some are not. Some have been out for years, and others are just coming out. Some have supportive connections with their families, and some do not. Some have children and grandchildren, and some have neither. Aging occurs within the context of these diverse life circumstances. In addition, older gay men and lesbians have lived most of their lives in a society that has been actively hostile and oppressive toward homosexuality. Discrimination and stigma have profoundly affected their aging experience (Fullmer, 1995).

Older gay and lesbian adults also report worries about discrimination in health care, employment, housing, and long-term care, which compounded their anxieties about aging. As a result, many gay, lesbian, bisexual, and transgender (LGBT) older adults have spent the majority of their lives hiding their identities (Butler, 2008). Though same-sex marriage is now legal nationwide, it is important to remember that, as of 2015, only twenty-two states had laws against discrimination based on sexual orientation. Additionally, it seems that fears about discrimination, particularly in the realm of health care, are not unfounded. Surveys of nurse assistants have demonstrated levels of homophobia that, though lower than historical levels, are still moderate and, thus, troubling (Dickey, 2012; Johnson et al., 2005). Moreover, the majority of nursing home social service directors and nurse assistants reported receiving no training in working with LGBT patients; nor had they received training in homophobia (Bell et al., 2010; Dickey, 2012). As a result, many LGBT older adults rely on fictive kin, or very close friends who act as a de facto family, for informal caregiving (Muraco & Fredriksen-Goldsen, 2011).

Support groups for older gay men and lesbians can address some of the special needs of this late-life population, which differ in some ways from those of other older adults and in some ways from those of younger gay men and lesbians (Slusher et al., 1996). Many older gay men and lesbians have been private about their sexual orientation and have not been part of the gay community. Some have no family supports because they never married, have no children, and may be unconnected to other members of their biological families. Support groups typically meet to socialize, share a meal, and discuss issues of concern. They also provide formal settings that can act as families to celebrate holidays and birthdays. Having a formalized social support or having an LGB social network has been shown to ameliorate the stress and loneliness often reported by LGB older adults (Kuyper & Fokkema, 2010).

Older gay men and lesbians have special concerns because, until recently, their partners have not been recognized by law. They need to know legal strategies for protecting property and wishes at death. They need options for home care that enable them to avoid homophobic nursing homes and retirement housing. They need help with fear of disclosing their gay identity, lack of freedom because of being "in the closet," and difficulty experiencing being gay as a "positive thing" (Slusher et al., 1996). Obviously, group organizers and leaders need to be sensitive to gay issues.

Ever-Single Older Adults

In 2012, only 5 percent of older adults in the United States had never married, as Figure 17.1 shows. Because ever-single adults have been on their own their entire lives, they have learned to cope with aloneness and to be autonomous and self-reliant, qualities that facilitate successful aging. The family life of ever-single older people revolves around

What Do You Think?

How would you advise a young-old person to prepare for later stages of adulthood? Would your advice differ for a person in a couple or for a single person? Would it differ for a man or a woman?

parents, siblings, nieces and nephews, and friends (Newtson & Keith, 1997). Olga, for example, chose not to marry because she was blind, which she believed would prevent the marriage that was proposed from having enough privacy. She lived with her ever-single sister and mother for almost all of her adult life. By the time her mother died, two other sisters had become widows and moved back "home." She survived all three sisters and, in her seventies, moved in with a fourth sister and her husband. Although never married, she was never isolated and had many close family relationships.

Overall, those who are ever-single report less loneliness and strain than those who are either widowed or divorced, which is likely because those who never marry, in many cases, have chosen to never marry (Pudrovska, Schieman, & Carr, 2006). Robert Atchley (1997) found that social contact of ever-single women depended on SES. Middle-class ever-single older teachers had about the same level of social interaction married older teachers did, but ever-single older telephone operators had much lower social interaction than married telephone operators. However, those who are ever-single tend to have higher incomes and higher levels of educational attainment than their married or previously married counterparts, suggesting that they do not lack social contact (Pudrovska, Schieman, & Carr, 2006).

Relationships with Family and Friends

Relationships with family and friends are important at all stages of life. Social support has been shown to affect mental health, ability to cope with stressful events, health, and mortality from infancy to late life (Antonucci, 1997). It is a direct parallel to attachment, a concept we introduced in our discussion of infancy in Chapter 5. Secure relationships have lifelong importance; family and friend relationships among older adults emerge from the early social relationships between mothers and infants (Feeney & Noller, 1996; Hazen & Shaver, 1990; Troll, 1994). Primary attachments to parents persist throughout life. Bonds formed later to siblings, spouses, children, and grandchildren are also powerful.

The importance and structure of relationships with family and friends throughout life can be best understood using Laura Carstensen's socioemotional selectivity theory (SST), a continuity theory that states that, throughout life, we try to maximize benefits and minimize risks in our relationships (Carstensen, 1992). Across adulthood, interactions with acquaintances and friends decline in frequency, while interactions and emotional closeness increase with relatives and close friends, so that in late life, most of our social convoy, described next, consists of those who are close to us (Carstensen, 1992). As a result, the interactions we have become less negative and more positive (English & Carstensen, 2014).

social convoy The term used to describe the lifelong social network of family and friend relationships that develop over the life course and provide social support from infancy through late life.

The term **social convoy** is used to describe the dynamic concept of lifelong social networks. Figure 17.2 shows two examples of social convoys. The convoy model of social relations emphasizes, first, that some relations are more important than others; spouses, parents, and children are more important than other relatives, friends, and coworkers, which is in line with the SST theory described earlier. Second, relationships develop over time. The mother-infant relationship grows and develops as both child and mother grow and change, but stability and continuity exist in the relationship as well. Third, social relations are influenced by characteristics of the individual such as age, gender, ethnicity, marital status, and situational characteristics (for example, employment status). Toni Antonucci (1991) used data from a study of relationships among mature adults (age fifty or older) to provide evidence for the life course continuity of attachment and social support. Her data were both cross-sectional (ages fifty to ninety-eight) and longitudinal because she recontacted as many respondents as she could (404) four years later. She found that respondents had an easy time categorizing their social relations into three

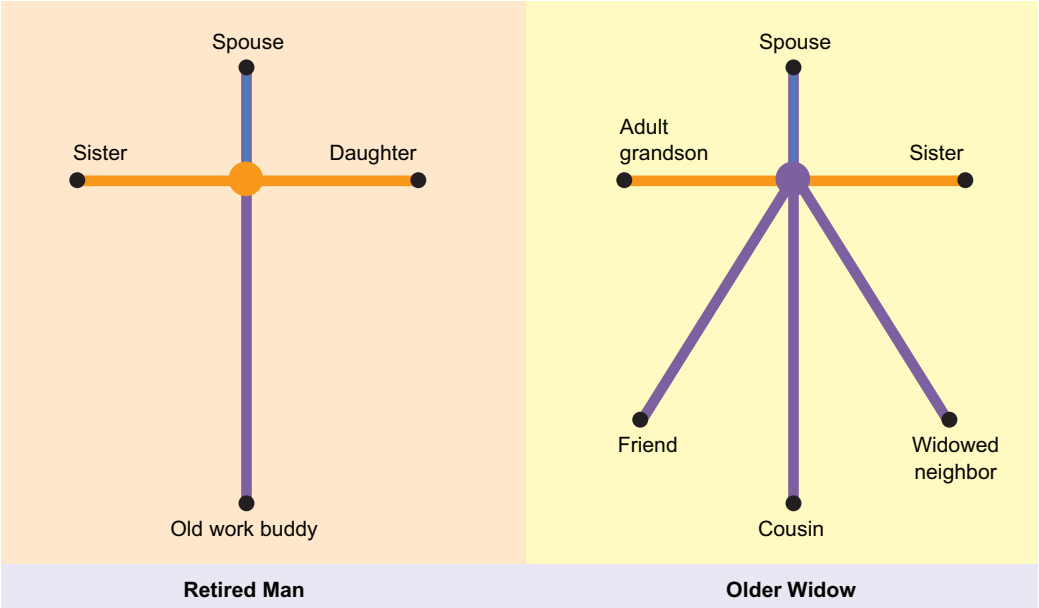


FIGURE 17.2
Examples of Social Convoys

As these two social convoys of an older adult man and woman show, members of convoys fall into three levels of closeness.

levels of closeness and that these categories stayed stable over the four-year interval. She found no gender differences in network composition—both men and women had more women in their network—and no age differences in the number of people who provided support. Older people were more likely to have network members who were older and had been in their network longer. They were less likely to live within an hour of the members of their network or to see them as often as younger people saw their network members. While no difference was found in how many people they received support from, they provided support for fewer network members than younger adults did. Antonucci also found that early social support had a positive influence on well-being, even in the presence of negative life events.

The most important relationships are with spouses, parents, and children, as we discussed earlier in this chapter and in Chapter 15 when we considered relationships during middle adulthood. For the young-old, the issues of aging parents and young adult children are the same as those for middle-aged adults facing the same family stage issues. Remember that the boundary between middle and late adulthood in not clear; family stage usually is more relevant than age. For the old-old and very old, the issues surrounding being cared for by middle-aged children become relevant. We looked at this from the perspective of middle-aged children in Chapter 15 and will address it again from the late-life parent's perspective when we consider the "problems of living" later in the chapter. Here, we focus on late-life relationships with siblings, grandchildren, great-grandchildren, friends, and fictive kin.

Siblings

When relatives outside of the inner circle of spouse, parents, and children are considered, the sibling relationship appears to be the strongest bond for those who have a surviving sibling (Johnson & Barer, 1990). After being very important in the child and adolescent years, relationships with siblings often go underground during early adulthood, when energy is devoted to establishing independent lives and families of one's own. As we discussed in Chapter 15, middle-aged siblings often focus on one another again for the first time when their aging parents need care. Siblings who may have had little involvement with one another find themselves in more frequent contact as they cooperate around arrangements for their parents' care. While tensions from earlier years are likely to affect families that come together in this way, most siblings work to keep their mutual rivalries and grudges from interfering with parental care, and many are able to get to know one another better and defuse petty issues from childhood (Moyer, 1992). This often enables

the siblings to overcome residual family problems so the later years can be a time of increased closeness and sharing (Bedford, 1989; Gold 1990). However, the quality of sibling relationships often declines after the death of their parents, particularly if siblings did not contribute equally to the care of their parents (Bedford & Avioli, 2012).

Older adult siblings often form one of the strongest social support systems for the older adult, during good times and bad. Siblings travel together, provide emotional support, and share family memories. They knew us when we were young and energetic and provide a generational solidarity as we get old. The tie between siblings is particularly enduring, at least on the emotional level; siblings can act as confidants, caregivers, and cherished friends. Colleen Johnson and Barbara Barer (1990) found that three-quarters of older adults with siblings reported that the relationship was emotionally rewarding. In a study of immigrant Italian American siblings, Johnson (1985) also found a positive impact of ethnicity on late-life sibling interactions. The death of older adult siblings has a profound effect on the remaining siblings because it changes the family constellation: a younger sister may become the oldest, one of many may become the only one remaining. As each sibling dies, those who remain feel less buffered from their own mortality (Moyer, 1992).

While many studies have suggested that African American families have greater solidarity (Bedfore & Avioli, 2012) than white families, only a few studies have focused on sibling ties (Johnson & Barer, 1990). White and Riedmann (1992) found that African Americans, Mexican Americans, and whites were no different in the degree to which they viewed their siblings as a source of support, while Asian Americans had more faith in their sibling networks. In a comparison of suburban African American and white late-life sibling pairs, Deborah Gold (1990) found that African Americans tended to report more positive attitudes toward their siblings and to show greater interest in providing support for them than did whites. In analyzing the descriptions of eighty-nine white and sixty-four African American sibling pairs, Gold coded for mention of closeness, envy, resentment, instrumental support, emotional support, acceptance/approval, psychological involvement, and contact. Although an overwhelming majority of the sibling relationships were categorized as intimate, congenial, or loyal (95 percent African American and 78 percent white), a substantially greater percentage of the white relationships were categorized as apathetic or hostile (22 versus 4.5 percent). The concepts of envy and resentment were used far less frequently by African Americans than by whites to describe their sibling relations, but only among gender combinations that included men (male-male and male-female pairs). Similarly, more recent research has demonstrated that the most common reasons siblings stay in touch is out of obligation or for social support and liking (Myers, 2011).

In a large, national survey of adults with at least one full sibling who had left the parental home, Lynn White and Agnes Riedmann (1992) found that gender is also important to sibling relationships. This may well be because of the gender differences in kinkeeping skills that we discussed in Chapter 15. The presence of any living sister was associated with large increases in sibling contact, and this effect doubled for female respondents. Sister-sister ties were the strongest and brother-brother ties the weakest. Sisters are more likely to receive advice from siblings, and brothers are more likely to provide physical assistance to their siblings (Bedford & Avioli, 2012). In a survey of more than five hundred people over age fifty-five who had one or more siblings, Ingrid Connidis and Lori Campbell (1995) found that women and respondents with sisters, the ever-single, and the childless tended to have particularly active sibling ties. A majority of respondents said they would turn to their siblings for help if they needed. In fact, childless siblings, in general, provide both advice and assistance in child rearing well into their late life (Bedford & Avioli, 2012).

The importance of siblings in later life shows that the extended family rather than the nuclear family can serve as a source of social support. Siblings have a lifelong bond that can be rekindled or refined in late adulthood. Among inner-city African Americans, Johnson and Barer (1990) found that relationships with nieces and nephews often persisted after the deaths of their siblings. More distant relatives, such as cousins, may also become close friends. Only children, siblings who cannot reconcile their resentment or estrangement, and those whose siblings live very far away must look to other family members or friends as family.

Adult Grandchildren

Given the changing patterns of mortality that we saw in Chapter 16, more grandchildren know their grandparents not only as children but as adults, and more older people function as grandparents (and, in many cases, great-grandparents). Because grandparenthood usually begins in middle adulthood, we began our discussion in Chapter 15. Once again, the problems and pleasures of being a grandparent to young grandchildren do not differ for people who are already in late adulthood when they become grandparents. Stage of life is more important than age. In this section, we focus on the relationships of older grandparents and their adult grandchildren. Do grandchildren grow away from their grandparents as they grow up, or do they form more voluntary relationships with them? What characteristics of grandparent and grandchild lead to continuing association?

Continuing Connection

Research points to a continuation of the bond between grandparents and grandchildren that, as we saw in Chapter 15, begins early in the grandchildren's lives. Grandparents continue to interact with adult grandchildren, which can be a continued source of generativity (Hebblethwaite & Norris, 2011). Even when their parents divorce, adult grandchildren continue to see their grandparents on their own (Cooney & Smith, 1996). In fact, having a good relationship with a grandparent can ameliorate risk for depression among children living in a single-parent home (Ruiz & Silverstein, 2007). Karen Roberto and Johanna Stroes (1995) distributed questionnaires to 142 college students. Eighty-nine percent had living grandparents and 25 percent had both sets of grandparents still living. On average, the grandchildren interacted with their grandparents once a month or less. The researchers found that adult grandchildren, both grandsons and granddaughters, did more activities with their grandmothers than with their grandfathers, particularly participating in brief visits, attending family gatherings, talking over important issues, and helping with chores. Grandchildren reported being more influenced by their grandmothers than their grandfathers in religious beliefs, sexual beliefs, family ideals, educational beliefs, moral beliefs, and personal identity issues. There was no difference in the degree to which their grandmothers and grandfathers influenced their political beliefs and work ethics. Grandchildren rated their relationships with their grandmothers to be stronger than their relationships with their grandfathers. They believed their grandmothers understood them better, and vice versa; communication was better with their grandmothers; and they shared more similar life views with their grandmothers. No differences were found in grandchildren's appraisals of their relationships with maternal and paternal grandparents. The college students reported that enjoyment in being with their grandparents was a strong motivation for maintaining a relationship with them. In a separate study, when respondents were asked to identify the grandparent with whom they were emotionally closest, 75 percent mentioned a grandmother. This reflects the fact that many had only a grandmother living, in addition to a preference for the grandmother when the grandfather was also alive (Hodgson, 1995).

Although the degree of association between these adult children and their grandparents varied, overall it was "remarkably high." Contact was more frequent for younger than older grandchildren, for those living within an hour's drive than those living farther away, for those who felt emotionally close to their grandparent than those who did not, and for those who had frequent contact with their parents than those who had infrequent contact. Seventy percent of the grandchildren rated their relationship with their closer grandparent as "close" or "quite close." In addition to grandmothers being chosen as closer more frequently than grandfathers, maternal grandparents were chosen more frequently than paternal ones. Another important element was whether the grandchild had lived with the grandparent at some point in his or her life. If the grandparent had acted as a surrogate parent for the grandchild, the attachment was strong and permanent. While closeness often began early in life, many in the sample reported their relationships had become closer over time. As adults, the grandchildren appreciated their grandparents more and wanted their own children to know the grandparents as their great-grandparents. In addition, a personal crisis or increasing need on the part of the aging grandparent had brought them together.

Cultural Variation

Adult grandchildren assist their grandparents in a variety of ways that foster the grandparents' well-being (Piercy, 1998). Adult grandchildren are increasingly providing instrumental care to their grandparents (Blanton, 2013) and, subsequently, may face the unique challenge of also caring for their own parents and children, and frequently need additional assistance (Boquet et al., 2011). The degree to which this assistance is emotional or instrumental depends on the cultural attitudes of the particular ethnic group. Nieli Langer (1995) found that middle-class Jewish older adults had few expectations of material support from grandchildren. Their relationships with their adult grandchildren were based on reciprocity of meaningful emotional support. In contrast, the active role of grandparent in African American and Hispanic life is thought to be critical (Facio, 1997; Ralston, 1997; Yee, 1992). As we saw in Chapter 15, African American grandmothers take in grandchildren at a much higher rate than do white grandmothers, and thus develop strong emotional bonds with at least some of their grandchildren that continue when the grandchildren are adults. Among older inner-city African Americans, Johnson and Barer (1990) found that some had so many grandchildren that they could not keep track of them all; only grandchildren who were bound by ties of affection were counted. More than half of the respondents reported they had at least one grandchild who provided them with emotional support. While African American families often have a great many grandchildren, they are not the only families that do. Authors Robert and Michele Hoffnung were, respectively, the twelfth and fourteenth of their maternal grandmother's twenty grandchildren. While we saw this grandmother fairly often, it was usually in the company of many other aunts, uncles, and cousins. Although warm, there was nothing distinctive about our bond with her. We were part of an undifferentiated group of grandchildren.

Great-Grandchildren

Because we are living longer, it is more likely now than ever before that individuals will be alive to interact with their great-grandchildren. Similar to our experiences with our grandchildren, great-grandchildren provide a source of generativity to great-grandparents (Doka & Mertz, 1988). However, great-grandparents tend to be slightly less invested in their great-grandchildren than their grandchildren (Drew & Silverstein, 2004), perhaps due to the exponential increase in number of people from one generation to another or other life circumstances, even though the role both of grandparent and great-grandparent are linked with well-being of each generation. Overall, great-grandparents report that their role gives them a sense of longevity and that their contribution to their families will live beyond them (Doka & Mertz, 1988).

Friends

While interactions with family are crucial at times of crisis, studies show that interaction with friends is more important to everyday well-being in later life (Hatch & Bulcroft, 1992). Having friends is prevalent in middle age and later life; 85 to 93 percent of middle-aged and older people report they have close friends (Atchley, 1997). Individuals without close friends are more likely to be men, older, and working class. Of all types of support, friends most often provide emotional intimacy and companionship (Connidis & Davies, 1990). Larry Mullins and Mary Mushel (1992) found that among older persons, having friends was associated with not being lonely, whereas the presence or absence of spouse or children did not affect level of loneliness. Unlike family ties, which remain fairly consistent through old age, contact with friends can be subject to more variation. Health or economic problems, geographic distance, retirement, or change of neighborhood may make interaction difficult, and many late-life friendships end due to illness, moving, or death (Blieszner & Roberto, 2012). Minnah, for example, had many good friends in her neighborhood. When Hassan became ill, Minnah and Hassan sold their home and relocated to an apartment near a middle-aged

niece and nephew. Minnah found it difficult to make new friends in her new neighborhood because she could not get out and would not invite people in due to Hassan's invalid behavior. She remained in phone contact with her old friends, but missed their companionship very much.

Does gender affect friendship in later life? The few consistent findings are that older women have more gender-homogeneous friendship networks than older men and are more likely to be involved in supportive relationships. Even in late life, women report that closeness, self-disclosure, and intimacy were the most important traits in a friendship, whereas the duration and frequency of contact in a relationship were more important factors for men (Blieszner & Roberto, 2012). Older men and women tend to have equally age-homogeneous friendship networks (Adams, 1997). However, the findings are generally inconsistent, with some studies showing no differences and others showing some. Believing that some of the inconsistency in previous findings was related to the importance of life circumstances, such as marital status and retirement status, Laurie Hatch and Kris Bulcroft (1992) used a longitudinal design to investigate gender differences in friendship contacts in ever-single, widowed, and divorced African American and white women and men. They found that widowed women had more frequent contacts with friends than did all other gender and marital groups. They also found declines in the frequency of contact with friends over time, with the declines greatest among formerly married men.

Fictive Kin

Often members of the social convoy become so important that the relationship between kin and friends becomes blurred. Parents' best friends often are treated like aunts and uncles while children are young and assume some of the attendant responsibilities. This family closeness can persist into adulthood. One mechanism for formalizing such relationships is through godparentage. Likewise, some relatives are so close in affection and interests that they become best friends. The merging of voluntary and obligatory relations sometimes produces **fictive kin**, or, as we referred to these relationships when discussing ever-single adults, *constructed relationships*. Among the Herero of Botswana, fictive kin relationships are common and provide flexibility in "family" caregiving for older adults (Keith et al., 1994). Fictive kin are particularly prevalent

fictive kin Constructed relationships, such as foster child, god-parent, or very close friendships, that merge voluntary and obligatory relations take on the significance of biologically related kin.

The emotional intimacy and companionship that these older friends provide each other is important to their everyday well-being. Men tend to have larger friendship networks with whom they engage frequently, whereas women place greater importance on friendship and engage in more intimate relationships.

Source: beeboys/Shutterstock.com.

in the African American kinship system, in which foster parents or foster children, for example, often are considered equivalent to relatives by blood or marriage (Chatters et al., 1994). As noted earlier in this chapter, gay and lesbian older adults are also highly reliant on fictive kin for social support and often caregiving as well (Muraco & Fredriksen-Goldsen, 2011). Sometimes fictive kin result from formal relationships; for example, a nanny may always hold the kinship title of *granny* in a child's life. Among older adults, a homemaking/companion may visit several times a week, share the same cultural background, and become an intimate companion thought of as a "daughter," "granddaughter," or "pal." Although fictive kin sometimes are accepted as though they were family members, they are not expected to fulfill the responsibilities of kin (Cicirelli, 1994). This is particularly significant to older adults as they consider their prospects for caregiving, as we saw in our discussion of ever-single adults.

Childlessness

Perhaps because of the ability of people to create fictive kin, as well as the importance of friends in late life, studies indicate that being without children does not have a negative impact on well-being in later life. Because none of the studies separate child free by choice, childless by circumstance, and childless due to death, *childless* refers here to all of these situations. However, rates of childlessness have doubled over the previous four decades, demonstrating the importance of understanding the impact of being childless in late life (Umberton, Pudrovska, & Reczek, 2010). In a study of confidant and companion networks, Ingrid Connidis and Lorraine Davies (1990) found that childless women tend to develop ties with friends as both companions and confidants to a greater extent than older adults who are parents. Unmarried childless women are very socially active, whereas childless men rely heavily on their wives for social support (Wenger et al., 2007), which explains why childless unmarried men experience high levels of depression and loneliness (Umberton et al., 2010). Siblings are a more primary component of their confidant network than for older parents, especially for a childless woman who is single or widowed. Childless men place greater emphasis on friends as companions as well, but turn to relatives for confidants. Among childless women, friends and siblings are especially important as confidants, while among childless men, siblings are less important in this role than other relatives. Living parents or children occupy the center stage in most adults' lives; when that inner circle is reduced, siblings become a more important part of adults' social support networks (White & Riedmann, 1992).

Internet and Social Media Use

Though the perception is that the Internet is used almost exclusively by the young, those in midlife and late life represent the most rapidly growing segment of the online population (Madden, 2010), with upward of 38 percent of those age sixty-five and older having an online presence (Maab, 2011). Though those in midlife and late life use the Internet primarily for email, news, and search engines, between 2009 and 2010, the number of those age sixty-five and older utilizing forms of social media like Facebook or LinkedIn doubled (Maab, 2011; Madden, 2010). Those in late life who use social media are more likely to rate highly on personality measures of openness to new experiences (Correa, Hinsley, & de Zuniga, 2010), and are likely to have joined a site at the encouragement of someone from their past trying to reconnect (Madden, 2010). Older adults who are highly engaged with their online community report lower levels of perceived stress (Wright, 2000). Considering both the exploding prevalence of social media use among older adults and the importance of social support during late life, additional research investigating the impact on social, psychological, and physical health outcomes is needed.

Problems of Living: The Housing Continuum

Aging in place—not moving to a nursing home—has become the ideal for both gerontologists and older people themselves. From the perspective of gerontologists, too many

What Do You Think?

Based on what you have read about relationships in late adulthood in this chapter, what family relationships do you imagine will be important to you in your old age? Why? In what ways does thinking about this issue make you want to change the way you relate to your kin? How do you think your use of social media might impact your well-being as you age? How might your use of technology make your late life different from older adults now?

older people enter nursing homes when they could and should have remained in their own households (Callahan, 1992). From the perspective of older adults, they prefer to grow older where they have been younger (Kinsella & Phillips, 2005). They feel comfortable and familiar with their surroundings and have developed informal support networks nearby. Older adults are likely to relinquish their own households only when they have limited economic resources and become frail or widowed. This is true for apartment dwellers as well as homeowners. Fully 95 percent of older people live in the community (outside of institutions), and only 13 percent live in households headed by relatives other than their spouses (Lipman, Lubell, & Salomon, 2012; Pynoos & Golant, 1996). Women are more likely than men to live with relatives other than their spouse or with nonrelatives, likely because they outlive their male spouses (Federal Interagency Forum on Aging-Related Statistics, 2012).

Economics plays a large part in the housing decisions of late adulthood, just as it does earlier in life. Eighty percent of all older persons live in their owner-occupied dwellings, 50 to 65 percent of which no longer have a mortgage (Lipman et al., 2012; U.S. Department of Health and Human Services, 2012). Even so, older adults are reported to spend between 30 percent (Federal Interagency Forum on Aging-Related Statistics, 2012) and 50 percent (Lipman et al., 2012) on housing expenditures, which is the most common housing problem. Older adults who own their homes can cash them in and buy entry into a home for the aged, provide housing for adult children, or continue to live on their own as independent couples or widows. Not surprisingly, large differences exist in the distribution of housing assets among older Americans. Women and racial/ethnic minorities have fewer assets. Homeownership rates are low among ever-single, separated, or divorced adults, among nonwhites and Hispanics, and among urban dwellers. African Americans, more than any other group, have been systematically limited as to choice of housing because of residential segregation. As older adults, they suffer from the multiple effects of low income, racial segregation, and ageism, which leave them with fewer housing choices (Skinner, 1992). Another option that homeowners are increasingly utilizing is the reverse mortgage, which permits homeowners to borrow against the equity in their home (Lipman et al., 2012). However, homeowners should be aware that being overly reliant on such funding could lead to loss of the house later in life (Lipman et al., 2012).

Although most adults prefer to continue living on their own, frailty brings the needs for housing modifications and special services. Stairs are likely to cause difficulty, for example, and shopping may become problematic. Limited finances may also push older adults to consider other housing alternatives. Older adults need a range of options, including independent living, semi-independent living, and group housing that provides long-term care. Table 17.3 lists housing types by the degree of independence they offer. As we discuss the various options, you will see that some facilities provide more than one level of independence and that similar housing types may provide older residents with different levels of control over their living conditions.

Most adults prefer to continue living independently for as long as they are able. Health and economics play a large part in the housing decisions of late life.

Source: Berna namoglu/ Shutterstock.com.

Independent Living

Among older adults, renters tend to be older than homeowners, are more likely to be women, and are disproportionately Hispanic and African Americans. Renters are significantly more likely than homeowners to pay excessive housing costs, defined as more

TABLE 17.3 Levels of Housing by Degree of Independence

Notice that some types of housing, such as an independent household, provide the possibility of more than one degree of independence.

Type of Housing	Description	Examples
Independent Household:		
Fully independent	Household is self-contained and self-sufficient; residents do almost all of the cooking and household chores.	Private home, apartment, shared housing
Semi-independent	Household is self-contained but not self-sufficient; requires help with household chores.	Utilizes homemaker/companion, Meals on Wheels, adult foster care, or family caregiving
Group Housing:		
Congregate housing	Household may be self-contained but receives some communal services, typically meals.	Retirement community, assisted-living facility
Personal care home	Resident unit is neither self-contained nor self-sufficient.	Group home or adult care facility
Nursing home	Resident unit is neither self-contained nor self-sufficient; total care is provided, including personal and health care.	Skilled nursing facility

than 30 percent of before-tax income (Mutschler, 1992). Seventy-one percent of older adult renters spent more than 25 percent of their monthly income on housing expenses. Most renters live in apartments in buildings with more than five units (Lipman et al., 2012). This provides them with the advantage of neighbors close by, affording some security and some social support. Another advantage of renting is not being responsible for yard and building maintenance; the management may also provide, some routine inside maintenance, such as installing storm windows. On the other hand, renters may not be allowed to modify their homes to facilitate their functioning as they face increasing physical limitations.

naturally occurring retirement community (NORC) A housing development that is not planned or designed for older people but attracts a majority of older residents because it provides a supportive social environment and access to services and facilities that can prolong independent living.

Naturally occurring retirement communities (NORCs) are housing developments that are not planned or designed for older people but that attract a majority of residents age sixty or more. They provide a supportive social environment and access to services and facilities that can prolong independent living among older residents, and they are commonly used by middle-class older adults (Golant, 2011). They are unlike planned older adult housing in that they are not specifically designed for older adults, are age integrated, are often single buildings or small complexes of buildings, and go unnoticed as retirement communities (Hunt & Ross, 1990). NORCs are the most common form of alternative housing for older people in the United States; only 5 percent live in planned retirement communities, and 27 percent live in NORCs (AARP, 1990; Lipman et al., 2012). NORCs develop both by aging in place and by in-migration. These apartments are attractive to both younger and older people because of their location. Younger residents like being close to public transportation, work, and leisure activities, while older residents like being close to grocery stores, drugstores, banks, variety stores, department stores, post offices, doctors' offices, cleaners, libraries, churches and synagogues, and restaurants (Hunt & Ross, 1990). Safety of the neighborhood is of primary importance to both age groups. Older residents also value the proximity of friends and age peers. In fact, all of these characteristics are representative of NORCs that promote

healthy aging (Masotti et al., 2006). Skinner (1992) points out that many older African American and other minority elders end up in inner-city neighborhoods that, although the buildings take on the identity of NORCs because of the density of the aging population, lack the services necessary to support the aging residents. Inner-city aging housing is likely to lack security and protection, convenience shopping, and transportation. This leaves older residents confined to their homes out of fear and frailty. These elders "are not only aging in place, they are stuck in place, prisoners in their own homes, without the ability to move to more appropriate housing" (p. 51). Safe neighborhoods, household modifications, and services and age peers available within walking distance facilitate independent living, but frailty or disability may render them insufficient.

Assisted Living

Assisted living, *or semi-independent living,* refers to some degree of help with daily living that enables older adults to age in place. Assisted living can include informal and formal supports. Informal supports are provided by relatives and friends; formal services include older adult housing, retirement communities, and community services. Informal supports, "the good efforts of their relatives and friends," enable at least three out of five marginally functioning elders to continue to reside in the community (Morris & Morris, 1992, p. 41). Retirement communities provide a range of options—from independent living to twenty-four-hour skilled nursing as the aging individual's needs change. Community services include senior centers, special transportation, Meals-on-Wheels, visiting nurses or health aides, homemaking companions, telephone reassurance, and adult day care. The wide variability in services is aimed to permit people to age in the same place, even if their health status should change. However, few facilities do this well, and the ones that do are often prohibitively expensive for many older adults (Whitbourne & Whitbourne, 2011). Services may be applicable to the needs of the elderly population in general or targeted to the specific needs of a subgroup of that population. The "Working With" interview, for instance, focuses on community services for Holocaust survivors.

assisted living Semi-independent living in which some degree of informal and formal help with daily living enables older adults to continue to live in the community.

Older adult or senior housing is federally subsidized and specially designed to meet the needs of old and disabled adults who are poor and have few other alternatives. Construction is barrier free so that walkers and wheelchairs can navigate easily and provides emergency alarm buttons and architectural features that can enhance functioning. There are common social areas, and residents usually have the opportunity to receive some supportive services, such as meals, transportation, homemaking, and nursing, depending on the facility. Despite the high visibility of older adult housing, however, only 3 to 5 percent of older Americans live in these projects (Kendig, 1990), and need is outpacing supply (Lipman et al., 2012).

Retirement communities are private, age-specific housing alternatives. Older people of means buy into nonprofit continuing care retirement communities before they are in need of care. The cost often amounts to a person or couple's life savings. The benefit is availability of a range of care options from congregate housing to long-term care for life as the individual's needs change. **Congregate housing** provides some communal services, at least a central kitchen and dining room. Amos and Barbara bought membership in a retirement community when both were seventy and in good health. Because they still needed to help their only daughter to manage her own life, they felt it was imperative to plan for their own caregiving. They sold their two homes and moved into an attractive, self-contained apartment in the retirement community. They made the choice to eat breakfasts and lunches in their own kitchen and dinners in the main dining room. If and when either needs more care, the community will provide increasing levels of assistance to long-term care. And if one of them needs institutionalization, this choice will enable them to continue to live together. Private retirement communities serve only a small percentage of older people, but recently have become more popular (Pynoos & Golent, 1996). Lower-SES older adults are more likely to rely on

congregate housing Housing that provides older adults with some communal services such as a central kitchen and dining room.

WORKING WITH Louise Staley, Community Worker

Helping Holocaust Survivors in Late Adulthood

As a caseworker for a private, nonprofit agency, Louise Staley makes home visits to community-living older Holocaust survivors. She assesses their needs, provides counseling, and helps them get the services necessary to age in place. Louise is in her late twenties, holds a bachelor's degree in gerontology, and had several years of social work experience before taking her current job.

Michele: *Who are your clients?*

Louise: They are all Holocaust survivors. The youngest are in their sixties; the oldest is 102. I would say 70 percent are women. All but two of the men are part of a couple in which I mostly work with the wife. My clients don't come to me; I go to them. A hospital or a friend calls the agency to refer the client. After my boss makes the initial call, I am assigned to the case. Then I call the client to introduce myself and set up the first visit.

Michele: *Do the clients pay the agency?*

Louise: No. The agency is funded by the United Jewish Federation, United Way, fund raisers, as well as donations from clients. The agency began in 1936 to help those escaping the Holocaust. When people would arrive in New York, the agency would help them find jobs, apartments, English-language lessons. The help was practical and didn't include a lot of counseling.

Michele: *Are your clients poor?*

Louise: No, the majority of my caseload is not poor, but agency-wide about 60 percent have money and 40 percent do not. Of my fifty cases, about five or six are poor. Before retirement they were homemakers, teachers, dressmakers, janitors, house cleaners. They may not have college education, but they have a decent amount of retirement money. The majority have pensions, some have inheritances, and all have savings. As Holocaust survivors, they are extremely good at saving. The negative part is that it is hard for them to spend when they need help. Even eight dollars an hour for a few hours of housekeeping help seems like a huge amount of money to them.

Hoarding is a big issue with this population because of their horrible experiences with scarcity. Two of my clients always used to meet me in the lobby; they refused to let me into their home. One finally let me in, and it was so cluttered I could barely walk. She saves everything.

Michele: *Are all of your clients Jewish?*

Louise: By birth, yes. Four have decided they are no longer Jewish, though they have not taken on another religion. All talk about how important being Jewish was to them before the Holocaust, but some are angry about their religion. Some are still very religious. Almost all are more trusting of Jews.

the community services discussed earlier as they age in place. Figure 17.3 shows that with increasing age, a greater proportion of older people who live alone use community services, and that use is more prevalent among the poor.

Long-Term Care

long-term care Health care and personal care, such as bathing, shopping, and laundry, usually provided by friends and relatives but sometimes by nursing homes.

The term *long-term care* generally brings to mind nursing homes, which are stereotyped as the final destination of the very old. But **long-term care** is a much broader concept that refers to ongoing assistance to people with chronic illnesses and disabilities in a wide variety of settings. While some long-term care is *health care,* most of it is *personal care* and consists of help with everyday activities such as bathing, getting in and out of bed, using the toilet, grocery shopping, doing laundry and housework, and preparing meals. Most long-term care is provided by relatives and friends in the person's independent household. Only about 6 percent of older people live in institutions, including nursing homes, boarding homes, and psychiatric hospitals, although somewhere between 30 and 50 percent will spend a short time in a nursing home after an early discharge from the hospital (Atchley, 1997; Lipman et al., 2012; Whitbourne & Whitbourne, 2011).

Spouses, adult children, and other relatives are the major providers of personal care, as we have discussed, but paid help is also important. Robyn Stone, Gail Cafferata, and Judith Sangl (1987) found that the average caregiver spent four hours a day, seven days

WORKING WITH Louise Staley, Community Worker

Helping Holocaust Survivors in Late Adulthood *continued*

Michele: *Does it bother them that you aren't Jewish?*

Louise: The first question they asked me is "Are you Jewish?" I tell them no, and then I work hard to win their trust. With two, I don't think I have succeeded yet. They let me come, but we haven't made significant progress. As Holocaust survivors, trust is a major issue, and many are understandably angry. This combination can be challenging to work with.

Michele: *How is working with Holocaust survivors different from working with other older clients?*

Louise: The circumstances of their lives are very different from the rest of the older adult population. They had a life-altering experience. They suffered major loss—something, someone, most likely a combination. Therefore, when they are looking toward their own death, they are also revisiting a death scenario they have been trying not to remember for fifty years. As a group, they dealt with their losses by denial—not thinking about them at all. This denial has been going on for fifty years. As clients they do not take well to counseling. Perhaps if they had had counseling when they first suffered their losses, it would have been different.

To a Holocaust survivor, the idea of going to a place like a nursing home feels like being sent to the camp again. About twenty of my clients are camp survivors. Others had to leave their home and country and lost family members. The 102-year-old got out of Germany in her forties. She took a housekeeping job in England early enough to get her furniture out, too. But her family wouldn't budge, and she left them behind and feels guilty about that. She left everyone but one niece.

Michele: *What services does your agency provide?*

Louise: We try to help these survivors in a variety of ways. We identify services they need and help counsel them to accept them. During the winter we run what we call Kaffeehaus once a month, where they can come and socialize. We provide entertainment, coffee, tea, and Jewish cookies. We also have Passover seders and Hanukkah parties, so they will be able to celebrate Jewish holidays even if they are living alone.

What Do You Think?

1. What role does religion play in the lives of these now older adult Holocaust survivors? In what ways is it positive? In what ways is it negative?
2. Why are formal caregiving services particularly important for this older adult population? Why is enabling them to age in place critical?

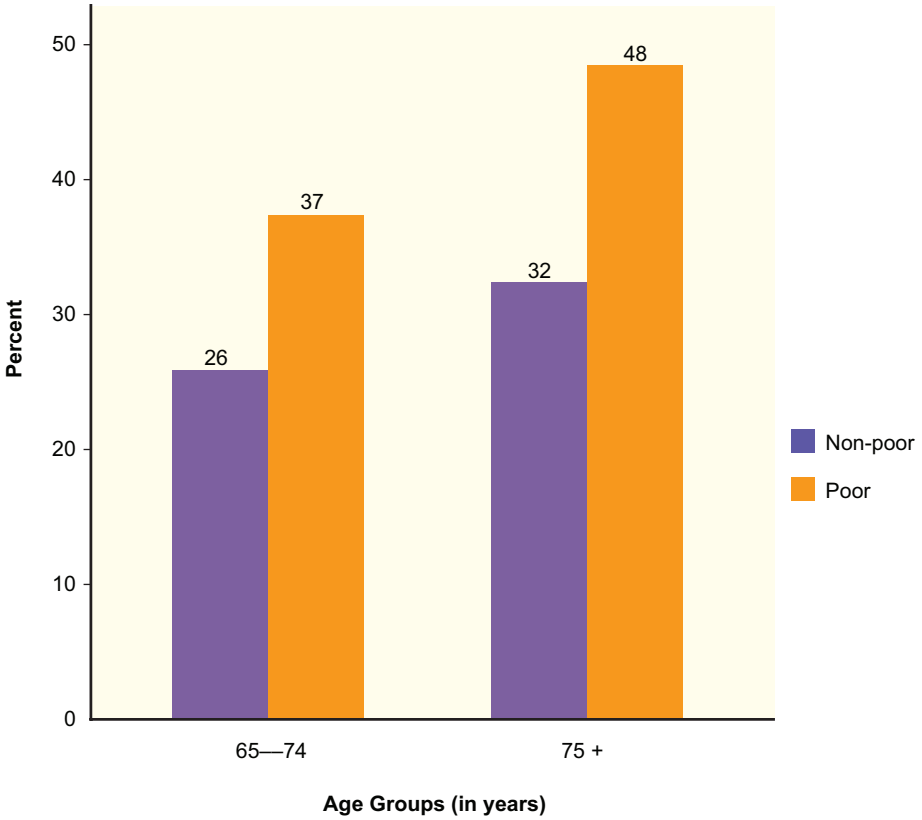
a week providing care for an aging relative. Many families combine informal caregiving with some formal services to enable the family to meet the heavy burden of providing personal care. Paid help seems to work best when it is supervised by family, because the people who need the care are vulnerable to abuse and exploitation by strangers. Late-life African Americans who experience functional declines are less likely to be institutionalized and more likely to rely on coresidence and informal caregiving than are whites (Gallant, Spitze, & Grove, 2010; Skinner, 1992). This is a joint result of the availability of social support systems in the African American community as well as poverty. Nursing homes are expensive, and those that participate in Medicaid often have long waiting lists. In addition, African American older parents value and expect more assistance from their children than do whites (Gallant, et al., 2010; Lee et al., 1998).

Adult day care, another formal service that can supplement family caregiving, can be especially helpful for people with Alzheimer's disease or other neurocognitive disorders, but care must be taken to ensure that *quality* care is provided (Zarit & Reamy, 2013). It is a community-based group program designed to meet the needs of adults with functional impairments. Within a safe, supervised environment, staff provide a comprehensive program of physical, social, cognitive, and functional activities to maximize remaining strengths and minimize deficits. Individuals participate on a planned basis, during specified hours, two to five days a week. This provides some relief and support to caregivers and enables them to continue car-

FIGURE 17.3
Proportion of People Age 65 and Older Who Live Alone and Use Community Services, by Age Group and Poverty Status, 1990

Older people who cannot afford private services are more likely to use community services.

Source: U.S. Senate Special Committee on Aging (1991).



ing for the impaired family member at home. Staff members also acquaint the caregivers with other community resources and provide them with emotional support (Engstrom et al., 1993).

Control over Living Conditions

It is not always possible for people to age in place. Their losses of function may be too great, or the dwelling may become inappropriate to their needs for safety and maneuverability. When they move, whether to the home of a family member or to group housing, the strong preference is for some space that they personally control. In a study of life satisfaction in a variety of older adult housing situations, Robert Vallerand, Brian O'Connor, and Marc Blais (1989) found that French-speaking Canadian residents of "high self-determination" nursing homes had levels of satisfaction comparable to those

The formal support of home health care enables this older couple to live semi-independently. Assisted living often includes informal help from family and friends, as well as formal services.

Source: Rob Marmion/ Shutterstock.com.

of community-dwelling older adults and significantly higher than those of residents of "low self-determination" nursing homes. Table 17.4 presents the five criteria they used for self-determination. More recent research using the same model has demonstrated that when nursing home residents feel in control of their living conditions, they were much more likely to experience improvements in measures of depression, life satisfaction, and self-esteem over the following year (Philippe & Vallerand, 2008).

In a review of the literature, Judith Rodin (1986) found negative effects on the health of older people when personal control of their activities is restricted. For example, being forced to move has been associated with adverse health outcomes among older adults, such as more hospitalizations and nursing home admissions, greater incidence of stroke and angina pectoris, and poorer self-health assessment. When the older people were exposed to any control-enhancing experimental manipulation, such as choice of when or where to move or about aspects of their new living arrangements, little decline in health and psychological status was found.

Studies designed to encourage self-reliance among older adults in institutions such as convalescent and nursing homes showed that increasing responsibility among older adult residents led to increased alertness, more activity, and reports of feeling happier, in contrast to those who were encouraged to believe the staff would tend to their needs (Rodin, 1986). Enhanced control has also led to improvements in memory, satisfaction, and physical health in some studies. Rodin points out, however, that although "the strength of the relation between control and health increases with aging . . . there is more variability in perception and desire for control with advancing age, presumably because of the accumulation of different life experiences" (p. 1271). This means that most older people respond positively to the opportunities for control, but others prefer not to be responsible.

Choice, then, becomes one of the most important aspects of the housing continuum. It is wise for older people and their families to consider options and make housing choices in advance of health crises; yet a recent survey revealed that more than half of older people have done little or no planning for their future housing needs (AARP, 2012). This lack of planning is likely because 41 percent of mid- and late-life adults think they will maintain good health, 31 percent do not foresee any difficulty navigating their home during late life, and 35 percent believe that they will always be capable of driving (AARP, 2012). Looking into the possibilities for home remodeling or relocation to prolong independent living is best done in advance, as is learning about the opportunities for congregate housing in the geographic region most convenient to family and friends. As we have seen, Tom and Frances and Amos and Barbara made different choices at the same stage of life, but both couples chose before they experienced a crisis. Even when long-term care requires institutionalization, a nursing home should be chosen carefully, with an attempt to match the individual's need for control to the level of control available. While more than half of people over sixty-five will spend some time in a nursing home, it is not the

TABLE 17.4 Criteria for Self-Determination in Nursing Homes

Residents of "high self-determination" nursing homes had levels of satisfaction comparable to those of community-dwelling older adults and significantly higher than those of residents of "low self-determination" nursing homes.

1. How much choice do residents have regarding mealtimes?
2. To what extent is the nursing home staff responsible for residents' personal care?
3. How free are residents to decorate and arrange the furniture in their rooms?
4. Are the residents allowed to have or care for a pet?
5. To what degree does the staff encourage or discourage personal initiative?

Source: Based on Vallerand et al. (1989).

What Do You Think?

Consider one of your relatives who is in late adulthood. How suitable are his or her housing arrangements for aging in place? Consider the available housing alternatives. Role-play with a classmate how you might discuss the pros and cons of each alternative with your relative.

end of meaningful and enjoyable life. This becomes exquisitely clear in Tracy Kidder's (1993) description of the friendship and daily lives of two old men who met and became roommates in a nursing home. The nursing home Kidder studied has two levels of residency providing more or less control based on the resident's level of functioning. Despite increasing frailty, older adults continue to have interests that extend beyond their aging bodies. Even for individuals with neurocognitive disorders, a client-centered approach provides age-appropriate activities rather than treating them like children, promotes use of the cognitive abilities that remain intact, and encourages day-to-day decision making about clothing, food, and activities (Hofland, 1994; Zarit & Reamy, 2013). (See the "Working With" interview in Chapter 16 on page 604.)

Interests and Activities

We saw earlier in this chapter that many older adults continue to work, although most retire from their career jobs or reduce their hours if they are self-employed, especially after age seventy. How do they spend the hours freed from the constraints of employment? The answer depends to a large extent on the socioeconomic standing of the aging person. Those who have enjoyed high levels of education, occupational status, and income are likely to be in good health and to have resources that provide many options for activities, whereas those who have had low levels of education, occupation, and income likely have health limitations and fewer resources in their later years. Health acts as a threshold for leisure, and financial security plays a critical role in supporting various activities (Adams, Leibbrandt, & Moon, 2011; Cutler & Hendricks, 1990; Dorfman, 2013). Being in poor health and limiting social leisure pursuits is linked to low levels of subjective well-being (Simone & Haas, 2013). Poverty is a barrier to involvement in community activities, especially among people who formerly were middle class (Kelly, 1993). For low-income or ethnic/racial minority older adults who have never had secure regular employment, increased leisure may not be part of late adulthood because they need to continue earning.

Other factors influence the use of leisure time in late adulthood as well. Educational attainment and occupation influence the preference for activities. Although some individuals learn to dance or draw in late adulthood, there is evidence that developing **activity competence**, the skills and knowledge needed to take advantage of opportunities for activities, generally is established in earlier adult years. Those who are better educated therefore are better prepared to feel competent engaging in a variety of activities. Individuals with spouse, family, or friends tend to be more active in communal activities than those who are alone. Using an eight-year longitudinal method to study older adults (average age seventy-two at the start of the study), Frances Carp (1978/1979) found that type of living arrangement affected leisure activity patterns. People who moved to retirement communities or other congregate housing increased their activity levels, whereas those who remained in the community decreased their activity levels. Obviously self-selection was a factor: those who selected living situations with extensive activity programs must have desired such activities. As we saw in Chapter 15, gender affects choice of leisure activities: women are more likely to choose passive, social, and expressive activities, whereas men tend to choose active and less expressive activities and to join more organizations (Cutler & Hendricks, 1990). As a result of these many factors, the leisure pursuits of older people vary greatly.

activity competence
The skills and knowledge necessary to take advantage of opportunities for leisure activities. Because it is generally established during earlier adult years, older adults who are better educated are more prepared to feel competent engaging in a variety of activities.

Past patterns of activity shape the way older adults use their time. When they retire, for example, most people continue to do the same activities they did before retirement, but at a different pace, in line with selection and optimization with compensation theory, discussed earlier in this chapter (Baltes & Baltes, 1990; Kelly, 1993). Activity patterns of middle age tend to persist into late adulthood, but gradually, as people become frail, the activity becomes constricted, which can have an impact on perceived well-being (Simone & Haas, 2013). In his nineties, Marcellus was tending a yard instead of a farm. Because of his interest in inventing things, he was able to continue tending the yard despite his frailty. Another old man might have eventually restricted his gardening even more—to tending flower boxes, for example. We discussed in Chapter 15 how older adults continue to work. Much of this chapter has indicated how their involvement with family continues. Here we examine older adults' involvement in community organizations, religion and spirituality, and the more solitary activity of contemplation.

Community Involvement

Community organizations include political parties, labor unions, veterans' groups, fraternal organizations, community service groups, professional organizations, religious institutions, parent-teacher organizations, neighborhood associations, and many other groups designed to achieve a purpose or pursue some shared interest. Midlife engagement in activities in which cognitive stimulation occurs has been linked to subsequent cognitive benefits up to twenty years later (Kareholt et al., 2011). People show considerable stability in their general levels of participation in community organizations from middle age until their sixties, when involvement gradually decreases (Cutler & Hendricks, 1990). Poor health, inadequate income, and problems with transportation all contribute to decreases in participation (Atchley, 1997). While membership in community organizations has been associated with well-being, it is impossible to separate the fact that members tend to have higher levels of health, income, and education—all of which are linked to well-being—than do nonmembers.

Volunteerism

Efforts have been made to involve older adults as volunteers to provide services for the community, enable older adults to pass on their knowledge to younger people, and provide the volunteers with meaningful activity (Chambré, 1993). The Foster Grandparent Program, Retired Senior Volunteer Program (RSVP), and Service Corps of Retired Executives (SCORE) are just three organizations formed especially for seniors. Volunteerism provides a continuing link with the community, as well as ways to substitute similar activities for the reduced work and family roles of later life (Chambré, 1993). Volunteerism is linked to higher quality of life, increased ratings of mental and physical health and well-being (McDonald et al., 2013), as well as with reduced mortality risk (Oun, Yeung, & Brown, 2013). According to the Administration on Aging, rates of volunteerism among older adults have been on the rise for the last several decades, and as of 2009, nearly 24 percent volunteer in some capacity. Looking only at formal organizations, however, greatly underestimates the amount of volunteering that older adults actually do because it does not include informal helping within the family and community.

If we broaden the definition of *volunteerism* to include providing informal service, almost all retired adults do volunteer work. In a study of retired Minnesota workers, Lucy Fischer, Daniel Mueller, and Philip Cooper (1991) found that nearly 60 percent of the older adults provided help for their families, most by caring for grandchildren. In fact, about 30 percent of preschool children with working mothers were cared for by their grandparents (U.S. Census Bureau, 2008). More than 40 percent provided help to their neighbors, usually in the form of transportation or visiting. In addition, 53 percent were doing organized volunteer work, mostly through their religious institutions. On average, these Minnesota adults were spending fourteen hours a month doing voluntary service. If

we added caregiving to family members within the home, the percentages would likely be even higher. More recent research has demonstrated similar findings: women are likely to visit sick friends, help with housekeeping, and prepare meals for friends and neighbors, while men are likely to be running errands and driving friends and neighbors (Martinez et al., 2011). In a study of the help and support that older women provide to kin and friends, Sally Gallagher and Naomi Gerstel (1993) found that 96 percent of married women and 92 percent of widows had provided some type of help to at least one relative or friend in the previous month.

Older volunteers face some problems. First, talented older people sometimes find themselves assigned to menial work that is beneath their knowledge, experience, and dignity. This makes them feel undervalued. Second, volunteers are sometimes placed in positions without sufficient training. This puts them in the unfortunate position of feeling tested rather than feeling prepared and welcomed. Third, many older volunteers need additional income and would prefer paid part-time work. This has led the National Council of Senior Citizens to object to any program that recruits older people to do on a volunteer basis work for which younger people are paid. Fourth, people who are retired may be unwilling to commit to a rigid volunteer schedule that would limit their freedom to travel. Organizations need to find ways to encourage short-term contributions, such as to one-time events or recurring events. Fifth, transportation often is a problem for older volunteers. If it were provided, older adults who no longer feel comfortable driving would be able to volunteer their services.

Continuing Education

Another kind of community involvement is through Elderhostel programs. Begun in 1975, Elderhostel is a nationwide program in continuing higher education. It offers one-week summer programs that include a campus dorm room, cafeteria meals, college-level courses, and extracurricular activities at low cost. Participants are not expected to have prior knowledge of the subject matter and receive no grades. Elderhostel now has nearly two thousand educational sites in the United States, Canada, and 150 countries worldwide (Elderhostel, n.d.; Goggin, 1992). It has grown to include service programs, in which hostelers provide volunteer service to worthy causes around the world; performance programs, such as choral, instrumental, dance, and theater; and intergenerational programs that bring together hostelers and people under age twenty-five.

Michael Brady (1984) sampled 560 Elderhostel participants in twenty New England programs and found that the typical participant was sixty-eight years old, retired, married, and well educated. Only 12 percent had high school education or below, while 42 percent of the men and 24 percent of the women had graduate or professional degrees. More of the participants were women (67 percent) than men (33 percent), and more of the women (37 percent) than the men (9 percent) were widowed. Brady's participants completed two scales that measured their perceived academic benefit. Those persons with lower levels of education and lower annual incomes reported receiving more benefits from the Elderhostel programs than the more privileged participants. This may be because they were attending college for the first time and therefore derived more benefits from the noncognitive elements of college life, they actually learned more from the courses, or they were more willing to report having benefited. Huey Long and Dawn Zoller-Hodges (1995) found that Elderhostel programs had desirable personal and social outcomes for participants. The educational researchers assessed knowledge, attitudes, and behaviors following five Elderhostel programs. Participants grew in many ways, including cultural appreciation, self-appreciation, historical appreciation, social contact, travel, content learning, and general learning.

Lifelong learning takes place in many different settings. Many senior centers, community centers, and libraries offer topical or skill-based classes to older adults (Dorfman, 2013). Religious institutions often have classes to study their faith's literature as well (Merriam &

Houses of worship have been shown to be a very important institution for many older adults, and many note their religious faith as their most significant source of psychological support.
Source: bikeriderlondon/Shutterstock.com.

Kee, 2014). Additionally, many older adults take advantage of courses offered at local colleges and universities, all of which have been linked to maintenance of cognitive abilities, as well as well-being, for themselves and their communities (Merriam & Kee, 2014).

Religion and Spirituality

Churches or synagogues are the organizations to which older people most frequently belong. Membership in religious organizations is higher at older ages, especially after age seventy-five (Atchley, 1997; Hill, Burdette, & Idler, 2011). Church and synagogue attendance and membership in church-affiliated groups and fraternal organizations, as well as leadership positions in these organizations, all reflect greater involvement of people over age sixty-five than under (Koenig, 1995). As the "A Multicultural View" feature indicates, men often need more help than women to adjust to the loss of their spouses, and religious institutions provide support for widowers who are active members.

When attending formal services becomes too difficult as a result of declining health, disability, transportation problems, or relocation, many older adults compensate by increasing religious practices at home, such as reading the religious texts, listening to religious broadcasts, praying, or studying religion (Ainlay & Smith, 1984; Hill et al., 2011). Older people continue to feel an emotional attachment to the religious institution where they had been involved even when they have relocated and that institution is many miles away or when they are homebound and can no longer participate (Payne & McFadden, 1994). Involvement in religion has been linked to better mental health, physical health, and lower mortality risk (Hill et al., 2011). It seems that this relation between religious involvement and these benefits can be explained by the increased social support and the better health behaviors promoted by most religious institutions (Hill et al., 2011).

The Social Support of Religious Institutions

Religious institutions form an important source of social support among racial/ethnic minorities. For older Hispanics, the Catholic church has been shown to be the most important social institution in their communities, and their religious faith has been called their most significant source of psychological support (Gallant, Spitze, & Grove, 2010; Maldonado, 1995). Older African Americans look to their churches for both formal and informal support (Gallant et al., 2010; McFadden, 1996). Some African American churches create spiritual families and assign kin terms to their members, fostering

A Multicultural View

Men and Grief

Grief is a natural and universal reaction to loss, but in the United States males and females express it differently. Although ethnicity and social class contribute to norms regarding the expression of grief, in our society gender has a large impact as well (Lister, 1991). In their study of 434 adult African Americans, Japanese Americans, Mexican Americans, and white Americans, Richard Kalish and David Reynolds (1981) found that men more often than women reported that they "never" thought of their own deaths, they would fight rather than accept their own deaths, they would try very hard to control their grief-related emotions in public, and grief should last three months or less. Men, especially Japanese American men, had attended more funerals than women in the prior year. Mexican American men were more accepting of crying than were other men.

Men fare less well than women when their spouses die (Piazza & Charles, 2012). In a study of 350 widowed adults, Stephen Shuchter and Sidney Zisook (1993) found that compared to women, men showed less acceptance of the deaths of their spouses, became involved in romantic relationships sooner, expressed themselves less, and drank more, findings confirmed with meta-analyses (Stroebe, Schut, & Stroebe, 2007). Women felt a greater degree of helplessness and tended more to experience their dead spouses in a protective role. A greater proportion of women had an overall "good" or "excellent" adjustment to widowhood. While widows are at a somewhat higher risk for mortality than married women, widowers have an excessive mortality rate compared to married men and a rate typically higher than that of widows (M. S. Stroebe & Stroebe, 1993). In a study of older newly widowed men and women, Delores Gallagher-Thompson and her colleagues (1993) found that bereaved males faced a substantially higher risk of death, particularly within the first year of bereavement. Widowers also suffer greater health impairment compared to married men than widows compared to married women (W. Stroebe & Stroebe, 1993).

Why do men adjust so relatively poorly after losing their spouses? Two explanations have been advanced. First, gender differences in adjustment, health, and mortality after widowhood have been attributed to the greater availability of social support to women than to men. Men are more likely to depend on their spouses for emotional support, nurturance, and connections to other social relationships with family and friends so that the loss of a partner results in a decrease of social supports for widowers but not for widows. Men have a difficult time assuming the kinkeeping and other social roles their wives have handled (Piazza & Charles, 2012). Camille Wortman and her colleagues (1993) found that widowhood was associated with significantly more strained relationships, particularly with children, for men but not for women. Loneliness and lack of social support are major problems in adapta-

the development of fictive kin. "Church mothers" are available as lay therapists and confidants to members of the church who have problems (Johnson & Barer, 1990).

Spirituality and Faith

Spiritual development appears to be age related but not age determined. Among members of more than five hundred Protestant congregations, individuals judged to have *mature faith* were likely to be older (Benson & Elkin, 1990). Mature faith is the final stage of James Fowler's (1991) faith-knowing system of growth and development of the spiritual domain (we discussed the development of faith in Chapter 12; see Table 12.5). The growth of faith, according to Fowler, is a universal process that is not necessarily religious in orientation; rather, it is an integral aspect of daily life that "serves to organize the totality of our lives and gives rise to our most comprehensive frames of meaning" (Fowler, 1986). Peter Benson and Carolyn Elkin (1990) conclude that "Maturity of faith is strongly linked to age, increasing with each successive decade, and is most likely to be found among those over 70" (p. 3).

Contemplation

reminiscence Recall of past experiences and events that occurs among people of all ages and promotes spiritual integration during late life.

Some of the activities that promote spiritual integration are solitary ones. Robert Butler (1975) has suggested that contemplation is a valuable use of time in late adulthood. Reminiscence and life review are two contemplative processes that are thought to serve special functions in late life. **Reminiscence** is the recall of past experiences and

A Multicultural View

Men and Grief *continued*

tion to loss (Lopata, 1993). Widowed men who were active in church or synagogue were less depressed than those without this social connection, which reflects the importance of religious institutions in providing older adults with emotional as well as spiritual comfort. (Siegel & Kuykendall, 1990).

Second, although men experience loss and grief, in American society their expression of grief is not always apparent. Bereaved individuals who are communicative with others about their thoughts and feelings are more likely to have a positive adjustment (Lund et al., 1993). Men are likely to report fewer symptoms and less affective distress than are women when their spouses die. Perhaps because of this, though widows have higher depression scores one year after the death of their spouses, widowers have higher depression scores two to four years later (Sanders, 1993). Women often respond more dramatically than men to the death of a child as well (Rubin, 1993).

Although grief is expected of men following the death of a spouse or child, this is mediated by the cultural message that men should be stoic and controlled. Male socialization includes a sanction against the expression of feelings as well as an ideal of independent action (Lister, 1991). Taken together, these proscriptions on male behavior prepare men poorly for expressing grief. As a result, men tend to be instrumental, to "do something" after a death, rather than allow themselves to feel. Men tend to return to their usual activities sooner than women. Women are more likely to turn their feelings into social actions that do not deny the feelings, such as Mothers Against Drunk Driving and the movement to develop resources for AIDS babies and children. Men are also less likely to seek assistance, whereas women more often will turn to relatives, friends, or professionals for help with their grief. Men are much less interactional about their feelings and more likely to deny them or drown them in drink or drugs (Stroebe et al., 2007). However, it is important to note that different people grieve differently. Bonanno and colleagues described five separate patterns of grief in the 1.5 years following the loss of a spouse, demonstrating that there is no "right" way to grieve and that others should be mindful of this when interacting and possibly judging the bereaved (Bonanno et al., 2002).

While individual men do express their grief and it is possible to imagine a culture in which men would be encouraged to do so, we have not found such a culture to describe. Perhaps some cultures exist and have not been studied, but the literature overwhelmingly indicates that men are encouraged to act and discouraged to express feelings. In anthropological studies of death rituals in diverse societies, "men say it is the women who feel the death most and it is they who do most of the crying and wailing" (Woodburn, 1982, p. 189), and "it is women who take on mourning for death" (Bloch, 1982, p. 215).

events, and occurs among people of all ages. Through it, individuals introspectively define themselves (Parker, 1995). Reminiscence has been associated with measures of life satisfaction and sense of well-being. Utilizing the Uses of Reminiscence scale shown in Table 17.5, Sharan Merriam (1993) compared African American and white men and women in their sixties, eighties, and one hundreds. She found no age differences in the uses of reminiscence among these three groups of older adults. She did find significant race and gender differences, though. African Americans more than whites used reminiscence to teach others about the past, lift their spirits, understand themselves better, tell of their accomplishments, combat loneliness, help them to accept changes in their lives, understand what life is all about, put their lives in order, and deal with knowing that life is finite. Men more than women used reminiscence to teach others about the past, tell of their accomplishments, make future plans, deal with a present problem, put their lives in order, cope with knowing that life is finite, and deal with unpleasant or troublesome memories. Those who reminisced more were less depressed and coped with health problems more effectively. Moreover, focused reminiscence on problem solving has been linked to decreased symptoms of anxiety, and focusing reminiscence away from bitterness can alleviate depressive symptoms among older adults (Korte et al., 2011).

Life review, according to Robert Butler (1975), is a universal inner experience of older people "characterized by the progressive return to consciousness of past experiences, in particular the resurgence of unresolved conflicts which can now be surveyed

life review A universal inner experience of older people that helps them evaluate their lives, resolve remaining conflicts, and make decisions about material and emotional legacies, according to Robert Butler. Life review promotes the resolution of Erikson's conflict of *integrity versus despair.*

TABLE 17.5 Uses of Reminiscence Scale

Reminiscence, the recall of past experiences and events, occurs among people of all ages and has been associated with measures of life satisfaction and sense of well-being.

People think about or talk about their past for many different reasons. Do you think about or talk about your past in order to:

	Never				Very Often
Relive a pleasant experience	1	2	3	4	5
Teach others about the past	1	2	3	4	5
Lift your spirits	1	2	3	4	5
Get relief from boredom	1	2	3	4	5
Entertain others	1	2	3	4	5
Understand yourself better	1	2	3	4	5
Cope with a loss	1	2	3	4	5
Tell of your accomplishments	1	2	3	4	5
Make future plans	1	2	3	4	5
Get over feeling lonesome	1	2	3	4	5
Help accept changes in your life	1	2	3	4	5
Understand what life is all about	1	2	3	4	5
Deal with a present problem	1	2	3	4	5
Put your life in order	1	2	3	4	5
Deal with knowing your life is finite	1	2	3	4	5
Help you to relax	1	2	3	4	5
Deal with unpleasant or troublesome memories	1	2	3	4	5

Source: Adapted from Merriam (1993).

and reintegrated" (p. 412). This evaluative process, an aspect of Erikson's developmental stage of integrity versus despair, enables old people to take stock of themselves and decide what they will do with the rest of their lives. It enables them to find new significance and meaning in their lives and to prepare for death. This preparation often includes decisions about the material and emotional legacies they wish to leave to others. Life review can lead to family reconciliation, which, as we saw in Chapter 15, may enable adult siblings to become friends as they arrange for care of aging parents. Life review may make the experience of social isolation one of pleasant solitude rather than loneliness.

Looking Back/Looking Forward

Let us look back once again to our lifespan themes presented in Chapter 1 and see how they apply to late adulthood. Because problems of living are most frequent among adults in their later years, we will use this topic as a focus as we revisit our themes.

What Do You Think?

For one week, keep a list of your daily contacts with people who are in late adulthood. You will probably have only limited contact if you are rarely off campus, but pair up with someone who commutes to broaden the possibilities. Where do you see older adults? What are they doing? What does your list reveal about their activities and interests? Do you recognize any ageist thoughts or behaviors you experienced?

- **Continuity within change**——Most people wish to age in place, preferring to continue living in their familiar homes and communities. A variety of factors, however, may make that difficult. Communities change and may no longer be safe. Functional disabilities, such as no longer being able to drive, may make the same community less desirable because it lacks adequate public transportation. An aging house may require too much work and money to keep up. The death of one's partner may make caring for a house alone too difficult or too expensive.

  Even before any of these changes occur, aging people sometimes look ahead to the prospect of frailty and needing care and decide to choose better locations for their later years. If they own a home that they can sell and have retirement funds, the options for housing located near adult children, in retirement communities, or in warmer climates may attract them. They exhibit continuity in wanting to extend as long as possible their years of independent living and satisfactory quality of life. They change by recognizing new circumstances and making new choices.

- **Lifelong growth**—Whether choosing to stay in place and modify the current residence, choosing a new one that better meets current needs, or moving to older adult housing or an adult child's home as the result of some unexpected change in fortune, older individuals and couples typically find opportunities for growth. Although not everyone adjusts easily, research amply demonstrates that older men and women are resilient in the fact of retirement, widowhood, and physical changes. If the new location enables more social participation, interaction with children and grandchildren, and access to libraries, museums, and elderhostels, it may well be cognitively stimulating and lead to the positive brain changes that come from environmental enrichment. Even quiet contemplation often produces growth in understanding, appreciation, and compassion.

- **Changing meanings and vantage points**—The social convoy of relationships established during infancy and maintained throughout the lifespan contributes to the quality of life in late adulthood. One motivation for aging in place is to stay close to friends and neighbors who have enriched daily life. But as friends age and die, the ties with adult children and grandchildren often take on new meanings. Aging parents move closer to the homes of their adult children and depend on them more for emotional and practical assistance. Both older parents and adult children must learn how to make this transition with mutual respect. We saw that parents who adopted an authoritative style and established patterns of listening to their children and to their children's opinions with caring concern and respect but without hierarchical pressure had better communication and relations with them when the children reached adolescence and early adulthood. The benefits of authoritative parenting continue well into late adulthood when the pattern of help flowing from parent to child needs to be reversed. The meaning of parenthood changes as parent and child reach different stages of development.

  Similar factors come into play between aging partners. A relationship started in early adulthood will need to undergo changes by the time it reaches late adulthood. As retirement changes daily life and as illness or disability alters what each partner can

do, having a sharing, nonhierarchical relationship can make the transitions easier. It can also better prepare both partners for the possibility of widowhood, when the other will no longer be there to do gender-stereotyped tasks.

- **Developmental diversity**—Whether and when people become frail varies dramatically, which influences their ability to continue to live independently and age in place. Genetic makeup, social and economic circumstances, and lifelong health behaviors contribute to some people being active and spry in their very late adulthood while other people die or become disabled or disoriented much earlier. Late adulthood depends for its quality on all that has come before. Yet everyone lucky enough to live to be very old will face reduced sensory acuity and increasing frailty.

  Gender matters in more pronounced ways during late adulthood than at other stages of adulthood. Women and men have different patterns of morbidity and mortality. In addition, currently older people had different work patterns, which have resulted in different economic circumstances in retirement. Most men have more pension provisions and more social security benefits because they have been the wage earners. Ever-single older women are more likely than married ones to have adequate pensions and social security because they have had work patterns most similar to men of their cohort. Because women live longer and have fewer economic resources, more women live to be very old and very poor. Housing choices are fewer for women without financial resources, and more of them end up in nursing homes. More women experience the death of their spouse and are alone when they look ahead and prepare for death, the final stage of life.

Chapter Summary

- **What is ageism?** Ageism is the stereotyping of and discrimination against people because they are aging or old, and is a part of contemporary American culture.
- **What is successful aging, and what contributes to it?** *Successful aging* refers to the maintenance of psychological adjustment and well-being across the full lifespan. It requires psychological resilience in the face of age-related stress. Longitudinal studies such as the Harvard Grant and Berkeley Older Generation studies show considerable evidence for continuity of psychological adjustment into late adulthood, as well as increased agreeableness and acceptance of the past as "something that had to be." These findings provide support for Erikson's eighth stage of life, integrity versus despair. Neither activity theory nor disengagement theory can account for successful aging. While remaining active has been associated with high life satisfaction, successfully aging individuals exhibit a range of activity levels based on their life experiences and personalities.
- **What factors influence how retirees adjust to their new life circumstances?** Retirement is not simply a work/stop-work decision; many individuals follow nontraditional retirement patterns. Health status and financial security affect satisfaction with retirement.
- **How does marital status affect well-being in late adulthood?** Older married people appear to be happier, be healthier, and live longer than widowed and divorced people of the same age. They rely on their spouses to provide care when coping with disease or frailty. Wives are spousal caregivers more often than husbands. They also tend to provide more hours of care, get less outside assistance, and experience considerable stress as a result. Widowhood causes a disruption to self-identity and relationships with others, but does not appear to have negative impacts on subsequent health, ability to function, or well-being.
  Socially active unmarried older adults are more likely to meet potential dating partners. Successful remarriage is more likely when there has been a long prior friendship and the couple has social and financial resources. Older lesbian and gay couples have satisfactions in their relationships similar to those of heterosexual couples and concerns similar to those of most aging adults. They have additional concerns about discrimination in health care, housing, and long-term care because of their sexual preference. Ever-single adults learn to cope with aloneness and to be autonomous and self-reliant, qualities that facilitate successful aging. They develop a rich variety of supportive relationships.
- **Which relationships are significant in late life, and in what ways?** Starting in infancy, individuals develop social convoys of stable and continuous relationships that develop and change over time. The most important relationships are with spouses, parents, and children. Outside of this inner circle, siblings provide the strongest bond. They offer emotional support, share memories, and sometimes provide instrumental

support as well. Adult grandchildren continue their bonds with their grandparents. They tend to be closer to grandmothers than to grandfathers and closer to grandparents they knew well as children. Interaction with friends in later life is more important to well-being and more subject to variation than relationships with kin. Fictive kin are constructed relationships that blur the distinction between friends and family. They appear particularly important in the lives of ever-single adults and in the African American community. Childless older adults develop ties with friends and other relatives who provide them with a social network that sustains their well-being.

- **Why is choice in housing critical in old age?** Older adults generally prefer to age in place. This is generally easier for homeowners than renters, but in either case disease or frailty may require modification of the old home or a new housing alternative. *Independent living* refers to maintaining a household with little assistance. Older adults often choose naturally occurring retirement communities (NORCs), which provide a supportive social environment that can prolong independent living. Assisted living can occur in one's own home, in a retirement community, or in older adult housing. Informal services of relatives and friends, formal services, or a combination of both can provide assistance with activities of daily living that enable semi-independence. Long-term care can also be found in a variety of settings, such as a relative's home, a retirement community, or a nursing home. The level of self-determination in these settings is related to levels of satisfaction of the residents.
- **How do the interests and activities of late life show both continuity and change?** Though formal volunteering among the older is rather low, most older adults do volunteer when informal work is also considered. Membership in religious institutions is higher at older ages and declines more slowly than other community memberships. This is probably due to cohort effects, as well as to increased spirituality in late life. Reminiscence and life review are two contemplative activities that are associated with better adjustment among old adults.

Key Terms

activity competence (p. 642)
activity theory (p. 614)
ageism (p. 610)
assisted living (p. 637)
congregate housing (p. 637)
disengagement theory (p. 614)
fictive kin (p. 633)
integrity versus despair (p. 613)
life review (p. 647)
long-term care (p. 638)
naturally occurring retirement community (NORC) (p. 636)
reminiscence (p. 646)
social convoy (p. 628)
successful aging (p. 610)